NLRB Rulemaking on Health Care Collective Bargaining Units: Predictability, But at What Cost?

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NOTE

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INTRODUCTION

On April 21, 1989, the National Labor Relations Board finalized a historic decision making process. For the first time in its history, the Board utilized its rulemaking power under the National Labor Relations Act to substantively assert the appropriate number and description of collective bargaining units on an industry-wide basis. The Rule provides that all acute care hospitals in the nation must recognize, and bargain with, eight (8) individual collective bargaining units.

The Board will no longer determine appropriate health care bargaining units on a case-by-case basis. Nearly every hospital in the nation, regardless of policy, operating procedure or makeup of labor force, must accept each of the eight units at the whim of its employees. Moreover, each of these eight units are presumptively appropriate. This ubiquitous policy reverses the case-by-case method used to determine appropriate collective bargaining units in hospitals since Congress articulated a national health care labor policy in the 1974 amendments to the Act, and generally since the creation of the Act.

1. Hereinafter "NLRB" or "Board".
4. 29 C.F.R. § 103.30 (1990) [hereinafter, "Rule"].
5. See infra, note 56 and accompanying text. The Board has never before utilized rulemaking to assert an appropriate collective bargaining unit. Since the promulgation of the Act, the Board has invariably made a case-by-case factual determination of the appropriate unit. The Rule does provide an adjudicatory process in the event of "exceptional circumstances." See infra, note 96 and accompanying text.
The NLRB clearly has the power to articulate its interpretation of the Act through rulemaking. Nevertheless, this does not relieve the Board of its obligation to interpret the Act within its language and Congressional intent. The Rule appears to be violative of § 9(b), § 9(c)(5), and the explicit congressional directive accompanying the grant of Board jurisdiction over the health care industry in the 1974 amendments to the Act. Additionally, and the chief issue to be confronted is whether the implications of the Rule are contrary to the Congressional intent of the 1974 amendments to the Act.

The Rule was immediately challenged in federal court by the American Hospital Association and the case was appealed up to the U.S. Supreme Court. In a nondistinctive and surprisingly brief opinion, the Court rejected the legal challenges to the Board's rulemaking power and refused to address the substance of the Rule, simply deferring to the expertise of the Board. The Supreme Court merely determined that the Rule is not facially invalid, yet in no way considered its wisdom, potential implications or concurrence with Congressional policies.

This Note examines the potential impact of the Rule on our national health care system. The discussion will raise the issue of the Rule's impact on health care costs; a factor that is rarely addressed and one given little or no consideration by either the NLRB or the Court, yet clearly one of the primary concerns of many Congressmen during the enactment of the 1974 amendments. Part I discusses the

7. See 3 N.L.R.B. Ann. Rep. 174 (1938) ("[T]he Board must consider whether there is that community of interest among the employees which is likely to further harmonious organization and facilitate collective bargaining."); see also, N.L.R.B. v. Hearst Publications 322 U.S. 111, 134 (1944) ("[W]ide variations in the forms of employee self-organization and the complexities of modern industrial organization make difficult the use of inflexible rules as the test of an appropriate unit.")
8. See 29 U.S.C. § 156 (1988); see also infra note 96 and accompanying text. Section 6 of the NLRA provides the Board with rulemaking power in accord with the Administrative Procedure Act.
9. See infra notes 165-168 and accompanying text. The Court rejected this challenge to the Rule.
10. See infra notes 120-122 and accompanying text. This challenge was not raised before the Court.
11. See infra notes 169-170 and accompanying text. The Court also rejected this challenge to the Rule.
lack of concurrence of the Rule with Congressional labor policy and the public interest concerns encompassed within. Part II briefly examines the history and standards of past health care bargaining unit determination doctrine. This includes reviewing the path taken by the Board and why it has now turned to its rarely used rulemaking function. Part III addresses the effect of the Rule on the operational costs of a health care institution. This section also examines the resulting effect of ever increasing health care administrative costs on the availability of affordable, high quality health care. Part IV examines the judicial rationale and standards utilized in the American Hospital decision and why the Court refused to act as a check on this exercise of administrative power. Finally, this Note discusses how the substance of the Rule cannot be reconciled with the priorities of a greater national health care goal. In light of the critical state of our health care system, its failure to provide basic care to a substantial portion of our population, and its drain on our economy and national resources, the Board’s Rule and the Court’s rationale may have exacerbated a problem whose effect reaches far beyond labor policy. Only the NLRB can effectively alleviate this situation by reconsidering the Rule’s substance and aligning its priorities and policies toward a common national agenda.

I. CONGRESSIONAL HEALTH CARE LABOR POLICY

The National Labor Relations Act was meant to be a broad, flexible document serving as the basis for a national labor policy. The National Labor Relations Board was created to administer and interpret the Act. Congress granted the Board with two means to effect a national labor policy, adjudication and rulemaking. The original Act, the Wagner Act of 1935, did not espouse a particular position on Board jurisdiction over the health care industry, nor a distinction between proprietary and nonprofit hospitals.

The Board initially interpreted the Act to include nonprofit hospitals within its jurisdiction. This interpretive position was statuto-

14. See infra notes 19-53 and accompanying text.
15. See infra notes 54-95 and accompanying text.
16. See infra notes 123-159 and accompanying text.
17. See infra notes 160-173 and accompanying text.
18. See infra notes 174-187 and accompanying text.
20. See Central Dispensary & Emergency Hosp. 50 N.L.R.B. 393 (1943), aff’d, 145 F.2d 852 (D.C. Cir. 1944), cert. denied, 324 U.S. 847 (1945). The D.C. Circuit held that the hospital was engaged insufficient commerce to warrant federal regulation despite its nonprofit status. 145 F.2d at 853.
rily overruled by the Taft-Hartley amendments to the Act, which explicitly exempted nonprofit hospitals from the jurisdiction of the Act.\textsuperscript{21} Despite the rationale of Central Dispensary, Congress deemed nonprofit hospitals as not engaged in "commerce."\textsuperscript{22} Thereafter, Board doctrine was uncertain on the question of asserting jurisdiction over the remainder of the health care industry.\textsuperscript{23} This uncertainty of perspective may be understood as a reflection of the dichotomy of traditional views of medicine as a parochial, charitable, and altruistic profession, with the reality of the increasingly sophisticated nature of the practice and cost of medicine, and the realization of the breadth of its impact on a national scale.

As medicine became more sophisticated, growth in the health care industry was explosive.\textsuperscript{24} The practical distinction between proprietary and nonprofit hospital became insignificant. Along with this growth emerged employee desire for collective representation. With the statutory protection of the Act for employees of proprietary but not nonprofit institutions, a needless disparity in working conditions developed. Without the procedural protection of the Act, labor unrest became commonplace with recognition strikes causing inevitable disruption of patient care.\textsuperscript{25} In 1959-1960 hospital strikes became a national issue with a four month strike in Chicago; 84 days in Seattle; and 46 days in New York.\textsuperscript{26} It was left to the states to fill the legislative void created by Taft-Hartley and subsequent Board doctrine. Some states tried to quell this problem by enacting their own labor legislation. Few states acted and those that did created a patchwork of differing rights and rationale.\textsuperscript{27} With the prospect of

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  \item \textsuperscript{21} Labor Management Relations Act, ch. 120, sec. 101, § 2(2), 61 Stat. 136, 137 (1947) (codified as amended at 29 U.S.C. § 152(2) (1988)). Nonprofit hospitals were explicitly excluded from the definition of "employer" in § 2(2) of the Act. The Taft-Hartley language excluded "any corporation or association operating a hospital, if no part of the net earnings inures to the benefit of any private shareholder or individual." \textit{Id.}
  \item \textsuperscript{22} \textit{See} 93 Cong. Rec. 3520 (1947) (statement of Mr. Hartley).
  \item \textsuperscript{23} \textit{See} Flatbush General Hosp., 126 N.L.R.B. 144 (1960) (Board decided to no longer assert jurisdiction over proprietary hospitals); \textit{see also}, Butte Medical Properties, 168 N.L.R.B. 166 (1967) (Board reversing Flatbush by asserting jurisdiction over proprietary hospitals with annual gross revenue of at least $250,000).
  \item \textsuperscript{24} \textit{See} 120 Cong. Rec. 12,937 (1974), (statement of Sen. Williams). In 1973, ten times the number of hospital workers were employed than at the time of the Taft-Hartley amendments. \textit{Id.}
  \item \textsuperscript{25} \textit{See} Kochery & Strauss, \textit{The Nonprofit Hospital and the Union}, 9 Buffalo L. Rev. 255 (1960).
  \item \textsuperscript{26} \textit{Id.}
  \item \textsuperscript{27} \textit{See} ABODEELY, J.E., \textit{et.al., The NLRB and The Appropriate Bargaining Unit}, 243-4 (rev. ed. 1981). Only eight states granted state labor board jurisdiction over nonprofit hospitals: Connecticut, Massachusetts, Michigan, Minnesota, New York, Rhode Island, Wash-
increasing division, undermining national labor policy and the potential for life-threatening work stoppages, Congress ultimately responded with the 1974 amendments to the Act.\footnote{Mandelman: NLRB Rulemaking on Health Care Collective Bargaining Units: Predi ngton, and Wisconsin. Id. at 243 note 13.}

The 1974 Amendments were an attempt to incorporate the unique nature of health care institutions within the framework of the Act. The nonprofit exemption was eliminated by repealing the exclusion of nonprofit hospitals from the definition of “employer” in Section 2(2).\footnote{Health Care Institutions Act of July 26, 1974, Pub. L. No. 93-360, 88 Stat. 395 (codified at 29 U.S.C. §§ 152, 158, 169, 183 (1988)).} Section 2(14) was created to define health care institutions.\footnote{29 U.S.C. § 152(2) (1988).} Section 8(d) was amended to extend the contract termination notification period from 60 to 90 days, and increasing the involvement of the Federal Mediation and Conciliation Service (“FMCS”).\footnote{29 U.S.C. § 152(14) (1988).} Section 8(g) was created to prevent any concerted work stoppage without providing 10 days prior notice to the employer and the FMCS.\footnote{29 U.S.C. § 158(d) (1988).}

Yet another major issue arose during the hearings for the amendments; the potential effect of fragmentation of collective bargaining units. Many Congressmen were concerned about the potential effects of widespread unionization in the health care industry. Senator Taft expressed fears that proliferation of bargaining units in health care would lead to wage leapfrogging and whipsawing and that labor relations would become a part of the delivery of care to patients.\footnote{29 U.S.C. § 158(g) (1988).} The Senator further noted that the public interest demanded the consideration of the cost of medical care:

> 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.\textsuperscript{34}

The unique hospital setting, where many different classes of workers are necessary to administer the wide range of services provided, was analogized to the construction industry which had experienced extreme fragmentation of collective bargaining units, resulting inter-union rivalries, jurisdiction disputes, frequent work-stoppages and enormous administrative burdens on employers.\textsuperscript{35}

The danger of unit proliferation in health care is real. The U.S. Department of Labor's Dictionary of Occupational Titles lists 234 nonmanagerial "medical services".\textsuperscript{36} Given job overlap, there are approximately 60 separate medical services in a hospital.\textsuperscript{37} This does not include nonmedical hospital occupations such as electrician or painter.\textsuperscript{38} Built upon this is a strict hierarchy based upon education, training, level of responsibility, and even individual codes of ethics.\textsuperscript{39} It is also very difficult to move among classifications since this may require intensive education and training.\textsuperscript{40} This tends to solidify the hierarchical lines and encourages each group to seek common self-interest.\textsuperscript{41} Many groups have formed professional associations to represent these interests.\textsuperscript{42} Work-stoppages may be an effective economic weapon, but in health care they may result in, at best, a reduced quality of patient care, and at worst, the cost of innocent lives.

Moreover, the composition of the unit will invariably affect its size; obviously the greater the number of bargaining units created along each individual job classification, the smaller each unit.\textsuperscript{43}

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34. Id.
35. See id. "The administrative problems from a practical operation viewpoint and labor-relations viewpoint must be considered by the Board on this [unit proliferation] issue. Health-care institutions must not be permitted to go the route of other industries, particularly the construction trades, in this regard." Id.
37. Id.
38. Id.
40. Id. at 266.
41. Id.
42. Groups such as the American Nursing Association, the American Society of Medical Technologists, the National Federation of Licensed Practical Nurses, have formed to assert these narrow interests. X-Ray technicians, physical therapists, dieticians and many others are also nationally represented. Many traditional craft unions also represent the variety of plumbers, painters, electricians, clerical workers, engineers etc.
43. See Kilgour, The Health Care Bargaining Unit Controversy: Community of Interest
size of the unit and the breadth of its composition has been empirically shown to affect the success of an organization drive. Thus, the issue of what units will gain certification is of a critical nature and consequently, hotly contested. The factual circumstances of labor organization in health care make this industry ripe for the very problems of unit proliferation, wage leapfrogging, whipsawing and life threatening work stoppages.

During the hearings for the Congressional amendments, a debate raged as to the consequences of widespread unionization of the health care system and how to avoid these potential problems. Proposals were made to limit the number of bargaining units. Senator Taft introduced a bill, one component which would statutorily limit the number to four. However, under strong opposition from the labor lobby and the Department of Labor, the bill was withdrawn.

A compromise was achieved to address these potential problems and promote the public interest, yet not risk the amendments to the Act in a battle to statutorily limit bargaining units. Both the House and the Senate agreed to issue an explicit warning to the Board in the committee reports to avoid fragmentation of collective bargaining units in the health care industry:

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

44. Redle and Rakich, *Judicial Review of NLRB Rulemaking in the Health Care Industry: Implications for Labor and Management*, 16 Emp. Rel. L. J. 333 (1990). As the size of the bargaining unit decreases, the union is more likely to win an organization election. *Id.* at 343.


46. *See* Taft, *American Hospital Association v. NLRB: Can the NLRB Promulgate Rules Establishing Per Se Appropriate Bargaining Units for Acute Care Hospitals?*, 24 J. Health and Hospital Law 1 (AHA 1991). S.2292 was never submitted to the floor, thus its support within Congress was never really tested. Senator Taft withdrew the bill because he knew there was strong opposition to it on both sides. Ironically, the AFL-CIO was not opposed to the low number of proposed bargaining units but to the idea of a fixed number. The Nixon Administration felt that such rigid action was unnecessary, that the Board should be allowed to act flexibly in bargaining unit determinations. *Id.*
Despite the fact that no explicit identification of appropriate units was included, Senator Taft supported this method since it represented "agreed upon language" and stressed the need to "reduce and limit" the number of bargaining units in health care, yet it still allowed the Board to act flexibly. Senator Williams emphasized that he expected the Board to act on behalf of the public interest when "exercising its specialized experience" to make unit determinations in this area.

Most importantly, it appears that this was probably the only method that could have survived. Congress had never before statutorily mandated the appropriate units in any industry; it created section 9(b) of the Act as a guide and appointed the Board as the fact finder to make this determination. The wording of section 9(b) reflects the nature of determining an appropriate unit. It is a very fact-specific issue and, quite possibly, there is no such thing as a "correct" unit. If Congress had legislatively mandated finite units in health care, it surely would have been inundated by pressure to also do this in other industries that are similarly vulnerable to labor unrest. Such a task is not Congress' responsibility, nor would it be wise, as it would have undermined the Board's flexibility and thus its ability to properly adjudicate labor disputes. Also, the Board exists to relieve Congress from just such a task as an "expert" body.

This apparently innocuous statement in the legislative history of the 1974 amendments has been the source of enormous dissention in health care labor relations and between the Board and various courts of appeal for fifteen years. Ultimately, this statement led the Board to utilize its rarely used rulemaking procedure. Despite the difficulty in interpreting and applying a policy congruent with this statement, it is clear that this was more than just common legislative history, it was a direct indication of Congressional intent created by compromise. While the language indicating intent on unit proliferation and its dangers did not reside in the language of the statute itself, Senator Taft remarked:

I believe this is a sound approach and a constructive compromise, as the Board should be permitted some flexibility in unit determi-
nation cases. I cannot stress enough, however, the importance of great caution being exercised by the Board in reviewing unit cases in this area.\textsuperscript{62}

Moreover, before the vote on the final legislation
every effort must be made to prevent a proliferation of bargaining units in the health care field and this was one of the central issues leading to the 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.\textsuperscript{63}

**II. Why Rulemaking - Post 1974 Case Law**

Unfortunately, the Board encountered enormous difficulty in attempting to maintain a consistent doctrine to effect this Congressional intent. Compounding the problem was that various circuit courts were adding inconsistent interpretations of the mandate.\textsuperscript{64} The result was unpredictability and confusion. In maintaining the procedure of creating doctrine through adjudication, the Board continued to review disputes on a case-by-case basis. Primarily two doctrines emerged: (1) the "Community of Interests" test and, (2) the "Disparity of Interests" test.\textsuperscript{65} In an effort to settle the issue and to reduce confusion and litigation, the Board decided to utilize its rulemaking power to mandate the appropriate bargaining units on an industry-wide basis, rather than choose among the doctrines; neither which produced satisfactory results in the unique health care setting.

*A. The Community of Interests Test*

The NLRA does not espouse a method for the selection and approval of a collective bargaining unit, only that the unit be "appropriate."\textsuperscript{66} The traditional doctrine which developed for ascerta-
ing the correct composition of a collective bargaining unit is the "Community of Interests" test. It may be characterized as commonality of wages, hours, and working conditions; extent of common supervision; degree of common employee skills and functions; interchangability and contact with other employees and prior history of collective bargaining.

The Board's first attempts at health care bargaining unit determinations after the new amendments were greatly anticipated. In the first case decided, Mercy Hospital of Sacramento, the NLRB approved a separate registered nurses unit, a unit of all other professional employees, separate business office clerical, and a combined service and maintenance employee unit. The most notable aspect of the case is the manner in which the Board purportedly balanced the Congressional admonition against unit proliferation with application of the traditional community of interests test. Applying community of interests, the Board authorized a separate nursing unit, but rejected a petition for a unit of medical technologists. In making this finding, the Board noted that the nurses' "peculiar role and responsibilities" and "greater degree of separateness" than most other professionals, "entitled" them to a separate unit. The Board relied heavily on the nurses' history of separate representation; this appears to have been the only substantial distinction between the nurses' role in the hospital with any other professional group. The implication of this holding was that a separate registered nurses unit was per se appropriate.

58. See Kilgour, supra note 43 at 83. For full discussion of relevant factors utilized in unit determination see Abodeely, supra note 27, at 11-83. The community of interests test as its goal fostering collective bargaining which achieves mutual benefit to all employees within the unit. Id. at 12. "The Board's objective... is to... maximize employee freedom of choice while rendering decisions that will promote harmonious labor relations through effective and efficient collective bargaining. In each case, the Board balances the aforementioned factors, assigning to each a weight commensurate with the Board's determinations of its relative importance." Id. at 13.
60. See id. at 766-69.
61. Id. at 767.
62. Id. at 767. This decision was made over the finding of the regional director, who believed that the nurses should be included in an all-professional unit. Id.
63. This presumption of an appropriate registered nurses unit was borne out in later cases. See, e.g., NLRB v. St. Francis of Lynwood, 6001 F.2d 404 (9th Cir. 1979); see also notes 82-86 and accompanying text.
It was only in rationalizing the dismissal of the petition for the separate medical technologist unit that the Board turned to the Congressional mandate to avoid proliferation of health care bargaining units. From the reasoning underlying this decision, it is clear that the Board was not taking the mandate and its attendant issues of public policy very seriously. It appears that the Board was merely attempting to fit its traditional standard while giving the appearance of considering the issues raised by Congress.

The case history of determining the appropriateness of a separate unit of skilled maintenance employees also provides insight into the lack of concern by the NLRB for the issues raised by Congress in noting the particularized nature of unit determination impact in the health care industry. Initially, the Board rejected a separate unit of skilled maintenance employees. But a divided Board could not agree on the impact of the Congressional mandate; the majority cited the mandate as the basis of the decision, while the dissent felt that the mandate did not preclude the unit if it was appropriate under the traditional community of interests test. The next time the issue arose, the entire Board agreed that the Congressional mandate did not preclude separate maintenance units.

In Allegheny General Hospital the Board simply applied the traditional standard for maintenance units developed in other contexts and found the separate maintenance unit appropriate. The Third Circuit unanimously reversed the decision as violative of the Congressional mandate, finding that "merely applying the traditional 'community of interests' criteria did not fulfill the Board's duty to consider the public interest in preventing bargaining unit proliferation." Despite this warning by the Third Circuit, the Board there-

64. Id. at 768. Here the Board turned to the statement of Senator Taft that adverse effects might occur if each professional classification were allowed to form a separate unit. This holding, which allowed an all professional unit excluding registered nurses, was affirmed a year later in Methodist Hospital of Sacramento, Inc., 223 N.L.R.B. 186 (1976).

65. At no time did the Board explain how a separate unit of registered nurses and business office clerical withstood the concerns underlying the congressional admonition, whereas a medical technologist unit did not.


67. See Jewish Hosp. Ass'n, 223 N.L.R.B. 614 (1976) (ultimately finding on the facts that the separate unit was not warranted).

68. 239 N.L.R.B. 872 (1978), enforcement denied, 608 F.2d 965 (3d Cir. 1979).


70. 239 N.L.R.B. at 873. "If Congress intended the NLRB to abandon the traditional criteria, it could have easily amended Section 9(b) to so provide." Id.

71. 608 F.2d at 971.
after continued to apply the community of interests standard, finding separate maintenance units appropriate.\textsuperscript{72} Clearly, the primary purpose of the Congressional admonition and much of the legislative history meant to differentiate the distinct nature of health care from other traditional industries. The Board again based their unit determinations on adherence to traditional standards and not the policies and unique nature of the circumstances and effects of health care labor relations.

The NLRB's rationale continually expanded to allow approval of greater variety and numbers of units under the "Community of Interests" test: registered nurses, other professionals, technical employees,\textsuperscript{73} service and maintenance employees,\textsuperscript{74} business office clerical\textsuperscript{75} and guards.\textsuperscript{76} Soon, physicians,\textsuperscript{77} skilled maintenance employees,\textsuperscript{78} stationary engineers,\textsuperscript{79} chauffeurs-drivers,\textsuperscript{80} even boiler operators\textsuperscript{81} were approved as separate units.

\textbf{B. Disparity of Interests Test}

Apparently, the NLRB was experiencing extreme difficulty in reconciling the application of the community of interests test and the Congressional admonition against proliferation of bargaining units. Much criticism of the Board developed on the issue of unit determinations by various circuit courts, with resulting denials of enforcement. In particular, sharp criticism resulted from the flagrant failure to abide by judicial precedent and the failure to consider the public interest by giving greater weight to the nonproliferation mandate.

\textsuperscript{72} See e.g., Garden City Hosp., 244 N.L.R.B. 108 (1979); Divine Providence Hosp., 248 N.L.R.B. 78 (1980).
\textsuperscript{73} See Barnert Memorial Hosp. Ctr., 217 N.L.R.B. 775 (1975) (holding that the congressional admonition did not preclude unit of all technical employees).
\textsuperscript{74} See Newington Children's Hosp., 217 N.L.R.B. 793 (1975). "[A] service and maintenance unit in a service industry is the analogue to the plantwide production and maintenance unit in the industrial sector, and as such is the classic appropriate unit." Id. at 794.
\textsuperscript{76} See Section 9(b)(3) requires that any unit of guards must be separate from other employees. 29 U.S.C. 159(b)(3) (1988).
\textsuperscript{77} See Ohio Valley Hospital Association, 230 N.L.R.B. 604 (1977) (physicians occupy a unique role within the industry and a class unto themselves).
\textsuperscript{78} See Allegheny Gen. Hosp., 239 N.L.R.B. 872 (1978) (solely applying traditional community of interests test), enforcement denied, 608 F.2d 965 (3d Cir. 1979) (Board standard violative of congressional admonition); see also supra, note 6 and accompanying text.
\textsuperscript{79} See Mary Thompson Hosp. v. NLRB, 621 F.2d 858, 864 (7th Cir. 1980) (denying enforcement of Board approval of separate unit of four stationary engineers).
\textsuperscript{80} See Michael Reese Hosp. & Medical Center, 242 N.L.R.B. 322 (1979).
Ultimately it was the Board's creation of an irrebuttable presumption of the validity of a separate nurses unit that sparked a court to suggest another method for the Board to make unit determinations.

From the very first health care bargaining unit case following the 1974 amendments to the Act, the Board found separate registered nurses units *per se* appropriate. The Board continued to approve separate nurses units based on their "singular community of interest among themselves, separate and distinct from that possessed by other professional employees in health care institutions" and often simply relied on the *Mercy Hospital* precedent.

In *NLRB v. St. Francis of Lynwood*, the Ninth Circuit refused to enforce a bargaining order where the Board's determination of an appropriate nurses-only unit was based solely on the precedent of *Mercy Hospital*. During the hearings on the case, the Board refused to allow the hospital to present evidence rebutting the similarity of the circumstances to that of *Mercy Hospital*. The court felt that this rationale completely ignored the premise of the 1974 amendments to the Act:

> The Methodist-Mercy precedent contravenes that congressional admonition by establishing an irrebuttable presumption in favor of certain units. While Congress did not pass S.2292 . . . , that failure does not sanction the Board's establishment of its own more extensive five-unit standard. . . .

The court suggested that the Board could best achieve a balance of Congressional directive and employee right to representation by adopting a "disparity of interests" test. This new concept would have the Board begin the analysis with the broadest possible unit and then exclude employees with disparate interests.

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83. Dominican Santa Cruz Hosp. 218 N.L.R.B. 1211 (1975). *See also*, supra, note 61 and accompanying text.

84. 601 F.2d 404 (9th Cir. 1979). As a result of the irrebuttable presumption, the employer was barred from presenting evidence that would refute the appropriateness of the nursing only unit. This not only is in direct contravention to the nonproliferation mandate but was probably a violation of the rulemaking procedure under *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759 (1969) (the Board would be in violation of the Administrative Procedure Act by issuing a new standard through an adjudicatory proceeding), *but, c.f.*, *NLRB v. Bell Aerospace Co.*, 416 U.S. 267 (1974) (choice between rulemaking and adjudication is within Board's discretion but reliance on adjudication can amount to abuse of discretion).

85. *Id.* at 418-19.

86. *Id.*

87. *See Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450, 458 n.6 (10th Cir. 1981), *modified sub. nom.* Beth Israel Hosp. & Geriatric Center, 688 F.2d 697 (10th Cir. 1980).
The Board agreed that an irrebuttable presumption could result in separate units where the circumstances would not necessarily warrant it; this could result in inadequate attention to the Congressional mandate. Yet the Board felt that the distinction between "disparity of interests" and "community of interests" was only semantic, and on remand, they still used the community of interests test.

In continuing to utilize the traditional standard for unit analysis, Board orders were repeatedly denied enforcement by various circuit courts. Yet, the Ninth and Tenth Circuits continued to advocate the "disparity of interests" test; other circuits primarily based their findings on a lack of consideration for the non-proliferation mandate and the failure to abide by judicial precedent.

In *St. Francis Hospital*, the Board refused to adopt the "disparity of interests" test, but instead came up with a new two-tiered system. However, just two years later, (with a significant change in Board membership), the Board rejected the *St. Francis I* standard and adopted the full "disparity of interests" test in *St. Francis II*. The effect of "disparity of interests" was as predicted, the Board was soon finding specialized units inappropriate.

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88. See, e.g., Allegheny General Hospital v. NLRB, 608 F.2d 965 (3rd Cir. 1979)(mere application of "community of interest" test does not fulfill Board duty to prevent bargaining unit proliferation), cert. denied, 445 U.S. 971 (1980); see also, Long Island College Hosp. v. NLRB, 566 F.2d 833 (2d Cir. 1977)(determinations on separate maintenance units in "disarray"), cert. denied, 435 U.S. 966 (1978); Mary Thompson Hosp. Inc. v. NLRB, 621 F.2d 858 (7th Cir. 1980) (Board paying "mere lip-service" to the congressional admonition); NLRB v. Frederick Memorial Hosp., Inc., 691 F.2d 191 (4th Cir. 1982) (refusal to enforce separate nursing unit).


90. 265 N.L.R.B. 1025 (1982)

91. Tier one: the petitioned-for unit had to fit within one of seven presumptively valid units. These ironically are the very same seven units (exclusive of guards) found to be correct in the final Rule. If the unit failed to fit within one of these units then it could never be certified. Tier two: only once a proposed unit was found to fit one of the seven classifications, the traditional "community of interests" test was applied.

92. 271 N.L.R.B. 948 (1984). The *St. Francis I* majority consisted of Members Fanning, Jenkins, and Zimmerman (all appointees of President Carter); the dissenting minority consisted of Chairman Van de Water and Member Hunter (both Reagan appointees). The *St. Francis II* majority consisted of Chairman Dotson, and Members Hunter and Dennis (all Reagan appointees); the only dissent came from Member Zimmerman.

St. Francis II was soon overruled and remanded by the D.C. Circuit.\textsuperscript{94} The Court reasoned that nothing in the legislative history or the nonproliferation mandate supported the adoption of the “disparity of interests” standard.\textsuperscript{95} On remand, the Board still utilized “disparity of interests”, reasoning that it was doing so at its own discretion.\textsuperscript{96} Any predictability for employers, employees and unions was obliterated and there appeared no end to the litigation; the system had failed.

C. The Move to Rulemaking

Section 6 of the Act gives the Board the power to establish policy through the creation of rules pursuant to the Administrative Procedure Act (“APA”).\textsuperscript{97} Administrative rules have the binding force of law pursuant to a Congressional grant of authority. While most federal administrative agencies have utilized their rulemaking authority to carry out the task of policymaking, the NLRB has primarily held to the case-by-case method of adjudication. The Board has often been criticized for its position and has continually been urged to shift its emphasis to rulemaking.\textsuperscript{98} The NLRB has very rarely utilized this procedure, and before the situation addressed within this Note, had never used it to determine appropriate collective bargaining units.\textsuperscript{99}

Under the APA, the Board provides a mechanism whereby the public is given notice of the proposed rulemaking and an opportunity to comment. This allows interested parties to provide information to the agency with the hope of influencing the substance of a rule, and it also allows public access to information pertaining to the rule

\textsuperscript{94} International Bhd. of Elec. Workers, Local 474 v. NLRB, 814 F.2d 697 (D.C. Cir. 1987).

\textsuperscript{95} Id. at 708.


\textsuperscript{97} 29 U.S.C. § 156 (1988). This section provides in relevant part, “the Board shall have authority from time to time to make, amend, and rescind, in the manner prescribed by the Administrative Procedure Act, such rules and regulation as may be necessary to carry out the provisions of the Act”. 29 U.S.C. § 156.


\textsuperscript{99} See 29 C.F.R. §§ 103.1, 103.2, 103.3 (1991). The only time the NLRB has utilized their rulemaking authority has been to establish jurisdiction over colleges and universities, symphony orchestras, and the horse and dog racing industries. Id.
before it is finalized. Rulemaking creates uniformity, which increases predictability for all parties, thereby reducing litigation.

Rulemaking is also an extremely slow and cumbersome prospect.\textsuperscript{100} It is thus inflexible, failing to allow affected parties to quickly respond to changing market needs. By indiscriminately applying to all, the result may be totalitarian in comparison to case-by-case adjudication. Allowing special interest groups to lobby their position, the loudest (i.e., best funded) parties may influence the creation of law. The Rule is created and decided by non-elected, appointed bureaucrats who are subject to immediate political pressures. The review process is cumbersome and often circular; parties must bring suit against the administrative agency. Similar to what happened in the instant case, courts often simply defer to the “expertise” of the agency, leaving adversely affected parties with no recourse short of petitioning Congress to amend the very law that granted such power to the agency.

In July of 1987, the first notice of proposed rulemaking was published ("NPR I").\textsuperscript{101} The proposed rule approved of six units and treated health care institutions differently based on size and classification. In July of 1988, the second notice of proposed rulemaking was published ("NPR II").\textsuperscript{102} At this point, the proposed Rule had inflated the number of units to eight (8), but had eliminated nursing homes and psychiatric hospitals from its jurisdiction.\textsuperscript{103} On April 21, 1989, the finalized Rule was published.\textsuperscript{104} The Rule provides that the eight units are \textit{per se} appropriate regardless of the factual circumstances, although it does contain an “extraordinary circumstances” provision that would allow the Board to revert to an adjudicatory proceeding in certain instances.\textsuperscript{105} The Board has been explicit that it will not allow the extraordinary circumstances provision to become a loophole; it will be very narrowly construed.\textsuperscript{106}

\textsuperscript{100.} To finalize this rule took fully two years, at which time it was enjoined in the courts until the Supreme Court handed down its final decision in 1991; fully four (4) years after the initial notice.


\textsuperscript{103.} \textit{Id.} The units were now registered nurses, physicians, other professionals, technical employees, skilled maintenance employees, business office clerical, other non-professionals and guards. \textit{Id.} This is the same set of units established in the final version of the Rule.


\textsuperscript{105.} \textit{Id.} at 16,345. A proposed unit of five (5) or fewer employees would constitute extraordinary circumstances. This is not a \textit{per se} inappropriate unit, but will be determined by Board adjudication.

\textsuperscript{106.} \textit{Id.} It will only apply where the circumstance is “truly extraordinary — but at the
On the same day as the declaration of the final Rule, the American Hospital Association ("AHA") filed a complaint in United States District Court for the Northern District of Illinois seeking preliminary and permanent injunctions on the Board’s application of the Rule.\(^{107}\) The injunctions were granted by the district court, finding that the Rule violated the Congressional admonition against proliferation of bargaining units in health care.\(^{108}\) The district court was reversed by the Court of Appeals for the Seventh Circuit.\(^{109}\) The Seventh Circuit rejected all three of the arguments presented by the AHA.\(^{110}\) On April 23, 1991, the Supreme Court summarily affirmed the Seventh Circuit.\(^{111}\) Justice Stevens, writing a very brief opinion for a unanimous Court, disposed of all three of the AHA’s arguments and deferred to the discretion of the Board.\(^{112}\)

The Board certainly had the best of intentions in attempting to settle the health care bargaining unit fiasco. Yet, clearly their primary concern was to end this controversy and avoid any future conflagrations with the circuit courts over what is the proper standard of bargaining unit determination, not on the public policy issues raised by Congress.\(^{113}\)

In regard to the cost implication of the Rule, many organizations commented about its foreseeably adverse impact and incongruence with Congressional intent.\(^{114}\) The Board addressed the issue of cost on a basis of whether or not to make a rule, rather than the more pertinent basis of the proliferative nature of the substantively asserted units.\(^{115}\) Ultimately, the Board concluded that cost was not

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\(^{108}\) See id. The three primary arguments of the AHA were: 1) the Rule violated Section 9(b) of the Act, that bargaining unit determinations "must be made in each case"; 2) the Rule violated the congressional admonition against bargaining unit proliferation; 3) the substance of the Rule was arbitrary and capricious. Id.

\(^{109}\) American Hosp. Ass’n v. NLRB, 899 F.2d 651 (7th Cir. 1990).

\(^{110}\) Id. The court found that the Rule was consistent with the "in each case" language of § 9(b) of the Act, that it did not violate the nonproliferation mandate, and was neither arbitrary or capricious.

\(^{111}\) American Hosp. Ass’n v. NLRB, — U.S. —, 111 S. Ct. 1539. See infra, section IV.

\(^{112}\) Id.

\(^{113}\) See, 52 Fed. Reg. 25,142 (1987). The Board candidly indicated its intent in announcing the proposed rules: "[t]he Board has resolved to utilize notice-and-comment rulemaking rather than be presented with continuing lengthy and costly litigation over the issue of appropriate bargaining units in each case." Id. It is ironic that the Board itself would utilize the words "in each case" in alluding to the bargaining unit determination procedure.


a relevant consideration. The Board appeared to feel that costs are to be considered only to the extent that they effect the stability of the health care institution, but this clearly seems to ignore the numerous statements by Congress during its debates, that the Board must consider the larger public policy issues that unionization in health care raises. They state that the costs associated with improvements in wages and working conditions “are not relevant to the Board’s decision as to appropriate bargaining units.” The Board rationalizes this idea by noting that Congress must have anticipated such increased costs, since the 1974 amendments were passed to remedy poor wages and working conditions in health care. Although this may be true, Congress also explicitly delegated to the Board the authority to consider public policy in making unit determinations in health care; a demand not made of the Board when considering any other industry.

It is in addressing these concerns that the Board’s rationalization misses the point. Even without rulemaking, health care workers are assured the protection of the Act in their right to exercise free choice in selecting their collective bargaining representative. The superficial problem of establishing parity of wages and working conditions for health care workers with other industries referred to by the Board was remedied by the 1974 amendments. The issue now draws squarely into question the very public policy concerns raised in granting NLRA jurisdiction over health care. The Board does not address the balance that might be achieved in formulating new units. They merely went about systematically approving the units commonly found appropriate in the past. No examination appears to have been made as to whether similar gains in stability and predictability could be made while balancing the public policy issues of health care quality, access, and cost, by considering a wholly new unit structure.

116. 54 Fed. Reg. 16,339 (1989). “In any event, it would not be suitable for the Board to reject appropriate bargaining units on the basis that the very things sought by collective bargaining - negotiating and grievance processing - can be obtained only at some financial cost.” Id.

117. See 53 Fed. Reg. 33,909 (1988). The Board clearly took a narrow view of the legislative history. “In view of Congressional [sic] concern in the health care amendments with the ability of health care institutions to deliver uninterrupted health services, it is relevant to consider whether multiple units increase costs to health care institutions so as to disrupt the stability of the institutions.” Id.

118. Id.

119. Id.

120. See supra note 34, 49 and accompanying text

As to explicit concerns such as increased medical costs caused by inflated expenses for contract negotiation, wage and benefit increases, administration, and legal fees, the Board summarily dismissed the issue by claiming that no empirical or specific evidence was presented.\textsuperscript{122} Based on the substance of the Rule and the reports of the rulemaking hearings, apparently little weight was given to the Congressional admonition or the public interest in ensuring access to low cost, high quality health care.

It must be noted that the substantive method used by the Board in arriving at the approved final eight units appears to be based on the extent of prior organization of units in the industry. This is illustrated by the fact that no apparent consideration was given to innovative units. Also, the units arrived at by the "fact finding" rulemaking procedure are the very same eight units that were routinely approved prior to rulemaking.\textsuperscript{123}

Extent of organization is a factor that may be considered in a bargaining unit determination, but it cannot be used as the primary basis.\textsuperscript{124} If the Board did, in fact, arrive at these eight units primarily on the basis that they are the units that have always been approved, the validity of this exercise of rulemaking must be called into question. This issue was not one of the legal challenges to the Rule raised by the American Hospital Association, but some commentators have pointed out this inconsistency.\textsuperscript{125}

\textsuperscript{122} See 53 Fed. Reg. 33,909 (1988). It is interesting to note that during this extensive factfinding mission where the Board conducted "careful analysis of the comments it received," (see citation) the Board would only consider an issue, raised by Congress, as far as the facts presented to it during the comment period. American Hosp. Ass'n v. NLRB, --- U.S. ----, 111 S. Ct. 1539, 1546 (1991). Also note that evidence was presented at the hearings that the legal fees incurred in one round of bargaining for six units were over $250,000 and that the proposed cost of negotiating with eight units would be about $360,000. Stickler, Union Organizing Will be Divisive and Costly, Hospitals, July 5, 1990, at 68-70.

\textsuperscript{123} See, e.g., St. Francis Hospital (I), 265 N.L.R.B. 1025 (1982). In St. Francis I the Board announced the seven units that it believed were "potentially appropriate" based on community of interests. These are the exact same units "found" appropriate by the rulemaking process: registered nurses, physicians, other professional employees, technical employees, business office clerical employees, skilled maintenance employees, and service and maintenance employees. The eighth unit would be guards, which under § 9(b)(3) is appropriate.

\textsuperscript{124} See 29 U.S.C. § 159(c)(5) (1988). Section 9(c)(5) provides: In determining whether a unit is appropriate for the purposes specified in subsection (b) the extent to which the employees have organized shall not be controlling; see also NLRB v. Metropolitan Life Ins. Co., 380 U.S. 438 (1965) (upholding Board position that extent of organization remains a relevant factor in bargaining unit determination).

\textsuperscript{125} See King & Swift, NLRB Rulemaking: Health Care and Beyond, in 5th Annual Labor and Employment Law Institute 116, 128 (H. Wren ed. 1990); see also, Taft, American Hospital Association v. NLRB: Can the NLRB Promulgate Rules Establishing per se Appropriate Bargaining Units for Acute Care Hospitals, J. Health and Hosp. L., January 1991, at
III. HEALTH CARE COSTS AND THE LABOR FACTOR

A. Health Care In Crisis

With the recent economic recession resulting in widespread job losses and the impending 1992 presidential election, the nation has become hyper-sensitized to proposed economic policies and how the government will restore the situation. Recent events in Europe, the impending implementation of the European Economic Community, the marked trade imbalance with Japan, and the extreme loss of confidence in American industry to compete effectively in the international arena have all forced our society to grapple with our status in the world economy and how we will maintain not only our standard of living, but basic necessities. The culmination of much of this national anxiety has focused a sharp eye on the future of American health care; it has become one of the preeminent national issues of the 1992 election.

Health care is in crisis due to ever increasing costs, which fewer are able or willing to afford. Health care expenditures cost our nation $666.2 billion, 12.2% of our gross national product in 1990. Despite this staggering figure, 37 million people, approximately 15% of this nation's population, have no health insurance and therefore have little access to quality health care. Despite the fact that more than half a trillion dollars is spent every year on health care, our nation has the 18th highest infant mortality rate in the world.

The largest portion of the payment for health care is made through private health insurance. While 85% of the population has some health coverage, insurance data indicates that employers pay 89% of all health insurance premiums through employee fringe benefit programs. In 1989, businesses spent $173.4 billion on health care services for their employees and dependents. In the present economic climate, this burden is becoming too great to bear as employers are finding this significant part of their labor cost af-

3. Id.
6. Id. at 129.
fecting their ability to effectively compete in the international marketplace. This is a cost that is often passed on to the consumer; it is estimated that over $700 of the cost of an American car is for the payment of health care insurance premiums.

B. The Fundamental Problem: Rising Cost

The enormous escalation in the cost of health care is attributable to many factors such as the aging of the population bringing more people into the system. The rush to implement costly new technologies in the often misconceived belief that newer is always better does not often outweigh benefits gained. The system of re-payment of a fee for each service performed provides only incentive to the health care provider to perform more services in order to generate greater revenue. Since the patient’s out-of-pocket expense is only a small fraction of the cost of the service, there is no disincentive to maximize use of the system. The practice of defensive medicine for fear of litigation causes great inefficiency, and the conformation with increasing regulation also adds further expense without increasing the quality of health care.

The greatest share of increases in health care spending is attributed to price inflation. In his study of the government economic data, Professor Wing has noted that health spending inflation is too great to be fully accounted for by general economic inflation. As measured by the Medical Care Price Index (“MCPI”), national health expenditures have continually and significantly exceeded the Consumer Price Index (“CPI”) every year for the past twenty years; in some years at twice the rate of the CPI.

Spending for hospital services consumes the largest individual portion of the national health budget; generally about 40% of all

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134. See Morreim, Cost Containment and the Standard of Medical Care, 75 Cal. L. Rev. 1719, 1720 (1987).
135. Id.
136. Id.
137. Id.
139. See Wing, American Health Policy in the 1980’s, 36 Case W. Res. L. Rev. 608, 24 (1986).
140. Id. at 625. The Medical Care Price Index (MCPI) is the medical care component of the Consumer Price Index (CPI). Id.
spending. In 1990, hospital expenditures amounted to $256.0 billion, a 10.1 percent increase over 1989. Hospital expenditures account for even higher proportions of total government expenditures through Medicare and Medicaid. "Given this dominant role of the hospital in modern American medicine, the analysis of the underlying causes of the growth in hospital expenditures becomes critically important for evaluating both the reality of the need for cost containment and the appropriate responses to that need."

C. The Labor Factor

In 1987, hospital services cost $194.7 billion, of which personnel costs accounted for 60% of that amount. Labor cost inflation is viewed by hospital industry analysts as the most important element in health care cost inflation. Unionization plays a role in these costs; studies have shown that health care unionization consistently gains statistically significant wage and fringe benefit increases over non-unionized health care workers. This "wage effect" would be acceptable if increases in productivity ("non-wage" effect) could be shown to offset any adverse impact on hospital expenditures.

In a study of 367 hospitals, economists have shown that unionization in the health care setting results in average wage increases of 8.8% without any offsetting increase in worker productivity; in some instances worker productivity is decreased. The study found that hospital unionization resulted in statistically significant wage increases ("wage effect") over non-unionized hospital workers for each department measured. Increases of up to 12% (laundry service

141. Id. at 631. Hospital spending has accounted for at least 40% of the national health care budget since the 1975 figures. Id. at 629.
142. See Levi, supra note 126 at 32.
143. Id. at 631. These figures represent only direct hospital charges, not physician charges, separately billed procedures or rehabilitation following hospitalization.
144. Id. Hospital price inflation was 11.4% in 1983, when the MCPI was 8.7% and the CPI was 3.2%. Id. at 634.
146. See Solovy, Health Care in the 1990s: Forecasts by Top Analysts, Hospitals, July 20, 1989, at 34.
149. Id.
workers), and 8.8% averaged for the entire hospital occurred.\textsuperscript{150}

In analyzing the impact of unionization on hospital costs not attributed to wages ("nonwage effect"), the study found that no gains in productivity were seen, and in some instances productivity was reduced.\textsuperscript{151} In unionized hospitals with no recent job actions, hospital costs per patient-day increased with no detectable effect on productivity, thus the entire effect of increased hospital cost was attributable to wage increases.\textsuperscript{152} In unionized hospitals with a recent job action, increases in overall hospital costs were even greater, indicating increases in pay and reductions in productivity.\textsuperscript{153} Moreover, these effects are understated since threat effects cannot be accounted for.\textsuperscript{154}

Unionization in the hospital setting increases costs through increased wages and fringe benefits with no offsetting increase in productivity.\textsuperscript{155} This is not to state that unionization has no place in hospitals, but when philosophically compared to other competitive industries that are cyclically sensitive to demand and cost competition, and where there is the ability to set finite output productivity goals, there is no comparable role for unions in hospitals.\textsuperscript{156}

Predictions of future utilization of the health care system will have a profound effect on the working conditions of the health care employee. These changes may well increase the importance of collective bargaining in the health care institution and are certain to further increase the proportionate cost of health care labor. The continued aging of the population, increasing numbers of AIDS patients, drug addicted patients and the increase in violent crime contribute to increased utilization of the inpatient rather than outpatient services.\textsuperscript{157} This will require expansion of inpatient services with more health care workers employed for service at odd hours and increased

\begin{footnotesize}
\begin{enumerate}
\item[150.] \textit{Id.} at 259 (Table 3). The wage increases of unionization over non-unionization for occupations measured were: RNs (5.9%); food services (9.7%); housekeeping (11.1%); laundry (12.0%); licensed practical nurses (7.8%); aides and orderlies (9.9%); plant operations (4.6%). \textit{Id.} The authors of the study note that previous research has shown even higher hospital wage effects. \textit{Id.} at 252 (citing Feldman, Lee and Hoffbeck, \textit{Hospital Employees' Wages and Labor Union Organization}, Final Report, Grant No. 1-R03-HS03649-01, National Center of Health Services Research (Minneapolis: University of Minnesota, Nov. 1980)).
\item[151.] \textit{Id.} at 259.
\item[152.] \textit{Id.}
\item[153.] \textit{Id.}
\item[154.] \textit{Id.} at 261.
\item[155.] \textit{Id.}
\item[156.] \textit{Id.} at 261-62.
\end{enumerate}
\end{footnotesize}
intensity of procedures.\textsuperscript{158} Many forecasters predict that health care labor cost inflation to be as high as 9\% over the coming years, much higher than for other types of workers.\textsuperscript{160} The shortage of employees in some sectors of the industry, particularly nurses, exacerbates the situation, resulting in continuous wage pressure.\textsuperscript{160}

Given the combined circumstances of the condition of the nation’s economy, expansion of the health care system with its attendant shortage of workers and the new NLRB Rule, the health care industry is poised for extraordinary growth in unionization. The hospital industry is still largely non-unionized, since only about 20 percent of all hospital workers are union members.\textsuperscript{161} There are about 5,500 acute care hospitals with 3.3 million workers that would come under the jurisdiction of the Rule.\textsuperscript{162} With high unemployment rates and erosion of the traditional industrial base of unions, health care is viewed by many as the “last frontier” of unionization.\textsuperscript{163}

\textbf{IV. Judicial Rationale in American Hospital}\textsuperscript{164}

The Act has placed the power to articulate a national labor policy in the Board. The Board has the ability to interpret the Act and gap-fill in areas where there is very broad statutory language. Yet, Board orders are not self-enforcing and are subject to judicial review.\textsuperscript{166} In reviewing the Board’s interpretation on questions of law, a court may determine whether the decision comports with statutory purpose, if not, the Board order will be denied enforcement.\textsuperscript{168}

\begin{itemize}
  \item \textsuperscript{158} Id. at 10.
  \item \textsuperscript{159} See Solovy, \textit{Health Care in the 1990s: Forecasts by Top Analysts}, Hospitals, July 20, 1989, at 34.
  \item \textsuperscript{160} Id. For example, in 1989 many major nursing collective bargaining agreements were settled with unusually high salary increases. These terms had to be agreed to due to staffing shortages. The impact of these contracts has created a domino effect where other sectors of health care employees expect similar increases. In one example, in 1989 the League of Voluntary Hospitals and Homes of New York settled an agreement with a union representing mainly hospital maintenance and clerical employees with wage increases and bonuses equaling 22\% over three years. Eubanks, \textit{Hefty Wage Hikes for Nurses Create a Domino Wage Effect}, Hospitals, Jan. 5, 1990, at 68.
  \item \textsuperscript{161} See Terese Hudson, \textit{AHA to Monitor Impact of Recent NLRB Ruling}, Hospitals, June 20, 1991, at 66.
  \item \textsuperscript{162} Id.
  \item \textsuperscript{163} Id. Unions appear to be readying themselves for such a drive. The American Federation of State, County, and Municipal Employees (AFSCME), has devoted 40 percent of its organizing budget to the health care organization; the American Nurses’ Association has given each of its state groups $500,000 for organizing. Id.
  \item \textsuperscript{164} \textit{---} \textit{---} U.S. \textit{---}, 111 S. Ct. 1539 (1991).
  \item \textsuperscript{165} 29 U.S.C. § 160(e), (f) (1988).
  \item \textsuperscript{166} See Shapiro, \textit{The Choice of Rulemaking or Adjudication in the Development of Administrative Policy}, 78 Harv. L. Rev. 981(1965).
\end{itemize}
The Court has in recent years afforded greater levels of deference to Board policy decisions. The *Chevron* doctrine has been developed in determining the propriety of judicial intervention. This doctrine has a two stage analysis: (1) is the Congressional intent clearly articulated in the statutory language; (2) and only if not, the court may determine whether the agency decision comports with a permissible construction of the statute. The *American Hospital* Court never explicitly utilized this level of analysis and expressly refused to address the substance of the Rule.

Ironically, it is Justice Stevens writing for a unanimous court, as he did in *Chevron*, who continues the pattern of Court deference to administrative action. In dismissing the first challenge to the Rule, that it violates the language of section 9(b) of the Act, Justice Stevens lends distressingly broad deference to the Board. Section 9(b) states that the Board “shall decide in each case” whether the proposed collective bargaining unit is appropriate. Clearly the Rule will allow blanket approval of the designated eight units regardless of the factual circumstances in which they will occur; this philosophy seems completely contrary to the words of § 9(b).

Justice Stevens’ “plain meaning” of the “in each case” language is apparently “in every case”. He states that the § 9(b) words cannot carry the implication that the Board can never make an industry-wide rule mandating appropriate bargaining units. He feels that the Rule can be reconciled since it will be applied in “each” case, and states that in the present context the phrase is “synonymous with ‘whenever necessary’ or ‘in any case’ in which there is a dispute”.

Justice Stevens finalizes this rationale with the statement that “[e]ven if we could find any ambiguity in § 9(b). . . we would still defer to the Board’s reasonable interpretation of the statutory text” and cites to *Chevron*. Apparently by implication Justice Stevens was utilizing “Step One” of the *Chevron* test, yet his concluding statement on this issue does not appear to be consistent with *Chevron*. Step One of *Chevron* is to ascertain Congressional intent; this is not generalized intent, but more specifically, in Justice Stevens’ own

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171. Id. at 1543
words, whether Congress has "directly spoken to the precise question at issue."

Quite clearly in granting the Board its § 6 rulemaking power, Congress never expressly considered the issue of appropriate collective bargaining units, yet it did in § 9(b) where not only is there no consideration of the use of rulemaking but the statute expressly states that the Board should decide what the appropriate unit is "in each case." Thus it does not seem clear that Congress has "directly spoken on the precise question at issue", and if this is the case then *Chevron* states that the analysis advances to "Step Two." From the direction of Justice Stevens' analysis even if he were to reach step two, no doubt deference would be granted to the Board.

The fact that the Court's analysis never reached step two when the statutory language does not address this issue becomes ever more important when discussing the manner of analysis of the second argument; that the Rule is contrary to the legislative intent indicated in the Congressional mandate. Justice Stevens gives this argument extremely cursory review. The Justice astutely notes that the admonition against proliferation of bargaining units, found in the Senate and House Committee Reports, cannot have the "force of law".

He then summarily states that the Board did give consideration to this issue without any analysis of whether the Rule comports with the Act in light of this legislative history. In an unusual conclusion to his argument, Justice Stevens states "the remedy for noncompliance with the admonition is in the hands of the body that issued it" and "[i]f Congress believes that the Board has not given 'due consideration' to the issue, Congress may fashion an appropriate remedy."

Clearly, Congress did not intend the admonition to be a law that could be "violated"; Congress has fashioned their response, the admonition itself; Congress has legislated on this issue, the procedure established in § 9(b). Apparently Congress did not legislate the appropriate number of collective bargaining units because *there is no correct number*; the procedure established seeks to have the Board determine that number on a factual basis. Justice Stevens seems to be saying that there will be no judicial review, or check, of the actions of the NLRB.

On the third and final argument that the Rule is arbitrary and capricious, Justice Stevens again dismisses the rationale. He simply

172. *Chevron*, 467 U.S. at 842.
174. *Id.*
adopts the Board's argument that the extensive record developed during the rulemaking proceedings and the 13-years of adjudicatory experience since the 1974 amendments give the Board “well reasoned justification” for the Rule. No mention is made of the fact that the resulting appropriate units are the very same ones proposed long before the rulemaking proceeding, nor any mention of the disarray and confusion of Board policy during that enlightening 13-year period.

One criticism of the approach taken by Justice Stevens is that it appears to be contrary to *Marbury v. Madison.* Courts, not administrative agencies, are to determine what the law is. Agencies are limited by the statutes that give them life. The court, not agencies themselves, should be the ones to define those limits. As eloquently stated by Board Member Johansen in his dissenting opinion of the rulemaking proceedings, “the countervailing arguments of the validity of this Board exercise center on the meaning of the Act, analysis of its legislative history, and interpretation of Congress’ intent.”

Neither various incarnations of the Board, nor the circuit courts, nor the parties, can agree on the proper scope of judicial review nor the Board’s duty and authority in such an exercise. As final arbiter of the scope of acts of the branches of government, the Supreme Court should resolve these issues, not defer to the “expertise” of the Board on these issues with continuing circularity. Justice Stevens defers to the Board upon reliance of the “substantial evidence” and “reasoned analysis” of the rulemaking process. Member Johansen notes, that the Board has set itself up for continuing criticism on this issue since, as is clear from the record, the findings underlying the Rule are “primarily anecdotal and statistical—and, therefore, lack the quality of pertinent evidence regarding a specific situation which lies at the core of the decisional process.”

V. CONCLUSION

The Rule has now been validated and the parade of “extraordinary circumstances” litigation has begun. Stability, predictability,
and curtailing litigation were the primary initiatives behind the Rule. Unfortunately, it appears that the promise of these noble goals will remain unattained. The Court never actually overruled the precedent of community of interests, nor addressed the substance of the Rule. Thus employers have nothing to lose in attempting to challenge the propriety of proposed units by claiming “extraordinary circumstances” or failure of the scope of particular units to comport with the community of interests standard. It is too early to determine how the Board will ultimately approach these cases and whether or not they will be allowed to soften the impact of the Rule on acute care hospitals. Yet, so far the Board has lived up to its promise of narrowly construing “exceptional circumstances” and rigidly applying the Rule.

In *St. Margaret Memorial Hospital*, the employer argued that the petitioned-for skilled maintenance unit was inappropriate under community of interests. The employer was precluded from proffering evidence to contradict the presumed appropriateness of the unit. It was indicated by the employer that the *American Hospital* decision did not overrule the precedent of *Allegheny General Hospital v. NLRB* or *St. Vincent’s Hospital v. NLRB*, both of which held that a separate skilled maintenance unit was in violation of the Congressional mandate. The Board felt that this judicial precedent is irrelevant. “[N]otwithstanding that legal precedent concerning unit determinations which are contrary to the appropriateness of the . . . separate units recognized by the Rule were not expressly overruled,” this does not compel a finding of extraordinary circumstances. The Board held that the community of interests argument is not substantially different than what was considered during the rulemaking proceeding, and therefore, no extraordinary circumstances exist.

Soon afterward, however, the Board decided the *Park Manor Care Center, Inc.* case with a very surprising analysis. The exclusion of nursing homes from the analysis of the Rule was upheld, but the Board determined that the traditional community of interests standard was not appropriate and remanded the case to the Regional
Director for unit determination. The Board was reluctant to categorize its new test, but called it "pragmatic or empirical community of interests." Acute care employers have also taken to challenging unit determinations on a "scope of unit" basis. Here, the Board has relied on a strict community of interests standard, and has not used public policy in making the determination. In Jewish Hospital of St. Louis, the Board refused to review the Regional Director's decision as not raising a substantial issue. Yet, in making the scope of unit determination, the Board and the Regional Director utilized a traditional community of interests test and in no way considered public policy. For example, secretaries for the hospital maintenance department were excluded from the maintenance unit. In Meriter Hospital, Inc., the scope of the unit for technical employees was decided on strict community of interest grounds, finding that operating room technicians were sufficiently skilled to be included in the unit. Despite the "extensive record" and "carefully reasoned analysis", Board decisions on appropriate health care collective bargaining units appear to be in similar disarray as before. The only difference now is that by bringing this decisional process under the protective umbrella of rulemaking, the Board has insulated these rulings, affecting thousands of employers, millions of workers, and leaving patients at the mercy of the system (both in terms of insurance costs, out of pocket costs and the quality of care), barred from judicial review and the public policy concerns explicitly called for by Congress.

The Board decision making process, its resulting Rule, and the Court analysis validating it, have operated in a vacuum that is nonresponsive to the realities of the critical status of the industry upon which they impinge. Throughout the process, the focus has

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189. Id. Nursing homes are explicitly excluded from the definition of acute care hospital in the rule. See 29 C.F.R. § 103.30 (1991).
190. Id.
193. Id.
been too narrowly defined and overall public policy is given no weight. Although national health care expenditures are absorbing over 12% of our gross national product, 15% or more of our population have no access to affordable health care. With large percentages of operating profits being exhausted in employee health insurance payments, employers are wincing under the pressure to compete in the international arena and maintain such benefit programs. Consequently, with the prospect of ever increasing costs, health care is becoming a luxury. Nationalized health care has become one of the most important issues for the 1992 presidential election, not because the public feels the need for better care, but to contain costs so it might become more widely available.

There is no doubt that the Board has the rulemaking power to establish principals upon which it may streamline the adjudication of labor disputes. The Board's goal of increasing predictability and decreasing litigation in collective bargaining unit determinations is an important one. Yet, clearly their focus and their aims were far too narrow for a policy that will touch the pocketbooks of every American in the form of further health care cost inflation and increased governmental expenditures for Medicare and Medicaid, or in decreased access to affordable hospitalization. This nearsighted approach becomes even more inexcusable when viewed in light of the fact the Congress explicitly warned the Board to avoid fragmentation of bargaining units in health care.

In approving the Rule and failing to address its substance, perhaps the Court feared a reversion to the disarray of prior Board decisions on the health care bargaining unit issue. However, to allow such broad based, unchecked, unaccountable power to formulate policy that will directly increase one of the most costly expenses that many Americans face, seems to raise a serious separation of powers problem. The Court "missed the boat" in utilizing its power as one of the three branches of our federal government on this long standing problem.

Congress addressed this issue in the 1974 amendments, expressly indicating that application of traditional criteria were inappropriate for this unique industry. The guidelines of its intent was placed in the admonition to prevent bargaining unit proliferation, with express statements urging the Board to consider public policy in making this determination. It is therefore highly unlikely that Congress will revisit this problem.

Throughout the rulemaking process, the effect of the Rule on the cost of health care was given no more than cursory attention.
Had the Board fully accounted their responsibility to incorporate public policy concerns when making health care unit determinations, the resultant rule surely would have been different. It cannot be denied that the cost of health care is a very strong concern for all Americans. Although it is but one piece of a complex puzzle, the labor factor is an important issue in health care costs.

The present composition of the NLRB views the Rule and its affirmation by the Supreme Court as an unbridled success. A reconsideration of the substance of the Rule by the Board is therefore highly unlikely. However, the Board must not lose sight of the fact that the Court did not approve the units arrived at, but merely the rulemaking activity. Given the deference that Board decisions are afforded by the Court, it remains up to the Board to ensure that they follow their Congressional directives.

In applying the Rule and interpreting “extraordinary circumstances” the Board must account for these public policy issues. Nonetheless, even such full consideration in application will not effect the majority of health care unit determinations. In order to ensure that the public policy concern over health care cost is appropriately considered in bargaining unit determinations, a reconsideration of the substance of the Rule will be necessary. Unfortunately, it appears that nothing less than a drastic change in Board membership will allow this to occur.

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