1984

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HEALTH CARE UNIT DETERMINATIONS: THE BOARD IGNORES THE MANDATE OF CONGRESS AND THE COURTS OF APPEALS

Michael A. Curley*

INTRODUCTION

In 1974, Congress amended the Labor Management Relations Act (the “Act”)1 so as to extend coverage to non-profit health care institutions.2 This change, made through deletion of exclusionary language in the Act which had been added in the 1947 Amendments,3 was brought about by Congress' belief that no justifiable reason existed for excluding employees in this expansive industry.4

In choosing to extend the Act to non-profit health care institutions, Congress recognized that the delicate nature of health care operations would necessitate the consideration of factors not relevant in other settings.5 There has been considerable controversy concerning the extent to which the traditional approaches of the National Labor Relations Board (the “Board”) to resolving management/labor problems should be altered in health care settings. Two areas where this debate has been especially interesting are: (1) solicitation rights of health care employees;6 and (2) “appropriate unit” determinations in health-care facilities, the subject of this article.

* B.S., Drexel University, 1980; J.D., Villanova University Law School, 1983; Associate, O'Melveny & Myers, Los Angeles, California; Member California Bar.

2. 29 U.S.C. §152(14) defines “health-care institution” as “... any hospital, convalescent hospital, health maintenance organization, health clinic, nursing home, extended care facility, or other institution devoted to the care of sick, infirm or aged persons.” Id. For further discussion of the 1974 amendments to the Act, see 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).
3. 29 U.S.C. §152. Coverage was afforded by striking the following from the definition of employer in §152(2): “any corporation or association operating a hospital, if no part of the net earnings inures to the benefit of any private shareholder or individual.” Id.
After examining briefly the Board's traditional standards for unit determination, this article will analyze the 1974 Amendments as they apply to unit determinations. Next, it will examine the post-amendment decisions of the Board and the various courts of appeals in this area of law, culminating in an analysis of the Board's recent St. Francis Hospital decision. Finally, it will examine reasons for the widening gap between the Board and the courts of appeals as well as suggest the author's views on how this conflict ultimately should be resolved.

**HISTORY**

*The Board's Traditional Standards for Determining Appropriate Units*

Section 9(b) of the Act empowers the Board to determine the appropriate bargaining unit in each case. The Board is given broad discretion, limited only by its obligation "to assure employees fullest freedom in exercising the rights guaranteed by [the Act]." In maintaining its dual function of ensuring employees their guaranteed right to organize and bargain collectively and at the same time fostering industrial stability, the Board is not required to find the most appropriate unit; rather,
an appropriate unit.\textsuperscript{17} Even with this broad grant of discretion to the Board there have been instances where courts of appeals have refused to enforce Board unit determinations.\textsuperscript{18}

As was noted earlier, the Act gives little guidance to the Board in the way of criteria to be used in determining appropriate units under Section 9(b).\textsuperscript{19} The Board, in fulfilling its function of assuring employees the fullest freedom in exercising the rights guaranteed by the Act,\textsuperscript{20} must avoid finding appropriate a unit which is too narrow, for such a unit would curtail the bargaining power of the union representing that unit and may generate "in-fighting" among the employees in the plant.\textsuperscript{21} Conversely, a unit that is too broad will, among other things, frustrate effective communication as well as hamper effective negotiation and administration of the labor contract.\textsuperscript{22} It is generally agreed by both union organizers and management representatives that the smaller the unit and the more homogeneous, the easier it is for the union to organize and prevail in an election. Thus, it is a prevalent management strategy to use the representation hearing to expand the size of the unit and to increase the heterogeneity of its composition.

The Board’s traditional test, which strikes what is believed to be the appropriate balance in unit determination cases, is the so-called “community of interests” test.\textsuperscript{23} The factors which the Board will look to in determining “community of interests” include: (1) similarity in scale and manner of determining earnings; (2) similarity in benefits, working conditions and hours; (3) similarity in the type of work; (4) similarity in qualifications, skills and training; (5) frequency of contact with other employees;

\textsuperscript{17} NLRB v. Pinkerton’s Nat’l Detective Agency, Inc., 202 F.2d 230 (9th Cir. 1953). See also NLRB v. Morand Bros. Beverage Co., 91 N.L.R.B. 409, 26 L.R.R.M. 1501 (1950), enforced, 190 F.2d 576 (7th Cir. 1951).
\textsuperscript{18} Id. See, e.g., NLRB v. West Suburban Hosp., 570 F.2d 213 (7th Cir. 1978). It should be noted at this point that unit determinations made by the Board are not directly subject to judicial review. The usual route for judicial adjudication of Board unit determination is for the employer to refuse to bargain with the representative of the unit which it feels was incorrectly granted separate representation. Upon an 8(a)(5) charge filed by the union, the General Counsel will issue an unfair labor practice complaint and move to transfer the case to the Board and then move for summary judgment. The Board does not permit in the unfair labor practice proceeding any relitigation of the issues decided in the representation proceeding. The Board will grant the motion and then, upon its petition to enforce or the employer’s petition to review the court of appeals can then determine the propriety of the Board’s action in finding the unit appropriate. See, e.g., NLRB v. West Suburban Hosp., 570 F.2d 213 (7th Cir. 1978).
\textsuperscript{19} See 29 U.S.C. §159(b). See also supra note 14 and accompanying text.
\textsuperscript{20} Id.
\textsuperscript{21} For further discussion of the problems facing the Board in unit determinations, see R. GORMAN, supra note 14, at 68–69.
\textsuperscript{22} Id. at 68.
\textsuperscript{23} For further discussion of the traditional “community of interests” test, see A. COX, D. BOX & R. GORMAN, CASES AND MATERIALS ON LABOR LAW at 300 (8th ed. 1977). The term “community of interests” has become a term of art in the issue of unit determination, and has been so developed in the case law. Id.
(6) geographic proximity; (7) continuity of production processes; (8) common supervision; (9) collective bargaining history; (10) desires of the employees affected; and (11) extent of union organization.24

Application of the Board’s “community of interests” test is well illustrated in American Cyanamid Company.25 There, the issue was whether maintenance employees enjoyed a sufficient community of interests that they might be deemed an appropriate bargaining unit apart from production employees.26 The Board found that: (1) the employer had failed in his attempt to prove that the maintenance employees were not separately identifiable from production workers due to employer’s integrated operation; (2) the maintenance employees were established in separate departmental sections and had their own supervision; and (3) the maintenance employees performed work requiring particular skills not required of the plant’s production workers.27 The Board held that based upon this evidence the maintenance workers enjoyed a “community of interests” entitling them to separate representation under the Act.28

The 1974 Congressional Admonition

As previously noted, Congress extended the coverage of the Act to a majority of the nation’s health care employees in 1974 by amending the Act’s definition of “employer.”29 Since the Taft-Hartley Act, the term “employer” had excluded non-profit hospitals; the 1974 Amendments deleted this exclusion. Prompting this change was the congressional conclusion that there was no acceptable reason why the large number of employees in non-profit, non-public hospitals should continue to be excluded from the coverage of the Act.30

Congress recognized, however, that due to the peculiar nature of health care operations as compared to industrial settings, work stoppages in health care facilities could lead to far more serious consequences.31 Sensitivity to this danger led to the incorporation of special notice provisions in the 1974 Amendments regarding strikes and other work stoppages.32

24. See id. at 275. Section 9(c)(5) of the Act prohibits the Board from relying solely upon the extent of organization in determining the appropriate unit.
26. Id. at 910, 48 L.R.R.M. 1152.
27. Id.
28. Id.
29. See 29 U.S.C. §152(2). See also supra notes 1, 2 and accompanying text.
31. Id. at 3948-52. The peculiar circumstances involved in a health-care work stoppage stem from the foreseeable consequences of such a stoppage in a hospital setting as compared with an industrial setting including the possible interruption of critically necessary health-care treatment to patients. Id.
Section 1(d) of the 1974 Act amended the notice provisions of Section 8(d) of the Act by requiring (1) ninety-day notice of termination or expiration of a contract in the health-care industry, as opposed to sixty-day notice in other industries; (2) sixty-day notice of contract termination or expiration to the Federal Mediation and Conciliation Service (FMCS); (3) a thirty-day notice to FMCS regarding initial contract disputes arising after recognition and, (4) requiring health care institutions and labor organizations to participate in mediation at the direction of FMCS.\(^3\)

Section 1(e) of the 1974 Act added Section 8(g) to the Act which provides for a mandatory ten-day written notice from labor organizations to health care institutions prior to engaging in picketing, strikes or other concerted refusals to work.\(^4\)

A related provision offered by Senator Taft and based upon the same considerations would have limited the number of allowable appropriate health care bargaining units to four: (1) professional employees; (2) technical employees; (3) clerical employees; and (4) maintenance and service employees.\(^5\) Congress chose not to limit the Board's discretion in unit determination in this manner.\(^6\) However, Congress' concern for the underlying problem manifested itself in the following all-important admonition which was included in both the House and Senate Reports accompanying the final version of the bill:

Due consideration should be given by the Board to prevent 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 *Endicott of West Virginia*, 203 NLRB No. 170, 83 LRRM 1242 (1973).\(^7\)

During the floor discussion of the bill, Senator Taft emphasized the need to prevent a proliferation of bargaining units in the health care field and stated that the need to avoid such proliferation was a central point which led to agreement on the 1974 Amendments.\(^8\) The legislative history thus clearly shows that Congress, in allowing the Board discretion in determining appropriate bargaining units in the health care field, “expected

\(^{34}\) National Labor Relations Act §8(g), 29 U.S.C. §158(g)(1976).
\(^{36}\) 29 U.S.C. §152(2). See also *supra* note 32 and accompanying text.
\(^{37}\) S. Rep. No. 93-766, *supra* note 30 at 3950. The uniform legislative history is unique in the Amendments to the Act and represents a carefully negotiated compromise by union and management representatives.
\(^{38}\) See 120 CONG. REC. 12944–45 (1974).
the Board ... to give substantial weight to the public interest in preventing unit fragmentation." 39

Unit Determination Decisions of the Board and the Courts of Appeals: Sharply Different Views On Interpretation of the Congressional Admonition

Shortly after the 1974 Amendments, the Board decided Shriner's Hospital,40 wherein five stationary engineers employed by the San Francisco-based hospital for crippled children sought separate representation.41 A total of eighty-eight employees worked at the hospital.42 The engineers involved were responsible for twenty-four-hour-a-day operation and maintenance of the boilers.43 On occasion they were asked to perform other maintenance tasks as well as some security duties.44 No special training was required prior to employment as a stationary engineer.45

Based on these facts, the Board held that the five stationary engineers did not possess a sufficiently separate and distinct "community of interests" to warrant a separate unit.46 The Board relied upon the congressional admonition in the 1974 Amendments, stating that Congress, in adopting the health care amendments, recognized the uniqueness of the health care industry in terms of serving the sick, the infirm and the aged, and thus the need for special consideration.47 The Board also relied upon the peculiar nature of the health care industry and, after weighing all of the traditional unit determination criteria, concluded that the high degree of integration of operations performed in health care facilities, when combined with the congressional admonition, counseled against the allowance of several separate units, determining that to hold otherwise would totally frustrate the congressional intent.48

In the decisions following Shriner's Hospital, the Board's reliance upon the congressional admonition lessened and it began to apply its traditional "community of interests" approach. The Board decided Mercy Hospitals of Sacramento49 in 1975. There, the Board allowed a separate

39. See NLRB v. Mercy Hosp. Ass'n, 606 F.2d 22, 25–26 (2d Cir. 1979). For a further analysis demonstrating the rational connection between broader appropriate units and fewer work stoppages, see R. Gorman, supra note 14, at 66–69.
41. Id. at 807, 89 L.R.R.M. at 1078.
42. Id.
43. Id.
44. Id. The security tasks which were required of the maintenance employees followed no set schedule and took up only a small proportional amount of the worktime of the employees in question.
45. Id.
46. Id.
47. Id. at 808, 89 L.R.R.M. at 1079.
48. Id. at 807–08, 89 L.R.R.M. at 1079–80.
unit of registered nurses (RNs), contending that the twenty-four-hour-a-day responsibilities of RNs, uniform national licensing for RNs and a history of exclusive representation entitled RNs to a unit separate from other professionals. The Board's per se policy of separate representation for RNs was rejected by the Ninth Circuit in St. Francis Hospital of Lynwood. The court called for application of a "disparity of interests" approach in lieu of the traditional "community of interests" approach which the Board continued to apply in health care institutions, despite the congressional admonition against unit proliferation.

In response to the Ninth Circuit's decision in St. Francis Hospital of Lynwood, the Board, in Newtown-Wellesley Hospital, retreated from its per se position that RNs were entitled to a separate unit. However, despite the Ninth Circuit's view of the statutory interpretation of the 1974 Amendments to the Act, the Board continued to apply the traditional "community of interests" test on the health care unit question. After Newton-Wellesley, the Board, in Brookwood Hospital, found that a separate unit of RNs was appropriate even though the RNs were involved in a "team" concept of patient care and worked closely with other professionals.

In 1976, the Board decided St. Vincent's Hospital wherein a group of four boiler operators employed by the non-profit New Jersey corporation operating a health care facility sought separate representation from other maintenance employees. Noting that the boiler operators spent approximately ninety percent of their working time in the basement boiler room segregated from co-workers, were specially licensed by the state, and had different shifts from other maintenance employees, the Board applied its traditional standards which recognized that licensed boiler room employees could constitute a separate unit. An election was ordered with the boiler room employees constituting an appropriate unit. Nowhere in the brief majority opinion is there any mention of the

50. Id. at 767, 89 L.R.R.M. at 1099-1101.
51. 601 F.2d 404 (9th Cir. 1979).
53. Id. at 411, 104 L.R.R.M. at 1386.
54. Id. at 412, 104 L.R.R.M. at 1387.
56. Id. at 748-49, 105 L.R.R.M. at 1331-32.
58. Id.
59. Id.
60. Id.
61. Id. In a separate concurring opinion, Member Penello attempted to distinguish Shriner's Hosp. from St. Vincent's Hosp., relying upon the findings that the employees involved in Shriner's Hosp. were often asked to perform tasks in other areas of the hospital, that the night shift engineers were often asked to move patients in Shriner's Hosp. and that the engineers in Shriner's Hosp. were not required to be specially licensed. Id. at 639-40, 89 L.R.R.M. at 1513-14 (Member Penello, concurring).
congressional admonition concerning unit proliferation in the health care field.\textsuperscript{62}

Upon the hospital's petition for review, the Court of Appeals for the Third Circuit denied enforcement of the Board's order.\textsuperscript{63} The court recognized the broad discretion granted the Board in determining appropriate units but found that the Board's failure to heed the congressional admonition against unit proliferation in the health care field was in violation of its duty.\textsuperscript{64} The court noted that the Board majority failed to even address the admonition\textsuperscript{65} and found this fact determinative, stating that in view of the considerable attention devoted to the problem of unit proliferation in the health care field during the congressional debate on the amendments, it was obvious that Congress attached much importance to the unit proliferation problem.\textsuperscript{66} The court further stated that the legislative history of the 1974 Amendments clearly called for the Board to apply a standard in health care unit determination cases which is different from its traditional unit determination approach.\textsuperscript{67} Absent from the court of appeals' decision in \textit{St. Vincent's} is the strong language present in later courts of appeals decisions rebuking the Board's use of the traditional "community of interests" analysis.\textsuperscript{68} The reason is that the court, unaware that the Board was resisting any change from the application of traditional unit determination standards, did not foresee the Board's refusal to follow its suggested approach.\textsuperscript{69}

In \textit{NLRB v. West Suburban Hospital,}\textsuperscript{70} the conflicting interpretations of the congressional admonition by the Board and the judiciary became apparent.\textsuperscript{71} In the proceedings before the Board, a group of twenty-one maintenance employees sought separate representation from the other 360 non-professional employees at an Illinois non-profit hospital.\textsuperscript{72} The Board relied upon its findings that the maintenance employees spent a great deal of their time in a particular area of the hospital segregated from other non-professional employees and that they interacted

\textsuperscript{62} See \textit{id.} The congressional admonition was addressed in the separate concurring opinion of Member Penello. \textit{id.} at 639. However, he felt that under the facts of the case, separate representational status was appropriate despite the admonition. \textit{id.} at 639-40.

\textsuperscript{63} \textit{St. Vincent's Hosp. v. NLRB, 567 F.2d 588 (3d Cir. 1977).}

\textsuperscript{64} \textit{id.} at 592-93. The court stated that section 9(b) of the Act authorizes the Board to determine appropriate units and "contains few restrictions on the Board's discretion and courts rarely disturb its determinations . . . unless they exceed the Board's power." \textit{id.} (citing \textit{Packard Motor Car Co. v. NLRB, 330 U.S. 485 (1947))}.

\textsuperscript{65} \textit{id.} at 590-93.

\textsuperscript{66} \textit{id.} at 591.

\textsuperscript{67} \textit{id.} at 592.

\textsuperscript{68} See infra notes 73-110 and accompanying text.

\textsuperscript{69} \textit{id.}

\textsuperscript{70} \textit{570 F.2d 213, 216 (7th Cir. 1978).}

\textsuperscript{71} \textit{id.} at 216.

\textsuperscript{72} \textit{West Suburban Hosp., 224 N.L.R.B. 1349, 92 L.R.R.M. 1369 (1976).}
with each other approximately fifty percent of their working time, and found that the twenty-one maintenance employees constituted a separate appropriate unit. The Board majority did mention the congressional admonition against undue proliferation in the health-care field, but only briefly, thus demonstrating that it did not view it as a major factor. The dissent at the Board level did not focus upon the admonition against unit proliferation either, but rather upon traditional factors, in finding that a "community of interests" sufficient to warrant separate representation did not exist.

The Seventh Circuit denied enforcement of the Board's order which required the hospital to bargain with the newly certified bargaining unit consisting of the twenty-one maintenance employees. The court began its analysis by stating that the Board's appropriate unit determination would be reviewed against the backdrop of the legislative history of the 1974 Amendments to the Act. After reviewing the history of the Amendments, the court focused upon earlier courts of appeals decisions determining that the Board's traditional approach in unit determination cases was improper in health care cases due to that legislative history. Finding that the Board had paid mere lip-service to the congressional admonition against unit proliferation in health care facilities, the court concluded by finding that the Board was not giving it the "due consideration" mandated by the legislative history of the Amendments. The court of appeals decision in West Suburban Hospital evinces a belief that the Board failed to heed a congressional mandate, but does not contain the strong chastisements characteristic of later courts of appeals decisions on this issue.

Two 1979 decisions, NLRB v. Mercy Hospital Association and Allegheny General Hospital v. NLRB, demonstrate the increasing concern of the courts of appeals regarding the Board's failure to follow an acceptable approach in health care unit determination cases. In Mercy

73. Id. at 1351, 92 L.R.R.M. at 1370–71.
74. Id.
75. Id.
76. Id. at 1351–52, 92 L.R.R.M. at 1371–72.
77. 570 F.2d at 216.
78. Id. at 214 (citing Memorial Hosp. of Roxborough v. NLRB, 545 F.2d 351 (3d Cir. 1976); St. Vincent's Hosp. v. NLRB, 567 F.2d 588 (3d Cir. 1977)).
79. See supra notes 29–37 and accompanying text.
80. 570 F.2d at 215–16.
81. Id. at 216.
82. See supra notes 73–110 and accompanying text.
83. 606 F.2d 22 (2d Cir. 1979), cert. denied, 445 U.S. 971 (1980).
84. 608 F.2d 965 (3d Cir. 1979).
85. See supra notes 73–110 and accompanying text. By this time, a variety of the circuits had expressed dissatisfaction with the Board's approach to determining appropriate units in the health care field. See Husband, Determining Appropriate Units in Health Care Institutions — The Gap Widens, 32 Lab. L.J. 780 (1981).
Hospital, a group of twenty-three maintenance employees sought separate representation. 86 The facility was a non-profit hospital with 1,287 employees working in thirty-two departments. 87 The Board had applied its traditional "community of interests" standard and found the unit sought by the maintenance employees to be an appropriate unit. 88

As was by then becoming a pattern, the court of appeals denied enforcement due to the Board’s failure to give sufficient weight to the congressional admonition against unit proliferation in health care facilities. 89 The court noted that the Board had begun to view the admonition as merely a warning to avoid the extensive proliferation of units allowed in the construction industry, but not necessarily as advice to avoid the extent of proliferation found in other areas. 90 The court rejected this approach and interpreted the admonition as calling for a standard more protective not only than that applied in the construction industry, but than that applied in other industries as well. 91

In Allegheny General Hospital, the appellate court’s attitude toward the Board’s approach to health-care unit determinations is expressed in the opinion’s initial paragraphs:

This petition for review of an order of the [Board] requires us to review the actions of an agency which declines to follow our precedent while conceding the applicability of that precedent. We hold that the NLRB must respect the applicable decisions of this court, and therefore we grant the [Hospital’s] petition for review and deny the Board’s cross petition for enforcement. 92

The Board, using its traditional “community of interests” test, 93 had held that the maintenance employees were entitled to separate representation from other service employees. 94 The Board argued before the court of appeals: (1) that the court must uphold any Board order which is "reasonably defensible;" 95 (2) that the courts of appeals had wrongly decided St. Vincent’s and Memorial Hospital; 96 and (3) that it had heeded the congressional admonition against health care unit proliferation in deciding the case. 97 All three arguments were rejected by the court. 98

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87. Id.
88. Id.
89. 606 F.2d at 28.
91. Id. at 27-28.
92. 708 F.2d at 966.
94. Id. at 873, 100 L.R.R.M. at 1031.
95. 608 F.2d at 967.
96. Id. See also supra notes 47–59 and accompanying text.
97. 608 F.2d at 967.
The court concluded that while agencies charged with administering federal law in specific areas are entitled to deference, the final determination concerning interpretations of congressional mandates rests with the courts. In response to the Board’s disagreement with the courts of appeals’ decisions in St. Vincent’s and Memorial Hospital, the court noted that the Board was not seeking to follow precedent by distinguishing a case factually from those cases binding as precedent. Rather, the court noted, this was “a most unusual circumstance in which a federal agency has refused to apply the law announced by the federal judiciary.” The court refused to reconsider the recent decisions challenged by the Board, based upon a failure by the Board to show subsequent events calling for such reconsideration as well as upon subsequent reliance on the decisions by sister circuits. The court stressed the doctrine of stare decisis and asserted the power of the federal judiciary to interpret statutes enacted by Congress.

Finally, in responding to the Board’s contention that it had given due consideration to unit proliferation as required by judicial interpretation of the 1974 Amendments, the court noted that the Board had expressly relied upon American Cyanamid, which did not in any way consider the special concerns regarding unit proliferation present in health care facilities.

In 1980, the Court of Appeals for the Seventh Circuit decided *Mary Thompson Hospital, Inc. v. NLRB.* The court’s anger and frustration with what was seen as an intentional refusal to heed an obligatory duty by the Board was openly expressed in the case. The Board had applied its traditional “community of interests” tests and found that four stationary engineers were entitled to separate representation. The Board majority failed to even mention the congressional admonition against unit proliferation in health care facilities. This, along with the Board’s open disregard of what the court believed to be clear precedent in the area, promp-
ted the court to state that "such flagrant disregard of judicial precedent must not continue."11

The court began its analysis by noting that in Shriner's Hospital the Board had properly considered the congressional admonition concerning unit proliferation.12 The court then noted that in cases following Shriner's Hospital, the Board had not faithfully followed that congressional directive and had returned to its traditional "community of interests" test in health care cases.13 The court next proceeded to analyze several courts of appeals cases which expressly called for an approach different from the Board's traditional method of deciding such cases.14 Only after proceeding through this thorough analysis did the court chastise the Board for violating its duty.15

Chief Justice Fairchild filed a brief dissenting opinion.16 It stressed the fact that the admonition was not incorporated in the amendments as enacted,17 nor was it necessary in the interpretation of these amendments.18 Judge Fairchild therefore felt that the weight to be given the admonition was a matter between Congress and the Board, and that if Congress felt that the Board was not heeding the admonition, the proper remedy would be a further change in the statute itself.19 Concluding his dissent, Judge Fairchild expressed the belief that even though his was a "purist approach," he felt it was an appropriate one.20

The Board's Most Recent Response to Mounting Criticism: St. Francis Hospital

On December 16, 1982, the Board decided St. Francis Hospital,21 wherein thirty-nine maintenance employees sought separate representation from the other approximately 400 employees in the combined maintenance and service departments.22 St. Francis was a 529-bed hospital in Memphis, Tennessee with approximately 1,300 total employees.23

The Regional Director had relied upon the Board's decision in Allegheny General Hospital24 in finding that the maintenance

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11. 621 F.2d at 864.
12. Id. at 861 (citing Shriner's Hosp., 217 N.L.R.B. 806, 89 L.R.R.M. 1076 (1975)).
13. 621 F.2d at 861-62.
14. Id. at 862-63.
15. Id. at 864.
16. Id. (Fairchild, J., dissenting).
17. Id. (Fairchild, J., dissenting).
18. Id. (Fairchild, J., dissenting).
19. Id. (Fairchild, J., dissenting).
20. Id. (Fairchild, J., dissenting).
22. Id., No. 120, slip op. at 3.
23. Id., No. 120, slip op. at 2.
24. 239 N.L.R.B. 872, 100 L.R.R.M. 1030 (1978), enforcement denied, 608 F.2d 965 (3rd Cir. 1979). See also supra notes 82-96 and accompanying text.
employees involved were entitled to separate representation. The Board noted that in Allegheny General enforcement of its order had been denied by the Court of Appeals for the Third Circuit based on what that court believed to be a failure by the Board to heed the congressional admonition against undue unit proliferation in health care facilities. In St. Francis, the Board accepted the Third Circuit’s criticisms of its Allegheny General decision as justified. However, it expressed the view that the fault with the Board decision in Allegheny General lay not with failure to heed the admonition, but rather with a failure to explain precisely the approach being used by the Board in health care unit determination cases.

The Board focused upon the language and the history of the 1974 Amendments. It noted that Congress had chosen not to limit health care units to four predetermined possibilities as Senator Taft had proposed, but rather had chosen to leave health care unit determinations to the expertise of the Board, which was to consider the congressional admonition in making its decision.

After examining a number of decisions which the Board believed demonstrated that it was not using in health care settings merely the same traditional standards used in industrial settings, the majority opinion next outlined the approach contemplated to give due consideration to the congressional admonition against undue unit proliferation in health care facilities.

125. 265 N.L.R.B. No. 120, slip op. at 4, 112 L.R.R.M. 1153 at 1154.
126. Id., No. 120, slip op. at 5–6, 112 L.R.R.M. at 1154.
127. Id., No. 120, slip op. at 6, 112 L.R.R.M. at 1155.
128. Id., No. 120, slip op. at 5–6, 112 L.R.R.M. at 1155.
129. Id., No. 120, slip op. at 7–11, 112 L.R.R.M. at 1155–56.
130. Id.
131. Id. The majority first pointed to St. Catherine’s Hosp., 217 N.L.R.B. 787, 89 L.R.R.M. 1070 (1975), wherein a group of licensed practical nurses sought separate representation. Id. They relied upon Madeira Nursing Center, 203 N.L.R.B. 323, 83 L.R.R.M. 1033 (1973), which was decided 18 months prior to passage of the amendments of 1974, and which relied upon traditional practice in finding a separate unit of licensed practical nurses appropriate. Id. The Board in St. Catherine’s nonetheless rejected the request for separate representation of the LPNs thus overruling Madeira. 265 N.L.R.B. No. 120, slip op. at 11, 112 L.R.R.M. 1153 at 1156. The Board in St. Francis next cited Kaiser Found. Hosps., 219 N.L.R.B. 325, 89 L.R.R.M. 1763 (1975), which was the first post-amendment consideration of the appropriateness of separate units for pharmacists in health-care facilities. Id. While noting that many of the traditional industrial factors counseling for separate representation were present, the Board denied the request for separate representation as inconsistent with the congressional intent in the legislative history of the 1974 Amendments to the Act. Id. The Board in St. Francis also cited Levine Hosp. of Hayward, Inc., 219 N.L.R.B. 327, 90 L.R.R.M. 1097 (1975) (residual employees were denied separate representational status) and Duke Univ., 217 N.L.R.B. 799, 89 L.R.R.M. 1065 (1975) (switchboard operators denied separate unit based upon legislative history of the 1974 amendments) as evidence that they were using standards in health-care unit determinations different from those used in traditional settings. 265 N.L.R.B. No. 120, slip op. at
The Board's approach involved a two-tier analysis wherein the first level identified certain groups of employees commonly found in health care facilities.132 The seven such groups were: physicians, registered nurses, other professional employees, technical employees, business office clerical employees, service and maintenance employees and skilled maintenance employees.133 Under the Board's approach, if the employee group seeking separate representational status falls into one of the seven listed categories, the Board will proceed to the second level of analysis which involves application of the traditional "community of interests" standards to determine if the group constitutes an appropriate unit.134 If the group does not fall into one of the listed categories, the Board will proceed no further and will dismiss the petition for separate representational status unless "extraordinary and compelling" facts are presented to the Board which justify the allowance of a smaller unit.135 The Board majority believed that in setting up this screening system, which in its eyes restricts the number of potentially appropriate units more so than does the unaltered application of the traditional "community of interests" approach, it had met its statutory duty to protect against proliferation of units in health-care facilities.136

The Board majority next focused upon the "disparity of interest" analysis called for by the two dissenting opinions137 as well as by two recent courts of appeals decisions.138 The majority stated its belief that the logical extension of the "disparity of interests" test would lead to finding the largest unit allowable consistent with the Act, and would limit the number of possible health care units to two: professionals and non-professionals.139 The Board opinion stated that this result would be entirely inconsistent with long established congressional views on unit

12-14, 112 L.R.R.M. 1153 at 1157.
132. 265 N.L.R.B. No. 120, slip op. at 15, 112 L.R.R.M. at 1157.
133. Id.
134. Id., No. 120, slip op. at 15-16, 112 L.R.R.M. at 1157-58.
135. Id., No. 120, slip op. at 16, 112 L.R.R.M. at 1158.
136. Id.
137. Id., No. 120, slip op. at 16-18, 112 L.R.R.M. at 1158-59. Resolving the problem through use of the "disparity of interests" approach means that instead of looking at what employees have in common and granting separate representation if sufficient evidence is found (as in the approach of the "community of interests" approach), the inquiry begins by asking what factors are different concerning the employees' work atmosphere. The presumption, under "disparity of interests," is against separate representational status, and only upon a showing by the employees that denying them separate representation will deny their organizational rights guaranteed by the Act will separate representation be granted. While the starting point for resolution of a unit determination problem is different under the "disparity of interests" test, it does not necessarily mean a unit seeking separate status is facing an insurmountable burden. It will simply place a heavier burden upon that unit than the unit would face under the traditional community of interests test used in industrial settings.
138. See Presbyterian/St. Lukes Medical Center v. NLRB, 653 F.2d 450 (10th Cir. 1981), Beth Israel Hosp. and Geriatric Center v. NLRB, 677 F.2d 1343 (10th Cir. 1981).
139. 265 N.L.R.B. No. 120, slip op. at 21, 112 L.R.R.M. at 1159.
determination.\textsuperscript{140} Had Congress intended such a radical change, the opinion continued, it would have made it in the statute itself rather than in an admonition contained in the legislative history.\textsuperscript{141}

After restating what it believed to be the proper approach to health care unit determination cases and its view that the “disparity of interests” analysis was one factor, albeit not dispositive, in the “community of interests” standard, the majority turned to the facts of \textit{St. Francis} itself.\textsuperscript{142} The Board focused upon many of the traditional “community of interests” criteria—levels of skill, separate supervision, special training requirements, segregation from other employees, and differences in pay scale—and held that the thirty-nine maintenance employees were entitled to separate representation.\textsuperscript{143}

In a lengthy dissent, Chairman Van De Water quarreled with the majority approach on three major grounds.\textsuperscript{144} He asserted: (1) that the majority view ignores and is inconsistent with the congressional mandate calling for limitation of unit proliferation in health-care facilities, (2) that the majority’s view ignores and contravenes the interpretation of that congressional mandate by the courts of appeals; and, (3) that the Board majority’s position in \textit{St. Francis} is inconsistent with its former position on the issue while purporting to continue to use the same approach.\textsuperscript{145}

In his analysis, Van De Water used language of former Board decisions to demonstrate that the Board has not been, as was contended by the \textit{St. Francis} majority, using an approach different in health care cases than that used in more common industrial cases.\textsuperscript{146} Again using prior Board decisional language, Van De Water pointed out that the Board has (incorrectly, in his view) been interpreting the congressional admonition as a mandate to avoid the excessive unit proliferation allowable in the construction industry, but not as requiring standards in health care cases which are more strict than those applied in other non-construction industrial cases.\textsuperscript{147} Van De Water’s dissent next proceeded through a circuit-by-circuit analysis of courts of appeals cases wherein this interpretation of the admonition was unequivocally rejected, and a standard was applied in

\textsuperscript{140} Id.
\textsuperscript{141} Id.
\textsuperscript{142} Id., No. 120, slip op. at 28, 112 L.R.R.M. at 1161. The majority view ignores the unique and unprecedented fact that the legislative history of the health care amendments, i.e. the House and Senate Committee Reports, are identical. These Committee Reports were the product of careful and prolonged negotiations among the health care industry, union representatives and the members of Congress.
\textsuperscript{143} Id., No. 120, slip op. at 28-33, 112 L.R.R.M. at 1161–62.
\textsuperscript{144} Id. (Chairman Van De Water, dissenting).
\textsuperscript{145} Id.
\textsuperscript{146} Id.
\textsuperscript{147} Id.
health care unit determination cases which is more strict than the usual industrial standard.\footnote{148}

Van De Water concluded his dissent by calling for a “disparity of interests” analysis in health care unit determination cases rather than the traditional “community of interests” standard.\footnote{149} He felt that only through this approach, which had been suggested by two of the courts of appeals decisions discussed in his dissent, could the Board give due consideration to the congressional admonition against unit proliferation in health care.\footnote{150} The “disparity of interests” approach would allow units more limited than all professional and all non-professional employees only upon a showing that the unit sought enjoys a “notable disparity of interests from employees in the larger unit which would prohibit or inhibit fair representation for them if they were denied separate representation.”\footnote{151}

Member Hunter also dissented and called for application of “disparity of interests” analysis in health-care unit determination cases.\footnote{152} Hunter accused the Board majority of “don[ning] sackcloth [and] pay[ing] verbal homage to the circuits [while] undertak[ing] a flawed analysis of legislative history and precedent, all in an effort to breathe new life into its approach to unit determination in this unique industry.”\footnote{153} He further stated that what the Board majority purports to be a “new” analytical approach is little more than “a rehash of the same old analysis that has been rejected by every circuit that has considered the issue.”\footnote{154} Many of the criticisms of the majority opinion found in Member Hunter’s dissent mirror those of Chairman Van De Water\footnote{155} as well as those of the various courts of appeals decisions which have addressed the issue of health care unit determination in light of the congressional admonition against unit proliferation.\footnote{156}

**Analysis**

The dispute between the Board and the courts of appeals on the issue of health care unit determinations can be broken down into two separate parts: (1) there is a sharp and basic disagreement concerning the weight to be afforded the congressional admonition against undue unit proliferation in health care facilities as expressed in the legislative history to the

\footnote{148}{Id.}  
\footnote{149}{Id.}  
\footnote{150}{Id.}  
\footnote{151}{Id.}  
\footnote{152}{Id. (Member Hunter, dissenting).}  
\footnote{153}{Id.}  
\footnote{154}{Id.}  
\footnote{155}{See supra notes 134–41 and accompanying text.}  
\footnote{156}{See supra note 75 and accompanying text.}
1974 Amendments to the Act; (2) the Board and the courts of appeals sharply differ over the degree to which the Board is bound to follow courts of appeals' decisions on issues of statutory construction.\(^{157}\)

The Board majority believes that it retains discretion to decide unit determinations, notwithstanding contrary statutory interpretation by a court of appeals, and also feels that since Senator Taft's proposal limiting to four the number of possible appropriate units in health care unit determinations met with defeat, the Board maintains the same unit determination discretion in health care as in other areas, subject only to the mandate of considering the congressional admonition in reaching its decision.\(^{158}\) The courts of appeals, on the other hand, believe that the Board has failed to give due weight to the admonition, and on the *stare decisis* issue, the Third Circuit recently stated:

[It is in this court by virtue of its responsibility as the statutory court of review . . . that Congress has vested a superior power for the interpretation of the congressional mandate. Congress has not given to the NLRB the power or authority to disagree, respectfully or otherwise, with decisions of this court.\(^ {159}\)]

The reasoning quoted above from the Third Circuit's opinion in *Allegheny Hospital* seems appealing, especially in light of the hierarchical system of judicial review of Board determinations.\(^ {160}\) The courts of appeals lie between the Board and the Supreme Court in that system. Thus, it would seem logical that the Board would be bound by courts of appeals' decisions in the same way that the Board and the courts of appeals are bound by Supreme Court decisions. However, it would be erroneous to accept the view of the Third Circuit—that the Board is bound to follow the courts of appeals—without further inquiry, both because that proposition is by no means the only acceptable argument on the issue and because acceptance of such a view would leave a number of unanswered questions.

When the Supreme Court resolves an issue of national labor law it speaks in language which binds the entire nation. The views of the Supreme Court override any contrary views held by different courts of appeals or by the Board and become the law of the land. Such is not the case when a court of appeals renders an opinion on a particular issue of labor law. There are now thirteen circuits, and to take the language expressed by the court in *Allegheny Hospital* to its logical extreme would

\(^{157}\) See supra notes 29–37 and accompanying text.

\(^{158}\) See supra notes 83–87 and accompanying text.

\(^{159}\) 608 F.2d at 970 (citing Volkswagenwerk Aktiengesellschaft v. FMC, 390 U.S. 261 (1968)). The court also relied upon the landmark case for judicial review, *Marbury v. Madison*, 5 U.S. (1 Cranch) 137 (1803).

\(^{160}\) See supra notes 29–37 and accompanying text.
mean that the first court of appeals to decide an issue would write binding law for the entire nation, which the Board would be bound to follow until another court of appeals reached a different conclusion, or until the Supreme Court decided the issue.

Moreover, the views expressed in Allegheny Hospital fail to give any guidance on how the Board would be forced to act in the very common situation where there is disagreement among two or more courts of appeals on a particular issue. It would not be acceptable merely to have the Board follow the views of the then-majority of courts of appeals, for to do so would very likely force the Board to switch sides a number of times before all of the courts of appeals have spoken.

Another possible alternative would be for the Board to follow the courts of appeals in those circuits which have spoken on an issue and to follow its own contrary views where a court of appeals has yet to confront the issue. Aside from the lack of uniformity that would result from such an approach, the Board's views on the stare decisis value of courts of appeals decisions make this alternative a highly unlikely one.

While there may be situations where, because of a conflict between circuits or the fact that only a limited number of circuits have confronted an issue, the Board may justifiably maintain a position contrary to that of a court of appeals. The health care unit determination issue, however, does not present such a situation.

As previously addressed herein, the appropriate standard for health care unit determinations has been considered on many occasions by the various courts of appeals. There is no conflict among those decisions. In every court of appeals decision to confront the issue, the Board's failure to properly heed the congressional admonition against unit proliferation in the health care industry has been held improper. Because the courts of appeals have unanimously rejected the Board's stance on the health care unit determination issue and because decisions of the courts of appeals bind the Board on questions of statutory construction, the Board is thus duty-bound to take a more restrictive approach than the traditional "community of interests" test which it has used in such cases.

Even aside from the impropriety of the Board's position as a matter of its obligatory duty to accept statutory construction decided by the Supreme Court and the courts of appeals, the Board's position is flawed. The legislative history of the 1974 Amendments unequivocally calls for a more restrictive approach to health-care unit determinations. Yet, under the Board's approach, an employer in an average sized hospital

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161. See supra notes 63–110 and accompanying text.
162. Id.
163. See supra notes 29–38 and accompanying text.
would be forced to bargain with as many as seven different units164 whereas that employer's industrial counterpart would usually have to bargain with only two: production/maintenance and office/clerical. This comparison demonstrates the fact that the Board's position fails to afford the health care employer with the protection against unit proliferation which was incorporated in the 1974 Amendments to the Act. Only by incorporating such protections was a compromise possible in Congress, enabling passage of those Amendments.165

That Congress chose to treat the health care industry differently than other industries is likewise not subject to dispute. The special strike-notice provisions, the provision for FMCS fact finding and the special notice provisions regarding termination or expiration of a contract166 demonstrate a treatment of the health care industry which treatment is unique to that industry alone in the almost 50 years of operating under the Act.

More specifically, in the congressional admonition against unit proliferation in health care, both the Senate and the House committees "noted with approval" three Board decisions focusing upon health-care unit issues.167 These decisions were carefully selected and in all three of the cited decisions, separate representational status was denied to groups of health care employees seeking their own unit.168 Thus, aside from the language of the admonition itself, the cases cited were to be used as guidelines in constructing the Amendments, calling upon the Board to use an approach in health care more restrictive than that used in other industries.169 This the Board has unjustifiably refused to do.

The Board's contention in St. Francis that it is applying a more restrictive test in health care settings through its so-called screening process is both transparent and unacceptable. Examination of the relevant cases reveals that the Board's purportedly "new" approach described in St. Francis is nothing more than a reiteration, using different language, of its seven unit Mercy Hospitals of Sacramento approach.170 That approach was justifiably rejected by the courts of appeals and will no doubt be rejected again should the Board continue to adhere to it. The time has come for the Board to stop rationalizing and changing the wrappings of an approach which is erroneous and which has been shown to be so by the courts of appeals, and to follow that approach mandated by those courts.

The simplest and surest method of deciding with finality exactly what Congress called for in the 1974 Amendments to the Act would be

164. See supra notes 132-33 and accompanying text.
165. See supra notes 29-32 and accompanying text.
166. See supra notes 33-34 and accompanying text.
167. See supra note 37 and accompanying text.
168. Id.
169. Id.
for the Supreme Court to hear a case involving an issue of unit determination in a health care facility. However, the law in this area is sufficiently developed that Supreme Court determination should not be necessary. The law regarding health care unit determinations has become clear, both from the congressional intent itself as expressed in the legislative history behind the 1974 Amendments to the Act and from the decisions of the courts of appeals which have interpreted that statutory language: a more restrictive approach for determining appropriate units is required in health care than in other industries. The Board’s continuing and unjustified position to the contrary, if unaltered, will harm the system of resolving labor disputes and encourage unnecessary litigation by health care employers seeking to obtain their rights which were granted by Congress in the 1974 Amendments to the Act.

CONCLUSION

While legislative amendment or Supreme Court decision of the issue of health care unit determinations would resolve the sharp conflict which has existed between the Board and the courts of appeals, the Board should alleviate the need for such action by accepting the fact that the approach it has been following is erroneous and indefensible. The Board’s position is erroneous in two respects: (1) it fails to heed the congressional admonition against health-care unit proliferation which was essential in the compromise which led to passage of the 1974 Amendments to the Act; and, (2) it contravenes the duty of the Board to accept the uniform views of the courts of appeals on an issue of statutory construction. The precious resources of Congress and the Supreme Court should not have to be called upon to decide an issue which should have been finally resolved long ago.*

*Editors’ Note: After this article had been completed and set in print for publication, the Board or August 13, 1984 reconsidered its still recent St. Francis decision and, as urged herein, adopted a more restrictive approach to health-care determination cases. St. Francis Hosp., 271 N.L.R.B. No. 160, 116 L.R.R.M. 1471 (1984) (St. Francis II). The Board’s new approach represents “a clear rejection of Board precedent to this point since the 1974 health-care amendments.” 271 N.L.R.B. slip op. at 19, 116 L.R.R.M. at 1471. While the courts of appeals decisions discussed in this article had been unanimous in rejecting the Board’s traditional approach to health-care unit determination cases, there was disagreement regarding whether a strict “disparity of interests” test should be adopted or whether the Board would be called upon to balance the traditional “community of interests” factors against the congressional admonition, which the courts of appeals felt was not being given sufficient heed by the Board. Compare NLRB v. St. Francis Hosp. of Lynwood, 601 F.2d 404 (9th Cir. 1979) (“disparity of interests” test adopted) with Trustees of the Masonic Hall v. NLRB, 699 F.2d 626 (2nd Cir. 1983) (balancing test adopted). The Board in St. Francis II chose to adopt a “disparity of interests” test but cautioned that it would not be the rigid disparity of interests test urged by some courts of appeals. 271 N.L.R.B. slip op. at 16, 116 L.R.R.M. at 1471. The Board chose to leave to future cases the definition and parameters of its new “disparity of interests” test. Because the issue of health-care unit determination constitutes the single issue with the largest number of cases presently pending before the Board, and because the Board’s new test will be evolving over the next several years as the Board decides those cases, the analysis contained in this article continues to be relevant and to provide guidance on the issue of health-care unit determination.