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Appropriate Bargaining Units in Health Care Institutions: An Analysis of Congressional Intent and Its Implementation by the National Labor Relations Board

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APPROPRIATE BARGAINING UNITS IN HEALTH CARE INSTITUTIONS: AN ANALYSIS OF CONGRESSIONAL INTENT AND ITS IMPLEMENTATION BY THE NATIONAL LABOR RELATIONS BOARD

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INTRODUCTION

The 1974 amendments[1] to the National Labor Relations Act[2] extended that Act's coverage to all private health care institutions, including the non-

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[1] Act of July 26, 1974, Pub. L. No. 93-360, 88 Stat. 395, amending 29 U.S.C. §§ 151-68 (1973).

[2] 29 U.S.C. §§ 151-68 (1976). The original Act, commonly referred to as the Wagner Act, was enacted in 1935. 49 Stat. 449. Prior to the 1974 amendments, the Act had been significantly amended by the Labor Management Relations Act of 1947, or Taft-Hartley Act, tit. 1, ch. 120, 61 Stat. 136, 29 U.S.C. §§ 141-67, 171-97 (1971), and by the Labor Management Reporting and Disclosure Act of 1959, or Landrum Griffin Act, Pub. L. No. 86-257, 73 Stat. 519, 29 U.S.C. §§ 401-503 (1971). One of the 1974

profit hospitals which previously had been specifically excluded from the Act.[3] Health care institutions constitute a unique and complex industry, employing at the time of the amendments' passage nearly one and one-half million[4] variously skilled and heretofore largely unorganized persons.[5] Congress, aware of the considerable task with which the National Labor Relations Board would be confronted in determining appropriate bargaining units for the industry,[6] expressed its intention that the Board give due consideration to the prevention of a "proliferation" of collective bargaining units in health care institutions.[7] Since the passage of the amendments, a substantial controversy has arisen over the manner in which the congressional concern with "proliferation" should be treated.[8] While a majority of the Board has been willing to find as many as nine separate units to be appropriate,[9] one

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amendments. Section 213, is an addition to the Labor Management Relations Act (29 U.S.C. § 183 (Supp. 1979)).

[3] Discussions of the legislative and judicial histories of non-profit hospitals and the National Labor Relations Act may be found at SUBCOMM. ON LABOR, SENATE COMM. ON LABOR AND PUBLIC WELFARE, LEGISLATIVE HISTORY OF THE COVERAGE OF NONPROFIT HOSPITALS UNDER THE NATIONAL LABOR RELATIONS ACT, 1974, 93rd Cong., 2d Sess. (Nov. 1974) 9-10, 104-12, 270-72, 372 [hereinafter cited as LEGISLATIVE HISTORY] and in Feheley, *Amendments To The National Labor Relations Act; Health Care Institutions*, 36 OHIO ST. L.J. 235, 238-40 (1975); 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 (1975); Ford, *The 1974 Health Care Amendments to the National Labor Relations Act: Jurisdictional Standards and Appropriate Bargaining Units*, URBAN L.J. 351 (1977); Comment, *National Labor Relations Act—History and Interpretation of the Health Care Amendments*, 60 MARQ. L. REV. 921 (1977).

[4] LEGISLATIVE HISTORY, *supra* note 3, at 10, 94, 272, 291. The health care industry currently employs approximately five million persons. FEDERAL MEDIATION AND CONCILIATION SERVICE, IMPACT OF THE HEALTH CARE AMENDMENTS TO THE NLRA ON COLLECTIVE BARGAINING IN THE HEALTH CARE INDUSTRY 3 (1979) [hereinafter cited as FMCS STUDY].

[5] *See, e.g.*, Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1041 (1978) (Penello, M., dissenting), *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979).

[6] *See, e.g., Proposed Amendments to the National Labor Relations Act: Hearings on H.R. 11357 Before a Subcomm. of the House Comm. on Education and Labor*, 92 Cong. 1st & 2d Sess. 175 (1972); *Hearings on H.R. 11357 Subcomm. of the Senate Comm. on Labor and Public Welfare* 92d Cong., 2d Sess. 34-5, 114-15, 158, 169-72, 238-39 (1972).

[7] See text and note at note 16 *infra*.

[8] For a variety of reasons, the pattern of bargaining units which is established in health care institutions is of considerable significance to health care institutions, their employees, the labor organizations which represent them and to the general public. The numbers and types of units established can reasonably be expected to have an impact upon the incidence of labor disputes in health care institutions, and thus upon the interruption of the delivery of services by such institutions, the costs of health care services, the administrative burden of managing health care institutions, the effectiveness of the organizational efforts of labor organizations and of their representation of employees, and the effectiveness of the collective bargaining process.

[9] *See, e.g.*, Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030 (1978), *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979). The Board has held that appropriate units may be comprised of registered nurses, physicians, all other professionals, all technical employees, business office clerical employees, either powerhouse unit or maintenance department employees, all other service and main-

member, John Penello, has argued vigorously that only six units should be considered appropriate.[10] The courts of appeals, meanwhile, have rebuked

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tenance employees, *id.*, 100 L.R.R.M. at 1035-37, and chauffeur-drivers. Michael Reese Hospital and Medical Center, 242 N.L.R.B. No. 50, 101 L.R.R.M. 1157 (1979). A ninth separate unit may exist at health care institutions that employ guards, since Section 9(b) of the Act (29 U.S.C. § 159(b)(3) (1976)) requires a separate unit for guards. In Peninsula Hospital Center, 219 N.L.R.B. 139, 90 L.R.R.M. 1034 (1975), the Board approved a separate unit for guards. The Board has departed from this pattern of units when it has perceived unusual circumstances. *See, e.g.*, Bay Medical Center, Inc., 218 N.L.R.B. 620, 89 L.R.R.M. 1310 (1975) (licensed practical nurses excluded from unit of technical employees because of separate bargaining history). Member Penello has predicted that the Board will find more units to be appropriate if it continued to apply the standards utilized to date. Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1046 (1978) (Penello, M., dissenting), *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979). It is conceivable that a second unit of physicians comprised of interns, fellows and residents may be approved in the future. In Physicians National House Staff Ass'n v. Murphy, 100 L.R.R.M. 3055 (D.C. Cir. 1979), the Court of Appeals for the District of Columbia overturned the Board's decision that medical residents, interns and fellows are not "employees" within the meaning of the Act. However, the court has granted the Board's petition for a rehearing of the case and has withdrawn its earlier opinion. DAILY LAB. REP. No. 112, (BNA) A-14 (June 8, 1979). Member Fanning believes such housestaff to be "employees" and would find appropriate a separate unit comprised of such persons. Cedars-Sinai Medical Center, 223 N.L.R.B. 251, 259 n.29, 91 L.R.R.M. 1398, 1406, n.29 (1976) (Fanning, M., dissenting). A bill (H.R. 2222) requiring that such housestaff be deemed "employees" under the Act was recently defeated by a vote of the House. DAILY LAB. REP. No. 231, (BNA) A-4 (Nov. 29, 1979).

[10] *See, e.g.*, Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1046 (1978) (Penello, M., dissenting), *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 2789 (3d Cir. 1979). According to Member Penello, the only appropriate bargaining units in hospitals are composed of registered nurses, all other professional employees, business office clerical employees, craft maintenance or powerhouse units in rare cases, and all other nonprofessional employees. *Id.* Member Penello would also recognize the requirements of § 9(b) regarding separate units of guards. Former Board Members Kennedy and Walther also disagreed with certain aspects of the majority's approach. *See, e.g.*, Mercy Hospitals of Sacramento, Inc., 217 N.L.R.B. 765, 773-74, 89 L.R.R.M. 1097, 1106-07 (1975) (Kennedy, M., dissenting in part), *enf't denied in part*, in a connected proceeding, 589 F.2d 968, 98 L.R.R.M. 2800 (9th Cir. 1978); St. Catherine's Hospital, 217 N.L.R.B. 787, 790-91, 89 L.R.R.M. 1070, 1075 (1975) (Kennedy, M., dissenting); Ohio Valley Hospital Ass'n, 230 N.L.R.B. 604, 606-08, 95 L.R.R.M. 1430, 1433-34 (1977) (Walther, M., dissenting). Labor organizations generally have urged the creation of more separate bargaining units than have health care employers. Narrow units usually increase the success of organization efforts and decrease conflict within unit membership during collective bargaining. However, during oral arguments conducted by the Board in 1975 concerning six leading health care bargaining unit cases, two prominent health care labor organizations supported approval of a very limited number of separate units.

The American Federation of State, County and Municipal Employees asserted that as a general proposition units comprised of four separate groups of employees should be deemed appropriate: professional employees, technical employees, office clerical employees, and service and maintenance employees. Newington Children's Hospital, et al., 217 N.L.R.B. 793, 89 L.R.R.M. 1108, Oral Argument (Jan. 27, 1975), Record at 56. The Service Employees International Union argued that generally three separate units should be approved by the Board—units comprised of all professional employees, all non-professional employees, and all office clerical employees. *Id.* Record at 84, 86, 89.

the Board for being inconsistent and erratic in making bargaining unit determinations.[11]

This article will review the legislative history of the 1974 amendments as it relates to the establishment of bargaining units. Significant congressional expressions will be identified and specific issues which may affect these congressional expressions and actions will be considered. Implementation of congressional intent by the National Labor Relations Board in determining service and maintenance units, business office clerical units, technical employee units, registered nurse and physician units, maintenance department units, and powerhouse and chauffeur-driver units will be examined.[12] Where appropriate, alternative approaches will be suggested.

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[11] *See* St. Vincent's Hospital v. NLRB, 567 F.2d 588, 592-93 n.6, 97 L.R.R.M. 2119, 2123 n.6 (3d Cir. 1977) (Board's implementations of congressional policy inconsistent); The Long Island College Hospital v. NLRB, 566 F.2d 833, 844, 96 L.R.R.M. 3119, 3127 (2d Cir. 1977), *cert. denied*, 435 U.S. 996 (1978) (Board's non-proliferation decisions in a state of "disarray"); NLRB v. West Suburban Hospital, 570 F.2d 213, 216, 97 L.R.R.M. 2929, 2932 (7th Cir. 1978) (Board "embarked upon an erratic course in making bargaining unit determinations"); and NLRB v. St. Francis Hospital of Lynwood, 601 F.2d 404, 414, 101 L.R.R.M. 2943, 2950 (9th Cir. 1979) (Board's establishment of irrebuttable presumption of appropriateness of separate units of registered nurses contravenes congressional admonition).

Section 9(b) of the National Labor Relations Act confers upon the Board the power to designate appropriate bargaining units. However, Section 9(b) prescribes no precise rule for the establishment of most bargaining units and thus, of necessity, the Board has been accorded a large measure of discretion in this regard and its decisions are rarely disturbed. Ford Motor Co. v. NLRB, 99 S. Ct. 1842, 1848 (1979); South Prairie Constr. Co. v. Int'l Union of Operating Engineers, 425 U.S. 800, 805 (1976); Packard Motor Car v. NLRB, 330 U.S. 485, 491 (1947); NLRB v. Mercy Hospitals of Sacramento, 589 F.2d 968, 98 L.R.R.M. 2800 (9th Cir. 1978). Nevertheless, it remains the responsibility of the courts to insure that the Board's exercise of discretion is not so unreasonable and arbitrary as to exceed its powers. Ford Motor Co. v. NLRB, 99 S. Ct. at 1849; Allied Chemical & Alkali Workers v. Pittsburgh Plate Glass Co., 404 U.S. 157, 171-72 (1971); Packard Motor Car Co. v. NLRB, 330 U.S. 485, 491 (1947); NLRB v. Pinkerton's, Inc., 428 F.2d 479, 481, 74 L.R.R.M. 2355, 2356 (6th Cir. 1969); NLRB v. Mercy Hospitals Order of Sacramento, 589 F.2d 968, 973, 98 L.R.R.M. 2800, 2803 (9th Cir. 1978); NLRB v. Wolverine World Wide, Inc., 477 F.2d 969, 971, 83 L.R.R.M. 2309, 2310 (6th Cir. 1973); NLRB v. Delaware-New Jersey Ferry Co., 128 F.2d 130, 136-37, 10 L.R.R.M. 611, 617 (3d Cir. 1941). The discretion which the board exercises must be that accorded by Congress. NLRB v. Metropolitan Life Ins. Co., 380 U.S. 438, 443 (1965); Phelps Dodge Corp. v. NLRB, 313 U.S. 177, 197 (1941). Moreover, the Court of Appeals for the Third Circuit has said that the Board's insistence upon the establishment of separate maintenance units, contrary to the court's interpretation of the Act, is tantamount to operation "outside the law" by the Board. Allegheny General Hospital v. NLRB, 608 F.2d 965, 970, 102 L.R.R.M. 2784, 2789 (3d Cir. 1979); NLRB v. Mercy Hospital Ass'n, 606 F.2d 22, 26 n.2,102 L.R.R.M. 2259, 2261 n.2 (2d Cir. 1979).

[12] The examination of "congressional intent" contained in the following pages has not been undertaken without apprehension. Two distinguished authors have asserted that American courts have no intelligible and consistently applied theory of statutory interpretation. H. HART & A. SACKS, THE LEGAL PROCESS: BASIC PROBLEMS IN THE MAKING AND APPLICATION OF LAW 1201 (Tentative Ed. 1958) [hereinafter cited as HART & SACKS]. A nearly overwhelming majority of judicial opinions dealing with statutory interpretation focuses upon the "intent of the legislature" as the applicable test

I. Congressional Intent Concerning Health Care Institution Bargaining Units

A. *Significant Congressional Expressions*

In enacting the 1974 amendments, Congress sought to satisfy "twin objectives": extension of the rights guaranteed by the National Labor Relations Act to nonprofit hospital employees and provision of adequate safeguards for patients against the disruption of health care services by labor disputes.[13] It was hoped that extension of the Act to health care employees would eliminate the need for recognitional strikes and thus reduce potential disruptions of patient care.[14] Congress was also concerned that a large number of bargaining units

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or criterion. 2A D. Sands, Statutes and Statutory Construction § 45.05 (4th ed. 1973) [hereinafter cited as Sands]. However, the question of whether legislative intent is a valid concept for use in deciding issues of statutory interpretation has been a classic subject of debate. *Id.* § 45.06. It has been argued that the idea of a legislative intent should be regarded as nothing more than a fiction since the chances that several hundred legislators will possess the same perceptions and intentions are infinitesimally small. *Id.* § 45.06. Some Justices have suggested that courts should inquire what the statute means. *Id.* § 45.07. This alternative approach focuses upon the manner in which a statute is understood by persons other than members of the legislature, *id.*, and its application is reflected in opinions which recite the premise that intention must be determined primarily from the language of the statute itself and which express preference for "common", "ordinary" and "normal" meanings of words. *Id.* § 45.08. For every maxim of construction there is almost always an opposite. Hart & Sacks at 1221, and no single canon can give a certain and unerring answer to the question of legislative intent. Sands § 45.05, at 16. The question of legislative meaning involves "questions of judgment too subtle for articulation," *id.*, and when an effort is made to formulate a sound and workable theory, the most that can be hoped for is that the theory will have some foundation in experience and the best practice of the wisest judges and that it is calculated to serve the ultimate purposes of law. Hart & Sacks at 1201.

[13] *See* Legislative History, *supra* note 3, at 256-57, 120 Cong. Rec. 13560 (May 7, 1974) (Remarks of Sen. Humphrey). A general discussion of the legislative history of the 1974 amendments may be found in Feheley, *Amendments To The National Labor Relations Act: Health Care Institutions*, 36 Ohio St. L.J. 235 (1975).

[14] Legislative History, *supra* note 3, at 10, 120 Cong. Rec. 12944 (May 2, 1974). Because of its concern with the disruption of health care services likely to be caused by work stoppages, Congress amended Section 8(d) of the Act to provide that where collective bargaining involves employees of a health care institution, earlier notice of the termination or modification of a collective bargaining agreement than is required in other industries must be given to the other party and to the Federal Mediation and Conciliation Service. *See* 29 U.S.C.A. § 158(d) (Supp. 1979). Also, the health care institution and labor organization must participate in all meetings undertaken by the Service. 29 U.S.C.A. § 158(d) (Supp. 1979). A labor organization must give a 10-day written notice to the health care institution and to the Service before engaging in picketing, strikes or other concerted refusals to work. 29 U.S.C.A. § 158(g) (Supp. 1979). Under certain conditions, the Director of the Service may appoint an impartial Board of Inquiry to investigate and make reports concerning disputes. 29 U.S.C.A. § 183 (1978). Thus far, bargaining in health care institutions has nonetheless often been conducted on an "eleventh hour" basis and in an atmosphere of crisis. FMCS Study, supra note 4, at 434-35. Strikes have occurred in health care institutions with a frequency and duration similar to that experienced in other industries. *Id.* at 322, 324, 438. However, this may be due in considerable part to the large number of first contract bargaining situations being experienced in the health care industry. *Id.* at 438.

might lead to disruptions in patient care.[15] To meet this concern, Congress expressed its desire that "proliferation" of bargaining units in health care institutions be avoided. The reports of both the Senate and House committees to which the amending bills were referred stated in identical words Congress's directive to the Board in this regard:

> Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in *Four Seasons Nursing Center,* 208 NLRB No. 50, 85 LRRM 1093 (1974), and *Woodland Park Hospital,* 205 NLRB No. 144, 84 LRRM 1075 (1973), as well as the trend toward broader units enunciated in *Extendicare of West Virginia,* 204 NLRB No. 170, 83 LRRM 1242 (1973).[1]
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> [1] By our reference to *Extendicare,* we do not necessarily approve all of the holdings of that decision.[16]

Few congressmen made statements which clarify the expression of the House and Senate committees.[17] Senator Taft, a co-manager of the Senate bill and a major figure in the enactment of the amending legislation,[18] explained that the committee language represented a compromise between the approach which he had favored, which would have set a statutory limit of four bargaining units in a health care institution, and mere extension of the Act's coverage to nonprofit hospitals without any congressional expression of concern regarding the number of bargaining units.[19]

According to Senator Taft, resolution of the bargaining unit problem was one of the "central issues" involved in the passage of the 1974 amendments.[20] He explained that his concern about bargaining unit proliferation had been inspired by the potential number of separate bargaining units represented by the diverse professional interests and job classifications in the health care industry.[21] The creation of a "multiplicity" of bargaining units

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[15] *See* LEGISLATIVE HISTORY, *supra* note 3, at 114, 120 CONG. REC. 12944 (May 2, 1974); Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1038 (1978) (Penello, M., dissenting), *enf'd denied,* 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979).

[16] LEGISLATIVE HISTORY, *supra* note 3, at 12, 120 CONG. REC. 11622 (April 24, 1974) (Senate Committee on Labor and Public Welfare), 274-75, 120 CONG. REC. 11622 (April 24, 1974), (House Committee on Education and Labor).

[17] Much of the ground work of the 1974 legislation was laid outside the chambers of Congress in negotiations among representatives of Congress and health care industry management and labor. *See* LEGISLATIVE HISTORY, *supra* note 3, at 91, 98, 103, 120 CONG. REC. 12943-44 (May 2, 1974).

[18] *See, e.g.,* LEGISLATIVE HISTORY, *supra* note 3, at 113, 361, 369-70, 120 CONG. REC. 12944 (May 2, 1974). It is fair to characterize Senator Taft as the author of the 1974 amendments since they are taken primarily from his earlier proposals which were contained in S. 2292 and S. 3088. See text accompanying notes 81-90 *infra.*

[19] *Id.* at 114, 120 CONG. REC. 12944 (May 2, 1974). See text accompanying note 116 *infra.*

[20] *Id.* at 255, 120 CONG. REC. 13559 (May 7, 1974).

[21] *Id.* at 113-14, 120 CONG. REC. 12944-45 (May 2, 1974).

would cause administrative problems such as jurisdictional disputes, work stoppages, and increased costs of care due to wage competition between units.[22] Senator Taft stated that he could not "stress enough" the importance of exercising great caution in deciding health care institution bargaining unit cases.[23]

Senator Williams introduced the amending bill in the Senate[24] and served as Chairman of the Committee on Labor and Public Welfare[25] which reported the Senate version of the bill. On the day on which the Senate adopted the report of the Conference Committee concerning the bill, Senator Williams addressed himself to the subject of bargaining unit fragmentation.[26] The emphasis of his statement was somewhat different from that of Senator Taft.[27] Senator Williams expressed the opinion that while the National Labor Relations Board had generally tended to avoid the unnecessary proliferation of bargaining units, some circumstances, particularly a certain history of bargaining or a "notable disparity of interests," require the recognition of a number of separate units.[28] Thus, according to Senator Williams, while the Board should give due consideration to the Committee's admonition to avoid undue proliferation, Congress did not, within this framework, intend to preclude the Board from exercising its expertise in determining appropriate bargaining units.[29]

Seven days after the House adopted the Conference Report, Congressman Ashbrook submitted a joint statement[30] on behalf of himself and Congressman Thompson, the cosponsors[31] of the amending bill in the House.

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[22] *Id.*

[23] *Id.* at 114, 120 CONG. REC. 12945, See Appendix A for the full text of Senator Taft's remarks of May 2nd and 7th, 1974.

[24] *Id.* at 1, 120 CONG. REC. 7383 (March 20, 1974).

[25] *Id.* at 361, 365, 120 CONG. REC. 9145, 13561 (April 2, May 7, 1974).

[26] *Id.* at 363, 120 CONG. REC. 22575 (July 10, 1974).

[27] Senator Williams responded to an address delivered by the General Counsel of the NLRB on June 13, 1974, Daily Lab. Rep. No. 115 (BNA) D-1 (June 13, 1974) and to Senator Taft's remarks on May 7, 1974. LEGISLATIVE HISTORY, *supra* note 3, at 362, 120 CONG. REC. 13559 (May 7, 1974). Senator Williams considered the General Counsel's address and Senator Taft's remarks to be inconsistent with the intent of the Senate Committee on Labor and Public Welfare. LEGISLATIVE HISTORY, *supra* note 3, at 362, 120 CONG. REC. 22575 (July 10, 1974).

[28] *Id.* at 363, 120 CONG. REC. 22575 (July 10, 1974).

[29] *Id.* See Appendix B, for the full text of Senator Williams's remarks of July 10, 1974.

It is worth noting that Senator Williams and other congressmen—including Senator Taft—referred in their remarks to "undue proliferation" rather than simply to the "proliferation" condemned in the Senate and House committee statements. To the extent that these references constitute a more expansive proscription, the statements of the committees must be accorded controlling force. See authorities cited in note 69 *infra*.

[30] LEGISLATIVE HISTORY, *supra* note 3, at 409, 120 CONG. REC. E. 4849 (daily ed. July 18, 1974), 120 CONG. REC. 22948-49 (July 11, 1974). While Congressman Ashbrook's remarks were made on July 18, they were inserted into the Congressional Record, so that they appear to have been made on July 11.

[31] LEGISLATIVE HISTORY, *supra* note 3, at 266, 288, 290, 409, 120 CONG. REC. 16899, 22948 (May 30, July 11, 1974).

Congressman Ashbrook explained that while he and Congressman Thompson generally associated themselves with the remarks of Senator Williams concerning a number of aspects of the legislation, their joint statement was necessary to insure that Senator Williams's remarks would not be misinterpreted.[32] While the joint statement did not deal with the subject of bargaining units, Congressman Ashbrook's additional "personal comment" did. Congressman Ashbrook noted that while the Board had, as indicated by the cases cited in the committee report, "acted at its discretion" in an acceptable manner in the past in deciding unit cases, the Board should be cognizant of Congress's concern for patient care and employee rights when deciding unit questions in health care institutions.[33]

Eleven days after the House had adopted the Conference Report, Congressman Thompson inserted a statement in the record concerning the bargaining unit issue.[34] Congressman Thompson noted that the House committee, by stressing its concern about undue proliferation of bargaining units, had not intended to preclude the Board from certifying "traditional craft and departmental units such as stationary engineers in the health care field."[35]

The statements summarized in the preceding paragraphs demonstrate that Congress felt and expressed a strong desire that a "proliferation" of bargaining units in health care institutions be avoided. However, as is also apparent from the preceding summaries, the expressions of concern by the Senate and House committees and by individual congressmen are too general to translate readily into a precise formula which is useful for deciding unit cases. Some assistance in determining just what Congress meant by its reference to an undesirable "proliferation" of bargaining units can be gained by examining several issues which have since arisen in the course of litigation.

B. *Issues Raised Concerning Congressional Expressions and Actions*

1. Which Statements May Be Considered

There is some disagreement with respect to whether all of the comments referred to above may be considered in making an assessment of congressional intent. The Supreme Court has stated that remarks of legislators made after the passage of legislation cannot serve to change the legislative intent which was expressed before the passage of the legislation.[36] Post-passage re-

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[32] *Id.* at 409, 120 CONG. REC. 22948 (July 11, 1974).

[33] *Id.* at 411, 120 CONG. REC. 22949 (July 11, 1974). See Appendix C for the full text of Congressman Ashbrook's remarks.

[34] LEGISLATIVE HISTORY, *supra* note 3, at 411, 120 CONG. REC. E. 4899 (daily ed. July 22, 1974), 120 CONG. REC. 22948 (July 11, 1974).

[35] *Id.* See Appendix D for the full text of Congressman Thompson's remarks. While Congressman Thompson's remarks were made on July 22, they were inserted into the Congressional Record so that they appear to have been made on July 11.

[36] United States v. Mauro, 436 U.S. 340, 367-68 (1977) (Burger, C.J. and Rehnquist, J., dissenting); Regional Rail Reorganization Act Cases, 419 U.S. 102, 132 (1974); Fogarty v. United States, 340 U.S. 8, 13-14 (1950); United States v. United Mine Workers, 330 U.S. 258, 282 (1947). *See* United States v. Wise, 370 U.S. 405, 411, 414 (1962); Gemsco, Inc. v. Walling, 324 U.S. 244, 265 (1945). The Court has also stated that the "views of a subsequent Congress form a hazardous basis for inferring

marks of legislators must be deemed to be only the personal views of the legislators who made them.[37] Such a policy appears justified for several reasons. Comments made by congressmen after the passage of legislation cannot possibly have influenced either the course of the legislative proceedings or the voting by legislators. Post-passage comments may be made after the purposes and issues which shaped the legislation have faded in the mind of the speaker and from the public eye. Also, such comments are likely to be made at times and under circumstances that render unlikely or impossible the responses, including refutation, which might have followed if they had been uttered prior to passage of the legislation. Finally, post-passage remarks are often made at times when the speaker is strongly tempted to tailor his comments to new issues which may not have been foreseen clearly, if at all, at the time of passage.

NLRB Member Penello has argued that Congressman Thompson's comments fall into the category of post-passage remarks and should not be consid-

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the intent of an earlier one." Waterman Steamship Corp. v. United States, 381 U.S. 252, 269 (1965); quoting United States v. Price, 361 U.S. 304, 313 (1960); United States v. Philadelphia National Bank, 374 U.S. 321, 348-49 (1963).

In Penn Mutual Co. v. Lederer, 252 U.S. 523, 538 (1920), the Court said that no assistance could possibly be derived from the legislative history of an act passed almost six years after the act in question. Among the decisions in which lower courts have declined to accord weight to post-passage remarks are Volkswagen of America v. United States, 340 F. Supp. 982, 988-89 (Cust. Ct. 1st Div. 1972), *aff'd*, 494 F.2d 703 (C.C.P.A. 1974); De La Salle Institute v. United States, 148 F. Supp. 792, 800 (E.D. Pa. 1957), *aff'd*, 252 F.2d 456 (3d Cir. 1957); State Wholesale Grocers v. Great Atlantic & Pacific Tea Co., 154 F. Supp. 471, 485 (N.D. Ill. 1957), *rev'd on other grounds*, 258 F.2d 831 (7th Cir. 1959), *cert. denied*, 358 U.S. 947 (1959).

[37] United States v. Mauro, 436 U.S. 340, 367-68 (1977) (Burger, C.J., and Rehnquist, J., dissenting); Regional Rail Reorganization Act Cases, 419 U.S. 102, 132 (1974); National Woodwork Mfr.s Ass'n v. NLRB, 386 U.S. 612, 639 n.34 (1967). On one occasion, the Court did say that a statement which was made some five years after the passage of an act and which was made by the same committee which had reported the act in question was "virtually conclusive as to the significance of the Act." Sioux Tribe of Indians v. United States, 316 U.S. 317, 329-30 (1942). *See also* United States v. E.I. DuPont de Nemours & Co., 353 U.S. 586, 590 (1957). In Talley v. Mathews, 550 F.2d 911, 920 (4th Cir. 1977); the Court of Appeals for the Fourth Circuit relied upon *Sioux Tribe* in deeming certain post-passage statements to be "persuasive authority." Other decisions in which lower courts have considered post-passage remarks are General Service Employees Union Local No. 73 v. NLRB, 578 F.2d 361, 367-68, 97 L.R.R.M. 2906, 2910 (D.C. Cir. 1978); United States v. Papercraft Corp., 540 F.2d 131, 140 n.16 (3d Cir. 1976) (post-passage views bolstered pre-passage intent); and Allstate Insur. Co. v. Lanier, 242 F.Supp. 73, 87 (E.D.N.C. 1965), *aff'd*, 361 F.2d 870 (4th Cir. 1966), *cert. denied*, 385 U.S. 930 (1966). The Supreme Court has stated that legislation which declares the intent of an earlier statute is entitled to significant weight in interpreting the earlier statute. NLRB v. Bell Aerospace Co., 416 U.S. 267, 275 (1974); Red Lion Broadcasting Co. v. FCC, 395 U.S. 367, 380-81 (1969); FHA v. The Darlington, Inc., 358 U.S. 84, 90 (1958); United States v. Stafoff, 260 U.S. 477, 480 (1923); Stockdale v. Insurance Companies, 87 U.S. (20 Wall.) 323, 331 (1873); United States v. Freeman, 44 U.S. 548 (3 How. 556), 550-51 (564-65) (1844). *But see* Rainwater v. United States, 356 U.S. 590, 593 (1958); Levindale Lead and Zinc Mining Co. v. Coleman, 241 U.S. 432, 439 (1916); Ogden v. Blackledge, 6 U.S. (2 Cranch) 272, 276-77 (1804).

ered.[38] The Board majority,[39] however, and perhaps one court of appeals,[40] disagree. At least one commentator[41] and several interested parties[42] also have argued that Senator Williams's comments should be classified as post-passage. Existing legal precedent provides little guidance in resolving this controversy since the statements subjected to scrutiny in many previously reported cases were made long after passage of the legislation in question.[43] In contrast, all of the significant remarks relating to bargaining unit proliferation were made in close proximity to the time of passage. A brief summary of the 1974 legislative proceedings provides a useful view of the context in which those remarks were made.

On April 2, 1974, the Senate Committee on Labor and Public Welfare issued its report on S. 3203—the Senate version of the amending legislation.[44] This report contained the admonition against bargaining unit proliferation which has appeared above.[45] On May 2 and 7, 1974, Senator Taft made his statements concerning the bargaining units issue.[46] On May 7, 1974, S. 3203 was passed by the Senate.[47] H.R. 13678, the House version of this legislation, was reported by the Committee on Education and Labor on May 20, 1974.[48] This report contained the admonition concerning the proliferation of bargaining units; H.R. 13678 was passed by the House on May 30, 1974.[49]

H.R. 13678 as passed was identical to S. 3203, with the exception of two new sections which were not related to the bargaining units question.[50] The Conference Report containing a proposed resolution of the issues created by the addition of these two sections was submitted in the House on July 3,

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[38] Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1039 (1978) (Penello, M., dissenting), *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 278, (3d Cir. 1979).

[39] *Id.* at 1033 n.21.

[40] The Long Island College Hospital v. NLRB, 566 F.2d 833, 838 n.2, 96 L.R.R.M. 3119, 3122 n.2 (2d Cir. 1977), *cert. denied*, 435 U.S. 996 (1978).

[41] Emanuel, *Hospital Bargaining Unit Decisions*, in LABOR RELATIONS LAW PROBLEMS IN HOSPITALS AND THE HEALTH CARE INDUSTRY at 187, 202-03 (A. Knapp ed. 1977) [hereinafter cited as Emanuel].

[42] Brief for the American, California and Ohio Hospital Associations as Amici Curiae at 6-9, Allegheny General Hospital v. NLRB, Case Nos. 77-2090, 79-1085 (3d Cir. 1979).

[43] *See, e.g.*, United States v. Wise, 370 U.S. 405, 411, 414 (1962); Fogarty v. United States, 340 U.S. 8, 13-14 (1950).

[44] LEGISLATIVE HISTORY, *supra* note 3, at 8, 120 CONG. REC. 9145 (April 2, 1974).

[45] See text at note 16 *supra*.

[46] See Appendix A.

[47] LEGISLATIVE HISTORY, *supra* note 3, at 258, 264, 120 CONG. REC. 13561 (May 7, 1974).

[48] *Id.* at 269, 120 CONG. REC. 15660 (May 20, 1974).

[49] *Id.* at 338, 120 CONG. REC. 16916 (May 30, 1974).

[50] *Id.* at 348-49, 355-56, 120 CONG. REC. 16916 (May 30, 1974). One section provided that employees who objected on religious grounds to joining labor organizations or to supporting them financially would not be required to do so as a condition of employment; the other section called for the appointment of a board of inquiry to investigate and report upon labor disputes in certain instances.

1974;[51] five days later, the Report was submitted in the Senate.[52] The Senate adopted the Conference Report on July 10, 1974.[53] On that same day Senator Williams made his remarks concerning the bargaining units issues.[54] The Conference Report was approved by the House on July 11, 1974,[55] but members were granted five legislative days within which to revise and extend their remarks on the Report.[56] On the fifth legislative day, July 18, 1974, Congressman Ashbrook inserted his remarks concerning bargaining units.[57] Congressman Thompson inserted his remarks four days later on July 22, 1974.[58]

The language of the 1974 amendments themselves contained no mention of the bargaining units issue.[59] Thus, the statement concerning bargaining unit proliferation contained in the House and Senate committee reports which referred the amending bills to their respective bodies constitutes the first and, undoubtedly, the most significant expression of congressional will concerning the issue. The amending bills and the committee reports which accompanied them were the products of negotiation and careful tailoring by representatives of labor, management, and Congress.[60] Both Senator Taft and Senator Williams indicated that the committee reports reflected the intent of Congress.[61] Neither the Board, nor any court of appeal, nor any party to pertinent litigation has questioned the significance of the language contained in the committee reports with respect to bargaining unit proliferation.

All of the remarks made by congressmen concerning bargaining units were made subsequent to the issuance of the committee reports and neither Congress as a whole nor any of its committees thereafter made further statements concerning the issue. In this sense at least, all of the individual remarks could be termed "post-passage." Until the amending bills were passed in the Senate and House, however, additional legislative action relating to bargaining units was at least a possibility.[62] Senator Taft's remarks were the only sig-

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[51] *Id.* at 344-45, 120 CONG. REC. 22130 (July 3, 1974).

[52] *Id.* at 351-52, 120 CONG. REC. 22232 (July 8, 1974).

[53] *Id.* at 384, 120 CONG. REC. 22583 (July 10, 1974).

[54] See Appendix B.

[55] LEGISLATIVE HISTORY, *supra* note 3, at 408, 120 CONG. REC. 22949-50 (July 11, 1974).

[56] 120 CONG. REC. 22950 (1974).

[57] See Appendix C. Also reported at 120 CONG. REC. E. 4850 (daily ed. July 18, 1974). The remarks are inserted at 120 CONG. REC. 22949 (July 11, 1974).

[58] See Appendix D. The remarks are inserted at 120 CONG. REC. 22949 (July 11, 1974).

[59] *See* LEGISLATIVE HISTORY, *supra* note 3, at 412-14, Act of July 26, 1974, Pub. L. No. 93-360, 88 Stat. 395 (1974).

[60] *Id.* at 98, 112-13, 120 CONG. REC. 12944 (May 2, 1974).

[61] *Id.* at 256, 361, 120 CONG. REC. 13560, 9145 (May 7, 1974).

[62] Numerous amendments to the reported bills were introduced prior to passage of the bills. *See, e.g.*, LEGISLATIVE HISTORY, *supra* note 3, at 55-63 (Amdt. No. 1143 providing for trial of unfair labor practice cases in federal district courts); 69 (Amdt. No. 1213 prohibiting restriction of membership in labor organizations on account of race, color, religion, sex or national origin); 72-76, 120 CONG. REC. 13543 (May 7, 1974) (Amdt. No. 1215 providing for amendments to the Occupational Safety and Health Act of 1970); and 78-84 (Amdt. Nos. 1218 and 1240 concerning strike votes).

nificant comments made by a congressman concerning the bargaining units issue subsequent to the issuance of the committee report but prior to passage by either the Senate or the House of amending legislation. Following the passage of amending bills by the Senate and the House—particularly after the passage by the House of H.R. 13678—it became clear that the bargaining unit issue was no longer open. Since the bill passed by the House on May 30, 1974 was identical to that passed by the Senate except for two sections having nothing to do with the proliferation of bargaining units, the Conference Committee appointed thereafter did not consider the bargaining units issue. All comments concerning the proliferation of bargaining units which were made in the course of or subsequent to consideration of the Conference Committee's Report were therefore made after the issue had been effectively resolved and when the course of the proceedings and the votes of the members of Congress could not have been affected.[63] As a result, member who may have disagreed with the comments of Senator Williams, Congressman Ashbrook, or Congressman Thompson concerning the bargaining units issue may have deemed any dissenting response to be unnecessary. In light of these facts it can be argued with considerable force that the comments of Senator Williams, Congressman Ashbrook, and Congressman Thompson should be considered "post-passage" and not indicative of true congressional intent.

On the other hand, it can be argued with at least some persuasiveness that such a label should not be applied to the comments of Senator Williams or Congressman Ashbrook. Both made their remarks at a time when future issues were no more clearly in view than when the committee reports were issued and the comments of Senator Taft were made. Senator Williams and Congressman Ashbrook were thus in no better position to shape their comments to fit anticipated issues than Senator Taft had been. Also, Senator Williams and Congressman Ashbrook made their statements at a time when the subject matter of the health care amendments was, presumably at least, still in the minds of some congressmen. As a result, general comment on the subject of health care bargaining units should not have been totally unexpected. Congressman Ashbrook's remarks were inserted on the last permissible day for comments "on the conference report," but every congressman had reason to know of such cut-off date and had an opportunity to avail himself of it in the same manner as did Congressman Ashbrook.

In any event, the remarks of Senator Williams and Congressman Ashbrook are not clearly inconsistent with the statements in the committee reports and with the remarks of Senator Taft. Certainly Senator Williams's remarks are different in tone from those of Senator Taft, and, as previously

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[63] Theoretically, a failure by one of the houses to adopt the Conference Report could have led to the collapse of the entire legislative effort, but there is no reason to believe that this was ever a real possibility. As specifically mentioned in the legislative history, the debates during the time in question were conducted to consider the Conference Report. LEGISLATIVE HISTORY, *supra* note 3, at 358, 385, 120 CONG. REC. 22574, 22941 (July 10, 11, 1974). Also, the period for extension of remarks during which Congressman Ashbrook made his comments on the bargaining unit issue was reserved for "remarks on the conference report just agreed to." 120 CONG. REC. 22950 (1974).

indicated,[64] were apparently directed to what he viewed as an imperfect expression of congressional will by Senator Taft on bargaining units and other issues. Nevertheless, Senator Williams's comments concerning bargaining units are very general and may be interpreted consistently with those of Senator Taft.[65] The July 24 comments of Congressman Thompson, however, are "post-passage." Mr. Thompson's remarks were not made within the extension which he himself had requested for the addition of comments by any members of the House.[66] Thus there was no reason whatsoever for members of Congress who may have disagreed with his interpretation of committee statements concerning bargaining unit proliferation to believe that response was necessary.[67] Legislative actions which might have been inspired or votes which might have been changed by timely comments could have been in no way affected.

Congressman Thompson's statement concerning craft and departmental units[68] is plainly contrary to the intent expressed in the committee reports and in Senator Taft's statements of May 2 and 7, 1974.[69] While the commit-

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[64] See text and notes at notes 26-29 *supra*.

[65] Senator Williams said that within the framework of the congressional admonition the Board would not be precluded from exercising its experience and knowledge in deciding unit cases (see Appendix B); Senator Taft also acknowledged that the Board had been left with some flexibility in determining appropriate bargaining units. See Appendix A. *See* NLRB v. St. Francis Hospital of Lynwood, 601 F.2d 404, 415, 101 L.R.R.M. 2943, 2951 (9th Cir. 1979). See also text accompanying note 193 *infra*. In some clearly "post-passage" remarks made in 1977, Senator Taft appears to have confirmed the view suggested above regarding his and Senator Williams's 1974 comments:

> While there may have been different emphases by Senator Williams, myself, and others on the respective degrees of concern for the dangers of non-proliferation, as compared to propriety, size, and historical and comity considerations, we certainly intended to limit unit numbers to a minimum feasible number after applying our respective standards.

Taft, *Is Congressional Intent Being Realized, Or Are Significant Changes Needed?* in LABOR RELATIONS LAW PROBLEMS IN HOSPITALS AND THE HEALTH CARE INDUSTRY at 135 (A. Knapp ed. 1977) [hereinafter cited as Taft].

[66] 120 CONG. REC. 22950 (July 11, 1974).

[67] The Subcommittee on Labor of the Senate Committee on Labor and Public Welfare, which prepared the legislative history of the 1974 amendments, omitted any reference to the July 22, 1974 remarks of Congressman Thompson. See LEGISLATIVE HISTORY, *supra* note 3. This conspicuous absence indicates that the Subcommittee, which was chaired by Senator Williams, did not consider these remarks to be a part of the legislative history of the amendments. In Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030 (1978), *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979), both the Board majority and dissenting Member Penello labelled Thompson's remarks "post-passage." 100 L.R.R.M. at 1033 n.21, 1039. However, the majority and dissent disagreed with respect to whether such remarks could be considered. *Id.*

[68] See Appendix D.

[69] See Appendix A. Even if Congressman Thompson's remarks were not properly viewed as "post-passage," they would still have to be disregarded in view of their conflict with the committees' admonition concerning "proliferation." In cases of conflict between a committee report and a statement of an individual congressman, the committee report must be accorded controlling weight. United States v. U.A.W., 352 U.S. 567, 585-86 (1957), *reh. denied*, 353 U.S. 943 (1957); United States v. Wrightwood

tee reports contained no specific reference to craft or departmental units, in effect Senator Taft's remarks did. In explaining the language of the committee reports he stated that a concern had existed with respect to the ramifications of permitting "each professional interest and job classification" to form a separate bargaining unit.[70] Also, in warning against "unwarranted unit fragmentation," Senator Taft stated in part that "[h]ealth-care institutions must not be permitted to go the route of other industries, particularly the construction trades, in this regard."[71] If congressional intent concerning bargaining unit proliferation were interpreted to permit the Board to "determine traditional craft and departmental units" as suggested by Congressman Thompson, then the committees' admonition against unit proliferation and Senator Taft's comments on this admonition would be rendered meaningless.[72] To be consistent with the canon of statutory construction which has

Diary Co., 315 U.S. 110, 125 (1942); Duplex Printing Press Co. v. Deering, 254 U.S. 443, 474-75 (1921); American Airlines, Inc. v. C.A.B., 365 F.2d 939, 949 (D.C. Cir. 1966).

[70] LEGISLATIVE HISTORY, *supra* note 3, at 113, 120 CONG. REC. 12944 (May 2, 1974). See Appendix A for the complete statement by Senator Taft.

[71] LEGISLATIVE HISTORY, *supra* note 3, at 114, 120 CONG. REC. 12944-45 (May 2, 1974). See Appendix A. Bargaining in the construction industry is notable for its fragmentation along craft and function lines. See, e.g., R.B. Butler, Inc. 160 N.L.R.B. 1595 (1966) and cases cited therein.

[72] If the Board is not precluded from continuing to establish traditional craft and departmental units, the Board would not be constrained to establish any fewer units in the health care field than in any other industry. Generally in determining whether a potential craft unit exists, the Board looks for a unit which consists of "[a] distinct and homogeneous group of skilled journeyman craftsmen performing the functions of their craft on a nonrepetitive basis." Mallinckrodt Chemical Works, 162 N.L.R.B. 387, 397, 64 L.R.R.M. 1011, 1016 (1966). Board policy concerning departmental units is similar to that regarding craft units. The Board may create a departmental unit where it discerns "employees constituting a functionally distinct department, working in trades or occupations for which a tradition of separate representation exists." *Id.* at 397, 64 L.R.R.M. at 1016. *See also* American Potash & Chem. Corp., 107 N.L.R.B. 1418, 1423, 33 L.R.R.M. 1380, 1383 (1954).

Potential craft and departmental units abound in health care institutions. There are more than 238 separate job classifications in use in health care institutions and these classifications are commonly grouped into large numbers of separate departments. U.S. DEPT. OF LABOR, JOB DESCRIPTIONS AND ORGANIZATION ANALYSIS FOR HOSPITALS AND RELATED HEALTH SERVICES 2, 15 (rev. ed. 1971). Michael Reese Hospital and Medical Center, 242 N.L.R.B. No. 50, 101 L.R.R.M. 1157 (1979) (60 departments); St. Vincent Hospital and Medical Center of Toledo, 241 N.L.R.B. No. 90, 100 L.R.R.M. 1526 (1979) (86 departments); Montefiore Hospital and Medical Center, 235 N.L.R.B. 241, 97 L.R.R.M. 1474 (1978) (50 departments); San Jose Hospital & Health Center, Inc., et al. 228 N.L.R.B. 21, 96 L.R.R.M. 1391 (1977) (Several hospitals bargained as an association and the institutions were organized as follows: San Jose–30 departments and 290 job classifications; O'Connor Hospital–68 departments and 226 job classifications; Good Samaritan Hospital–45 departments and 178 job classifications; and Alexian Brothers Hospital–22 departments and 90 job classifications); West Suburban Hospital, 224 N.L.R.B. 1349, 92 L.R.R.M. 1369 (1977) (9 classifications in maintenance department); The Jewish Hospital Ass'n of Cincinnati, 223 N.L.R.B. 614 91 L.R.R.M. 1499 (1976) (20 departments; 10 classifications in engineering department); Riverside Methodist Hospital, 223 N.L.R.B. 1084, 92 L.R.R.M. 1033 (1976) (35-40 departments; 12 classifications in maintenance department); Newington Children's Hospital, 217 N.L.R.B. 793, 89 L.R.R.M. 1108 (1975) (13 departments); Nathan and Miriam Barnert Memorial Hospital Ass'n, 217 N.L.R.B. 775, 89 L.R.R.M. 1083

been enunciated by the Supreme Court, nothing in Congressman Thompson's post-passage remarks should be permitted to change the congressional intent which is reflected in the *pre-passage* statements of the committees and of Senator Taft.

The Board majority, however, finds no conflict between Senator Taft's remarks and those of Congressman Thompson. Of Senator Taft's remarks the Board has said:

> [S]enator Taft was thinking of a unit pattern similar to that of the construction industry, where employees have been grouped into units according to craft skills and job functions. If the pattern of the construction industry were used as a model for the health care industry, health care employees would be grouped into units according to "*each* professional interest and job classification." (Emphasis supplied) That is what the Senator wanted the Board to avoid.[73]

Apparently the Board reaches its accommodation of the two statements by concluding that Congressman Thompson's remark "reemphasized" the point that neither Senator Taft nor Congress "intended that every unit limited to a single professional group or job classification should be held *per se* inappropriate."[74] The Board made no effort to explain the basis for this conclusion which itself appears to be unwarranted.

Congressman Thompson's words actually reflect no intention to place any limitation upon the establishment of craft units in health care institutions. His words speak of the Board "continuing" to establish "traditional" craft and departmental units.[75] Only the use of the word "foreclose" by Congressman Thompson can be said to provide even a hint of the limitation upon the establishment of craft units that is implied by the Board's use of the term "*per se.*" The meaning of "foreclose" is ambiguous in the context of Congressman Thompson's statement and it cannot be said to signal clearly the existence of *any* intended limitation upon the establishment of craft units. In essence Congressman Thompson's comments prescribe business as usual with respect to the approval of craft and departmental units in health care institutions.

Senator Taft's words were similarly unqualified, but in a different sense with respect to the establishment of craft and function units. While he acknowledged in his statement that the Board would be accorded "some flexibility" in unit determination questions,[76] Senator Taft expressed concern about individual classification and professional interest units and simply stated that health care institutions should not be permitted to go the route of other in-

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(1975) (15 departments). If the Board is free to establish such groupings of Hospital employees as separate bargaining units, then by any reasonable measure "proliferation" of units would be the order in health care institutions.

[73] Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1033 (1978), *enf't denied,* 608 F.2d 966, 102 L.R.R.M. 2784 (3d Cir. 1979). *See also id.,* 100 L.R.R.M. at 1034; Riverside Methodist Hospital, 223 N.L.R.B. 1084, 1088, 92L.R.R.M. 1033, 1038 (1976) (Murphy & Fanning, MM., dissenting).

[74] Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. at 1034 (emphasis added).

[75] See Appendix D.

[76] See Appendix A.

dustries, particularly the construction industry.[77] He did not say that some craft units would be acceptable. But even if he did believe some craft units would be appropriate, his words certainly do not indicate a belief that they should be established with the ease and frequency indicated by Congressman Thompson. Thus, Senator Taft's remarks and those of Congressman Thompson are not consistent, and Congressman Thompson's remarks should not be considered in measuring congressional intent.[78]

In summary, the statements of the Senate and House committees and of Senator Taft concerning bargaining unit proliferation should be accorded controlling weight in measuring congressional intent since these statements are most clearly "pre-passage."[79] The remarks of Senator Williams and Congressman Ashbrook are of somewhat dubious status in this respect and are most properly viewed as "post-passage" statements. As such they cannot be utilized to alter the intent discerned from the committee and Taft statements. However, there appears to be no conflict between Congressman Ashbrook's statements and those of the Committees and Senator Taft. Senator Williams's comments are different in tone but are capable of consistent interpretation. The remarks inserted by Congressman Thompson are both post-passage and inconsistent with those of the committees and Senator Taft. Consequently, Congressman Thompson's statements should not be considered with respect to the issue of bargaining unit proliferation.[80]

2. The Failure of Congress to Enact a Bill Proposed by Senator Taft

Disagreement also exists concerning the degree of significance, if any, which should be accorded the failure of Congress to adopt a bill which was introduced in an earlier session of Congress by Senator Taft. On July 31, 1973, Senator Taft introduced S. 2292[81] which would have extended the coverage of the National Labor Relations Act to nonprofit hospitals.[82]

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[77] *Id.*

[78] Apparent confirmation of the conflict between Senator Taft's remarks and those of Congressman Thompson is provided by the then minority counsel to the Senate Committee on Labor and Public Welfare who stated that Senator Taft refused the request of a lobbyist, for the Operating Engineers union, to introduce in the Senate portion of the extension of remarks section of the Congressional Record the statement which was later inserted by Congressman Thompson. King, *Legislative Review: Is Congressional Intent Being Realized—Or Are Significant Changes Needed?* in LABOR RELATIONS LAW PROBLEMS IN HOSPITALS AND THE HEALTH CARE INDUSTRY 159 (A. Knapp ed. 1977) [hereinafter cited as King].

[79] Senator Taft's remarks are entitled to special deference, since he was, in essence, the author of the 1974 amendments. *See* Jennison v. Kirk, 98 U.S. 453, 459-60 (1878) and text accompanying notes 81-90 *infra*.

[80] In St. Vincent's Hospital v. NLRB, 567 F.2d 588, 591 n.3, 97 L.R.R.M. 2119, 2121 n.3 (3d Cir. 1977), the Court of Appeals for the Third Circuit said that the remarks of Senator Williams and Congressman Thompson should not be read "[T]o minimize the deep concern expressed in both committee reports before the passage of the measure, reiterated in the floor debates and included in the conference report that proliferation of the bargaining units should not be permitted."

[81] LEGISLATIVE HISTORY, *supra* note 3, at 9, 106, 119 CONG. REC. 26791 (July 31, 1973).

[82] *Id.* at 106, 119 CONG. REC. 26791 (July 31, 1973).

Moreover, this bill would have established special provisions affecting health care institutions on a wide variety of matters including the status of labor organizations as bargaining representatives, bargaining procedures, strikes and picketing, expedited relief from unfair labor practices, creation of certain causes of action, and the establishment of bargaining units.[83] Under this bill a maximum of four bargaining units consisting of all professional employees, all clerical employees, all technical employees, and all service and maintenance employees could have been deemed appropriate in health care institutions.[84] The Senate Subcommittee on Labor conducted hearings on the bill on July 31, August 1, August 2, and October 4, 1973.[85] After these hearings, Senator Taft's staff negotiated with health care representatives of both management and labor regarding issues raised by the bill.[86] Early in 1974, agreement was reached and on February 28, 1974, Senator Taft introduced S. 3088 which reflected the terms of this agreement.[87] The language of S. 3088 was identical to that of S. 3203, the bill which the Senate ultimately adopted.[88] While much of the language of S. 3088 was derived from the earlier S. 2292, the proposed statutory provisions of S. 2292 dealing with the establishment of bargaining units were excluded from S. 3088.[89] On March 13, 1974, the Senate Committee on Labor and Public Welfare discharged the Subcommittee on Labor from further consideration of S. 2292 and S. 3088.[90]

The Board majority has concluded that Congress "rejected" Senator Taft's bill, thereby indicating its intention that traditional criteria be utilized to designate bargaining units in the health care field.[91] The rejection also, according to the Board, reflects a congressional intent that these traditional criteria need not be employed to produce the results which Senator Taft's bill would have required.[92] Member Penello, however, has argued that the bill

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[83] *Id.* at 106-11, 119 CONG. REC. 26792-94 (July 31, 1973).

[84] *Id.* at 108-09, 457-58, 120 CONG. REC. 12944 (May 2, 1974). The bill also implicitly recognized that a fifth bargaining unit, comprised of guards, would be appropriate. *Id.* at 458. Section 9(b) of the Act already provided that no unit could be deemed appropriate which included with other employees individuals employed as guards to enforce against such other employees and other persons rules of the employer concerning the safety of the employer's property and of persons on the employer's premises. 29 U.S.C. § 159(b) (1973).

[85] LEGISLATIVE HISTORY, *supra* note 3, at 9, 111, 120 CONG. REC. 12943 (May 2, 1974).

[86] *Id.* at 111, 120 CONG. REC. 12943 (May 2, 1974).

[87] *Id.* at 9, 111, 120 CONG. REC. 4605 (Feb. 28, 1974).

[88] *Id.* at 112, 120 CONG. REC. 13561 (May 7, 1974).

[89] *Id.* at 112-16, 120 CONG. REC. 12944 (May 2, 1974).

[90] *Id.* at 9, 120 CONG. REC. 4605, (Feb. 28, 1974).

[91] Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1032, 1034 n.24 (1978), *enf't denied*, 608 F.2d 654, 102 L.R.R.M. 2784 (3d Cir. 1979); Jewish Hospital Association of Cincinnati, 223 N.L.R.B. 614, 616, 91 L.R.R.M. 1499, 1504 (1976). *See also* The Long Island College Hospital v. NLRB, 566 F.2d 833, 844, 96 L.R.R.M. 3119, 3126-27 (2d Cir. 1977), *cert. denied*, 435 U.S. 996 (1978). See text and notes at note 199 *infra*.

[92] Brief for Respondent at 13, Allegheny General Hospital v. NLRB, 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979).

was not "rejected" by Congress and that no inference concerning congressional intent may be drawn from the inaction of Congress.[93]

The Supreme Court has stated clearly that a rejection of legislative proposals by Congress should be given considerable weight in construing the meaning of statutes.[94] However, the justices have also disagreed over the distinction between a meaningful "rejection" and meaningless congressional "inaction."[95] The Court has cautioned that unsuccessful attempts to enact legislation are dubious guides for inferring legislative intent.[96] In essence, the Court appears to favor a case by case approach under which circumstances surrounding each unsuccessful proposal are weighed.[97] Caution may well be warranted here since S. 2292 was never voted on[98] and contained many features other than the bargaining unit provisions in question.[99]

In any event, if it is fair to infer that Congress "rejected" legislation which would have rigidly limited the Board to the establishment of no more than four bargaining units in health care institutions,[100] it is equally fair to infer

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[93] Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1039-40 (1978) (Penello, M., dissenting), *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979).

[94] *E.g.*, N.Y. Telephone Co. v. N.Y. State Dept. of Labor, 99 S.Ct. 1328, 1343 n.44 (1979); Johnson v. Railway Express Agency, Inc., 421 U.S. 454, 459 (1975); U.S. ex rel. Chapman v. FPC, 345 U.S. 153, 169 (1953). *See also* Ford Motor Co. v. NLRB, 99 S. Ct. 1842, 1848 (1979); United States v. Wise, 370 U.S. 405, 407-08 (1962); Fox v. Standard Oil Co., 294 U.S. 87, 96 (1935) (rejection of an amendment a circumstance to be weighed along with other circumstances). In a health care industry case dealing with the propriety of the Board's action in recognizing the unit certification of a state labor relations agency, The Long Island College Hospital v. NLRB, 566 F.2d 833, 839, 96 L.R.R.M. 3119, 3122 (2d Cir. 1977), *cert. denied*, 435 U.S. 996 (1978), the Court of Appeals for the Second Circuit considered as a part of the relevant legislative history the "rejection" by both houses of Congress of amendments that would have preserved from preemption by the 1974 health care amendments, certain state labor laws respecting health care institutions.

[95] *See* N.Y. Telephone Co. v. N.Y. State Dept. of Labor, 99 S. Ct. 1328, 1343 & n.44 (Justice Stevens for the Court), 1354 & n.22 (Justice Powell, joined by the Chief Justice and Justice Stewart, dissenting) (1979); NLRB v. Catholic Bishop of Chicago, 99 S. Ct. 1313, 1325-26 (1979) (Brennan, White, Marshall & Blackmun, JJ., dissenting).

[96] Red Lion Broadcasting Co. Inc. v. FCC, 395 U.S. 367, 381-82 n.11 (1969); United States v. Price, 361 U.S. 304, 310-12 (1960); Wong Yang Sung v. McGrath, 339 U.S. 33, 47-48 (1950).

[97] *See* United States v. United Mine Workers of America, 330 U.S. 258, 282 & n.43 (1947).

[98] United States v. Allen, 179 F. 13, 18-19 (8th Cir. 1910), *modified and aff'd on other grounds sub. nom.*, Goat v. United States, 224 U.S. 458 (1912).

[99] Gemsco, Inc. v. Walling, 324 U.S. 244, 265 (1945). *See* United States v. Wise, 370 U.S. 405, 419-20 (1962) (Harlan, J., concurring).

Some of the provisions of S.2292 were incorporated into S.3203 and ultimately into the 1974 amendments. However, portions of S.2292 other than those dealing with bargaining units—such as loss of status as bargaining representatives, removal of physicians from the definition of employee, expedited relief with respect to unfair labor practice charges, and the establishment of certain causes of action—were not incorporated into S.3203.

[100] Of course, the bill would have permitted separate units of guards. See note 84 *supra*.

that Congress "rejected" legislation that would have permitted the Board to determine appropriate bargaining units in health care institutions on exactly the same bases that it establishes bargaining units in other industries. During the 92nd Congress, Congressmen Thompson and Ashbrook introduced a bill in the House which would have removed the exemption of nonprofit hospitals as employers under the National Labor Relations Act[101] without adding any other provisions concerning health care institutions.[102] This bill was favorably reported by the House Education and Labor Committee and on August 7, 1972, was approved by a vote of the House.[103] The bill was forwarded to the Senate for consideration by the Committee on Labor and Public Welfare.[104] Senator Taft raised questions concerning the bill during the second day of hearings before the Subcommittee on Labor, and no further action was taken on it during the 92nd Congress.[105] Congressmen Thompson and Ashbrook introduced an identical bill in the House during the first session of the 93d Congress.[106] Hearings on this bill were conducted by the Special Subcommittee on Labor on April 12 and 19, 1973,[107] but this bill was never reported by the House Education and Labor Committee.[108]

On the Senate side, Senators Cranston and Javits introduced S. 794 on February 7, 1973.[109] Like the House bills, S. 794 would have, without more, removed the exemption of nonprofit hospitals.[110] The Senate Subcommittee on Labor conducted hearings on both S. 794 and Senator Taft's S. 2292 on July 31, August 2, and October 4, 1973.[111] As previously mentioned,[112] negotiations were undertaken thereafter by Senator Taft's staff and representatives of management and labor.[113] The agreement reached was reflected in

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[101] LEGISLATIVE HISTORY, *supra* note 3, at 105-06, 270, 288, 290 (H.R. 11357), 117 CONG. REC. 37142 (Oct. 20, 1971).

[102] *Id.* at 105-06, 290, 120 CONG. REC. 12941 (May 2, 1974).

[103] *Id.* at 105, 270, 120 CONG. REC. 12941 (May 2, 1974).

[104] *Id.* at 105, 120 CONG. REC. 12941 (May 2, 1974).

[105] *Id.* A report prepared by the Federal Mediation and Conciliation Service concludes that the demise of H.R. 11357 was caused by the intervention of Senator Taft and others who believed that provisions should be included which would accommodate the special characteristics of the industry and by senators who were concerned that bringing the bill to the floor would open the way for amendments of the NLRA opposed by organized labor. FMCS STUDY, *supra* note 4, at 19.

[106] LEGISLATIVE HISTORY, *supra* note 3, at 106, 270, 119 CONG. REC. 67 (Jan. 3, 1973), 120 CONG. REC. 12941 (May 2, 1974). The text of this bill, H.R. 1236, is found at *id.* 465.

[107] *Id.* at 270, 119 CONG. REC. D 224, D 245 (April 12, 19, 1973).

[108] As of May 2, 1974, the bill was still awaiting action by the Education and Labor Committee. LEGISLATIVE HISTORY, *supra* note 3, at 106. On May 20, 1974, the Committee reported H.R. 13678, the compromise bill, *id.* at 266, 269, 120 CONG. REC. 15660 (May 20, 1974).

[109] LEGISLATIVE HISTORY, *supra* note 3, at 9, 106, 119 CONG. REC. 3762 (Feb. 7, 1973).

[110] *Id.* at 488, 120 CONG. REC. 12941 (May 2, 1974).

[111] *Id.* at 111, 119 CONG. REC. D557, D565, D573, D674 (1973). See text accompanying note 85 *supra*.

[112] See text accompanying note 86 *supra*.

[113] LEGISLATIVE HISTORY, *supra* note 3, at 111, 120 CONG. REC. 12943 (May 2, 1974).

S. 3088 as introduced in the Senate and in H.R. 13678 as introduced in the House.[114] On March 13, 1974, the Senate Committee on Labor and Public Welfare discharged the Subcommittee on Labor from further consideration of both S. 794 and S. 2292.[115] Both S. 2292, which contained Senator Taft's absolute limit on the number of bargaining units, and S. 794, which would simply have removed the exemption of nonprofit hospitals, were "rejected" by Congress in the same manner.

Rather than focusing simply upon rejection of Senator Taft's proposal, it is fair to conclude that Congress desired something between the two bills. Senator Taft's statement that the bargaining unit question was a "central issue" in the passage of the amendments and his reference to the bargaining unit approach ultimately adopted by Congress as a "constructive compromise" which would permit the Board "some flexibility in unit determination cases" suggests a congressional intention that such a compromise approach be observed by the Board.[116] The ramifications of this approach for the application of traditional bargaining unit criteria in the health care industry will be discussed in a later section.[117]

3. The Significance of Decisions Cited in Congressional Statements

As previously indicated,[118] the Senate Committee on Labor and Public Welfare and the House Committee on Education and Labor cited with approval in their reports two Board decisions: *Four Seasons Nursing Center*[119] and *Woodland Park Hospital, Inc.*[120] In *Four Seasons*, the employer operated a nursing home in which approximately 143 employees, three of whom including a supervisor, were assigned to the maintenance department.[121] The nursing home was divided into seven separate departments. The Board dismissed a petition which sought an election for the maintenance workers as a separate

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[114] *Id.* at 112, 120 CONG. REC. 12944 (May 2, 1974).

[115] *Id.* at 9. Also discharged from further consideration was S.3088, *id.* at 9, which became S.3203. *Id.* at 9, 112.

[116] *Id.* at 114. *See* NLRB v. St. Francis Hospital of Lynwood, 601 F.2d 404, 101 L.R.R.M. 2943 (9th Cir. 1979). Additional support for this theory is found in Senator Taft's remarks on July 10, 1974—the day the Senate adopted the conference report. Senator Taft said that "straight application" of the Act would not have recognized the unique responsibilities and problems of the health care industry and that therefore he had pressed for "safeguards" which would avoid the "mechanical application of the standard National Labor Relations Act procedures." LEGISLATIVE HISTORY, *supra* note 3, at 373, 120 CONG. REC. 22579 (July 10, 1974). Senator Taft thereafter specifically discussed some of the special provisions of the 1974 amendments without mentioning the admonition regarding bargaining units. *Id.* at 373-74, 120 CONG. REC. 22579-80 (July 10, 1974). Thus, while his words would appear to contemplate the admonition as well as other provisions of the amendments, his failure to mention it specifically does serve to lessen the significance of his remarks of July 10 insofar as the bargaining units issue is concerned.

[117] See the text accompanying and following note 182 *infra*.

[118] See note 16 *supra* and accompanying text.

[119] 208 N.L.R.B. 403, 85 L.R.R.M. 1093 (1974).

[120] 205 N.L.R.B. 888, 84 L.R.R.M. 1075 (1973).

[121] 208 N.L.R.B. at 403, 85 L.R.R.M. at 1093 (1974).

unit. In doing so the Board noted common interests shared by the maintenance workers with other nursing home employees and emphasized the lack of skill and training required for performance of their duties.[122]

Similarly in *Woodland Park*, the Board dismissed a petition which sought an election for a separate radiology department unit in a proprietary general hospital. Upon reviewing various aspects of the hospital's operation, the Board concluded that the x-ray technicians did not possess a community of interest separable from that of other technical employees.[123] In reaching this decision the Board relied particularly upon the contacts and functional integration of the x-ray technicians with other technical employees, and noted that the establishment of a separate unit for x-ray technicians would, under the circumstances, "lead to severe fragmentation of units in the health care industry."[124] In response to a petition for a "broad unit" at the same hospital which was filed by a second union, the Board held that all hospital employees except professional and confidential personnel, registered nurses, dieticians, pharmacists, guards, and supervisors constituted an appropriate unit.[125]

The approving citation of these two cases by the Senate and House Committees clearly confirms their expressed desire that the number of bargaining units in health care institutions be carefully limited. By citing *Four Seasons*, Congress approved the denial of separate bargaining units for maintenance department employees. Likewise, the citation of *Woodland Park* reflects congressional support for the denial of separate bargaining units consisting of single departments of technical employees. In addition, approval of *Woodland Park* reveals support for the creation of broad bargaining units. This support became clearly evident when the Senate and House Committees noted with approval "the trend toward broader units enunciated in *Extendicare of West Virginia, Inc.*"[126]

In *Extendicare*, the employer operated a proprietary general hospital which employed approximately 140 persons.[127] The petitioner sought elections in three separate units comprised of licensed practical nurses (LPNs), technical employees, and service and maintenance employees. The hospital contended that a single unit composed of all such employees together with medical records department and business office employees would be appropriate. The Board held that two separate units were appropriate: one comprised of all LPNs and the other comprised of all service and maintenance and technical employees.[128] The Board found that the LPNs shared a com-

[122] *Id.*

[123] 205 N.L.R.B. 888, 889, 84 L.R.R.M. 1075, 1076-77 (1973).

[124] *Id.*

[125] Member Jenkins dissented, saying that in overruling in an earlier case, the Board was deciding that a unit of x-ray technicians was *per se* inappropriate. *Id.*

[126] 203 N.L.R.B. 1232, 83 L.R.R.M. 1242 (1973). The Committees specifically stated, however, that their reference to *Extendicare* was not meant to imply that they necessarily approved of all the holdings of that decision. See text at note 20 *supra*. LEGISLATIVE HISTORY, *supra* note 3, at 12, 120 CONG. REC. 11622 (April 24, 1974) (Senate Committee on Labor and Public Welfare), 274-75 (House Committee on Education and Labor).

[127] 203 N.L.R.B. at 1232, 83 L.R.R.M. at 1242.

[128] *Id.* at 1233, 83 L.R.R.M. at 1242-43.

The Board excluded medical records department employees, business of-

munity of interests distinct from that of other employees,[129] while the technical personnel shared a substantial community of interests with the service and maintenance employees.[130] The Board reasoned that since a community of interests existed, a separate unit of LPNs had been found appropriate, there were only seven technical employees and the petitioning union was willing to represent technical personnel with service and maintenance employees in a single unit, the creation of bargaining units for technical personnel separate from the service and maintenance employees would have resulted in "unwarranted unit fragmentation."[131]

The "trend toward broader units" in *Extendicare* which was noted by Congress can only relate to the combination by the Board of technical personnel with service and maintenance employees. Only in this respect did the Board create a unit larger than that sought by the petitioner. The Committees specifically stated in a footnote that their reference to *Extendicare* was not meant to imply approval of all the holdings of that decision.[132] This qualifying footnote appears to have been prompted by the establishment by the Board of a separate LPN unit. Disapproval of the separate LPN unit would be consistent with the thrust of the committees' statement concerning unit proliferation. This interpretation is also consistent with a statement by Senator Taft in which he referred to the footnote and criticized part of the holding in *Extendicare* as "not consistent with minimization of the number of bargaining units in health care institutions."[133] The National Labor Relations Board in *St. Catherine's Hospital of Dominican Sisters*[134] said that Senator Taft's remarks reflected his disagreement with the creation of a separate bargaining unit for LPNs in *Extendicare*.[135] Thus, according to the Board in *St. Catherine's*, such legislative history weighed heavily against finding appropriate a separate unit of LPNs or a "fragment" of a technical unit such as x-ray technicians.[136] The

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fice employees, registered nurses, professional employees, guards, and supervisors from these units.

[129] *Id.* at 1232, 83 L.R.R.M. at 1242.

[130] *Id.* at 1233, 83 L.R.R.M. at 1242-43.

[131] *Id.* Member Kennedy dissented, arguing that an overall unit was appropriate. He discerned little difference between the duties and functions of the LPNs in this case and those in other cases in which LPNs had been included in an overall unit. 203 N.L.R.B. at 1234, 83 L.R.R.M. at 1243. He asserted that the distinguishing difference between *Extendicare* and other cases appeared to be the desires of the unions seeking representation and concluded that the establishment of a separate unit of LPNs was a "fragmentation" of the comprehensive unit which would serve only to impede collective bargaining. *Id. See*, LEGISLATIVE HISTORY, *supra* note 3, at 255, 120 CONG. REC. 13559 (May 7, 1974).

[132] See text at note 16 *supra*. LEGISLATIVE HISTORY, *supra* note 3, at 12, 120 CONG. REC. 11622 (April 24, 1974) (Senate Committee on Labor and Public Welfare), 274-75 (House Committee on Education and Labor).

[133] LEGISLATIVE HISTORY, *supra* note 3, at 255, 120 CONG REC. 13559 (May 7, 1974).

[134] 217 N.L.R.B. 787, 89 L.R.R.M. 1070 (1975).

[135] *Id.* at 789, 89 L.R.R.M. at 1073.

[136] *Id.* The Text of the Board's statement in this regard is as follows:
Senator Taft had proposed legislation guaranteeing separate technical and clerical units. Thus his disagreement with *Extendicare* seemingly was with the creation of a separate unit for the licensed practical nurses, which he

Court of Appeals for the Third Circuit has cited *St. Catherine's* for the proposition that there is "some indication" in the legislative history that the reservations expressed by the committees about *Extendicare* were directed to the Board's exclusion of LPNs from a unit of technical, service and maintenance employees.[137]

It is possible, but not likely, that the qualifying footnote referred to the Board's exclusion of office workers from the unit of technical, service and maintenance employees. This action, too, carried with it the potential for an increase in the number of units at the hospital and thus was "not consistent with minimization of the number of bargaining units in health care institutions."[138] However, the Board's decision to exclude the office clericals drew little attention in the case compared to that focused upon the LPN issue by Member Kennedy's dissent. No participant in the debate which has been carried on since 1974 concerning the propriety of health care bargaining units has suggested that the footnote regarding *Extendicare* referred to the exclusion of office clericals.[139] Also, Senator Taft's S. 2292 would have permitted separate units of clerical employees.[140] It is unlikely that he had in mind the exclusion of clerical employees when he referred to the footnote regarding *Extendicare*.[141]

Thus the Committees' footnote concerning *Extendicare* reflects congressional disapproval of the establishment of separate bargaining units for LPNs. The citation of *Extendicare* itself, therefore, can be said to indicate congressional support for combining technical personnel with service and mainte-

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> regarded as not "consistent with minimization of the number of bargaining units in health care institutions."
>
> This legislative history weighs against our finding appropriate a separate unit of licensed practical nurses or a fragment of a technical unit such as x-ray technicians, certainly at the outset of our application of the Act to hospitals and in the absence of any broad experience in this area. Instead, we seek to avoid the undue proliferation of bargaining units which Congress intended the Board to avoid by finding in nonprofit hospital cases, as in other Board cases, that an appropriate unit may consist of employees who do not meet the strict requirements of the term "professional" employees but whose work may be described as of a technical nature.

The Board held a unit of all technical employees, including LPNs, to be appropriate. *Id.* at 790. In his dissent in Mount Airy Foundation, 217 N.L.R.B. 802, 804, 89 L.R.R.M. 1067, 1070 (1975), Member Kennedy stated that the committees' footnote regarding *Extendicare* referred to the Board's granting of a separate unit of LPNs in that case.

[137] St. Vincent's Hospital v. NLRB, 567 F.2d 588, 591 n.5, 97 L.R.R.M. 2119, 2122 n.5 (3d Cir. 1977).

[138] See Appendix A.

[139] The lack of attention focused upon the exclusion of office employees from broader units compared to that drawn by the exclusion of LPNs from such units is understandable. Clearly, LPNs share a far more substantial community of interests with technical, service, and maintenance employees than do office workers.

[140] See text at note 84 *supra*.

[141] Of course, Taft's S.2292 would have permitted a maximum of only five separate units. Thus, it is possible that his attitude toward separate clerical units would have been different in the context of S.2292 than in the context of the flexible approach ultimately adopted by Congress.

nance employees in a single bargaining unit. When *Woodland Park, Four Seasons,* and *Extendicare* are considered together and in the context of the committees' admonition against the proliferation of bargaining units, certainly they weigh against the creation of separate departmental units.[142]

Although the Board must always consider the "public interest" in determining the appropriate number of bargaining units in each case,[143] the "public interest" in cases involving health care institutions includes the prevention of unit proliferation. Both Senators Taft and Williams, in the course of their remarks, referred to the case of *NLRB v. Delaware-New Jersey Ferry Co.*[144] Senator Taft stressed the importance of preventing the proliferation of bargaining units in the health care industry and then stated that the Board needed to examine the public interest in determining appropriate bargaining units, citing *Delaware-New Jersey Ferry Co.* as authority.[145] Senator Williams also relied upon *Delaware-New Jersey Ferry Co.* in his statement that the Senate Committee, by warning against unit proliferation, did not intend to preclude the Board, "acting in the public interest," from exercising its experience and knowledge in determining appropriate units.[146]

In *Delaware-New Jersey Ferry Co.* itself the Third Circuit denied enforcement to that portion of a Board order which found a bargaining unit composed of both supervisory and non-supervisory maritime employees to be appropriate. The court reasoned that the Board had exceeded its administra-

[142] The citation of *Woodland Park* probably reflects congressional approval of the Board's denial of a request for a unit consisting of a single department of technical employees. The committees' reference to *Extendicare* appears to reflect congressional disapproval of the establishment of separate units of LPNs, and approval of combined units of technical and service and maintenance employees. The reference to *Four Seasons* probably reflects congressional rejection of units limited to maintenance department employees.

Four Seasons may not stand for such a broad proposition. The maintenance employees were not skilled employees. Also, the only two non-supervisory employees were assigned to the maintenance department in *Four Seasons*—a number which is doubtless much smaller than that found in maintenance departments of many hospitals.

This factor might appear to constitute a basis on the other side of the ledger for distinguishing *Four Seasons* from other hospital cases insofar as the need for separate unit treatment is concerned. The small number of maintenance employees involved in *Four Seasons* might provide a stronger basis for denying separate unit status than might exist at hospitals where larger numbers of maintenance employees are employed. However, Four Seasons Nursing Center employed only 143 employees altogether. Thus the ratio of the number of maintenance employees to total employees was not that different from many other hospitals. *See, e.g.*, Riverside Memorial Hospital, 241 N.L.R.B. No. 184, 101 L.R.R.M. 1056 (1979) (ratio of 50 maintenance employees to 2,500 total employees). More importantly, the number of employees in a proposed unit is of significance to the unit proliferation issue only insofar as it relates to the number of *groups* of employees which may constitute appropriate bargaining units. The unit proliferation issue turns on the question of how many bargaining units a given institution may be required to recognize and not on the question of how many employees are in each such unit.

[143] *See* NLRB v. Delaware-New Jersey Ferry Co., 128 F.2d 130, 137, 10 L.R.R.M. 611, 618 (3d Cir. 1942).

[144] *Id.*, 10 L.R.R.M. 611.

[145] See Appendix A.

[146] See Appendix B.

tive discretion by including supervisory and non-supervisory employees in the same unit.[147] Although noting that few of the supervisors objected to this arrangement, the court declared that the Board's duty is to serve the public interest and that such duty cannot be altered by the wishes of any of the parties involved.[148]

Obviously, the meaning of the "public interest" to which Senators Taft and Williams referred in their statements in 1974 regarding health care bargaining units is not precisely the same as that spoken of by the court in *Delaware-New Jersey Ferry Co.* Certainly the Senators had in mind their own views of what the public interest requires in the way of numbers of separate units in health care institutions. In his remarks on May 2, 1974,[149] Senator Taft discussed the issues of the jurisdictional disputes and work stoppages which would result from "unwarranted unit fragmentation," the administrative problems that would be created if health care institutions were treated as other industries—notably the construction industry—and the increase in costs of medical care which would result from wage "leapfrogging" and "whipsawing" that would be caused by "undue unit proliferation."[150] Following this discussion, Senator Taft said that the Senate committee had recognized certain "issues" concerning health care bargaining units and had taken a significant step in establishing the public interest as a factor to be considered by the Board.[151]

On May 7, 1974, Senator Taft again expressed his conviction that every effort should be made to prevent a proliferation of health care bargaining units by describing one of the findings of *Extendicare* as being inconsistent with the minimization of bargaining units in health care institutions.[152] He then added that a need existed for the Board to consider the public interest in this regard.[153] Clearly Senator Taft meant that the "public interest"

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[147] 128 F.2d at 137, 10 L.R.R.M. at 618.

[148] *Id.*

[149] See Appendix A.

[150] *Id.*

[151] *Id.*

[152] *Id.*

[153] *Id.* In St. Vincent's Hospital v. NLRB, 567 F.2d 588, 592, 97 L.R.R.M. 2119, 2122 (3d Cir. 1977), the Court of Appeals for the Third Circuit said that the "public interest in preventing fragmentation [of bargaining units] in the health care field" must be balanced against the significance attached to traditional community of interest factors in establishing bargaining units.

In Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1040 (1978), *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979), Member Penello said in his dissenting opinion that:

> As phrased by Senator Taft, the congressional mandate against multiplication of bargaining units in this field forms a "factor of public interest," beyond that of community of interest among employees, which the Board is required to take into account when making decisions about the appropriateness of units in a health care institution.

Member Penello expressed a similar sentiment in his dissent in Riverside Memorial Hospital, 241 N.L.R.B. No. 184, 101 L.R.R.M. 1056, 1059 (1979). See also text accompanying note 191 *infra*.

weighed in favor of minimizing the number of bargaining units in health care institutions.[154]

Senator Williams's reference to the public interest and his citation of *Delaware-New Jersey Ferry Co.* was preceded by his statement that while the Board has generally tended to avoid the unnecessary proliferation of units, circumstances sometime require the existence of a number of units, particularly where they are justified by a history of bargaining or by a "notable disparity" of interests.[155] He then concluded by saying that while the Senate committee intended that the Board give due consideration to its admonition concerning the proliferation of units, the committee did not intend within this framework to preclude the Board, "acting in public interest," from exercising its experience and knowledge in determining units.[156]

It is not clear from Senator Williams's statement whether he meant that the "public interest" would warrant the creation of a greater number of bargaining units than would the committees' admonition. If Senator Williams intended such meaning, it would be contrary not only to that expressed by the committees but also to that conveyed by Senator Taft and should not be considered in assessing the intent of Congress. If Senator Williams simply meant that Congress had intentionally left the Board with some flexibility in determining appropriate bargaining units, his statement is consistent with that of Senator Taft.[157] A fair and careful reading of Senator Williams's remarks would appear to warrant the conclusion that they are consistent with those of Senator Taft, since Senator Williams spoke of the Board's exercise of experience and knowledge "within [the] framework" of the congressional admonition regarding proliferation.

Section 9(b) of the National Labor Relations Act reflects a "public interest" which the Board has been directed by Congress to consider in determining appropriate bargaining units. In that section, Congress directed the Board in establishing appropriate bargaining units to determine what unit will assure employees the "fullest freedom in exercising the rights guaranteed" by the Act.[158] This public interest existed under the Act prior to the passage of the health care amendments and now applies to the establishment of bargaining units in health care institutions. However, as was indicated by Senator Taft, Congress has established another public interest factor which must also be considered by the Board in deciding bargaining unit cases in health care institutions—the public interest in minimizing the number of separate bargaining units established.

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[154] In NLRB v. Mercy Hospital Ass'n., 606 F.2d 22,25-26, 102 L.R.R.M. 2259, 2263 (2d Cir. 1979), the Court of Appeals for the Second Circuit relied upon the remarks of Senator Taft to conclude that Congress intended that "substantial weight" be given the "public interest in preventing unit fragmentation" when determining appropriate health care institution bargaining units.

[155] See Appendix B.

[156] *Id.*

[157] See text accompanying notes 64-65 *supra*.

[158] 29 U.S.C. § 159(b) (1976).

4. Senator Taft's Reference to the Construction Industry

In *Allegheny General Hospital* the Board expressed the opinion that Senator Taft's remarks concerning the proliferation of bargaining units in the health care field amounted only to a narrow concern that separate bargaining units not be established for each professional interest or job classification as they had been in the construction and certain other similarly organized industries.[159] The Board based its conclusion on Senator Taft's statements that if "each professional interest and job classification" were permitted to form a separate unit, numerous administrative and labor relations problems would follow,[160] and that "[h]ealth-care institutions must not be permitted to go the route of other industries, particularly the construction trades, in this regard."[161]

The Board also reasoned that to conclude that Taft's words reflected a broader concern would create a conflict between the statements of Senator Taft and the remarks of Senator Williams.[162] The Board noted Senator Williams's statement that the Board had, "as a rule," avoided unnecessary proliferation.[163] If Senator Taft's statements reflected a concern with respect to the manner of establishing units in industries other than the construction and similarly organized industries, then his view of the Board's treatment of the bargaining unit issue would be inconsistent with that of Senator Williams.[164] The Board expressed doubt that the two chief sponsors of the 1974 amendments would disagree about such an important aspect of the legislation.[165]

Member Penello disagreed with the majority's reasoning in *Allegheny General*.[166] He asserted that an impartial reading of Senator Taft's statement discloses a more general concern with the possible application to the health care field of the Board's approach to bargaining unit determinations and that the Senator had cited the construction industry only as a particularly undesirable example of unit proliferation.[167] Member Penello supported his reading

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[159] 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1033 (1978), *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979).

[160] *Id.* LEGISLATIVE HISTORY, *supra* note 3, at 113, 120 CONG. REC. 12944 (May 2, 1974). See Appendix A.

[161] *Id.* LEGISLATIVE HISTORY, *supra* note 3, at 114, 120 CONG. REC. 12944-45 (May 2, 1974). See Appendix A.

[162] *Id.* at 1034.

[163] *Id.*

[164] *Id.*

[165] *Id.* Congressman Ashbrook also indicated that the Board's past performance had been acceptable. He said that in the past the Board had "acted at its discretion in a congressionally approved manner." LEGISLATIVE HISTORY, *supra* note 3, at 411, 120 CONG. REC. 22948 (July 11, 1974). A full text of his statement is found in Appendix C.

[166] In NLRB v. Mercy Hospital Ass'n, 606 F.2d 22, 102 L.R.R.M. 2262 (2d Cir. 1979), the Court of Appeals for the Second Circuit also expressed a different reading of the legislative history. The court found a congressional intent that health care institutions be spared not only the "egregious" unit proliferation of the construction industry, but also the less extreme unit fragmentation caused by applying traditional unit criteria. *Id.* at 27, 102 L.R.R.M. 2784.

[167] *Allegheny General*, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1041, *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979).

of Senator Taft's statement by presuming Senator Taft to have been aware that the Board's treatment of the construction industry had been substantially dictated by a pattern of craft organization in effect at the time the Board asserted jurisdiction over the industry and by the existence of distinct craft skills.[168] According to Member Penello, the health care industry was predominantly unorganized in 1974 and free from craft skill classifications.[169] Thus, Senator Taft must have reasoned that if the Board were left to its own devices it would find the same units to be appropriate in health care institutions as were deemed appropriate in typical industrial facilities.[170]

Member Penello's supporting argument appears a bit too technical when considered in light of the Senator's statement itself. Even if Penello is correct in his assessment of the result which application of traditional community of interest factors to the skill levels and groupings of employees in the health care industry would have produced,[171] Senator Taft must have been concerned, nonetheless, that separate units similar to those of the "construction trades" might be established by the Board; otherwise, he would not have used such words. However, the fact that Senator Taft expressed concern about a construction industry model does not necessarily mean that his concern ended at that point.

The committee admonition which Senator Taft purported to explain was not limited in its terms to craft units of the sort found in the construction or similar industries. Rather, as has been discussed earlier,[172] Congress adopted a compromise approach which did not limit the number or types of bargaining units which could be estabished in health care institutions. Had the committees and Senator Taft been concerned only about the possible adoption of the construction industry model in the health care field, then presumably they would have said so in an unmistakable fashion. Indeed, as has also been discussed earlier,[173] the pre-amendment Board decisions cited by the committees can be said to reflect congressional disapproval of certain separate departmental units. Such units are broader in scope than are many of the separate classification and function units recognized in the construction industry.[174]

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[168] *Id.*

[169] *Id.*

[170] *Id.* Member Penello noted that in industry generally, the Board has not found groups of employees in individual job classifications within departments to be appropriate separate units. *Id.* at 1041 n.96.

[171] Member Penello reasoned that the Board's ordinary approach to the establishment of bargaining units would not have resulted in the creation of a pattern of units in the health care industry similar to that of the construction industry because more distinct craft skills existed in the construction industry. This assessment is by no means certain. The Board has established bargaining units in the construction industry on the basis of the functions performed by employees as well as on the basis of their possession of craft skills. Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1033 (1978), *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979); R.B. Butler, Inc., 160 N.L.R.B. 1595, 1599, 63 L.R.R.M. 1173 (1966). Also, the Board's construction industry standards have not required that employees in skilled trades units exercise "pure" craft skills. Hychem Constructors, Inc., 169 N.L.R.B. 274, 67 L.R.R.M. 1216 (1968).

[172] See text preceding note 116 *supra*.

[173] See text accompanying notes 118-42 *supra*.

[174] See note 171 *supra*.

Member Penello is on safer ground when he argues that an impartial reading of Senator Taft's statement reveals a concern with issues other than simply the fear of health care bargaining units established along craft or job classification lines. Senator Taft said that the health care industry should not be dealt with in the same manner as "other industries, particularly the construction trades."[175] His use of the phrase "other industries" contains no indication of any limitation of the scope of his reference to any particular industry or group of industries. The placement of the words "particularly the construction trades" following the words "other industries" and the usual meaning of the word "particularly" can only in fairness lead to the conclusion that Senator Taft cited the construction industry as an example of the treatment he had feared. It is reasonable to conclude that if he had meant only that health care industry bargaining units should not be established in the same pattern as that of the construction industry he would have said just that and nothing more. Furthermore, Senator Taft's use of the phrase "each professional interest"[176] in speaking of the potential proliferation of units can fairly be viewed to reflect a concern about the establishment of separate units broader than those limited to specific job classifications or functions. Registered nurses, for example, may be considered to constitute a "professional interest." But they may also be employed in a variety of classifications and functions such as surgical nurses, cardiology nurses, nurse anesthetists, instructors, clinical specialists, health care practitioners, and pediatric nurses.[177] The same may be said of physicians who may occupy positions as radiologists, psychiatrists, anesthesiologists, pathologists, pediatricians, emergency room physicians, and clinical physicians.[178]

The Board's argument that Penello's interpretation of Senator Taft's remarks would create a conflict between Taft's statement and that of Senator Williams is not necessarily correct. Senator Williams clearly addressed himself to an assessment of the Board's past performance in establishing bargaining units. That Senator Taft's remarks reflect a judgment of past Board performance is not as clear. While it can be argued with some force that Taft's expression of concern reflected an implied judgment of the Board's past performance, it is undeniable that Senator Taft did not expressly make such a

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[175] LEGISLATIVE HISTORY, *supra* note 3, at 114, 120 CONG. REC. 12945 (May 2, 1974). See Appendix A.

[176] *Id.* at 113, 120 CONG. REC. 12944 (May 2, 1974). See Appendix A.

[177] *See, e.g.*, Samaritan Health Services, Inc., 238 N.L.R.B. No. 56, 99 L.R.R.M. 1551, 1559 n.14 (1978) (nurse anesthetist, clinical specialist, bed control officer, director of projects and studies, utilization and review officer, and environmental control officer); Ohio Valley Hospital Ass'n, 230 N.L.R.B. 604, 95 L.R.R.M. 1430 (1977) (instructors and assistant instructors); Kaiser Foundation Health Plan of Colorado, 230 N.L.R.B. 438, 439, 95 L.R.R.M. 1376, 1377 (1977) (adult health care practitioner, maternity/GYN nurse, pediatric nurse practitioner and physician screening nurse); St. Mary's Hospital, Inc., 220 N.L.R.B. 496, 90 L.R.R.M. 1316 (1975) (clinicians and nursing care coordinators); Newton-Wellesley Hospital, 219 N.L.R.B. 699, 90 L.R.R.M. 1091 (1976) (nursing instructors and nursing school chairmen); The Trustees of Noble Hospital, 218 N.L.R.B. 1441, 89 L.R.R.M. 1806 (1975) (nurse anesthetists).

[178] *See* Ohio Valley Hospital Ass'n, 230 N.L.R.B. 604, 95 L.R.R.M. 1430 (1977); N.Y.U. Medical Center, 217 N.L.R.B. 522, 89 L.R.R.M. 1045 (1975).

judgment. Thus, Senator Taft's remarks could be deemed to constitute nothing more than an expression of concern which reflected no position whatever toward the Board's past actions regarding the establishment of bargaining units. Senator Taft was among those congressmen who referred to the health care industry as being "unique,"[179] and thus may not have formed a precise vision of what the Board would do if left to its own devices.

Moreover, the meaning of Senator Williams's assessment of the Board's performance was not quite as clear as the Board's stance might indicate. The Board neglected to note Senator Williams's statement that the Board had, "as a rule, *tended*"[180] to avoid unnecessary proliferation of bargaining units. Thus, Senator Williams's statement can be said to reflect a conclusion that to some unspecified extent the Board had not avoided an unnecessary proliferation of bargaining units.

In any event, in construing the meaning of the senators' words, little or no weight should be accorded the fact that one of two interpretations would allegedly create a conflict between the statements of the sponsors of the legislation. Senator Williams himself apparently deemed another portion of Senator Taft's statements concerning bargaining units to be inconsistent with Congress's intent.[181] Thus, there is some indication that the two men did in fact disagree to some extent about the issue, although their comments are susceptible to reasonable interpretations that would discern only differences in tone or degree.

5. The Board's Use of Traditional Criteria in Determining Appropriate Bargaining Units

Much of the disagreement over the Board's establishment of health care institution bargaining units has concerned the weight which the Board should accord the community of interest factors upon which it has traditionally relied. In determining appropriate bargaining units in other industries, the Board has evaluated factors such as the mutuality of interests in wages, benefits, and working conditions; shared skills and supervision; the frequency of contact with other employees; the extent of interchange and functional integration of employees in the proposed unit with other employees; and the area practice and pattern of bargaining.[182] Application of such criteria serves to assure the coherence necessary for efficient collective bargaining while at the same time preventing the suppression of a functionally distinct minority group of employees in an overly large unit.[183]

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[179] LEGISLATIVE HISTORY, *supra* note 3, at 373, 120 CONG. REC. 22579 (July 10, 1974).

[180] *Id.* at 363, 120 CONG. REC. 22575 (July 10, 1974) (emphasis added). See Appendix B.

[181] See text at notes 21-29 *supra*.

[182] *See* Riverside Methodist, 241 N.L.R.B. No. 184, 101 L.R.R.M. 1056, 1059, n.13 (1979)(Penello, M., dissenting); Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1032 (1978), *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979).

[183] Allied Chemical & Alkalai Workers v. Pittsburgh Plate Glass Co., 404 U.S. 157, 172-73 (1971). The Board has said that in determining appropriate bargaining

In two early cases concerning the propriety of hospital bargaining units, the Board stated that its consideration of all issues affecting the composition of appropriate units must necessarily take place against the background of the congressional directive concerning unit proliferation.[184] Accordingly, the Board concluded early that units similar to those which had been found appropriate in other industries may not be appropriate in the health care context,[185] and that "on balance," significance should be attached to the high degree of integration in operations at the health care facility.[186]

More recently the Board has indicated a belief that traditional community of interest factors should be applied in the health care industry in the same manner as in other industries so long as the resulting unit pattern does not resemble the pattern of bargaining units in the construction trades. In *Allegheny General Hospital* the Board stated simply: "Congress intended that the appropriateness of health care units should be determined by the Board's traditional community-of-interest criteria . . . ."[187] The Board also said that the application of such criteria had led the majority of the Board to conclude that its "unit approach to the industrial sector would also suit the health care industry" inasmuch as it would avoid proliferation and guarantee employees the fullest freedom to exercise their rights under the Act as required by Section 9(b).[188] Upon reviewing its decisions in the health care field, the Board concluded that the unit pattern which has emerged does not resemble the pattern of bargaining units in the construction industry.[189] Finally, in *Riverside Methodist Hospital,* the Board stated without any qualification that the ap-

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units it seeks to accomplish the double objective of insuring the rights of employees to self-organization and freedom of choice and fostering industrial peace and stability through collective bargaining. Kalamazoo Paper Box Corp., 136 N.L.R.B. 134, 137, 49 L.R.R.M. 1715 (1962).

[184] Mercy Hospitals of Sacramento, Inc., 217 N.L.R.B. 765, 766, 89 L.R.R.M. 1097, 1099 (1975), *enf't denied in part,* 589 F.2d 968, 98 L.R.R.M. 2800 (9th Cir. 1978); The Jewish Hospital Ass'n of Cincinnati, 223 N.L.R.B. 614, 616, 91 L.R.R.M. 1499, 1504 (1976). *See also* West Suburban Hospital, 224 N.L.R.B. 1349, 92 L.R.R.M. 1369 (1976), *enf't denied,* 570 F.2d 213, 97 L.R.R.M. 2929 (7th Cir. 1978).

[185] Shriners Hospital for Crippled Children, 217 N.L.R.B. 806, 808, 89 L.R.R.M. 1076, 1079 (1975). Three opinions were written in the decision. The majority was comprised of Members Penello, Kennedy and Jenkins.

[186] *Id.*

[187] 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1034, *enf't denied,* 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979). In addition the Board stated: "We think it is also clear that Congress intended that we should rely on our traditional community of interest criteria in making unit determinations in the health care industry." 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1032 (1978). In its brief regarding the petition for review filed by Allegheny General Hospital with the Court of Appeals for the Third Circuit, the Board asserted that "*Congress chose to leave the Board free to exercise its discretion* [in the health care field] *as it does in making unit determinations in other areas.*" (emphasis of the Board) Brief for Respondent at 9-10, Allegheny General Hospital v. NLRB, 608 F.2d 965 (3d Cir. 1979).

[188] 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1034, *enf't denied,* 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979).

[189] *Id.* at 1037.

plication of traditional community of interest criteria "fully satisfies legislative concern regarding unit fragmentation in the health care industry."[190]

Member Penello disagreed with the majority's opinion in *Allegheny General* by arguing in his dissent that the congressional "mandate" against unit proliferation forms, in Senator Taft's words, a "factor of public interest" which must be considered in conjunction with the Board's traditional community of interest criteria.[191] According to Member Penello, this factor of public interest may require the denial of petitions for units which might be appropriate in other industries.[192] In addition, the Court of Appeals for the third Circuit disagreed with the Board's manner of applying traditional criteria and refused to enforce a Board order in *St. Vincent's Hospital v. NLRB*.[193] While the Board has interpreted the court's decision in *St. Vincent's* to preclude reliance upon traditional unit criteria in deciding health care institution cases,[194] the court actually called for an approach similar to that urged by Member Penello. The court said that community of interest factors must be placed "in balance against the public interest in preventing fragmentation" of bargaining units in the health care industry.[195] The Courts of Appeals for the Second

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[190] 241 N.L.R.B. No. 184, 101 L.R.R.M. 1056, 1057 (1979). There are recent cases in which the Board has admitted that it must balance the traditional criteria with the congressional admonition, Michael Reese Hospital and Medical Center, 242 N.L.R.B. No. 50, 101 L.R.R.M. 1157, 1159 (1979), and that its consideration of bargaining unit cases must take place against the background of the congressional admonition, Montefiore Hospital and Medical Center, 235 N.L.R.B. 241, 242-43, 97 L.R.R.M. 1474, 1475 (1978).

[191] 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1040 (1978) (Penello, M., dissenting), *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979). See note 153 *supra* for the complete statement. Member Penello expressed a similar conclusion in Riverside Methodist, 241 N.L.R.B. No. 184, 101 L.R.R.M. 1056, 1059 (1979) (Penello, M., dissenting).

[192] 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1040, *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979).

[193] 567 F.2d 588, 97 L.R.R.M. 2119 (3d Cir. 1977).

[194] Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1031 (1978), *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979).

[195] 567 F.2d at 592, 97 L.R.R.M. at 2122.

The text of the court's statement was as follows:

> The legislative history of the health care amendments, however, makes it quite clear that Congress directed the Board to apply a standard in this field that was not traditional. Proliferation of units in industrial settings has not been the subject of congressional attention but fragmentation in the health care field has aroused legislative apprehension. The Board therefore should recognize that the contours of a bargaining unit in other industries do not follow the blueprint Congress desired in a hospital.
>
> Similarly, the factors of amount of contact between workers, separate immediate supervision, and the special skills of certain crafts must be put in balance against the public interest in preventing fragmentation in the health care field. A mechanical reliance on traditional patterns based on licensing, supervision, skills and employee joint activity simply does not comply with congressional intent to treat this unique field in a special manner.

Id.

Earlier, in *Memorial Hospital of Roxborough v. NLRB*, 545 F.2d 351, 361, 93 L.R.R.M. 2571, 2577-78 (3d Cir. 1976), the Court of Appeals for the Third Circuit

and Ninth Circuits have reached similar conclusions.[196] In *NLRB v. West Suburban Hospital*,[197] the Court of Appeals for the Seventh Circuit said that Congress has clearly required the Board to view evidence concerning traditional community of interest factors "in the context" of the expressed congressional policy of preventing the proliferation of bargaining units in the health care field.[198]

The Board defends its use of traditional criteria on two grounds. First, the Board reasons that if Congress has wished to preclude the use of traditional criteria it could have done so either by amending Section 9(b) of the Act, concerning the determination of appropriate bargaining units, or by adopting the approach originally advocated by Senator Taft in S. 2292.[199] While the Board's assertion of what Congress might have done is correct, it does not help to determine the degree of significance which should be given to traditional community of interest factors in determining appropriate units. Clearly Congress did not wish to prohibit the Board from considering such factors altogether. Indeed, the Board opinions cited by Congress in its proliferation admonition contained community of interest criteria analyses. On the other hand, Congress did not simply remove the exemption of nonprofit hospitals from coverage under the Act, thereby signalling the Board's right to apply community of interest factors to the health care field in the same manner as in other industries. Instead, Congress issued its admonition concerning the proliferation of bargaining units as an affirmative expression of intent. This intent cannot be disregarded by the Board in determining the weight to be assigned traditional criteria. The Board clearly exceeds its power when it attempts to implement the policy expressed in *Riverside Methodist*—that utilization of traditional criteria "fully satisfies" Congress's concern regarding unit fragmentation. The statement by Congress concerning proliferation of bargaining units must be deemed by the Board to mean *something*. In *Allegheny General* the Board did say that Congress intended to prevent the pattern of units established in the health care field from resembling that of the construction industry. As was demonstrated in the preceding section,[200] however, Congress's concern was broader than has been suggested by the Board. Thus, the Board's utilization of traditional criteria must reflect a congressional concern broader in scope than merely an intention to avoid the adoption of the construction industry model in the health care field.

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said that while the factor of the congressional admonition should not be "controlling" in the Board's unit determinations, it should be viewed as a "prescribed factor to guide" the Board's exercise of discretion.

[196] NLRB v. Mercy Hospital Ass'n, 606 F.2d 22, 27, 102 L.R.R.M. 2259, 2262 (2d Cir. 1979). NLRB v. St. Francis Hospital of Lynwood, 601 F.2d 404, 418-19, 101 L.R.R.M. 2943, 2953 (9th Cir. 1979).

[197] 570 F.2d 213, 97 L.R.R.M. 2929 (7th Cir. 1978).

[198] *Id.* at 215, 97 L.R.R.M. at 2931. In Bay Medical Center, Inc. v. NLRB, 588 F.2d 1174, 1178, 100 L.R.R.M. 2213, 2215 (6th Cir. 1978), *cert. denied*, 102 L.R.R.M. 2360 (1979), the Court of Appeals for the Sixth Circuit concluded that the Board had, in the case before it "balanced" the congressional policy against undue proliferation with the policy against disrupting existing bargaining relationships.

[199] Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1032 (1978), *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979).

[200] See text accompanying notes 172-181 *supra*.

The second basis used by the Board to support its manner of applying traditional criteria is Senator Williams's statement that "a notable disparity of interests between employees" will sometimes warrant the creation of separate units.[201] The Board reasons that the existence of a "notable disparity of interests" can be determined only by application of the Board's traditional community of interest criteria.[202] However, it is unreasonable to conclude that Senator Williams's statement was intended to permit the Board to rely exclusively upon its traditional criteria. In the sentence following the phrase relied upon by the Board, Senator Williams noted that the Senate committee clearly intended that the Board give due consideration to the committee's admonition concerning proliferation of bargaining units.[203]

In summary, the Board's apparent intention to rely almost exclusively upon the application of traditional community of interest criteria in establishing health care industry bargaining units is not justified by pertinent legislative history. Rather, an approach such as that suggested by Member Penello and the courts of appeals must be deemed to be the approach preferred by Congress. Congress intended that the Board consider both its warning against unit proliferation and traditional community of interest factors in establishing health care bargaining units. Therefore, it follows logically that Congress expected the Board to weigh the two factors on a case by case basis within congressionally indicated parameters.

C. *Summary of Indications of Congressional Intent*

The analysis in the preceding sections suggests a number of conclusions which, when considered together, provide guidelines for determining appropriate bargaining units in health care institutions. Congress used language which without a doubt prohibits the proliferation of bargaining units. Resolution of the bargaining unit issue was considered to be among the most important issues confronted by Congress in passing the 1974 amendments, and the adoption of identical mandates by the Senate and House committees constitutes a unique action insofar as the establishment of bargaining units in a particular industry is concerned. Congress intended to leave the Board the flexibility necessary to exercise its experience and expertise in establishing health care institution bargaining units. However, it did not intend to leave the Board with the same degree of flexibility which would have resulted had the health care amendments been passed without warnings against the proliferation of bargaining units. Thus, the Board may apply its traditional community of interest criteria in determining appropriate units, but it may not rely exclusively upon such criteria. Instead, the Board must exercise its discretion within the framework of the congressional admonition, and units which might be appropriate in other industries may not be appropriate in the health care industry.

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[201] LEGISLATIVE HISTORY, *supra* note 3, at 363, 120 CONG. REC. 22575 (July 10, 1974). For a complete statement of Senator Williams's remarks, see Appendix B.

[202] Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1034 (1978), *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979).

[203] LEGISLATIVE HISTORY, *supra* note 3, at 363, 120 CONG. REC. 22575 (July 10, 1974). See Appendix B.

Congress was wary of the creation of separate units for the many different job classifications and professional interests represented in health care institutions. Applying the traditional criteria in such a manner as merely to avoid the creation of a pattern of units in the health care industry which resembles the pattern in the construction industry is not sufficient to satisfy the concern of Congress regarding proliferation of units. The health care bargaining unit cases cited with approval by the congressional committees provide additional guidelines. Congress apparently does not approve of: separate units of LPNs, separate units of individual departments of technical employees, separate units of maintenance department employees or even of all technical employees, at least in certain situations. On the other hand, Congress apparently approves of the consolidation of several groups of employees into a single bargaining unit. While Congress did indicate its approval and disapproval of certain practices, it did not establish any specific measure or standard which it wished to have applied to unit cases in order to ensure the satisfaction of its concern regarding unit proliferation. The formulation of a precise rule in this regard is neither appropriate nor feasible in view of the flexibility which Congress apparently intended to leave to the Board.

The formula suggested by the Board suffers from a number of shortcomings. Member Penello, however, has proposed a test which appears to be a reasonable and appropriate approach to the problem. Member Penello has argued that separate units should be found appropriate in the health care industry only when employees in the proposed unit enjoy "an exceptionally high degree of community of interest among themselves, distinct and apart from other employees"[204]—a community of interest "significantly greater than that which would normally justify separate representation in other industries."[205] This test explicitly recognizes the right of the Board to apply community of interest factors and leaves the Board with flexibility in their application. However, it also recognizes Congress's desire that such criteria not be applied in the same manner as in other industries. Member Penello's standard enunicates a more stringent standard for the establishment of separate representation than is utilized in other industries.

Since Penello's formulation does not expressly set a limit on the number of units which may be created in health care institutions, tension may arise between the objectives of according separate unit status to groups enjoying exceptionally high degrees of interest and of limiting the number of separate units. Congress's concern with "proliferation" suggests only a limitation upon the number of units, and thus Penello's test is appropriately applied only when it is utilized in a manner that accords separate representation only to those groups of employees which enjoy the highest degrees of separate and distinct community of interests. In other words, Penello's test is properly employed only when it is used to limit the number of units established.[206]

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[204] Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1046 (1978) (Penello, M., dissenting), *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979).

[205] *Id.*, 100 L.R.R.M. at 1041.

[206] *See id.*, 100 L.R.R.M. at 1046 (Penello, M., dissenting).

II. Board Implementation of Congressional Intent

Although it appears that a process of evolution is still under way,[207] a number of specific guideposts in the Board's approach to the establishment of bargaining units in health care institutions are now clear. With respect to professional employees, the Board has indicated that it will find appropriate bargaining units comprised of three separate groups of employees: registered nurses,[208] physicians,[209] and residual professional employees.[210] With respect to non-professional employees, the Board has indicated that it may find appropriate separate bargaining units comprised of technical employees,[211] service and maintenance employees,[212] maintenance department employees[213] or powerhouse employees,[214] business office clerical employees,[215] and chauffeur-drivers.[216] In addition, Section 9(b) of the Act requires that guards not be placed in units with other employees.[217] Prior bargaining history in a

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[207] For instance, Member Penello predicted in his dissenting opinion in Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1046 (1978), *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979) that the Board will find more units to be appropriate as time goes on, particularly in the professional classifications. Recently the Board held a group of chauffeur-drivers to be an appropriate unit. Michael Reese Hospital and Medical Center, 242 N.L.R.B. No. 50, 101 L.R.R.M. 1157, 1159 (1979).

[208] *See, e.g.*, Mercy Hospitals of Sacramento, Inc., 217 N.L.R.B. 765, 770, 89 L.R.R.M. 1097, 1103 (1975).

[209] Montefiore Hospital and Medical Center, 235 N.L.R.B. 241, 243, 97 L.R.R.M. 1474, 1476 (1978); Ohio Valley Hospital Ass'n, 230 N.L.R.B. 604, 605, 95 L.R.R.M. 1430, 1431 (1977).

[210] *See, e.g.*, Mercy Hospitals of Sacramento, Inc., 217 N.L.R.B. 765, 769, 89 L.R.R.M. 1097, 1102 (1975).

[211] *See, e.g.*, Newington Children's Hospital, 217 N.L.R.B. 793, 795, 89 L.R.R.M. 1108, 1111 (1975); Nathan and Miriam Barnert Memorial Hospital Ass'n, 217 N.L.R.B. 775, 784, 89 L.R.R.M. 1083, 1096-97 (1975).

[212] *See, e.g.*, Newington Children's Hospital, 217 N.L.R.B. 793, 795, 89 L.R.R.M. 1108, 1111 (1975).

[213] *See, e.g.*, West Suburban Hospital, 224 N.L.R.B. 1349, 1351, 92 L.R.R.M. 1369, 1371 (1976), *enf't denied*, 570 F.2d 213, 97 L.R.R.M. 2929 (7th Cir. 1978).

[214] *See, e.g.*, Mercy Center for Health Care Services, 227 N.L.R.B. 1814, 1815, 94 L.R.R.M. 1534, 1536 (1977); St. Vincent's Hospital, 223 N.L.R.B. 638, 91 L.R.R.M. 1513 (1976), *enf't denied*, 567 F.2d 588, 97 L.R.R.M. 2119 (3d Cir. 1977); Kansas City College of Osteopathic Medicine, 220 N.L.R.B. 181, 182, 90 L.R.R.M. 1189, 1190 (1975). Where the Board has found separate maintenance units to be appropriate, boiler operators have been included. Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1037 (1978), *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979).

[215] *See, e.g.*, St. Catherine's Hospital, 217 N.L.R.B. 787, 790, 89 L.R.R.M. 1070, 1074 (1975); Mercy Hospitals of Sacramento, Inc., 217 N.L.R.B. 765, 770, 89 L.R.R.M. 1097, 1103 (1975). The Board's decision in *Mercy* concerning business office clericals was reversed and remanded in a connected proceeding, NLRB v. Mercy Hospitals, 589 F.2d 968, 98 L.R.R.M. 2800 (9th Cir. 1978), *cert. denied*, 440 U.S. 910 (1979), because of the Board's refusal to honor a stipulation of the parties.

[216] *See, e.g.*, Michael Reese Hospital and Medical Center, 242 N.L.R.B. No. 50, 101 L.R.R.M. 1157, 1159 (1979).

[217] 29 U.S.C. § 159(b)(3) (1973). *See also* Peninsula Hospital Center, 219 N.L.R.B. 139, 90 L.R.R.M. 1034 (1975).

specific health care institution,[218] the granting of comity by the Board to the unit determination of a state agency,[219] or an organizational structure which is out of the ordinary may increase or decrease the number of bargaining units deemed to be appropriate. Thus, pursuant to the Board's decisions to date, a health care institution may be confronted with nine or more separate bargaining units.[220] By way of contrast, the Board has found the following separate units to be appropriate in the industrial sector depending upon the circumstances with which it is presented: all professional employees, all production and maintenance employees, all technical employees and all office clerical employees.[221] Segments of any of these units may also be deemed appropriate.[222]

While denials of separate units can safely be assumed to be consistent with the admonition of Congress regarding the proliferation of units,[223] no such assumption can be made concerning the Board's creation of separate units. Consideration of Board action here will therefore be limited to an evaluation of the Board's action in approving these units. A complete analysis

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[218] *See, e.g.*, Bay Medical Center, Inc., 218 N.L.R.B. 620, 89 L.R.R.M. 1310 (1975); 224 N.L.R.B. 69, 92 L.R.R.M. 1380 (1976), *enf't granted*, 588 F.2d 1174, 100 L.R.R.M. 2213 (6th Cir. 1978).

[219] *See, e.g.*, Long Island College Hospital, 228 N.L.R.B. 83, 94 L.R.R.M. 1438 (1977), *enf't denied*, 566 F.2d 833, 96 L.R.R.M. 3119 (2d Cir. 1977), *cert. denied*, 435 U.S. 996 (1978).

[220] A Federal Mediation and Conciliation Service (FMCS) study, which included data up to December 31, 1976, concluded that the problem of unit proliferation appeared to be "limited." FMCS STUDY, *supra* note 4, at 439. The Service based this assessment upon the fact that only in approximately four percent of all bargaining situations did two or more unions represent employees at a single institution. *Id.* However, this figure excluded instances in which a single labor organization represented several units in a single institution. *Id.*

[221] Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1034-35 (1978), *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979).

[222] *Id.*

[223] The Board has in several instances denied petitions seeking elections in separate units of employees occupying a single job classification. San Jose Hospital and Health Center, Inc., 228 N.L.R.B. 21, 22, 96 L.R.R.M. 1391, 1392 (1977) (pharmacists); The Paul Kimball Hospital, Inc., 224 N.L.R.B. 458, 458, 92 L.R.R.M. 1342, 1342-43 (1976) (boiler operators); North American Medical Center, 224 N.L.R.B. 218, 220, 92 L.R.R.M. 1212, 1214 (1976) (emergency medical technicians); Dominican Santa Cruz Hospital, 218 N.L.R.B. 1211, 1211, 89 L.R.R.M. 1504, 1505 (1975) (medical laboratory technicians); Duke University, 217 N.L.R.B. 799, 799, 89 L.R.R.M. 1065, 1065 (1976) (switchboard operators); St. Catherine's Hospital, 217 N.L.R.B. 787, 788, 89 L.R.R.M. 1070, 1072 (1975) (LPNs); New York University Medical Center, 217 N.L.R.B. 522, 526, 89 L.R.R.M. 1045, 1049 (1975) (psychiatrists).

The Board has also denied some requests to establish separate departmental units. Riverside Methodist Hospital, 223 N.L.R.B. 1084, 1087, 92 L.R.R.M. 1033, 1036 (1976) (maintenance department employees); American Hospital Management Corp., 219 N.L.R.B. 25, 25, 89 L.R.R.M. 1499, 1499 (1975) (laboratory and x-ray department employees); Bay Medical Center, 218 N.L.R.B. 620, 622, 89 L.R.R.M. 1310, 1313 (1975), 224 N.L.R.B. 69, 71, 82 L.R.R.M. 1380, 1381 (1976), *enf'd*, 588 F.2d 1174, 1178, 100 L.R.R.M. 2213, 2215 (6th Cir. 1978) (housekeeping department). The Board also denied a request for a unit limited to "patient care" employees. Mount Airy Foundation, 217 N.L.R.B. 802, 89 L.R.R.M. 1067, 1069 (1975).

of the Board's approach would require, at least in some instances, extensive case by case analysis and comparison of the application of traditional community of interest criteria.[224] Such lengthy and detailed analysis is beyond the scope of this paper.[225] Instead, the following pages will note only such general observations regarding the Board's decisions as appear appropriate.

A. *Residual Units of Professional Employees, Service and Maintenance Units and Business Office Clerical Units*

The Board's approval of separate units for residual groups of professional employees, service and maintenance employees, and business office clerical employees appears to be appropriate.[226] These groupings are broad enough to encompass significant percentages of health care employees, thus potentially limiting the number of units. All three groupings might be characterized as "generic," their reach sweeping across departmental and classification lines. In general, according separate unit status to these groups avoids fragmentation of bargaining units and is consistent with the congressional non-proliferation admonition.[227] In addition these three groups qualify for separate treatment under traditional community of interest criteria. In *Newington Children's Hospital*,[228] for example, the Board noted that a service and maintenance unit in a health care institution is the analogue to the plantwide production and maintenance unit in the industrial sector and as such is the "classic appropriate unit."[229]

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[224] Furthermore, any conclusions reached concerning the application of traditional criteria in past decisions regarding a particular type of bargaining unit are subject to modification when applied to different organizational structures in future cases.

[225] The application of traditional community of interest criteria is often a difficult and subjective task in any industry. It frequently entails weighing the similarities and dissimilarities between the group of employees in the proposed unit and other groups of employees of the same employer and attaching varying degrees of significance to a large number of conflicting factors. Minor factual differences may justify opposite results. Atlas Hotels, Inc. v. NLRB, 519 F.2d 1330, 1335, 89 L.R.R.M. 3057, 3060 (9th cir. 1975). One court has noted that there are usually so many good reasons which may be urged in support of the propriety of any particular unit determination that anyone who atacks the appropriateness of any unit certified by the Board "wages an uphill fight." NLRB v. Schill Steel Products, Inc., 340 F.2d 568, 574, 58 L.R.R.M. 2177, 2181 (5th Cir. 1965). Examples of both the method utilized and the difficulty encountered by the Board in applying traditional community of interest criteria in health care cases may be found in The Jewish Hospital Ass'n, 223 N.L.R.B. 614, 91 L.R.R.M. 1499 (1976), West Suburban Hospital 224 N.L.R.B. 1349, 92 L.R.R.M. 1369 (1976), *enf't denied*, 570 F.2d 213, 97 L.R.R.M. 2929 (7th Cir. 1978) and Riverside Methodist, 223 N.L.R.B. 1084 (1976) and 241 N.L.R.B. No. 184, 101 L.R.R.M. 1056 (1979).

[226] There can be no doubt whatsoever regarding the propriety of the Board's creation of separate units for guards.

[227] In *Extendicare*, the Board held that a unit comprised of all service and maintenance employees and all technical employees constituted an appropriate separate unit.

[228] 217 N.L.R.B. 793, 89 L.R.R.M. 1108 (1975).

[229] *Id.* at 794, 89 L.R.R.M. at 1110. Member Penello has agreed with the Board majority in the creation of separate units for business office clerical employees, con-

In his dissent in *St. Catherine's Hospital*,[230] however, former Member Kennedy specifically rejected the notion that the interests of business office clericals are so distinct that they must be represented in a unit separate from other nonprofessional employees even when all parties agree to their inclusion in a comprehensive unit of nonprofessional employees. Similary, in *NLRB v. Mercy Hospitals of Sacramento, Inc.*,[231] the Court of Appeals for the Ninth Circuit reversed the Board's refusal to honor a stipulation of the parties placing business office clericals in an all clerical unit. The Board had found a separate unit for business office clericals to be appropriate and had, in an action analogous to its practice in the industrial sector,[232] placed clerical employees other than business office clericals in the service and maintenance unit.[233]

In spite of these criticisms, the Board's treatment of business office clericals appears to be consistent with the implications of *Extendicare*. In *Mercy Hospitals*, the separation of business office clericals from hospital clericals did not result in unit proliferation since the Board added the hospital clericals to the existing service and maintenance unit. The Board's policy of approving separate business office clerical units results in no more separate units than were created in *Extendicare*.[234]

B. *Technical Employee Units*

The preceding rationale applied in evaluating the need for residual professional, service and maintenance, and business office clerical units is equally applicable in determining the propriety of separate units for technical employees. Technical employee units are broad enough to encompass sizable groups of employees and cut across departmental and classification lines. Thus, they appear to be among the acceptable alternatives to units established according to "professional interest" or "job classification" which Senator Taft

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cluding that the Board has long recognized that these employees share "an unusually high degree of interest." Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1043 (1978) (Penello, M., dissenting), *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 2784 (3d Cir. 1979).

[230] 217 N.L.R.B. 787, 791, 89 L.R.R.M. 1070, 1075 (1975).

[231] 589 F.2d 968, 98 L.R.R.M. 2800 (9th Cir. 1978), *cert. denied*, 440 U.S. 910 (1979).

[232] In the industrial sector, the Board has accorded separate unit treatment to business office clericals and has included plant clericals in production and maintenance units. Fisher Controls Co., 192 N.L.R.B. 514, 515, 77 L.R.R.M. 1809 (1971); General Electric Co., 107 N.L.R.B. 70, 33 L.R.R.M. 1336 (1953).

[233] Mercy Hospitals of Sacramento, Inc., 217 N.L.R.B. 765, 770, 89 L.R.R.M. 1097, 1103-04 (1975).

[234] In *Extendicare* the Board excluded both business office clerical employees and medical records clerical employees from the unit of technical, service and maintenance employees. As was discussed earlier, see text accompanying notes 132-34, *supra*, Congress did not disapprove of the exclusion of these employees from the broad unit. Of course, the Board could reduce the number of units by placing *all* clerical employees in the service and maintenance unit. It did so in Appalachian Regional Hospitals, Inc., 233 N.L.R.B. 542, 96 L.R.R.M. 1528 (1977) where the union successfully sought a combined unit of service and maintenance, technical and clerical employees.

indicated were disdained by Congress.[235] Nevertheless, the Board's certification of such units has been strenuously criticized.[236] Member Penello, former Member Kennedy,[237] and some commentators[238] have argued that the Board's practice of approving separate technical units in the health care field is improper. They contend that the Board has given approval to such units automatically—contrary to its practice in other industries—and has ignored the ramifications of Congress's approval of the "trend toward broader units" reflected in *Extendicare.*

The Board's approach to granting separate technical units in the health care field does appear to be virtually automatic. In one of the leading cases concerning this issue the Board said:

> We shall, accordingly, grant a separate unit of technical employees here and at other health care facilities when such a unit is sought and the facts indicate that the employees sought in that unit are, in fact, technical employees.[239]

Approximately one year later the Board stated:

> The Board has, in cases involving health care institutions, recently indicated it will not normally compel the inclusion of technical employees in a unit composed of service and maintenance employees. We see no reason herein to deviate from precedent to require the inclusion of the technical employees in the service and maintenance unit.[240]

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[235] See Appendix A. Certainly Senator Taft could not object to the creation of separate technical units since his initial proposal—S.2292—would have permitted such units. See text at note 84 *supra*. However, Senator Taft's bill would have permitted a maximum of five units in health care institutions. Thus, his attitude toward permitting separate technical units might have been different in the context of S.2292 than in the context of the flexible approach ultimately adopted by Congress.

[236] *But see* NLRB v. Sweetwater Hospital Ass'n, 604 F.2d 454, 102 L.R.R.M. 2246 (6th Cir. 1979), in which the court enforced an order of the Board requiring a hospital to bargain with a separate unit of technical employees. The court indicated that "a different case would be presented" if at some future time the Board approved more than one unit to represent the hospital's other non-professional employees. *Id.* at 458 n.7, 102 L.R.R.M. at 2248 n.6.

[237] Allegheny General Hospital, 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1043 (1978) (Penello, M., dissenting), *enf't denied*, 608 F.2d 965, 102 L.R.R.M. 2874 (3d Cir. 1979); Newington Children's Hospital, 217 N.L.R.B. 793, 89 L.R.R.M. 1108, 1111 (1975) (Kennedy and Penello, MM., dissenting); St. Catherine's Hospital, 217 N.L.R.B. 787, 791-92, 89 L.R.R.M. 1070, 1075 (1975) (Kennedy, M., dissenting) (Penello, M., dissenting in part); Barnert Memorial Hospital, 217 N.L.R.B. 775, 784-86, 89 L.R.R.M. 1083, 1094 (1975) (Kennedy and Penello, MM., dissenting).

[238] Emanuel, *supra* note 41, at 19-22; King, *supra* note 78, at 165-69.

[239] Nathan and Miriam Barnert Memorial Hospital Ass'n, 217 N.L.R.B. 775, 777, 89 L.R.R.M. 1083, 1087 (1975).

[240] The Jewish Hospital Ass'n of Cincinnati, 223 N.L.R.B. 614, 617, 91 L.R.R.M. 1499, 1505 (1976). *See also* Children's Hospital of Pittsburgh, 222 N.L.R.B. 588, 590, 91 L.R.R.M. 1440, 1444 (1976); Pine Manor, Inc., 238 N.L.R.B. No. 217, 99 L.R.R.M. 1323, 1325 (1978).

The Board has established separate technical units in numerous cases,[241] deviating from the practice only under unusual circumstances.[242]

In the industrial sector, on the other hand, the Board does not automatically exclude technical employees from other units when their placement is in issue.[243] The Board abandoned such a policy nearly twenty years ago.[244] Instead, the Board makes a "pragmatic judgment" in each case based upon its analysis of traditional community of interest factors and the desires of the parties.[245] In view of Congress's admonition, it is anomalous that separate technical units apparently can be established with less difficulty in the health care field than in other industries.

Also, it cannot be denied that the "trend toward broader units" discerned in *Extendicare* involved only the Board's placement of technical employees with service and maintenance employees.[246] In *Extendicare* the Board noted several specific factors which made a separate technical unit inappropriate: the technical employee shared a community of interest with the service and maintenance employees; a separate bargaining unit for LPNs had been deemed appropriate; only seven technical employees were involved; and the petitioning union indicated a willingness to represent technical personnel with service and maintenance employees in a single unit.[247] At the very least, when such factors are present in health care institution cases, the Board should not ignore the implications of Congress's endorsement of *Extendicare*.[248] Moreover, it might well be argued that this endorsement should not be limited to the particular combination of facts present in *Extendicare*.

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[241] See Emanuel, *supra* note 41, at 198 n.59.

[242] Pine Manor, Inc., 238 N.L.R.B. No. 217, 99 L.R.R.M. 1323, 1325 (1978) (LPNs accorded self-determination election in order to choose between separate representation or inclusion in existing unit of service and maintenance employees—small number of employees overall and eight LPNs, community of interest with certain service and maintenance unit employees); Appalachian Regional Hospitals, Inc., 233 N.L.R.B. 542, 96 L.R.R.M. 1528 (1977) (small facility and small number of employees, union sought unit of all nonprofessional employees, community of interest with service and maintenance employees); National G. South, Inc., 230 N.L.R.B. 976, 95 L.R.R.M. 1478 (1977) (union sought unit of service and maintenance and technical employees and technical employees shared community of interest with service and maintenance employees); Illinois Extended Care Convalescent Center, 220 N.L.R.B. 1085, 90 L.R.R.M. 1387 (1975) (only four technical employees, the union was willing to stipulate to their inclusion in broad unit); Mount Airy Foundation, 217 N.L.R.B. 802, 89 L.R.R.M. 1067 (1975) (small facility, small number of technical employees, some of whom union agreed to represent in broad unit, remainder of whom were not licensed, registered or certified).

[243] Mack Trucks, Inc., 214 N.L.R.B. 382, 87 L.R.R.M. 1551 (1974); The Sheffield Corp., 134 N.L.R.B. 1101, 49 L.R.R.M. 1265 (1961).

[244] The Sheffield Corp., 134 N.L.R.B. 1101, 49 L.R.R.M. 1265 (1961).

[245] *Id.* at 1103-04, 49 L.R.R.M. at 1266.

[246] See text at note 132 *supra*.

[247] See text and notes at notes 129-31 *supra*.

[248] In Nathan and Miriam Barnert Memorial Hospital Ass'n, 217 N.L.R.B. 775, 89 L.R.R.M. 1083 (1975), the majority and the dissenters disagreed with respect to whether the facts presented in that case were, at least in part, analogous to those of *Extendicare*. The majority did acknowledge a "commonality of interests" between the

In summary, the certification of broad technical employee units encompassing significant numbers of employees limits the potential number of units in an institution and thus appears to be consistent with Congress's desire to avoid the proliferation of bargaining units. Nevertheless, the Board should show greater willingness to combine technical personnel with service and maintenance employees in a single unit. It should not grant separate technical units more readily in the health care field than in the industrial sector, but should display a greater sensitivity to the implications of Congress's approval of *Extendicare* and the admonition concerning proliferation. In instances in which service and maintenance employees share a community of interests with technical employees, and especially in instances in which the number of technical employees is relatively small and the creation of a unit combining technical with service and maintenance employees would not clearly result in a lack of representation for the technical employees, such combined units should be deemed appropriate.

C. *Registered Nurse and Physician Units*

Registered nurses (RNs) and physicians each appear to exemplify the separate "professional interests" of which Senator Taft spoke in explaining congressional concern with unit proliferation.[249] Separate units for RNs and physicians therefore appear to be inherently suspect. While little guidance may be found in legislative history regarding the propriety of separate units for physicians, the disapproval by Congress of the separate LPN unit created in *Extendicare* appears important when considering the establishment of separate RN units.[250]

A comparison of *Extendicare* with *Mercy Hospitals of Sacramento, Inc.*[251]—the leading case concerning separate RN units—reveals many common factors. In *Mercy*, the Board relied upon a history of separate collective bargaining and various aspects of the job responsibilities of RNs in according them separate unit status. Among the job-related factors deemed significant was the assertion that the responsibilities of RNs cannot be delegated to any other employees.[252] But in *Extendicare*, the Board noted that the duties of LPNs were not performed by any of the nurses aides or orderlies who were included in a service and maintenance unit.[253] In *Mercy*, the Board said that

technical employees and the service and maintenance employees. 217 N.L.R.B. at 777 n.26, 89 L.R.R.M. at 1087 n.26. However, the majority felt that such commonality was not so pervasive as to vitiate the technical employees' separate and distinct community of interests. *Id.* The dissenters concluded that the specialized training and working conditions of the technical employees in *Extendicare* were comparable to those in *Barnert*. 217 N.L.R.B. at 785 n.44, 89 L.R.R.M. at 1095 n.44.

[249] See Appendix A.

[250] RNs were excluded from the broad units in *Woodland Park* and *Extendicare*. However, their placement was not in issue in those cases, and thus little significance can be drawn from their exclusion.

[251] 217 N.L.R.B. 765, 89 L.R.R.M. 1097 (1975). *See also* Texas Institute for Rehabilitation and Research, 228 N.L.R.B. 578, 94 L.R.R.M. 1513 (1977). Since the *Mercy Hospitals* decision, the Board has routinely accorded RNs separate unit treatment. *See, e.g.*, Samaritan Health Services, Inc., 238 N.L.R.B. No. 56, 99 L.R.R.M. 1551 (1978). (1978).

[252] 217 N.L.R.B. at 767, 89 L.R.R.M. at 1100.

[253] 203 N.L.R.B. at 1232, 83 L.R.R.M. at 1243.

the Joint Committee on Accreditation of Hospitals and the laws of several states require hospitals to maintain separate departments of nursing and that authority over RNs in hospitals was centralized in directors of nursing; in *Extendicare* the Board noted that the LPNs worked in the nursing department of the hospital.[254] In *Mercy* the Board noted that RNs had graduated from accredited nursing schools while in *Extendicare* it made the same observation regarding LPNs. The Board made two other observations in *Mercy* regarding the responsibilities of RNs which were not expressly covered in *Extendicare*'s discussion of LPNs. The Board said that the overriding responsibility of RNs is to maintain the best possible patient care. But such responsibility obviously is the primary duty of LPNs as well as all health care institution employees.[255] The Board also noted in *Mercy* that, pursuant to this responsibility, RNs are required to "be on duty 24 hours a day, 7 days a week, 365 days a year."[256] If the Board meant that RNs are required to work nights, weekends and to be "on call" on occasion, the same can be said of LPNs and many other health care employees. It thus appears that Congress intended that work responsibilities more distinctive than those possessed by the RNs and relied upon by the Board in *Mercy* be shown in order to carve out a separate unit for a professional interest or job classification.

This conclusion is especially sound in light of the fact that the job factors relied upon in *Mercy* are hardly unique. The responsibilities of many health care employees cannot lawfully be delegated.[257] Despite this fact, the work of RNs and many other health care employees is closely integrated. In *Mercy* the Regional Director noted that the RNs worked closely with many other employees, including other professional employees such as pharmacists, physical therapists, dieticians and medical laboratory technologists.[258] The Regional Director concluded that all of the employer's professional employees shared a substantial community of interest.[259] In addition, the Joint Commis-

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[254] A "typical" hospital nursing department consists of forty percent registered nurses, twenty percent licensed practical nurses and forty percent nurses aides. Zimmerman, *How It Is With Nurses Thirty-two Months After The Taft-Hartley Amendments*, in LABOR RELATIONS LAW PROBLEMS IN HOSPITALS AND THE HEALTH CARE INDUSTRY 103, 104 (A. Knapp ed. 1977).

[255] In Mount Airy Foundation, 217 N.L.R.B. 802, 802, 89 L.R.R.M. 1067, 1068 (1975), the Board stated: "[I]f any particular fact is evident, it is the fact that all employees in health care industry, sharing as they must a genuine concern for the well-being of patients, are involved in 'patient care.' "

[256] 217 N.L.R.B. at 767, 89 L.R.R.M. at 1100.

[257] *See, e.g.*, NLRB v. St. Francis Hospital of Lynwood, 601 F.2d 404, 419, 101 L.R.R.M. 2943, 2954 (9th Cir. 1979); CAL. BUS. & PROF. CODE §§ 1269-70, 1280, 1627, 4385-86. Moreover, many RN duties are performed on occasion by other employees. *Id.*

[258] Mercy Hospitals of Sacramento, Inc., Case Nos. 20 RC-12299, 12300-02, pp. 8-10 (Region 20, Dec. 10, 1974). *See also* the dissenting opinion of Member Kennedy in Mercy Hospitals of Sacramento, Inc., 217 N.L.R.B. 765, 774, 89 L.R.R.M. 1097, 1107 (1975).

[259] Mercy Hospitals of Sacramento, Inc., Case nos. 20-RC-12299, 12300-02, pp. 16-17 (Region 20, Dec. 10, 1974). In its Brief in NLRB v. St. Francis Hospital of Lynwood, 601 F.2d 404, 101 L.R.R.M. 2943 (9th Cir. 1979), the Board argued that RNs are "generalists" who in the course of ensuring the coordination of patient care

sion on Accreditation of Hospitals does not require administrative authority over nursing services to be maintained in any more separate a fashion than required of many other hospital services, such as dietetic services, pathology services, pharmaceutical services and radiology services.[260] Moreover, twenty-seven of the RNs employed by Mercy Hospitals were not even assigned to the separate nursing department.[261] With respect to the Board's reliance upon the fact that RNs must be graduated from nursing schools and be licensed, many other professional and technical health care employees are subject to similar or even more stringent educational and licensing requirements.[262] As if recognizing these facts, the Board has denied separate representation to other professional groups whose separate communities of interest appear to be as distinct as that of the RNs in *Mercy*.[263]

In *Mercy*, the Board also relied heavily upon an "impressive" and "singular" history of separate collective bargaining by RNs in granting a separate unit.[264] However, no evidence whatsoever supporting this assertion had been developed at the hearing in *Mercy*.[265] The Board relied instead upon statements made in oral arguments asserting a history of separate RN bargaining[266] and upon Board decisions concerning RNs which had been rendered

summon and deal with other health care professionals. The Board also acknowledged that professional employee units which included RNs might also be appropriate units. *Id.* at 37.

[260] *See* JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS, XVI., 11-14, 109-10, 117-18, 135-36 (1978).

[261] Mercy Hospitals of Sacramento, Inc., Case Nos. 20-RC-12299, 12300-02, p. 9 (Region 20, Dec. 10, 1974). It should also be acknowledged that the labor relations policies of many hospitals are centralized. *See, e.g.*, Samaritan Health Services, Inc., 238 N.L.R.B. No. 56, 99 L.R.R.M. 1551, 1556-59 (1978).

[262] *See* Samaritan Health Services, Inc., 238 N.L.R.B. No. 56, 99 L.R.R.M. 1551 (1978); Sutter Community Hospitals of Sacramento, 227 N.L.R.B. 181, 94 L.R.R.M. 1450 (1976).

[263] *See, e.g.*, San Jose Hospital & Health Center, Inc. *et al.*, 228 N.L.R.B. 21, 96 L.R.R.M. 1391 (1977)) (pharmacists' union introduced evidence regarding bargaining history of pharmacist units); Beth Israel Hospital, 219 N.L.R.B. 520, 89 L.R.R.M. 1685 (1975) (pharmacists); New York Univ. Med. Center, 217 N.L.R.B. 522, 89 L.R.R.M. 1045 (1975) (psychiatrists).

[264] 217 N.L.R.B. at 767, 89 L.R.R.M. at 1100.

[265] Brief for Respondent at 33, NLRB v. St. Francis Hospital of Lynwood, 601 F.2d 404, 101 L.R.R.M. 2943 (9th Cir. 1979); Brief for American Hospital Ass'n as *Amicus Curiae* at 11, NLRB v. St. Francis Hospital of Lynwood, 601 F.2d 404, 101 L.R.R.M. 1943 (9th Cir. 1979); Brief for Employer at 20, Sierra Vista Hospital, Inc., Case No. 31-RC-3166 (Region 31, 1975); Emanuel, *supra* note 41, at 193; LABOR RELATIONS LAW PROBLEMS IN HOSPITALS AND THE HEALTH CARE INDUSTRY 76-7 (statements of Board Chairman John H. Fanning and Stephen P. Pepe) (A. Knapp ed. 1977).

[266] Brief for Petitioner at 30, NLRB v. St. Francis Hospital of Lynwood, 601 F.2d 404, 101 L.R.R.M. 2943 (9th Cir. 1979); Brief for Petitioner and 33-34, Lutheran Hospitals and Homes Society of America, Case Nos. 77-2000 and 2024 (10th Cir. 1979).

The remarks relied upon by the Board were apparently those of the counsel for the American Nurses Association to the effect that he knew of no instance in which registered nurses had been placed in a unit with other professional employees. Counsel noted, however, cases in which registered nurses had exercised an option to be included in units with other professional employees were an exception to this rule. Newington Children's Hospital, oral argument (Jan. 27, 1975) Record at 76.

prior to the passage of the 1974 amendments.[267] Even if the propriety of relying upon non-record information is admitted,[268] the Board's conclusion is fraught with shortcomings. First, the Board itself has said that bargaining history should not be considered controlling unless developed pursuant to determinations made by the Board.[269] Such was not the case with the supposed history relied upon in *Mercy*.[270] Second, the Board has held in cases decided both before and after *Mercy* that bargaining history which is relevant to the determination of appropriate units must exist in the employer's geographical area.[271] The Board's references in *Mercy* to the "singular history" of separate bargaining by RNs do not appear to be based upon a history of bargaining in the employer's area.[272] Furthermore, the principle of according emphasis to the history of bargaining in the employer's area would appear to call for case by case consideration. However, commencing with *Mercy*, the Board has taken the position that RNs may constitute a separate unit whenever such a unit is sought by the petitioning labor organization and is desired by the RNs involved.[273] In at least one case the Board even refused to permit a health care employer to introduce any evidence of the bargaining history in its area or of the operations and organization of its institution; instead the employer was permitted to make an offer of proof.[274] The Court

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[267] 217 N.L.R.B. at 767 n.11, 89 L.R.R.M. at 1100 n.11 (1975).

[268] *See generally* Brief for American Hospital Ass'n as *Amicus Curiae* at 19, NLRB v. St. Francis Hospital of Lynwood, 601 F.2d 404, 101 L.R.R.M. 2943 (9th Cir. 1979).

[269] Coca-Cola Bottling Co. of Baltimore, 156 N.L.R.B. 450, 452, 61 L.R.R.M. 1061, 1062 (1965); Humble Oil and Refining Co., 115 N.L.R.B. 1485, 1487, 38 L.R.R.M. 1114, 1114 (1956); Federal Telephone and Radio Co., 120 N.L.R.B. 1652, 1653, 42 L.R.R.M. 1230, 1230 (1958); General Electric Co., 107 N.L.R.B. 70, 72, 33 L.R.R.M. 1058, 1059 (1953).

[270] See note 330 *infra*, and Brief for Employer at 22, Sierra Vista Hospital, Inc., Case No. 31-RC-3166 (Region 31, 1975).

[271] Riverside Methodist, 223 N.L.R.B. 1084, 1087 n.7, 92 L.R.R.M. 1033, 1036 n.7 (1976); LaRonde Bar & Restaurant, Inc., 145 N.L.R.B. 270, 272, 54 L.R.R.M. 1365, 1366 (1963); Pan American Refining Corp., 64 N.L.R.B. 1543, 1546, 17 L.R.R.M. 197, 197 (1945); *see* Westwood-Ho Hotel Co. v. NLRB, 437 F.2d 1110, 1114, 76 L.R.R.M. 2585, 2588 (9th Cir. 1971); Riverside Methodist, 241 N.L.R.B. No. 184, 101 L.R.R.M. 1056, 1058 (1979).

[272] *See* 217 N.L.R.B. at 767, 89 L.R.R.M. at 1100; LABOR RELATIONS LAW PROBLEMS IN HOSPITALS AND THE HEALTH CARE INDUSTRY 76-77 (statements of Board Chairman John H. Fanning and Stephen P. Pepe) (A. Knapp ed. 1977). In Texas Institute for Rehabilitation and Research, 228 N.L.R.B. 578, 579, 94 L.R.R.M. 1513, 1514 (1977), the Board said that its *Mercy* decision had been based in part "on the exclusionary representation pattern of registered nurses across the country . . . ." *Id.*

[273] *See, e.g.*, Samaritan Health Services, Inc., 238 N.L.R.B. No. 56, 99 L.R.R.M. 1551, 1559 (1978); Dominican Santa Cruz Hospital, 218 N.L.R.B. 1211, 1212, 89 L.R.R.M. 1097, 1099 (1975); Mercy Hospitals of Sacramento, Inc., 217 N.L.R.B. 765, 766, 89 L.R.R.M. 1097, 1099 (1975).

[274] St. Francis Hospital of Lynwood, 232 N.L.R.B. 32, 97 L.R.R.M. 1297 (1977). Enforcement was denied in a connected proceeding, N.L.R.B. v. St. Francis Hospital of Lynwood, 601 F.2d 404, 422, 101 L.R.R.M. 2943, 2956 (9th Cir. 1979). *See also* Brief for the Respondent at 32 n.15, NLRB v. St. Francis Hospital of Lynwood, *id.* Brief for the American Hospital Ass'n as *Amicus Curiae* at 11, *id.*

of Appeals for the Ninth Circuit held the Board's action in that case to be arbitrary and capricious and stated that the Board's policy of treating separate RN units as irrebuttably appropriate contravenes the congressional directive regarding unit proliferation.[275]

Had the Board in *Mercy* considered the actual history of RN bargaining as it then existed, it would have seen a picture decidedly less clear than supposed. In California approximately six percent of the RNs employed were members of separate RN units and twenty percent of this number were employed in government hospitals.[276] The RN units were concentrated primarily in the San Francisco area.[277] There were forty-five such units[278] and three bargaining units which contained both RNs and other employees.[279] Only one non-government hospital in the Sacramento area where Mercy Hospitals are located had a separate RN unit.[280] No separate RN units existed in twenty-two states; in each of four states there was only one RN unit (and three of these were in government hospitals); in twenty-four states there were more than two RN units and in only eight of these states were there more than ten separate RN units.[281] There were "many" units which combined RNs with other employees.[282]

The Board has held that in order for evidence of bargaining history to be relevant to its determination of an appropriate unit, such evidence must establish a consistent pattern of bargaining in units similar to that sought by the

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[275] NLRB v. St. Francis Hospital of Lynwood, 601 F.2d 404, 414, 101 L.R.R.M. 2943, 2950 (9th Cir. 1979).

[276] Brief for American Hospital Ass'n as *Amicus Curiae* at 14-16, NLRB v. St. Francis Hospital of Lynwood, 601 F.2d 404, 101 L.R.R.M. 2943 (9th Cir. 1979). Brief for Petitioner at 38-39, *id.* Brief for Employer at 21, Sierra Vista Hospital, Inc., Case No. 31-RC-3166 (Region 31 1975); Emanuel, *supra* note 41, at 194.

[277] *Id.*

[278] Brief for American Hospital Ass'n as *Amicus Curiae* at 14-16, NLRB v. St. Francis Hospital of Lynwood, 601 F.2d 404, 101 L.R.R.M. 2943 (9th Cir. 1979); Brief for Employer at 21, Sierra Vista Hospital, Inc., Case No. 31-RC-3166 (Region 31 1975).

[279] *Id.*; Brief for Petitioner at 38-39, NLRB v. St. Francis Hospital of Lynwood, 601 F.2d 404, 101 L.R.R.M. 2943 (9th Cir. 1979); Brief for Employer at 22, Sierra Vista Hospital, Inc., Case No. 31-RC-3166 (Region 31 1975).

[280] Brief of Respondent at 34, NLRB v. St. Francis Hospital of Lynwood, 601 F.2d 404, 101 L.R.R.M. 2943 (9th Cir. 1979); Brief for Employer at 20, Sierra Vista Hospital, Inc., Case No. 31-RC-3166 (Region 31 1975).

[281] *See* authorities cited in note 276 *supra*; King, *supra* note 78, at 164; and Brief for Employer at 22-23; Sierra Vista Hospital, Inc., Case No. 31-RC-3166 (Region 31, 1975).

[282] Brief for American Hospital Ass'n as *Amicus Curiae* at 16, NLRB v. St. Francis Hospital of Lynwood, 601 F.2d 404, 101 L.R.R.M. 2943 (9th Cir. 1979); Brief for Employer at 23, Sierra Vista Hospital, Inc., Case No. 31-RC-3166 (Region 31 1975); Emanuel, *supra* note 41, at 194. *See King supra* note 78, at 164. The cases cited by the Board in *Mercy*, 217 N.L.R.B. 765, 767 n.11, 89 L.R.R.M. 1097, 1100 n.11, do not alter this picture. All of the cases pre-dated the 1974 amendments and none were cited by Congress. None of the cases cited dealt with the question of the propriety of separating RNs from other hospital professionals. Indeed, most of the cases cited were industrial sector cases.

petitioner.[283] It seems fair to say that the history of bargaining which existed in 1975 did not establish a consistent pattern of separate bargaining by RN's in either the Sacramento area, California, or the United States.[284] Furthermore collective bargaining history is only one of the several traditional criteria which the Board may consider in determining appropriate units.[285] Such history should not automatically be deemed controlling, especially in health care institution cases.[286] At the very least such evidence, as well as other traditional criteria, should be balanced against the congressional admonition regarding unit proliferation.[287]

The Board in *Mercy* did not identify sufficient factors to distinguish a separate community of interests possessed by RNs from that possessed by the LPNs in *Extendicare*, or by many other groups of professional employees. As the Board itself implicitly acknowledged in *Mercy*,[288] it must be mindful of the degrees of separate communities of interest which are possessed by employees in other professional groups and job classifications so that the standard of measurement which it applies in determining appropriate units is as uniform as is reasonably possible. According to the Board, the real question is whether the distinctions between the employees in the unit sought and other employees of the institution constitute such separate interests as to warrant a separate unit while refusing the same privilege to other groups of employees with similar skills.[289] As a general rule, separate RN units do not appear to

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[283] *See* Riverside Methodist, 241 N.L.R.B. No. 184, 101 L.R.R.M. 1056, 1058 (1979); Riverside Methodist, 223 N.L.R.B. 1084, 1087, 92 L.R.R.M. 1033, 1036 (1976); San Jose Hospital & Health Care Center, Inc., 228 N.L.R.B. 21, 22, 96 L.R.R.M. 1391, 1392 (1977); Anaheim Memorial Hospital, 227 N.L.R.B. 161, 162-63, 94 L.R.R.M. 1058, 1059 (1976); St. Joseph Hospital, 224 N.L.R.B. 270, 271-72, 92 L.R.R.M. 1209, 1210 (1976); Chester County Beer Distributors Ass'n, 133 N.L.R.B. 771, 773, 48 L.R.R.M. 1712 (1961).

[284] NLRB v. St. Francis Hospital of Lynwood, 601 F.2d 404, 417-18, 101 L.R.R.M. 2943, 2952-53 (9th Cir. 1979). The Board has admitted that the pattern of RN organization is not "geographically uniform" but has steadfastly discounted any asserted significance of such fact. Brief for Petitioner at 40, *id.*

[285] See text accompanying note 182 *supra*.

[286] *See* NLRB v. St. Francis Hospital of Lynwood, 601 F.2d 404, 418, 101 L.R.R.M. 2943, 2952-53 (9th Cir. 1979); North Memorial Medical Center, 224 N.L.R.B. 218, 219, 92 L.R.R.M. 1212, 1214 (1976).

[287] *See* Bay Medical Center v. NLRB, 588 F.2d 1174, 1178 (6th Cir. 1978), *cert. denied*, 100 S. Ct. 53, 102 L.R.R.M. 2360 (1979).

[288] 217 N.L.R.B. at 767, 769, 89 L.R.R.M. at 1100, 1101-02.

[289] The Jewish Hospital Ass'n of Cincinnati, 223 N.L.R.B. 614, 617, 91 L.R.R.M. 1499, 1504 (1976). *See* similar statements in Riverside Methodist, 241 N.L.R.B. No. 184, 101 L.R.R.M. 1056, 1061 (1979) (Penello, M., dissenting); Shriners Hospital for Crippled Children, 217 N.L.R.B. 806, 808, 89 L.R.R.M. 1076, 1079 (1975); Duke University, 217 N.L.R.B. 799, 800, 89 L.R.R.M. 1065, 1066 (1975); Brief for Petitioner at 26, NLRB v. St. Francis Hospital of Lynwood, 601 F.2d 404, 101 L.R.R.M. 2943 (9th Cir. 1979). To some extent the rationale developed can be applied from institution to institution; however, the focus of the Board regarding the nonproliferation admonition must be upon the institutional employer in the case before it. *See* Mercy Hospitals of Sacramento, Inc., 217 N.L.R.B. 765, 772-73, 89 L.R.R.M. 1097, 1104-06 (1975) (Fanning, M., concurring). Examples of the many and esoteric professional interests and classifications employed in health care institutions may be found in Samaritan Health Services, Inc., 238 N.L.R.B. No. 56, 99 L.R.R.M. 1551, 1560-66

be justified. However, the Board should approach the RN unit issue on a case by case basis[290] and should approve separate RN units only where the separate community of interests—including a history of separate bargaining in the employer's area—is so distinct from that of other professionals that separate unit treatment will not offend the congressional non-proliferation mandate.

The Board's treatment of employed physicians appears to be more reasonable. Physicians are likely to possess a separate community of interest more distinct than that possessed by any other professional in the health care field. In *Ohio Valley Hospital Association*,[291] the Board excluded house physicians and emergency room doctors from a professional unit sought by the petitioning union. The Board concluded that under any application of traditional criteria, physicians constitute "a class unto themselves."[292] The Board noted that all other patient care employees are subject to the professional direction of physicians while physicians themselves are subject only to limited supervision by other physicians.[293] They perform essential and non-delegable patient care functions, are paid substantially more than most other professional employees, and possess unique educations, training and skills.[294] Because of such factors, physicians will in most cases share an exceptionally strong community of interest among themselves.[295]

D. *Maintenance Department Units*

The Board's decisions regarding separate maintenance department units have been described by the Court of Appeals for the Second Circuit as being in a state of "disarray."[296] The Board has both granted and denied certification of separate maintenance units without drawing a clear distinction between the rulings.[297] The primary difficulty seems to be an admitted differ-

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(1978) and Sutter Community Hospitals of Sacramento, Inc., 227 N.L.R.B. 181, 185-89, 94 L.R.R.M. 1450, 1456-61 (1976).

[290] *See* NLRB v. St. Francis Hospital of Lynwood, 601 F.2d 404, 416, 101 L.R.R.M. 2943, 2951 (9th Cir. 1979).

[291] 230 N.L.R.B. 604, 95 L.R.R.M. 1430 (1977). In Montefiore Hospital and Medical Center, 235 N.L.R.B. 241, 243, 97 L.R.R.M. 1474, 1476 (1978), the Board held that employed physicians and dentists constituted an appropriate separate unit. The physicians and dentists comprised the entire complement of professionals employed and were the only group of employees not represented by a labor organization.

[292] 230 N.L.R.B. at 605, 95 L.R.R.M. at 1431.

[293] *Id.* In *Ohio Valley* the emergency room doctors reported to a chairman elected from among themselves. *Id.*

[294] *Id.*

[295] Member Penello agreed in *Ohio Valley* that physicians play a "unique" role in hospitals. *Id.* However, he concluded that the separate community of interest enjoyed by the doctors in that case had been submerged in the broader community of interest shared with other professional employees at the hospital. *Id.* Thus, he and Member Walther dissented in *Ohio Valley*.

[296] The Long Island College Hospital v. NLRB, 566 F.2d 833, 844, 96 L.R.R.M. 3119, 3127 (2d Cir. 1977), *cert. denied*, 435 U.S. 996 (1978).

[297] *See, e.g.*, the decisions cited in The Long Island College Hospital v. NLRB, 566 F.2d 833, 843, 96 L.R.R.M. 3119, 3126 (2d Cir. 1977), *cert. denied*, 435 U.S. 996 (1978) and NLRB v. West Suburban Hospital, 570 F.2d 213, 215 n.1, 97 L.R.R.M. 2929, 2931 n.1 (7th Cir. 1978).

ence of opinion among the Board members.[298] The Second Circuit has held that the Board had erred in deferring to the certification by a state agency of a maintenance and engineering unit.[299] Similarly, the Court of Appeals for the Third Circuit has held that the Board should consider the propriety of a maintenance department unit under Section 9(b) of the Act and the admonition of Congress regarding unit proliferation rather than grant comity to a stage agency certification.[300] That court has recently insisted in strong terms that its interpretation of the Act be followed by the Board and that neither separate maintenance nor powerhouse units be found appropriate.[301] The Court of Appeals for the Seventh Circuit has refused to enforce a Board decision which, according to the court, failed to indicate how the establishment of a separate maintenance unit implemented or reflected Congress's directive regarding unit proliferation.[302]

Nevertheless, the Board appears ready to grant requests for separate health care maintenance units.[303] In recent decisions approving such units the Board has rather mechanistically pointed out that in *Allegheny General Hospital*[304] it held that separate maintenance units are not improper in health care institutions and promised to rely upon the traditional community of interests test established in *American Cyanamid Company*[305] to determine whether a separate unit is warranted in a given case.[306] In *American Cyanamid*, a 1961 decision affecting the industrial sector, the Board indicated that the existence of the following factors would warrant separate representation for a group of maintenance employees: separate departmental status, separate supervision, utilization of maintenance skills and, in general, identity of a function separate from production.[307]

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[298] The Long Island College Hospital v. NLRB, 566 F.2d 833, 843, 96 L.R.R.M. 3119, 3126 (2d Cir. 1977), *cert. denied,* 436 U.S. 996 (1978).

[299] 566 F.2d at 844, 96 L.R.R.M. at 3127.

[300] Memorial Hospital of Roxborough v. NLRB, 545 F.2d 351, 361, 93 L.R.R.M. 2571, 2577 (3d Cir. 1976).

[301] *See* Allegheny General Hospital v. NLRB, 608 F.2d 965, 968-70, 102 L.R.R.M. 2784, 2788-89 (3d Cir. 1979).

[302] NLRB v. West Suburban Hospital, 570 F.2d 213, 216, 97 L.R.R.M. 2929, 2932 (7th Cir. 1978).

[303] *See, e.g.,* Southern Baptist Hospitals, 242 N.L.R.B. No. 192, 101 L.R.R.M. 1330, 1331 (1979); Faulkner Hospital, 242 N.L.R.B. No. 17, 101 L.R.R.M. 1095, 1096-97 (1979) (engineering and maintenance employees); Riverside Methodist, 241 N.L.R.B. No. 184, 101 L.R.R.M. 1056, 1057-58 (1979); St. Francis Hospital, 241 N.L.R.B. No. 124, 100 L.R.R.M. 1570, 1571 (1979); Fresno Community Hospital, 241 N.L.R.B. No. 73, 100 L.R.R.M. 1528, 1528-29 (1979) (plant operations subdivision comprised of engineering, electronics and maintenance departments); St. Vincent Hospital and Medical Center of Toledo, 241 N.L.R.B. No. 90, 100 L.R.R.M. 1526, 1527-28 (1979); Southern Maryland Hospital Center, 241 N.L.R.B. No. 91, 100 L.R.R.M. 1508, 1509 (1979). *See also* Garden City Hospital, 244 N.L.R.B. No. 108, 102 L.R.R.M. 1146, 1147-48 (1979).

[304] 239 N.L.R.B. No. 104, 100 L.R.R.M. 1030, 1036-37 (1978), *enf't denied,* 608 F.2d 965, 971, 102 L.R.R.M. 2784, 2789 (1979).

[305] 131 N.L.R.B. 909, 910, 48 L.R.R.M. 1152 (1961).

[306] *See* decisions cited in note 304 *supra.*

[307] 131 N.L.R.B. at 910, 48 L.R.R.M. at 1152. Overall production and maintenance units are deemed to be inherently appropriate in the industrial sector although a separate unit of maintenance employees may be appropriate if the facts establish a

The evolution of the Board's opinion on the maintenance unit issue is well illustrated by its decisions involving Riverside Methodist Hospital. In 1976 the Board dismissed a petition which sought an election in a unit limited to the hospital's plant operations department.[308] Stating that it would apply its traditional criteria and take into account the congressional admonition against proliferation of bargaining units, the Board concluded that the evidence failed to establish sufficient distinctiveness and homogeneity among the plant operations department employees to warrant a separate bargaining unit.[309] Then, three years later, the Board issued a decision granting a petition for an election in a unit comprised of all maintenance and power house employees in the hospital's plant operations department.[310] The Board acknowledged that the petition sought essentially the same unit as had been rejected three years earlier.[311] It went on, however, to state that the applicable standard for evaluating separate maintenance units is as set forth in *American Cyanamid*,[312] and that the application of traditional community of interest criteria "fully satisfies legislative concern regarding unit fragmentation in the health care industry."[313] Member Penello dissented, remarking that a measure of the Board's departure from previous policy was most graphically illustrated by the fact that the Board in 1976 had held inappropriate a separate maintenance unit consisting of ninety percent journeymen level craftsmen,[314] but had now approved a maintenance unit in Riverside which had *no* journeymen level employees.[315]

Separate maintenance departments in the health care field are suspect under the congressional admonition regarding unit proliferation for three reasons. First, the implications of congressional approval of the *Four Seasons* decisions which were discussed earlier[316] cannot be ignored. At the very least congressional approval of *Four Seasons* weighs heavily against the establishment of separate units of maintenance department employees who are not highly skilled. Moreover, there are bases for concluding that the implications of *Four Seasons* should not be interpreted restrictively.[317] Second, since health

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separate identity of such employees. Myers Drum Co., 165 N.L.R.B. 1060, 1060, 65 L.R.R.M. 1454, 1454 (1967).

[308] Riverside Methodist, 223 N.L.R.B. 1084, 1087, 92 L.R.R.M. 1033, 1036 (1976).

[309] *Id.*

[310] Riverside Methodist, 241 N.L.R.B. No. 184, 101 L.R.R.M. 1056, 1059 (1979).

[311] *Id.* The 1979 petition sought a unit of approximately 50 employees in about 15 classifications, while the 1976 petition had sought a unit of 35 employees in 12 job classifications. *Id.*, 101 L.R.R.M. at 1058. The Board also acknowledged, however, that it would have reached the result it did in 1979 even if the unit sought at that time had been identical to the one sought in 1976. *Id.*, 101 L.R.R.M. at 1058 n.7.

[312] *Id.*

[313] *Id.*, 101 L.R.R.M. at 1057.

[314] Jewish Hospital Ass'n of Cincinnati, 223 N.L.R.B. 614, 616, 91 L.R.R.M. 1499, 1504 (1976).

[315] 101 L.R.R.M. at 1061.

[316] See text and notes at 119-122 and 142 *supra*.

[317] *Id.*

care institutions are usually divided into many separate departments,[318] the establishment of separate units along departmental lines would constitute proliferation by any reasonable measure.[319] Third, the standard enunciated by the Board nearly twenty years ago in *American Cyanamid* and now relied upon in health care cases clearly does not reflect the concern expressed by Congress in 1974 regarding health care unit proliferation.[320]

Member Penello, in his concurring opinion in *St. Vincent's Hospital*,[321] properly suggested that a separate maintenance unit in a health care institution may be appropriate only when a standard more rigid than that applied in other industries can be met.[322] Such a standard can be met, he argued, when the proposed unit is comprised of licensed craftsmen engaged in traditional craft work; the work is performed in a separate and distinct location apart from other employees and is not normally performed throughout the health care facility; and there is, at most, minimal transfer or interchange of employees to and from the unit.[323] Application of such a standard would permit the creation of separate maintenance department units, but would, in keeping with Congress's concern regarding unit proliferation, sanction their creation only when the employees involved possess an exceptionally high degree of separate interests.

E. *Powerhouse and Chauffeur-Driver Units*

As mentioned earlier, the Board has created separate units for employees in powerhouse and chauffeur-driver classifications. Arguments against the creation of units along departmental and professional lines apply with equal or greater force to the approval of separate units limited to groups of employees occupying single job classifications. There are more job classifications in use in the health care industry than there are separate departments or professional interests. Although Senator Taft expressly referred to Congress's concern with possible separate unit status for groups of employees occupying individual job classifications,[324] Congress did not preclude the establishment of any particular kind of unit. It is within narrow, individual job classifications that the "exceptionally strong community of interest" of which Member Penello has written is most likely to be found. Therefore the Board

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[318] See note 72 *supra*.

[319] In his 1977 address, Senator Taft said that, "The Board rulings in cases involving separate maintenance departments or boiler operations seem to overlook this intended emphasis [regarding minimization of the number of bargaining units]." See note 65 *supra*.

[320] *See* Allegheny General Hospital v. NLRB, 608 F.2d 965, 970-71, 102 L.R.R.M. 2784, 2789 (3d Cir. 1979).

[321] 223 N.L.R.B. 638, 639-40, 91 L.R.R.M. 1513, 1513-14 (1976), *enf't denied*, 567 F.2d 588, 97 L.R.R.M. 2119 (3d Cir. 1977).

[322] 223 N.L.R.B. at 639-40, 91 L.R.R.M. at 1514.

[323] *Id.*

[324] See Appendix A. *See also* Levine Hospital of Hayward, Inc., 219 N.L.R.B. 327, 328, 90 L.R.R.M. 1087, 1088 (1975), in which the Board relid in part upon Senator Taft's words in dismissing a petition for an election in a unit limited to employees in a single classification.

should very carefully balance the strong separate communities of interest likely to be found among craft-like job classifications manned by small numbers of employees with the threat of unit proliferation posed by the potential number of such units.

Separate units for powerhouse employees, such as boiler operators or stationary engineers,[325] may be warranted in some circumstances; separate units for chauffeur-drivers, such as those permitted by the Board in *Michael Reese Hospital and Medical Center,*[326] are not justified. A reasonable prescription for establishing separate units of boiler operators is set forth in the concurring opinion of Member Penello in *St. Vincent's Hospital.*[327] This prescription would limit the creation of separate units to situations in which the community of interest shared by the employees is exceptionally strong. Thus the creation of separate boiler operator units would be precluded in situations such as *Shriners Hospital for Crippled Children,*[328] where exclusive application of traditional criteria might have dictated a different result, but would permit the establishment of such units in situations such as *St. Vincent's Hospital*[329] or *Mercy Center for Health Care Services.*[330]

The Board's decision in *Michael Reese Hospital*[331] does not satisfy this standard or any similar standard. In that case, the petitioning union sought to represent a unit of approximately 10 chauffeur-drivers. The hospital employed approximately 4,500 employees in 60 departments and already recognized six separate units, including a service and maintenance unit.[332] The hospital contended that according separate representation to the chauffeur-drivers would unduly increase the number of bargaining units at the facility and that the chauffeur-drivers could only be appropriately represented as a part of the service and maintenance unit. The Regional Director agreed with the employer. However, a three-member panel of the Board, with Member Jenkins dissenting, held that the chauffeur-drivers should be accorded sepa-

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[325] Congressman Thompson specifically indicated that units of stationary engineers would be appropriate. See Appendix D. However, for reasons discussed in the text accompanying notes 66-78 *supra*, Congressman Thompson's remark should not be considered.

[326] 242 N.L.R.B. No. 50, 101 L.R.R.M. 1157, 1159 (1979).

[327] See text and notes at notes 321-23 *supra.* The Court of Appeals for the Third Circuit disagreed with the Board's decision in *St. Vincent's.* St. Vincent's Hospital v. NLRB, 567 F.2d 588, 592-93, 97 L.R.R.M. 2119, 2122-23 (3d Cir. 1977). A careful reading of the court's opinion suggests that the court might have been more favorably disposed to the result reached by the Board had the Board offered any indication in its opinion that its action reflected a concern with Congress's admonition regarding unit proliferation.

[328] 217 N.L.R.B. 806, 89 L.R.R.M. 1076 (1975) (stationary engineers operated and maintained boilers, and performed general maintenance work in other areas of the hospital).

[329] 223 N.L.R.B. 638, 91 L.R.R.M. 1513 (1976) (licensed boiler operators, working in separate area, minimal contact with other employees and no interchange with other employees).

[330] 227 N.L.R.B. 1814, 94 L.R.R.M. 1534 (1977) (licensed stationary engineers, working in separate area, and minimal contact with other employees).

[331] 242 N.L.R.B. No. 50, 101 L.R.R.M. 1157 (1979).

[332] *Id.*, 101 L.R.R.M. at 1158 n.2.

rate representation. The Board's decision was premised on two conclusions: (1) the chauffeur-drivers possessed a separate community of interests, and (2) separate representation of the chauffeur-drivers would not offend the congressional admonition against unit proliferation because dismissal of the petition would relegate the employees to a perpetual lack of representation.

The Board noted that the chauffeur-drivers spent approximately sixty percent of their time away from the hospital grounds performing pickup, delivery, chauffeur, and messenger duties. Their contact with service and maintenance employees was minimal and there was no job interchange although a number of chauffeur-drivers were formerly service and maintenance employees. The chauffeur-drivers were part of a separate department which was responsible for their hiring and firing, although other departments of the hospital also played roles in such actions. The chauffeur-drivers, unlike most service and maintenance employees, did not wear uniforms, and, for the most part, received higher wages than did service and maintenance employees. Finally, unlike all but approximately fifty service and maintenance employees, the chauffeur-drivers worked a Monday through Friday schedule.

On the other hand, the Board admitted that the chauffeur-drivers were not highly skilled, received minimal training, the same fringe benefits as service and maintenance employees, and were covered by a grievance procedure similar to that contained in the service and maintenance contract. Also, the Board acknowledged that departments in the service and maintenance unit had autonomy similar to that possessed by the chauffeur-drivers' External Transportation Department and that service and maintenance employees in the laundry and in the print shop performed distinct duties in separate areas. The Regional Director, who had dismissed the petition, also noted that there were employees in the service and maintenance unit who drove other types of vehicles; that hospital personnel functions were centralized; and that the rate of pay of chauffeur-drivers was comparable to the highest pay grade in the service and maintenance agreement.[333]

Based upon these summaries, it seems fair to conclude that the chauffeur-drivers did not possess anything like the exceptionally strong, separate community of interests which should be a prerequisite to the certification of separate units along classification lines. The Board's own discussion indicates that the chauffeur-drivers possessed no stronger separate community of interests than did certain other groups of employees in the service and maintenance units. However, the Board concluded that separate representation of the chauffeur-drivers would not conflict with the congressional admonition regarding proliferation. Since, according to the Board dismissal of the petition for a separate unit would subject the chauffeur-drivers to a perpetual lack of representation. The Board thus reasoned that its action struck a proper bal-

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[333] Michael Reese Hospital and Medical Center, Case No. 13-RC-14821 (Region 13, Sept. 29, 1978). The Regional Director reasoned that in view of the "legislative stricture against undue proliferation of units in health care facilities," the characteristics of the chauffeur-drivers were not so different or unique as to warrant separate representation. *Id.*

ance between the admonition against proliferation and the Board's duty under Section 9(b) to accord employees the fullest freedom to exercise the rights guaranteed by the Act.[334]

The necessity for the Board's action seems dubious under the facts of the case. The Board reasoned that the union which represented the existing service and maintenance unit had not intervened in the proceeding and had not at any time filed a petition seeking a self-determination election for the chauffeur-drivers. However, the Board itself acknowledged that the service and maintenance union had made two prior unsuccessful attempts to have the chauffeur-drivers added to the service and maintenance unit.[335] As was noted by the Regional Director, the union had in 1973 sought through bargaining to have the security department employees, who were then functioning as chauffeur-drivers, added to the service and maintenance unit.[336] There was no reason therefore for the Board to speculate that dismissal of the petition would result in a "perpetual" lack of representation. Furthermore, the Board has not been troubled by such speculation in analogous circumstances. In many cases in which the Board has dismissed petitions for elections in units deemed to be inappropriate there has been no indication that any union would seek to represent the employees involved. For example, in *Levine Hospital of Hayward, Inc.*,[337] the Board declined to sanction a separate unit for medical records clerks and transcribers who historically had been excluded from an existing service and maintenance unit.[338] The Board merely invited the service and maintenance union or any other interested labor organization to represent a service and maintenance unit encompassing these employees.

III. Conclusion

The National Labor Relations Board has reacted to Congress's expressed intent that a proliferation of bargaining units be avoided in health care institutions. The Board has denied a number of petitions seeking to establish separate units and has formulated an approach which to date would sanction the establishment of as many as nine separate units in individual health care institutions. While the Board's approach would sanction more units at a health care institution than the Board has generally been recognizing in industrial facilities, it is fair to say that most health care institutions employ a more diverse workforce than do most industrial facilities. The Board's approach has also permitted more separate units than would a bill introduced by Senator Taft but not adopted by Congress. This result, too, is not unexpected inasmuch as Senator Taft indicated that Congress had adopted a compromise approach which would permit the Board more flexibility in establishing bargaining units than would his bill.

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[334] 242 N.L.R.B. No. 50, 101 L.R.R.M. at 1159.

[335] *Id.*

[336] Michael Reese Hospital and Medical Center, Case No. 13-RC-14821 (Region 13, Sept. 29, 1978).

[337] 219 N.L.R.B. 327, 90 L.R.R.M. 1087 (1975).

[338] 219 N.L.R.B. 327, 328, 90 L.R.R.M. 1087, 1088 (1975). *See also* Mercy Hospitals of Sacramento, Inc., 217 N.L.R.B. 765, 770, 89 L.R.R.M. 1097, 1103 (1975).

Yet the Board's approach has not been without its shortcomings. The automatic approval of separate units for technical employees disregards both the thrust of Congress's admonition against unit proliferation and the more specific implications of the *Extendicare* decision cited by Congress. As a general rule, the separate units for registered nurses routinely approved by the Board when sought are not justified either by traditional community of interest criteria or by bargaining history. Nor was the approval of a separate unit for chauffeur-drivers warranted in the *Michael Reese Hospital* decision. In determining the existence of appropriate separate maintenance or powerhouse units, the Board should apply the formula suggested by Member Penello.

These deficiencies in the Board's approach have been produced by two factors: the Board's recognition of virtually irrebuttable presumptions concerning the propriety of separate RN and technical employee units, and the nearly exclusive reliance by the Board upon traditional community of interest factors in approving separate bargaining units for registered nurses, technical employees and maintenance and powerhouse personnel. The Board has stated in recent decisions that this application of traditional criteria satisfies Congress's warning against unit proliferation. While Congress did not intend to preclude the Board from considering traditional criteria in determining appropriate health care units, it did intend that the Board give due consideration to the public interest factor expressed by the unit proliferation admonition. Member Penello's suggestion that separate units be approved only when the employees in a proposed unit enjoy an exceptionally high degree of community of interest constitutes an appropriate balance of traditional criteria with congressional intent.

With respect to the Board's presumption concerning certain units, it cannot be gainsaid that the establishment of general rules regarding the propriety of separate units is a desirable objective. The existence of such general rules affords employees, labor organizations, and health care institutions the predictability needed in the creation of bargaining units and promotes the efficiency of administrative and judicial processes. However, when parties dispute the propriety of proposed bargaining units, the Board can adequately consider traditional criteria and congressional intent only through case by case analyses. Only when the Board examines the personnel, organizational structures, and operations of the institution in which a unit is sought can it give due consideration to the congressional mandate against the proliferation of bargaining units.

Furthermore, in conducting such institution-by-institution analyses, the Board should expand the normal scope of its representation hearings. In order to evaluate adequately the need for separate bargaining units in each institution under consideration, the Board must evaluate more than the community of interests possessed by the petitioning employees; the Board must also examine, in at least a general manner, the communities of interest possessed by other employees. Only after such an examination is conducted can the Board adequately evaluate the ramifications which its decision may have upon the potential number of separate units in the institution. Obviously, the structure of an institution may change from time to time, and no final decision can properly be made by the Board with respect to petitions for separate

units which may be filed at the institution in the future. However, in order to carry out Congress's mandate as completely as possible, the Board should assess the institution's total potential for separate bargaining units while considering the propriety of each petition.

APPENDIX A

Senator Taft's remarks on May 2, 1974 were as follows:

> The issue of proliferation of bargaining units in health care institutions has also greatly concerned me during consideration of legislation in this area. Hospitals and other types of health care institutions are particularly vulnerable to a multiplicity of bargaining units due to the diversified nature of the medical services provided patients. If each professional interest and job classification is permitted to form a separate bargaining unit, numerous administrative and labor relations problems become involved in the delivery of health care. The provisions of S. 2292 placed a statutory limit of four bargaining units in a health care institution. While this precise approach was not adopted by the committee, report language was agreed upon to stress the necessity to the Board to reduce and limit the number of bargaining units in a health care institution. The report on page 5 states:
>
> > Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 208 NLRB No. 50, 85 LRRM 1093 (1974), and *Woodland Park Hospital*, 205 NLRB No. 144, 84 LRRM 1075 (1973), as well as the trend toward broader units enunciated in *Extendicare of West Virginia*, 203 NLRB No. 170, 83 LRRM 1242 (1973).
>
> I believe this is a sound approach and a constructive compromise, as the Board should be permitted some flexibility in unit determination cases. I cannot stress enough, however, the importance of great caution being exercised by the Board in reviewing unit cases in this area. Unwarranted unit fragmentation leading to jurisdiction disputes and work stoppages must be prevented.
>
> The administrative problems from a practical operation viewpoint and labor relations viewpoint must be considered by the Board on this issue. Health-care institutions must not be permitted to go the route of other industries, particularly the construction trades, in this regard.
>
> In analyzing the issue of bargaining units, the Board should also consider the issue of the cost of medical care. Undue unit proliferation must not be permitted to create wage "leapfrogging" and "whipsawing." The cost of medical care in this country has already skyrocketed, and costs must be maintained at a reasonable level to permit adequate health care for Americans from all economic sectors.
>
> The committee, in recognizing these issues with regard to bargaining unit determination, took a significant step forward in establishing the factor of public interest to be considered by the Board in unit cases.

LEGISLATIVE HISTORY at 113-14, 120 CONG. REC. 12944-45 (1974).

The senator's remarks on May 7, 1974 were as follows:

> As to the issue of bargaining units, I would like to clarify that my omission in my opening remarks to mention the footnote to the Extendicare case in the committee report, certainly was accidental. As stated in the committee report:
>
> > By our reference to Extendicare, we do not necessarily approve all the holdings of that decision.
>
> Part of the unit findings in that case, it can be argued, was overly broad and not consistent with minimization of the number of bargaining

units in health care institutions. Certainly, every effort should be made to prevent a proliferation of bargaining units in the health care field and this was one of the central issues leading to agreement on this legislation. In this area there is a definite need for the Board to examine the public interest in determining appropriate bargaining units. *NLRB v. Delaware-New Jersey Ferry Co.*, 128 F.2d 130 (3d Cir. 1942).

Id. at 255, 120 CONG. REC. 13559-60 (May 7, 1974).

APPENDIX B

Senator Williams' complete statement on the bargaining unit issue was as follows:

> [T]he National Labor Relations Board has shown good judgment in establishing appropriate units for the purposes of collective bargaining, particularly in wrestling with units in newly covered industries. While the Board has, as a rule, tended to avoid an unnecessary proliferation of collective bargaining units, sometimes circumstances require that there be a number of bargaining units among nonsupervisory employees, particularly where there is such a history in the area or a notable disparity of interests between employees in different job classifications.
>
> While the committee clearly intends that the Board give due consideration to its admonition to avoid an undue proliferation of units in health care industry, it did not within this framework intend to preclude the Board acting in the public interest from exercising its specialized experience and expert knowledge in determining appropriate bargaining units. *NLRB v. Delaware-New Jersey Ferry Co.*, 128 F.2d 130 (3d Cir. 1942).

LEGISLATIVE HISTORY at 362-63, 120 CONG. REC. 22949 (July 11, 1974).

APPENDIX C

Congressman Ashbrook's statement concerning bargaining units is as follows:

> [W]ith regard to the question of bargaining units, the Committee was quite concerned with the issue of undue proliferation of bargaining units and by language in the committee report has stressed the need for the Board to curtail such proliferation in health care institutions. In the past, as illustrated by Board decisions cited in the committee report, the Board has acted at its discretion in a congressionally approved manner. However, I would expect the Board to be cognizant of the concerns for patient care and employee rights in the Board's continuing review of bargaining unit questions in the health care institutions.

LEGISLATIVE HISTORY at 408, 120 CONG. REC. 22949 (July 11, 1974).

APPENDIX D

The complete text of Congressman Thompson's statement is as follows:

> Mr. Speaker, I would like to raise one additional matter of some importance as relates to the recent passage, on July 11, 1974, of S.3203, a bill to include the employees of non-profit hospitals under the coverage of the National Labor Relations Act.
>
> With respect to the question of bargaining units, the committee stressed its concern with preventing an undue proliferation of bargaining units in the health care industry. The committee cited certain Board decisions in the health care industry which would reflect the statutory mandates. By so doing, however, the committee did not intend to foreclose the Board from continuing to determine traditional craft and departmental units, such as stationary engineers in the health care field. With these directions, the Board in its continuing review of the health care industry should be free to employ its expertise in determining appropriate units.

LEGISLATIVE HISTORY at 408, 120 CONG. REC. 22949 (July 11, 1974).

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