

# Sunshine Act Meetings

Federal Register

Vol. 53, No. 170

Thursday, September 1, 1988

This section of the FEDERAL REGISTER contains notices of meetings published under the "Government in the Sunshine Act" (Pub. L. 94-409) 5 U.S.C. 552b(e)(3).

## COMMISSION ON CIVIL RIGHTS

August 29, 1988.

**PLACE:** Biltmore Hotel, 506 South Grand Avenue, Los Angeles, CA 90071.

**DATE AND TIME:** Friday, September 9, 1988, 3:00 p.m.-5:30 p.m.

**STATUS OF MEETING:** Open (matters I-X) and Closed (matter XI).

### MATTERS TO BE CONSIDERED:

- I. Approval of Agenda
- II. Approval of Minutes of July Meeting
- III. Staff Director's Report
  - A. Status of Earmarks
  - B. Personnel Report
  - C. Activity Report
- IV. Status Report: Federal Protection for Handicapped Infants
- V. SAC Report: "Civil Rights Issues in Birmingham"
- VI. SAC Report: "Segregation in Louisville and Lexington Public Housing"
- VII. SAC Report: "The Status of Civil Rights in Louisiana"
- VIII. SAC Report: "Civil Rights Issues in Wyoming"
- IX. SAC Recharter: Maryland and New York
- X. SAC Interim Appointment: North Carolina
- XI. Executive Session closed to the public at the end of the public meeting to discuss internal personnel matters

### PERSON TO CONTACT FOR FURTHER

**INFORMATION:** John Eastman, Press and Communications Division, (202) 376-8312.

William H. Gillers,  
*Solicitor.*

[FR Doc. 88-19949 Filed 8-30-88; 11:19 am]

BILLING CODE 6335-01-M

## FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

August 29, 1988.

**CHANGE IN PREVIOUS ANNOUNCEMENT:** Vol. 53, No. 167, August 29, 1988.

**TIME AND DATE:** 10:00 a.m., Wednesday, August 31, 1988.

**PLACE:** Room 600, 1730 K Street, NW., Washington, DC.

**STATUS:** Closed [Pursuant to 5 U.S.C. 552b(c)(10)].

**MATTERS TO BE CONSIDERED:** The Commission will consider and act upon the following:

1. *Paula Price v. Monterey Coal Company*, Docket No. LAKE 86-45-D. (Issues include

whether the judge erred in dismissing the discrimination complaint.)

It was determined by a unanimous vote of Commissioners that this meeting be closed and that no earlier announcement of the change was possible.

**CONTACT PERSON FOR MORE INFORMATION:** Jean Ellen (202) 653-5629/ (202) 566-2673 for TDD Relay.

Jean H. Ellen,

*Agenda Clerk.*

[FR Doc. 88-19966 Filed 8-30-88; 11:20 am]

BILLING CODE 6735-01-M

## FEDERAL RESERVE SYSTEM BOARD OF GOVERNORS

**TIME AND DATE:** 9:30 a.m., Tuesday, September 6, 1988.

**PLACE:** Marriner S. Eccles Federal Reserve Board Building, C Street entrance between 20th and 21st Streets, NW., Washington, DC 20551.

**STATUS:** Open.

### MATTERS TO BE CONSIDERED:

#### Summary Agenda

Because of its routine nature, no substantive discussion of the following item is anticipated. This matter will be voted on without discussion unless a member of the Board requests that the item be moved to the discussion agenda.

1. Proposed project regarding development of an electronic payments production system.

#### Discussion Agenda

2. Proposed amendment to Regulation Y (Bank Holding Companies and Change in Bank Control) to implement the limitations placed on grandfathered nonbank banks by the Competitive Equality Banking Act of 1987. (Proposed earlier for public comment; Docket No. R-0637)

3. Any items carried forward from a previously announced meeting.

**Note.**—This meeting will be recorded for the benefit of those unable to attend. Cassettes will be available for listening in the Board's Freedom of Information Office, and copies may be ordered for \$5 per cassette by calling (202) 452-3684 or by writing to: Freedom of Information Office, Board of Governors of the Federal Reserve System, Washington, DC 20551.

### CONTACT PERSON FOR MORE

**INFORMATION:** Mr. Joseph R. Coyne, Assistant to the Board; (202) 452-3204.

Date: August 30, 1988.

James McAfee,

*Associate Secretary of the Board.*

[FR Doc. 88-19979 Filed 8-30-88; 1:24 pm]

BILLING CODE 6210-01-M

## FEDERAL RESERVE SYSTEM BOARD OF GOVERNORS:

**TIME AND DATE:** Approximately 10:30 a.m., Tuesday, September 6, 1988, following a recess at the conclusion of the open meeting.

**PLACE:** Marriner S. Eccles Federal Reserve Board Building, C Street entrance between 20th and 21st Streets NW., Washington, DC 20551.

**STATUS:** Closed.

### MATTERS TO BE CONSIDERED:

1. Proposed statement to be presented to the Senate Committee on Banking, Housing, and Urban Affairs regarding consumer protection provisions in H.R. 5094, the Depository Institutions Act of 1988.

2. Federal Reserve Bank and Branch director appointments.

3. Personnel actions (appointments, promotions, assignments, reassignments and salary actions) involving individual Federal Reserve System employees.

4. Any items carried forward from a previously announced meeting.

### CONTACT PERSON FOR MORE

**INFORMATION:** Mr. Joseph R. Coyne, Assistant to the Board; (202) 452-3204. You may call (202) 452-3207, beginning at approximately 5 p.m. two business days before this meeting, for a recorded announcement of bank and bank holding company applications scheduled for the meeting.

Date: August 30, 1988.

James McAfee,

*Associate Secretary of the Board.*

[FR Doc. 88-19980 Filed 8-30-88; 1:24 pm]

BILLING CODE 6210-01-M

## FEDERAL RESERVE SYSTEM BOARD OF GOVERNORS

**TIME AND DATE:** 10:00 a.m., Wednesday, September 7, 1988.

**PLACE:** Marriner S. Eccles Federal Reserve Board Building, C Street entrance between 20th and 21st Streets NW., Washington, DC 20551.

**STATUS:** Closed.

### MATTERS TO BE CONSIDERED:

1. Consideration of testimony on banking issues in H.R. 5094, the Depository Institutions Act of 1988.

2. Proposed Federal Reserve Bank salary structure adjustments.

3. Personnel actions (appointments, promotions, assignments, reassignments, and salary actions) involving individual Federal Reserve System employees.

4. Any items carried forward from a previously announced meeting.

**CONTACT PERSON FOR MORE**

**INFORMATION:** Mr. Joseph R. Coyne, Assistant to the Board; (202) 452-3204. You may call (202) 452-3207, beginning at approximately 5 p.m. two business days before the meeting, for a recorded announcement of bank and bank holding company applications scheduled for the meeting.

Date: August 30, 1988.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 88-20022 Filed 8-30-88; 3:28 pm]

BILLING CODE 6210-01-M

**FEDERAL RESERVE SYSTEM BOARD OF GOVERNORS**

**"FEDERAL REGISTER" CITATION OF PREVIOUS ANNOUNCEMENT:** Notice forwarded to Federal Register on August 30, 1988.

**PREVIOUSLY ANNOUNCED TIME AND DATE OF THE MEETING:** 9:30 a.m., Tuesday, September 6, 1988.

**CHANGES IN THE MEETING:** Deletion of the following open item(s) from the agenda:

Proposed project regarding development of an electronic payments production system.

**CONTACT PERSON FOR MORE**

**INFORMATION:** Mr. Joseph R. Coyne, Assistant to the Board; (202) 452-3204.

Date: August 30, 1988.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 88-20021 Filed 8-30-88; 3:28 pm]

BILLING CODE 6210-01-M

**POSTAL SERVICE BOARD OF GOVERNORS Meeting**

The Board of Governors of the United States Postal Service, pursuant to its Bylaws (39 CFR 7.5) and the Government in the Sunshine Act (5 U.S.C. section 552b), hereby gives notice that it intends to hold a meeting at 1:00 p.m. on Monday, September 12, 1988, in Washington, DC, and at 8:30 a.m. on Tuesday, September 13, 1988, in the Benjamin Franklin Room, U.S. Postal Service Headquarters, 475 L'Enfant Plaza, SW., Washington, DC. As indicated in the following paragraph, the September 12 meeting is closed to the public. The September 13 meeting is open to the public. The Board expects to discuss the matters stated in the agenda which is set forth below. Requests for information about the meeting should be addressed to the Secretary of the Board, David F. Harris, at (202) 268-4800.

At its meeting on August 1, 1988, the Board voted to close to public

observation its meeting scheduled for September 12, 1988, to consider a temporary mail classification change affecting certain second-class mail matter (See 53 FR 30511, August 12, 1988). By telephone vote on August 29, 1988, the Board voted to add to the September 12, 1988, closed session agenda, consideration of additional funding for the Mid-Island, New York, Mail Processing Facility.

**Agenda**

**Monday Session**

September 12—1:00 p.m. (Closed)

1. Consideration of Temporary Mail Classification Change Affecting Certain Second-Class Mail Matter. (Mr. Heselton)
2. Mid-Island, New York, Mail Processing Facility Increased Funding Requirements. (Mr. Smith)

**Tuesday Session**

September 13—8:30 a.m. (Open)

1. Minutes of the Previous Meeting, August 1-2, 1988.
2. Remarks of the Postmaster General.
3. Postal Rate Commission FY 89 Budget.
4. U.S. Postal Service Tentative FY 90 Revenue Forgone Appropriation Request. (Mr. Coppie)
5. Review of Legislative Matters and Government Relations.
6. Tentative Agenda for October 3-4, 1988, Meeting in Richmond, Virginia.

David F. Harris,

Secretary.

[FR Doc. 88-20023 Filed 8-30-88; 3:40 pm]

BILLING CODE 7710-12-M

**POSTAL SERVICE BOARD OF GOVERNORS Vote To Close Meeting**

By telephone vote on August 29, 1988, a majority of the members contacted and voting, the Board of Governors voted to close to public observation its meeting scheduled for September 12, 1988, at United States Service Headquarters, 475 L'Enfant Plaza, SW., Washington, DC. The meeting will involve consideration of a management proposal to increase funding requirements for the Mid-Island, New York, Mail Processing Facility.

The meeting is expected to be attended by the following persons: Governors Alvarado, del Junco, Griesemer, Hall, McConnell, Nevin, Pace, Ryan and Setrakian; Postmaster General Frank; Deputy Postmaster General Coughlin; Secretary for the Board Harris; and General Counsel Cox.

The Board determined that, pursuant to section 552b(c)(9)(B) of Title 5, United States Code, and section 7.3(i) of Title 39, Code of Federal Regulations, the discussion of this matter is exempt from the open meeting requirement of the Government in the Sunshine Act [5

U.S.C. 552b(b)], because it is likely to disclose information, the premature disclosure of which would likely significantly frustrate implementation of a proposed procurement action.

In accordance with section 552b(f)(1) of Title 5, United States Code, and section 7.6(a) of Title 39, Code of Federal Regulations, the General Counsel of the United States Postal Service has certified that in his opinion the meeting may properly be closed to public observation, pursuant to section 552b(c)(9)(B) of title 5, United States Code, and section 7.3(i) of title 39, Code of Federal Regulations.

Requests for information about the meeting should be addressed to the Secretary for the Board, David F. Harris, at (202) 268-4800.

David F. Harris,

Secretary.

[FR Doc. 88-20024 Filed 8-30-88; 3:40 pm]

BILLING CODE 7710-12-M

**RAILROAD RETIREMENT BOARD**

**Public Meeting**

Notice is hereby given that the Railroad Retirement Board will hold a meeting on September 8, 1988, 9:00 a.m., at the Board's meeting room on the 8th floor of its headquarters building, 844 North Rush Street, Chicago, Illinois, 60611. The agenda for this meeting follows:

**Portion Open to the Public**

- (1) Repayment of the RUIA Loan
- (2) Proposal to Reorganize the Bureau of Retirement Claims
- (3) Proposed Part 203, Employees Under the Act, of the Board's Regulations
- (4) Proposed Disability Regulations
- (5) Registration for Unemployment Benefits by Mail
- (6) Proposed Changes in the RUIA Regulations
- (7) Payment of Unemployment Insurance During Work Stoppages under the Federal Railroad Safety Act

**Portion Closed to the Public**

- (A) Appeal of Nonwaiver of Overpayment, Ora R. Dicks
- (B) Appeal from Referee's Denial of Disability Annuity, Richard O. Carmack
- (C) Appeal from Referee's Denial of Disability Annuity, Adam J. Shakir
- (D) Freels v. U.S. Railroad Retirement Board

The person to contact for more information is Beatrice Ezerski, Secretary to the Board, COM No. 312-751-4920, FTS NO. 386-4920.

Dated: August 29, 1988.

Beatrice Ezerski,

Secretary to the Board.

[FR Doc. 88-20009 Filed 8-30-88; 3:27 pm]

BILLING CODE 7905-01-M

# Corrections

Federal Register

Vol. 53, No. 170

Thursday, September 1, 1988

This section of the FEDERAL REGISTER contains editorial corrections of previously published Presidential, Rule, Proposed Rule, and Notice documents and volumes of the Code of Federal Regulations. These corrections are prepared by the Office of the Federal Register. Agency prepared corrections are issued as signed documents and appear in the appropriate document categories elsewhere in the issue.

## DEPARTMENT OF COMMERCE

### National Oceanic and Atmospheric Administration

#### 50 CFR Part 672

[Docket No. 80745-8145]

#### Groundfish of the Gulf of Alaska

##### Correction

In proposed rule document 88-18809 beginning on page 31728 in the issue of Friday, August 19, 1988, make the following corrections:

1. On page 31730, in the second column, under **Classification**, in the second paragraph, in the fourth line, remove "MRM".

#### PART 672—[CORRECTED]

2. On the same page, in the third column, in amendatory instruction 2, in the second line, remove "MRM".

#### § 672.23 [Corrected]

3. On page 31731, in the first column, in § 672.23(b), in the sixth line, remove "MRM".

BILLING CODE 1505-01-D

## DEPARTMENT OF ENERGY

### Federal Energy Regulatory Commission

[Docket Nos. ER88-559-000 et al.]

#### Niagara Mohawk Power Corp. et al.; Electric Rate, Small Power Production, and Interlocking Directorate Filings

##### Correction

In notice document 88-19104 beginning on page 32100 in the issue of Tuesday, August 23, 1988, make the following correction:

On page 32101, in the first column, under **8. GWF Power Systems Company, Inc.**, the first line should read:

"[Docket No. QF85-588-002 et al.]"

BILLING CODE 1505-01-D

## ENVIRONMENTAL PROTECTION AGENCY

### 40 CFR Part 180

[PP 6F3453/R978; FRL-3428-9]

#### Pesticide Tolerances for Bifenthrin

##### Correction

In rule document 88-18375 beginning on page 30676 in the issue of Monday, August 15, 1988, make the following correction:

#### PART 180—[CORRECTED]

#### § 180.442 [Corrected]

On page 30678, in the second column, in § 180.442, the fifth line should read "trifluoro-1-propenyl)-2,2-".

BILLING CODE 1505-01-D

## ENVIRONMENTAL PROTECTION AGENCY

### 40 CFR Part 761

[OPTS-62035G; FRL 3366-6]

#### Polychlorinated Biphenyls in Electrical Transformers

##### Correction

In rule document 88-16194 beginning on page 27322 in the issue of Tuesday, July 19, 1988, make the following correction:

On page 27326, in the third column, in the second complete paragraph, in the eighth line, "§ 761.3(a)(1)(xv)(D)" should read "§ 761.30(a)(1)(xv)(D)".

BILLING CODE 1505-01-D

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Food and Drug Administration

[Docket No. 88N-0242]

#### Hydrocortisone Acetate and Pramoxine Hydrochloride; Drugs for Human Use; Proposal To Withdraw Approval; Opportunity for a Hearing

##### Correction

In the correction to document 88-14876 appearing on page 27450 in the issue of

Wednesday, July 20, 1988, make the following correction:

In the third column, in the first paragraph, in the second line, the page number should read "25013"

BILLING CODE 1505-01-D

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Food and Drug Administration

[Docket No. 88M-0159]

#### IOLAB® Intraocular; Premarket Approval of Models 85JS, 85JM, and 85JL Anterior Chamber Intraocular Lenses

##### Correction

In notice document 88-16300 appearing on page 27400 in the issue of Wednesday, July 20, 1988, make the following correction:

In the second column, under **Opportunity for Administrative Review**, in the sixth line, "360e(b)" should read "360e(g)".

BILLING CODE 1505-01-D

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Food and Drug Administration

#### Revised Chapter in Regulatory Procedures Manual; Recall Procedures; Availability

##### Correction

In notice document 88-16297 beginning on page 27400 in the issue of Wednesday, July 20, 1988, make the following correction:

On page 27401, in the first column, under **SUPPLEMENTARY INFORMATION**, in the 13th line, "or" should read "of".

BILLING CODE 1505-01-D

**DEPARTMENT OF THE INTERIOR****Bureau of Land Management**

[NM-940-08-4220-11; NM NM 056534, NM NM 016634, NM NM 0556981, NM NM 10388, NM NM 12780, NM NM 46827]

**Proposed Continuation of Withdrawals; Baca Recreation Area et al., New Mexico***Correction*

In notice document 88-17607 appearing on page 29392 in the issue of Thursday, August 4, 1988, make the following correction:

In the second column, under *Elder Canyon Administrative Site*, the second line should read "Sec. 35, NW ¼NE¼N W ¼, NE¼NW¼NW¼."

BILLING CODE 1505-01-D

**DEPARTMENT OF TRANSPORTATION****National Highway Traffic Safety Administration****49 CFR Part 571**

[Docket No. 81-11; Notice 25]

RIN 2127-AC45

**Federal Motor Vehicle Safety Standards; Lamps, Reflective Devices, and Associated Equipment***Correction*

In rule document 88-18537 beginning on page 31007 in the issue of Wednesday, August 17, 1988, make the following correction:

**PART 571—[CORRECTED]**

On page 31009, in the first column, in amendatory instruction 2, the first line should read: "2. Paragraphs (b)(1), (b)(2), and (b)(3) of".

BILLING CODE 1505-01-D

Federal Register

Thursday  
September 1, 1988

---

**Part II**

**National Labor  
Relations Board**

---

29 CFR Part 103

Collective-Bargaining Units in the Health  
Care Industry; Second Notice of  
Proposed Rulemaking

## NATIONAL LABOR RELATIONS BOARD

### 29 CFR Part 103

#### Collective-Bargaining Units in the Health Care Industry

**AGENCY:** National Labor Relations Board.

**ACTION:** Second notice of proposed rulemaking.

**SUMMARY:** This Second Notice of Proposed Rulemaking provides for appropriate bargaining units for various types of facilities in the health care industry. The Board has determined that establishing bargaining units by rulemaking will better effectuate the purposes and policies of the National Labor Relations Act than continuing lengthy and costly litigation over the issue of appropriate bargaining units in each case.

**DATE:** Comments must be received on or before October 17, 1988.

**ADDRESS:** Comments should be submitted in eight copies to: Office of the Executive Secretary, 1717 Pennsylvania Avenue NW., Room 701, Washington, DC 20570, Telephone: (202) 254-9430.

**FOR FURTHER INFORMATION CONTACT:** Curtis A. Wells, Associate Executive Secretary, 1717 Pennsylvania Avenue NW., Room 701, Washington, DC 20570, Telephone: (202) 254-9430.

**SUPPLEMENTARY INFORMATION:** The following is an outline of the contents of this Notice:

- I. Background
- II. Validity and Desirability of Rulemaking
- III. Standard to be Applied in Determining Appropriate Units
- IV. Two Units: All Professionals/All Non-Professionals
- V. Registered Nurses
- VI. Physicians
- VII. Other Professionals
- VIII. Technicals
- IX. Skilled Maintenance
- X. Business Office Clericals
- XI. Other Non-Professionals
- XII. One Hundred Bed Distinction
- XIII. Nursing Homes
- XIV. Specialized Hospitals
- XV. Partially Organized Facilities
- XVI. Facilities Covered
- XVII. Decisions to Which Rule Applies
- XVIII. Non-Conforming Stipulations
- XIX. Combined Units
- XX. Extraordinary Circumstances Exception
- XXI. Proliferation
- XXII. Docket
- XXIII. Regulatory Flexibility Act
- XXIV. Regulatory Text
- XXV. Dissenting Opinion

#### I. Background

In our original Notice of Proposed Rulemaking (NPR), we set forth at considerable length the reasons prompting the Board to embark on rulemaking to establish appropriate bargaining units in the health care field. These reasons are set forth fully at 52 FR 25142-25145, July 2, 1987.

Following the Notice, the Board conducted the three hearings announced in the Notice, as well as a fourth hearing requested by several interested parties and announced at 52 FR 29038. At these hearings, all who wished to testify were given an opportunity to do so, and all who wished to ask questions of the various witnesses were given that opportunity. Summaries (cited below as WS) submitted in advance by most of the prospective witnesses facilitated the questioning process.

The first hearing was held in Washington, DC on August 17 and 18, 1987; 20 witnesses appeared, and 496 pages of testimony were taken.

The second hearing was in Chicago, Illinois on August 31 and September 1, 1987; 27 witnesses appeared, and 521 pages of testimony were taken.

The third hearing was in San Francisco, California on September 14, 15, and 16, 1987; 39 witnesses appeared, and 762 pages of testimony were taken.

The final and longest hearing was back in Washington, DC on October 7, 8, 9, 13, 14, 15, and 16, 1987; 58 witnesses appeared, and 1766 pages of testimony were taken.

The comment period, which was originally to last through October 30, 1987, was thereafter extended three times upon the request of various parties [52 FR 36589, 43919, and 47029]. The evidence received by the Board at the hearings and during the comment period substantially exceeded, in both detail and exhaustiveness, what the Board had expected. The transcript of hearing totals 3545 pages, and the 144 individuals who came in person to testify included employees from virtually every broad classification under consideration: registered nurses, physicians, other professionals, technicals, skilled maintenance employees, service and related employees, and business office clericals. In addition, there were union and management negotiators from around the country; a number of professors of nursing, health care management, and other academic disciplines; hospital administrators; health care associations such as the American Medical Association (AMA); representatives of numerous unions including the American Federation of Labor and

Congress of Industrial Organizations (AFL), Service Employees International Union (SEIU), International Brotherhood of Teamsters (IBT), United Food and Commercial Workers International Union (UFCW), International Union of Operating Engineers (IUOE), American Nurses Association (ANA) and several of its state associations, Hospital Employees' Labor Program of Metropolitan Chicago (H.E.L.P.), United Nurses' Association of California (UNAC), Communication Workers of America (CWA), Union of American Physicians and Dentists (UAPD), New York State Federation of Physicians and Dentists; and representatives of various employer groups such as the League of Voluntary Hospitals and Homes of New York, American Hospital Association (AHA), New Jersey Hospital Association (NJHA), Metropolitan Chicago Healthcare Council, Missouri Hospital Association, Ohio Hospital Association, Affiliated Hospitals of San Francisco, California Association of Hospitals and Health Systems, Associated Hospitals of the East Bay, Hospital Council of Southern California, American Health Care Association, and Hospital Council of Western Pennsylvania.

During the comment period, the Board received written comments from 315 individuals and organizations, representing diverse points of view and offering information to supplement what the Board had learned from the oral testimony. These comments alone totalled approximately 1500 pages.

In addition, following the close of the hearings, lengthy comments in the nature of briefs were submitted by the AHA; the ANA; the Building and Construction Trades Department of the AFL-CIO; the IUOE; and the AFL, on behalf of SEIU; National Union of Hospital and Health Care Employees (NUHCE); Local 1199, Drug, Hospital and Health Care Employees Union, Retail, Wholesale, Department Store Union (Local 1199); Federation of Nurses and Health Care Professionals, American Federation of Teachers (AFT); American Federation of State, County and Municipal Employees (AFSCME); CWA; International Union, United Auto Workers; UFCW; and United Steelworkers of America.

The Board is gratified at, and appreciative of, the interest shown in these proceedings by all segments of the industry, including its employees and their representatives. The Board has spent a great deal of time reviewing the evidence collected and the comments received, and believes it is now far better qualified to resolve the issues

raised in the Notice of Proposed Rulemaking.

On July 1, 1988, the Board met in open session to discuss further the issue of appropriate bargaining units in the health care industry. The rules tentatively decided upon in that meeting and proposed below have been derived from our analysis of the empirical evidence and comments received during the rulemaking proceeding. The rules now proposed differ in several important respects from the rules proposed in our original Notice of Proposed Rulemaking. Because this is the Board's first major effort at substantive rulemaking, and because the Board is desirous of giving all interested parties a further opportunity to comment on the proposed rules, including the substantial revisions, we have provided for another period of comment. See, e.g., Note, *The Need for An Additional Notice and Comment Period When Final Rules Differ Substantially From Interim Rules*, 1981 Duke L.J. 377 (1981). This Second NPR contains a lengthy Supplementary Information Sec., addressing the major issues presented and containing numerous citations to the rulemaking record. We wish to emphasize that these citations are merely illustrative of the testimony upon which we relied and are not represented as the entirety of the record. We have carefully studied the complete rulemaking record, including the transcript, the witnesses' statements, the comments and briefs, and the exhibits, and have based our proposed rules on the entirety of this record, and not solely on the testimony specifically cited.

## II. Validity and Desirability of Rulemaking

### A. Introduction

The Board's statutory authority to engage in rulemaking is derived from section 6 of the National Labor Relations Act, which expressly gives the Board power to make "such rules and regulations \* \* \* as may be necessary to carry out the provisions of this Act \* \* \*."

In response to several commentators' concerns (e.g., AHA Br. 48; Comment 289, Ross WS Albanese. Charter Medical) and also to the concern expressed by our dissenting colleague, the fact that the language of section 9(b) requires a separate determination "in each case" does not in our opinion mean that the Board cannot promulgate rules to assist it (See discussion at 52 FR 25144.) It has long been the Board's practice to formulate "rules" to guide it in representation matters. See, e.g., the "contract bar rules," discussed in

*Appalachian Shale Products Co.*, 121 NLRB 1160 (1958); the "Excelsior Rule," enunciated in *Excelsior Underwear Inc.*, 156 NLRB 1236 (1966); and the *Peerless Plywood* rule, 107 NLRB 427, 429 (1953). Although these rules were formulated by adjudication rather than APA rulemaking, and a majority of the Supreme Court in *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759 (1969), upheld the validity of the particular rule (the *Excelsior* rule) as applied to the respondent in that case, the plurality implied, and the two dissents explicitly stated, that the Congressionally-preferred course for such prospective pronouncements would be APA rulemaking. To our knowledge, no court or academic commentator has ever made the contrary suggestion, that section 9(b) forbids utilization of APA procedures to formulate generally applicable representation case rules. As Kenneth Culp Davis observed with specific reference to the language of section 9(b), "The mandate to decide 'in each case' does not prevent the Board from supplanting the original discretionary chaos with some degree of order, and the principal instruments for regularizing the system of 'deciding in each case' are classifications, rules, principles, and precedents. Sensible men could not refuse to use such instruments and a sensible Congress would not expect them to." Davis, *Administrative Law Text* 145 (3d ed. 1972).<sup>1</sup>

In the Notice of Proposed Rulemaking, we set forth at length our reasons for embarking on this procedure in the health care industry. Initially, we noted that thirteen years had elapsed since the health care amendments were passed, but none of the Board's previously enunciated doctrinal formulas for determining appropriate health care units had yet met with general judicial acceptance. Moreover, in numerous cases it had proven necessary to engage in lengthy, costly litigation over the appropriate bargaining unit or units. In retrospect, it appeared to the Board that there had been relative uniformity of workforce configurations and job classifications from facility to facility, and even under adjudication the various Board members had reached virtually identical results from case to case. Hence, it did not appear that what some have termed "sensitive, case-by-case

adjudication" was serving any useful purpose. The Board also acknowledged that for years it had been urged to engage in APA rulemaking by numerous scholars and judges. In making the decision to engage in rulemaking, the Board expressed the expectation that this type of proceeding would produce the type of empirical evidence most appropriate for a determination as to which of the requested groups warranted separate bargaining units, while not creating such undesirable results as excessive proliferation, interruption in the delivery of health care services, jurisdictional disputes, wage whipsawing, and the like. A fuller exposition of the Board's initial reasons for undertaking rulemaking can be found at 52 FR 25143-145.<sup>2</sup>

Following its issuance of a Notice of Proposed Rulemaking, the Board permitted the parties to comment on this matter, and to present testimony in support of their positions. A significant number of health care providers, including the American Hospital Association, opposed the Board's rulemaking efforts. We have carefully considered all their arguments and the evidence submitted in support thereof.

### B. Industry's Position

1. *Dynamics and diversity of health care industry.* One argument advanced by a number of employers in opposition to rulemaking was that the dynamics and diversity of the industry preclude it. Thus, the imposition of diagnostic related groups (DRGs) has required new efforts at cost containment (WS Rhodes [AHA] at 1.4; Comment 108, Bonaventure; Comment 130, St. Vincent's Hosp. Ala; Comment 193, Dolly Vinsant Memorial Hospital; Comment 268, Kane). Inflationary pressures have increased while revenues, particularly for in-patient stays, have either decreased or have been governed by ceilings. (Comment 76, South Suburban Hosp; AHA Br. 3-4; Comment 81, Jordan Hospital; Comment 146, Kennebec Valley Medical Center.) Severe shortages in certain categories of

<sup>2</sup> In the NPR, we observed that a number of states, including Florida and Massachusetts, had engaged in rulemaking to formulate appropriate bargaining units for their own employees. 52 FR 25145, fn. 39. We take official notice that, as of November 1987, of the 22 states with comprehensive collective bargaining legislation for state employees, ten (Alaska, California, Connecticut, Florida, Iowa, Maine, Massachusetts, Michigan, New York and Ohio) set their units by administrative rulemaking, and four (Hawaii, Minnesota, Nebraska, and Wisconsin) designate them by statute. Only eight (Illinois, Montana, New Hampshire, New Jersey, Oregon, Pennsylvania, Rhode Island and Vermont) establish units through case-by-case adjudication.

<sup>1</sup> See also *Continental Web Press v. NLRB*, 742 F.2d 1087, 1093-94 (7th Cir. 1984), in which Judge Posner suggests that the Board's decision in that case with respect to lithographic units would have been more acceptable had the Board used "its dormant rulemaking powers;" and *NLRB v. Majestic Weaving Co.*, 355 F.2d 854, 859-61 (2d Cir. 1966) (Friendly, J.), cited by the court in *Continental Web Press*.

employees have required hospitals to be flexible, which, it is alleged, is inconsistent with the relative inflexibility of rules (Comment 133, Beth Israel Hosp.).

At the same time, there has developed an increasing diversity in hospitals and the services they provide (King, 4232; Comment 19, Johnson City Medical Center Hosp.). Thus, hospitals of all types and sizes are establishing new types of related health care services on outpatient as well as inpatient bases (AHA Br. 5; Dauner, 3217; Comment 44, McDonough District Hosp.; Comment 71, St. Mary Hosp.; Comment 76, South Suburban Hosp.; Comment 174, High Plains Baptist Hosp., etc.). Many hospitals are expanding their markets by developing a number of specialty units, such as arthritis units (AHA Br. 7, citing *Modern Healthcare*, July 31, 1987, p. 42); intensive cardiac care, intensive medical/surgical, and neonatal units (Comment 71, St. Mary's Hosp.); trach units, dialysis units, etc. (Comment 78, Greater Cincinnati Hosp. Council). Another change is that hospitals are using part-time workers in increasing numbers to accommodate rapid fluctuations in inpatient census and reduction in full-time employee schedules (AHA Br. 7). One large group of proprietary hospitals, National Medical Enterprises, has extensively analyzed services provided in its hospitals to determine what allegedly professional services could be handled by non-professionals; in some of its facilities, it has implemented the "caregiver" concept to replace traditional job labels, within the limits of the classifications' competency. (Donnelly, 4063-80.) It is alleged that rulemaking is not suited for today's diverse and complex institutions (AHA, King, 4232).

**2. Changing structure.** The industry's witnesses presented evidence that the structure of the industry is changing in that hospitals are becoming parts of larger systems encompassing intermediate care facilities, urgent care centers, nursing homes, surgery centers, clinics, etc. (Rhodes, 9-11; NJHA, 320-324, 325; Dauner, 3194; Comment 66, Holy Cross Health Sys.; Comment 203, Deaconess Hosp.). It is alleged that an inflexible rule will impede the Board's ability to respond quickly to rapid changes in the industry (AHA, pos. st. 2). It is claimed that, because of the myriad of recent changes, this is an inopportune time to engage in rulemaking, which would be better done after the industry has had time to settle down from the current changes (Robfogel, Chi II 233).

**3. Prospects for litigation.** A number of representatives of the industry contended that rulemaking will not reduce the amount of litigation, partly because it will still be unclear into what category various occupations fall (Rhodes, 14; Stickler, 49; Owley, 4379-80; Comment 213, Mulhall, AtlantiCare Medical Center); there will be continuing litigation over the "special situations" exception (Comment 148, Moeller, Mississippi Hosp. Assn.); and, in general, the industry anticipates more litigation rather than a conservation of agency resources (Stickler, letter dated June 19, 1987, RM 2-10; Comment 289, Ross).

### C. Opposing Position

**1. Litigation.** Though the vast bulk of industry commentators opposed rulemaking, two did not oppose it. Thus, one hospital agreed with the observation that unit determinations in the industry were confused and hard to follow, deeming rulemaking a "welcome relief." (Comment 5, Kane, Holy Redeemer Health System.) Kaiser also does not oppose rulemaking, having observed protracted litigation elsewhere in the industry. (Comment 313, addendum to Kaiser comment.) One student with prior experience as a department head in several hospitals observed that rulemaking may help reduce costs in the industry, so that parties can spend fewer dollars on legal maneuvering and less time on organizing campaigns, leading to more industrial stability. (Comment 122, Shumlas.)

The unions participating in these proceedings supported the Board's rulemaking efforts. (ANA Br. 192-93; New York State Federation of Physicians and Dentists, 79-80; Health Professionals and Allied Employees of New Jersey (HPAE), 122, 127; Union of American Physicians and Dentists, 3649; SEIU, 5155; IUOE, Br. 106; IBT, Saporta, 5101.) They acknowledged the protracted litigation that had theretofore ensued (e.g., Saporta, 5141-42; HPAE, 122, 24; Minnesota Nurses Assoc., WS Patek; Federation of Nurses and Health Profs, WS Owley & 4379-80), producing lengthy delays and great difficulties in organizing (e.g., Lumpkin, 84-85; Nathan, 79-80; Union of American Physicians and Dentists, 3649). One management-side consultant is reported to have admitted that such delays were often part of management's strategy in contesting health care units:

At a workshop on unions, Raymond Mickus, president of Raymond F. Mickus & Associates in Bannockburn, Ill., predicted that the NLRB rules will spark much more union activity. . . . Under the rules there will be much, faster elections, he said, adding

that employers won't have access to hearings or briefs which used to delay the proceedings \* \* \*. There also will be less costs for the unions because they will not have to spend the "megabucks" associated with the hearing process, he said. (Current Developments, BNA Daily Labor Report, Aug. 6, 1987, p. A-2.)

Shortly thereafter, another health care industry representative is reported to have said something very similar: "Delaying representation elections. The greater the time between the initial union petition and the election the less chance there is that the union will win." (Metzger, vice president of labor relations for Mount Sinai Medical Center, discussing management's strategy, though not necessarily advocating it himself. Reported in Current Developments, BNA Daily Labor Report, Sept. 29, 1987.)

**2. Diversity.** There is some variation between institutions. No two hospitals are exactly alike, but this is true of all institutions. The relevant question, however, is whether, despite surface differences, there are such similarities that certain institutions may properly be grouped as a class. AHA data from 1986 show that while there are a number of different types of health care providers, the overwhelming majority of private, acute care hospitals are general medical and surgical hospitals. Of the 4,381 registered, private acute care hospitals in the U.S., almost 90% are classified by AHA as general hospitals; less than 9% are classified as psychiatric. Of the general hospitals, 98% are medical and surgical hospitals, while only 2% are pediatric, obstetric, or rehabilitation hospitals. (AFL Exh. 7,8.) Inpatient activity accounts for 84% of hospital revenues, and 88% of inpatient beds are allocated to general medical and surgical care, obstetrics, pediatrics, and intensive care. (AFL Exh. 9,10.) The unions contend that the industry has not shown that such diversity as does exist is reflected in different functions for business office clericals, skilled maintenance employees, unskilled service workers, etc. at the different types of facilities.

The unions concede the presence of cost pressures which have changed the climate in which hospitals must operate today (AFL Br. 134; WS Berliner; Comment 293(i), Feldsine). However, they argue that change is endemic in the health care field, and contend that recent changes are not qualitatively different from changes brought about by the advent of private health insurance or introduction of Medicare and Medicaid, equally profound and dramatic changes (Kennedy, 5549-50). As reflected in the

testimony about particular job classifications, DRGs are an accounting and financing mechanism that has nothing to do with the organization of the hospital labor force, and that has not resulted in employees performing jobs that were traditionally performed by other groups of employees (Kennedy, 5551-53; Berliner, 5628-29). In fact, business office clericals' skills have been upgraded because of increased complexity of their work caused by financial pressures (Berliner, 5600). The unskilled workforce has become even less skilled and more vulnerable to layoffs caused by financial shortfalls (Berliner, 5603-04). Similarly, technical employee ranks have declined in the least skilled technical positions while increasing in the most skilled positions as a result of industry changes (WS Berliner at 11-12; WS Schoen at 14-15). Skilled maintenance employees continue to maintain the physical plant (AFL Br. 132). Neither has the role of RNs changed; they continue to provide direct care to patients and clients as in the past (ANA Br. 163).

3. *Changing structure.* There was evidence that, at least in California, the trend toward consolidation of ownership and management of hospitals into multi-hospital organizations appears to have ended (AFL Exh. 17 at p. 2, from California Assn. of Hospitals and Health Systems Report). Further, corporate mergers and larger organizational changes have not affected relationships between traditional job classifications; rather, the changes are in the corporate officers, locus, and method of corporate decision-making (Federation of Nurses and Health Profs, WS Owley; Patek, Chi I 48; Twomey, 126-127). In any event, the proposed rule does not purport to address the issue of the appropriateness of a single facility when an employer owns a number of facilities, which the Board will continue to address through adjudication. *Manor Healthcare Corp.*, 285 NLRB No. 31 (Aug. 6, 1987).

#### D. Conclusion

1. *Agency discretion.* The choice between deciding an issue through adjudication or APA rulemaking is, in the final analysis, within the informed discretion of an administrative agency. *SEC v. Chenery Corp.*, 332 U.S. 194, 203 (1947); *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 294 (1974); *NLRB v. Children's Baptist Home*, 576 F.2d 256, 260 (9th Cir. 1978); *NLRB v. St. Francis Hospital of Lynwood*, 601 F.2d 404, 414 (9th Cir. 1979). Here, we have carefully reconsidered our initial decision in light of all the evidence adduced at the hearings. After examining all this

evidence, we remain convinced that rulemaking for establishing appropriate bargaining units in health care institutions is both fair and desirable. The record of these proceedings has supported and amplified our original reasons, set forth in our first NPR, for engaging in rulemaking.

2. *Past adjudicatory decisions.* Our adjudicatory decisions as to appropriate units in the health care industry, where the facts of each case were painstakingly examined in numerous lengthy and costly representation case proceedings, have been remarkably uniform in results, varying only when the Board changed doctrinal formulations, e.g., from "community" to "disparity" of interests. (NLRB Exh. 5, revised.) Thus, for example, from 1975 to 1984, despite lengthy adjudicatory proceedings the Board found RN units appropriate in 24 out of 25 published cases;<sup>3</sup> technical units appropriate in 18 out of 18 cases; business office clerical units appropriate in 8 out of 8 cases; etc. Though adjudication led to varying results for skilled maintenance units, that was largely a function of a single Board member, Member Jenkins, reaching different results on different records. Other members were, individually, remarkably uniform, despite alleged differences in the records. E.g., Member and Chairman Fanning found the separate maintenance unit appropriate 29 out of 29 times; Chairman Murphy, 26 out of 26 times. Continuing to determine appropriate units in this way seems unproductive, especially considering the lack of universal judicial approval of any single doctrinal approach. (See NPR, 52 FR 25143.)

3. *Financial constraints.* It cannot be denied that health care institutions are at this time operating under serious financial constraints. However, the evidence fails to disclose that these constraints have significantly changed the manner in which individual employee classifications perform their specialties or relate to one another. For example, the record shows that maintenance employees continue to maintain the physical facilities, and RNs continue to provide direct patient care under state nursing practice acts. If anything, the work of the business office clericals has been shown to have become more specialized and discrete, due to the increasing complexity of reimbursement arrangements, and also the increasing use of computers and

word processing equipment. It is our judgment that the increased predictability which rulemaking will bring to the process of determining bargaining units will, in the long run, be a resource saver and, hence, result in cost savings not only for the Board but also for health care institutions as well as for employee organizations. Money expended on the *procedure* of determining appropriate units is not productively spent, except insofar as it leads to a greater understanding by the Board of the realities of the workplace; we believe the understanding of the health care industry we have achieved through this rulemaking proceeding has been greater than it was through adjudication, where each party presented a very narrow view of the evidence in order to achieve victory in that particular case. Lastly, insofar as adjudication enabled employers to delay and in that sense save additional costs that might be associated with unionization, we do not think that is an appropriate factor to be considered by the Board in support of continuing adjudication.

4. *Diversity of institutions.* Just as this proceeding has not shown that new cost constraints have made rulemaking inappropriate, neither do we find that any new diversification of institutions has had this result. Such diversity as exists has not been shown to be sufficiently significant to preclude uniform treatment for purposes of establishing the general contours of appropriate bargaining units<sup>4</sup> for acute care hospitals in all but truly extraordinary facilities. In fact, one witness, the Vice President of Human Resources, Hospital Council of Western Pennsylvania, testified that, even beyond acute care facilities, "the delivery of health care and the functional integration of services of those providing the care is similar if not nearly identical throughout the health care industry." (Cammarata, 4394). That same witness pointed out that this similarity in the way health care is delivered is "indeed mandated by various accreditation agencies throughout the health care field" (WS Cammarata at 3). The evidence discloses that the vast numbers of hospitals still perform acute care; insofar as other diverse facilities have developed, such as ambulatory facilities, freestanding emergency centers, etc., these will be considered *infra*, and in our definition of the types of facilities

<sup>3</sup> The sole exception was *Mount Airy Psychiatric Center*, 253 NLRB 1003 (1981), involving a psychiatric hospital. In each category, unpublished cases exhibited the same uniformity of result.

<sup>4</sup> See Subrin, *Conserving Energy at the Labor Board: The Case for Making Rules on Collective Bargaining Units*, 32 Lab. L.J. 9 (1987), at 105-108.

covered by this rulemaking or, alternatively, excluded. Recognizing the diversity of facilities other than acute care hospitals and nursing homes, as well as our limited experience with them, the original NPR excluded such other facilities from consideration in the rulemaking proceeding. These other health care facilities continue to be excluded from coverage.

5. *Litigation.* As described above, the Board anticipates that rulemaking will ultimately result in less, rather than more, litigation about the boundaries of appropriate units. It is acknowledged that there will still be litigation about the placement of individual job classifications within the broadly defined appropriate units. This was referred to in our initial NPR (52 NPR 25146), and in the proposed new rule itself (§ 103.30(a)); the Board does not see this as a reason not to engage in rulemaking in order first to establish the larger boundaries of the appropriate units. The Board believes it may well be legally necessary, and in any event is wise, to retain an exception for extraordinary circumstances. However, the Board intends to define that exception narrowly, so that it cannot be used as an excuse for unnecessary litigation and delay. See section XX, The Extraordinary Circumstance Exception, *infra*.

6. *Flexibility.* The Board's engaging in rulemaking has no logical connection with the industry's retention of complete flexibility in responding to the needs of the times. Rulemaking is rather a response to a perception that the industry's workforce is susceptible to rules of general applicability about the contours of bargaining units. Health care providers remain as free as they ever were to respond to external events except, of course, as limited by the constraints of any collective-bargaining obligations that may result from unionization; that, however, is a policy set by Congress, not the Board. If, for some reason we cannot now foresee, employers' flexibility to respond is inhibited, any party could, of course, petition for amendment or repeal of the rules, or the issuance of new rules. Board's Rules and Regulations, § 102.114.

7. *Other considerations.* Our colleague dissents and would not engage in rulemaking. However, were we to continue to decide the appropriateness of units in acute care hospitals solely by adjudication, we would not have the advantage of the great mass of evidence presented to us in this rulemaking proceeding. Indeed, the production of relevant information is one of the chief

advantages of rulemaking over adjudication. In addition, as noted above, adjudication itself has resulted in non-fact-sensitive, virtually uniform results, but at great cost in terms both of time and money. These problems, which we have observed in appropriate unit adjudications in this industry since the 1974 amendments, would not necessarily disappear, even were the Supreme Court to grant certiorari and endorse the "community of interests," "disparity of interests," or some other standard. Lengthy hearings would still be required, and the Supreme Court is unlikely to involve itself in particularized, detailed factual inquiries over various appropriate unit determinations. Finally, it is by no means certain that the Supreme Court would grant certiorari on this issue, having declined to do so in *NLRB v. Mercy Hospital Association*, 606 F.2d 22 (2d Cir. 1979), cert. denied 445 U.S. 971 (1980). On another occasion, the Solicitor General refused to file petitions for certiorari, despite the Board's request that he do so, in *NLRB v. Frederick Memorial Hospital*, 691 F.2d 191 (4th Cir. 1982), and *NLRB v. HMO International*, 678 F.2d 806 (9th Cir. 1982). The court in the most recent relevant case, *IBEW, Local Union No. 474, AFL-CIO v. NLRB*, 814 F.2d 697 (D.C. Cir. 1987), remanded to the Board for further consideration, leaving any petition for certiorari susceptible to the argument that the court's disagreement with the Board's result was in any event not final.

### III. Standard To Be Applied in Determining Appropriate Units

The Supreme Court has acknowledged on many occasions since the Act's passage that, under section 9, the Board possesses broad discretion to determine employee units "appropriate" for the purposes of collective bargaining.<sup>5</sup> Of course, even the Board's discretion is not without limits; if the Board's decision as to appropriate unit "oversteps the law," it must be reversed.<sup>6</sup> Within this limit, however,

<sup>5</sup> *Allied Chemical & Alkali Workers, Local No. 1 v. Pittsburgh Plate Glass Co.*, 404 U.S. 157, 171-72 (1971); *NLRB v. Hearst Publications*, 322 U.S. 111, 132-35 (1944); *Pittsburgh Plate Glass Co. v. NLRB*, 313 U.S. 146 (1941); *Phelps Dodge Corp. v. NLRB*, 313 U.S. 177, 199 (1941). Not all administrative agencies engaged in regulating labor-management relations possess such broad unit-making discretion. *Morris, The Developing Labor Law*, Second Edition, 415 at fn. 12.

<sup>6</sup> *Allied Chemical & Alkali Workers, supra*, 404 U.S. at 171-72.

the Supreme Court has noted that any decision as to appropriate units "involves of necessity a large measure of informed discretion, and the decision of the Board, if not final, is rarely to be disturbed."<sup>7</sup>

It has been observed that, in exercising its discretion to determine appropriate units, the Board must steer a careful course between two undesirable extremes: If the unit is too large, it may be difficult to organize, and, when organized, will contain too diversified a constituency which may generate conflicts of interest and dissatisfaction among constituent groups, making it difficult for the union to represent; on the other hand, if the unit is too small, it may be costly for the employer to deal with because of repetitious bargaining and/or frequent strikes, jurisdictional disputes and wage whipsawing, and may even be deleterious for the union by too severely limiting its constituency and hence its bargaining strength.<sup>8</sup> The Board's goal is to find a middle-ground position, to allocate power between labor and management by "striking the balance" in the appropriate place, with units that are neither too large nor too small.<sup>9</sup>

As if this task, committed to the Board's discretion, were not already sufficiently difficult, in the health care field there may be, as one court has phrased it, a "joker in the deck."<sup>10</sup> Much has been written, especially by reviewing courts, about the effect of the legislative history of the 1974 health care amendments on the Board's discretion to decide appropriate bargaining units. As the D.C. Circuit recently observed, in passing the 1974 amendments "Congress, in the final analysis, decided against modifying section 9 of the Act; \* \* \* hence, the same statutory standards that had existed before the enactment of the 1974 Amendments with respect to unit determinations and certification procedures remained in the statute, entirely unmodified."<sup>12</sup> Even

<sup>7</sup> *Packard Motor Car Co. v. NLRB*, 330 U.S. 485, 491 (1947).

<sup>8</sup> See Gorman, *Basic Text on Labor Law*, 66-69 (1976); Abodeely et al., *The NLRB and the Appropriate Bargaining Unit 12-13* (rev. ed. 1981); *NLRB v. Hillview Health Care Center*, 705 F.2d 1461, 1469-70 (7th Cir. 1983).

<sup>9</sup> *NLRB v. Hillview Health Care Center*, 705 F.2d at 1469.

<sup>10</sup> *Id.*  
<sup>11</sup> *IBEW, Local Union No. 474, AFL-CIO v. NLRB*, 814 F.2d 697, 699 (D.C. Cir. 1987).

<sup>12</sup> *Id.* at 701. The Supreme Court in *Packard, supra*, declined in that case to look at legislative history regarding whether "foremen" could appropriately constitute a bargaining unit, noting that "we are invited to make a lengthy examination of views expressed in Congress while this and later

the D.C. Circuit recognized, though, that other Courts had disagreed.<sup>13</sup> Two Circuits<sup>14</sup> have required the Board to apply a "disparity of interests" test, based largely on the legislative history, while eight others<sup>15</sup> have made it clear the Board should follow the committee's admonition to give "due consideration \* \* \* to preventing proliferation of bargaining units in the health care industry," though they fail to "dictate the precise weight to be accorded the admonition."<sup>16</sup> We believe that rulemaking renders it unnecessary to resolve this conflict, or pick one doctrinal formulation over the other, since rulemaking eschews doctrinal applications in favor of greatly expanded information gathering, to be followed by unit determinations based on empirical judgments of the type that Congress expected an expert, informed administrative body to make.<sup>17</sup>

Under adjudication the Board has typically stated it was applying either the "community of interests" or "disparity of interests" standard to the facts of the particular case, as indicated reaching virtually the same result in every case, depending on which doctrine was being applied (NLRB Exh. 5, revised). Under the "community of interests" test, the Board has found five or six units appropriate (not including a statutorily-required separate unit of guards, seldom if ever sought, and a separate unit of physicians, sought in only one published decision since 1974<sup>18</sup>); RNs, other professionals, technicals, service and maintenance, and business office clericals. In addition, some individual Board members have consistently found skilled maintenance units appropriate; others consistently found them inappropriate. (NLRB Exhibit 5, revised.) Under the "disparity of interests" test, the Board

has uniformly found three units appropriate, aside from the two seldom-sought units mentioned above: All professional employees, including RNs; technical employees; and service and maintenance employees, including business office clericals.

Though it had consistently reached different results under the two tests, the Board in *St. Vincent Hospital and Health Center*, 285 NLRB No. 64 (Aug. 19, 1987), minimized the conceptual difference between them. Both, the Board stated, looked at the same factors:

\* \* \* the "disparity-of-interests" standard to a significant extent embodies the "community-of-interests" approach. That is, even under the disparity approach, the Board judges the appropriateness of the unit sought in terms of, traditional community-of-interests criteria: employees' wages, hours, and working conditions; qualifications, training, and skills; frequency of contacts and extent of interchange with each other; frequency of transfers into and out of the unit sought; common supervision; degree of functional integration; collective-bargaining history; and area bargaining patterns and practices. Under the "disparity-of-interests" standard—as under the "community-of-interest" approach—the Board looks at the above factors as they are shared by employees in the unit petitioned for, and as they tend to set those employees apart from other employees. Where the "disparity-of-interests" formulation differs from the "community-of-interests" standard, according to the Board's *St. Francis II* decision, is in the significance afforded the above factors. Because of Congress admonition to avoid unit fragmentation, the "disparity-of-interests" test requires more in the way of "disparities" or differences between the employees requested and those in an overall unit to grant a separate unit in the health care industry than would be required under a "community-of-interests" formulation. (Slip op. at 10-11, footnotes deleted.)

It is difficult to weigh or quantify the requirement of "more" as it applies to separate, different interests, i.e., how much would be enough more to satisfy the "disparities" test? Regardless, as we observed in the NPR, "these tests over the past decade or so have developed a 'life of their own,' and have been taken to refer to more or fewer units, respectively \* \* \*." (52 FR 25143.) As the Board stated in *Newton-Wellesley Hospital*, 250 NLRB 409, 411 (1980), various courts' "disagreement with our approach may be largely semantic." And, as the Second Circuit said in *Masonic Hall v. NLRB*, 699 F.2d 626, 637 (1983), a court sometimes enforces the Board's decision if it "can infer from the Board's result that it has taken the nonproliferation policy into account." The court suggested that perhaps courts "focus \* \* \* on what the Board did as much on what it said." *Id.* As noted in

the NPR (52 FR at 25143), and in our discussion above, our decision to determine units by rulemaking reflected a desire to replace earlier doctrinal applications with formulations of units based on the facts, or realities, of the workplace, as learned from evidence presented to the Board by interested parties during the rulemaking proceedings.

Under rulemaking as under adjudication, we intend at all times to be mindful of avoiding undue proliferation, not only because this desire was expressed in the legislative history, but also because it accords with our own view of what is appropriate in the health care industry. It would be most undesirable to create or permit a large-scale splintering of the workforce into the numerous trades, technical disciplines, and professions typically found in health care institutions.<sup>19</sup> To give each such grouping a separate voice for organizing and negotiating would create a never-ending round of bargaining sessions and individualized demands not conducive to stability, industrial peace, or the smooth delivery of services to the public. We have entered the rulemaking endeavor with an intention to create a reasonable number of units that will realistically reflect pronounced natural groupings to be found in health care facilities: groupings that will not be so large that organizing them is exceedingly difficult, and representing them even harder because of inherent conflicts of interest within the groups; but large enough that unnecessary, repetitious rounds of bargaining are avoided along with such undesirable results as frequent strikes, wage whipsawing, and jurisdictional disputes. We have not begun with a preordained number, but at the end of our examination will consider whether the numbers of units found appropriate are, in fact, too numerous. See section XXI, Proliferation, *infra*. In any event, there will be no units found appropriate besides those permitted in the final rule.

Although under rulemaking we shall attempt to avoid the doctrinal formulations utilized under adjudication, many of the factors we consider will be similar. Thus, among the factors to be considered will be uniqueness of

legislation was pending to show that exclusion of foreman was intended. There is, however, no ambiguity in this Act to be clarified by resort to legislative history \* \* \*." *Id.* 330 U.S. at 492.

<sup>13</sup> 814 F.2d at 704.

<sup>14</sup> The Ninth and Tenth. See discussion by concurring Judge Buckley in *IBEW Local Union 474 v. NLRB*, 814 F.2d at 717.

<sup>15</sup> The Second, Third, Fourth, Fifth, Sixth, Seventh, Eighth, and Eleventh. See cases cited *id.* at 703-05.

<sup>16</sup> *Id.* at 717.

<sup>17</sup> See, e.g., Estreicher, *Policy Oscillation at the Labor Board: A Plea for Rulemaking*, in proceedings of NYU Annual National Conference on Labor (1984), reprinted in 37 Ad. L. Rev. 163, 172 (1985).

<sup>18</sup> *Ohio Valley Hospital Assn.*, 230 NLRB 604 (1977). See also *Montefiore Hospital & Medical Center*, 235 NLRB 241 (1978), where a separate unit of physicians and dentists was found appropriate, but largely because there were no other professionals employed at the employer's health center, which was deemed to constitute a separate appropriate location.

<sup>19</sup> As Abodeely notes, "the health care industry was believed to be particularly vulnerable to the formation of a multiplicity of bargaining units. From the doctors in the top echelon to pot washers on the bottom, the labor force of a large health care facility is composed of a highly stratified, complex myriad of occupational classifications." This was, Abodeely states, the purpose behind the proliferation language referred to in the legislative history. Abodeely, *supra*, at 245. See also *NLRB v. Hillview Health Care Center*, 705 F.2d at 1470.

function; training, education and licensing; wages, hours and working conditions; supervision; employee interaction; and factors relating to collective bargaining, such as bargaining history, matters of special concern, etc. Location and scope of the job market may be relevant: i.e., whether the classification is part of a job market external to the facility or even to health care, or rather shares a job market with others in the facility or, perhaps, in the areawide health care community; job market is a factor not extensively considered under adjudication, probably because evidence regarding it is not likely to be introduced during the litigation of a particular case. In addition to these factors, should the evidence reveal the possibility of a separate unit, we shall examine the likelihood that such a separate unit would result in interruption in the delivery of health care, wage whipsawing, or jurisdictional disputes, matters with which Congress expressed concern during the deliberations that preceded the 1974 amendments. (See, e.g., 52 FR 25145; *St. Francis Hospital (St. Francis I)*, 265 NLRB 1025, 1027, 1035 (1982) (dissent, Chairman Van de Water); but cf. *Manor Healthcare Corp.*, 285 NLRB No. 31, n.7 (Aug. 6, 1987).)<sup>20</sup> The emphasis, during our rulemaking deliberations, has been and will be on the empirical—what, according to the mass of evidence presented, is warranted and will facilitate collective bargaining without jeopardizing the public interest—as opposed to prior, more doctrinal, more conceptually oriented, determinations. We are confident we are now a better informed administrative body in exercising the substantial discretion which we possess in the area of unit determinations.

<sup>20</sup> Senator Taft, in opening the Congressional debate on the health care amendments, said: "The issue of proliferation of bargaining units in health care institutions has also greatly concerned me. Hospitals and other types of health care institutions are particularly vulnerable to a multiplicity of bargaining units due to the diversified nature of the medical services provided patients. If each professional interest and job classification is permitted to form a separate bargaining unit, numerous administrative and labor relations problems become involved in the delivery of health care. . . . I believe this is a sound approach and a constructive compromise as the Board should be permitted some flexibility in unit determination cases. I cannot stress enough, however, the importance of great caution being exercised by the Board in reviewing unit cases in this area. Unwarranted unit fragmentation leading to jurisdictional disputes and work stoppages must be prevented." *Legislative History of the Coverage of Non-Profit Hospitals Under the National Labor Relations Act*, at 113-14.

#### IV. Two Units: All Professionals/All Non-Professionals

Some members of the hospital industry have argued to us that if the Board engages in rulemaking, it should find only two units appropriate—all professional and all non-professional employees (in addition to guards). Upon consideration of the record, we determine that the evidence does not warrant limiting the number of units to two broad units.

##### A. Generally; History of the 1974 Amendments

While the industry generally supports two broad units of employees, the support is not universal. Some employers suggest other configurations including a wall-to-wall unit, a separate doctors' unit, and a separate technical unit. (Comment 1, Lancaster Fairfield Community Hospital; Comment 17, Middletown Regional Hospital; Comment 306, Herrin, attorney for health care associations.) Indeed, one employer felt that several separate units was equitable as each had its own characteristics. (Comment 2, Grays Harbor Community Hosp.) The position of some, in favor of two units, is inconsistent with evidence which shows that until *St. Francis II*, employers seldom requested all-professional or all non-professional units (Friedman, 5057), and that where employers did request broad units for elections they sometimes opposed such units during election campaigns or at the bargaining table (see Registered Nurses, section V). On the other hand, unions fully support more than two broad units for organizing (AFL Br. 112; IUOE Br. 8; Local 1199, 3742; FNHP, 3; UFCW, 4457; NUHHC, 4778; IBT, 5100; SEIU, 5161). These unions' position is consistent with the evidence presented of organizing history (see section V, Registered Nurses; section IX, Skilled Maintenance; section X, Business Office Clericals; etc.).

Contrary to some employers' claim that the legislative history of the hospital amendments supports a two-unit configuration, the history shows that Congress chose not to amend section 9(b) (assuring employees the fullest freedom in exercising rights guaranteed by the Act) in a way that would enact special representation case rules for the health care industry. Even Senator Taft's proposal, which embodied the proposal advanced by employer associations in the health care industry but which died in committee, contained special rules establishing as presumptively appropriate three non-professional units (technical, clerical,

service and maintenance), in addition to a professional unit and guards, for a total of five. Furthermore, the hospital industry agreed, in a negotiated compromise with organized labor, to abandon its request for special statutory rules limiting the number of hospital units in return for provisions governing strikes. (See Legislative History, *supra*, at 91 (Sen. Cranston); 256 (Sen. Taft); 288 (Rep. Thompson), cited in AFL Br. 18-27.) The arguments of many employers that all professionals interact on the job, and that there are insufficient distinctions between classifications of non-professional employees to warrant their separation into different units, and the unions' argument that the record supports separate associational interests, are dealt with under specific unit categories.

##### B. The Record Shows That Multiple Units Do Not Undermine Functional Integration of Work; Do Not Result in an Increase in Proliferation, Strikes, Jurisdictional Disputes, or Wage Whipsawing; and Do Not Substantially Increase Industry Costs

The industry's concerns with having more than two units are the following:

1. *Changes in the industry.* The industry has failed to support its claim by concrete evidence that the DRG method of government payments to hospitals has resulted in restructuring of hospital workforces away from traditional departments and toward a product-line organization that requires greater integration of employee functions. It is claimed that product line management (where different types of employees work in a service related group, for example cardiology) is used increasingly in hospitals and requires that traditional lines of employment be crossed to provide appropriate patient care as employees in a department cooperate (Abramovitz, 325; Comment 54, Gepford Hosp.; Comment 192, Chicago Healthcare Human Resources Assn; Comment 108, Resurrection Health Care Corp.). However, the evidence shows that product line management has less to do with actual practice on the wards than it does with financial operations performed in the business office (WS Kennedy at 6-7). There is no more interaction between professionals than under other forms of financial control. New financial requirements have not resulted in changes in interaction among hospital workers. (WS Kennedy at 6-7.) Even in hospitals where RNs and other professionals are subject to dual lines of control (combining authority under own licensure and under team or functional

department), RNs continue to report to nursing on clinical issues, and retain traditional responsibility for nursing (Comment 293(i), Feldsine; Thompson, Chi II 107; Kennedy, 5561; Fine, 3146-48). Contrary to the generalized claim (Comment 105, Mass. Hospital Assn.) that multiple units would be divisive since one department might contain employees from several units, specific evidence shows that separate units have not prevented effective use of product line management (Houston, 4031, 4048).

In arguing that hospital workforces have moved away from a traditional structure, the industry relies heavily on the team concept, claiming that its use has resulted in greater integration among employees requiring integration of units (Rhodes, 11-12). However, the team concept dates back many years in this industry (AFL Exh. 12, 13, 14; AMA, 4348). Hospital representatives relied on the existence of teams in their unsuccessful attempt to defeat the 1974 amendments (ANA Br. 126). The record does not demonstrate a substantial increase in the use of interdisciplinary teams since then (AFL Exh. 15, study by Temkin-Greener; WS Kennedy at 8-9).

Although the industry argued that the team approach is widespread in the country and gave examples of many types of teams such as discharge planning, and special unit teams like oncology, diabetes, and cardiac rehabilitation (Mixon, Chi II 275; Gallagher, 3543-45; Comment 191, Trinity Lutheran Hosp.), the weight of the evidence shows that utilization of team care is neither widespread among hospitals, nor extensively used within hospitals (Bachus, Chi I 132; Lumpkin, 89-90; Dauner, 3238-40; McCullough, 4819-20; Gilmore, 4910). A study of 60 randomly selected hospitals showed fewer than half used discharge planning teams; a minority of the hospitals had special unit teams such as diabetes, oncology, and cardiac rehabilitation (Attachment to AFL Br. from Supplemental Testimony of L. Kennedy). Some hospitals do not utilize the team concept at all (Gilmore, 4910). Most hospitals with teams have no more than six or seven teams, with two to eight members on a team (Coney, 162; Thompson, Chi II 14-15, 72; Mixon, Chi II 277, 294-296), and a majority of employees do not participate on those teams (Bachus, Chi I 129-132). Specialized hospitals, such as children's hospitals, which may use multi-disciplinary teams to a greater extent, are atypical (AFL Br. 104).

The evidence does not support the industry's claim that participation on teams changes the employee's role.

Collaboration among professionals is not new (Ballard, 56). For example, one of the most common teams is discharge planning which historically involves nursing and social work. But the team approach does not alter each licensed professional's responsibilities or scope of practice (Ballard, 56; Willman, 4461; Twomey, 131). For example, use of physicians, assistants and nurse practitioners does not alter physicians, scope of practice. Nor does participation on a team affect an employee's wages, hours of work, employment benefits, qualifications, training, skills, job functions, or history of bargaining (AFL Br. 104-105; Graybill, 4174-75; Houston, 4044-45). Where teams are used, only a small proportion of the professional employees are involved. Contact between the members of the team is limited; each member continues to perform the specialized work of his or her profession. The time spent on a team is limited; team members may perform their work separately and then exchange information; team members are not likely to engage in more than fleeting communication regarding collective bargaining matters. (Thompson, Chi II 107, 109, 118-119, 121; and see section V, Registered Nurses, *infra*.) Recognition by the Joint Commission on Accreditation of Hospitals (JCAH) of the need for collaboration on the interdisciplinary level (AHA Br. 16 citing JCAH sec.) does not itself demonstrate that any change in scope of practice occurs.

There is evidence that various employees interact on hospital committees to evaluate hospital programs, but the evidence failed to demonstrate that the interaction affects the professionals' responsibilities or scope of practice (see, e.g., AHA Position Statement p. 8).

The industry made general, unsupported claims that separate units would interfere with the development or use of the team approach (Graybill-Subrin colloquy, 4185-86; Donnelly, 4131; Coney, 162). There is no evidence that separate units have resulted in failure of professional integration and cooperation on teams (ANA Br. 139; Bullough, 4651-53). On the contrary, teams were shown to be compatible with presence of RN-only units (ANA Br. 123; Thompson, Chi II 86-87; Houston 4048; Bullough, 4651-52).

The industry's emphasis on teams and product lines focused almost exclusively on professional employees. There was no claim that these teams brought technical employees and unskilled service employees together in a single group. Nor was it claimed that business

office clericals were involved in health care teams. (AFL Br. 75.) The evidence shows that interdisciplinary teams do not include skilled maintenance employees (IUOE Br. 92; Mixon, Chi II 275).

The industry contends that the use of multi-skilled employees is widespread and on the increase as hospitals seek cost-cutting measures, address the needs of rural hospitals with limited full time staffing needs and large facilities with changing patient loads, and as employee shortages, aging and declining population lead to fewer workers; further, that adoption of the proposed units will abrogate the ability of facilities to effectively utilize multi-trained employees whose skills cut across unit lines (AHA Br. 8, 9; AHA Br. attachment 3 attaching survey by CAHEA; Rhodes, 11; Houston, 4025-26, 4040-42; Comment 137, McDonough District Hospital; Comment 189, Memorial Health System, Inc.; Comment 193, Dolly Vinsant Memorial Hospital). However, the evidence shows that cross-training *between job groups* was not substantial and did not result in blurring lines between separate units. There are no examples of any group of professionals being cross trained to perform work of RNs either in organized or unorganized settings (Stickler, 22-25; Twomey, 130-131). The interchange of RN functions is not a viable concept because state licensing statutes preclude cross-training of other health professionals in patient care duties and responsibilities of RNs (Ballard, 56-57; Dumpel, 3277-78; Lipari, 3702-03; Rosen, 4685-87; Comment 293(j), paper on licensure of health care personnel).

The evidence shows that multi-competency programs are overwhelmingly aimed at technical employees. They developed because of a perceived need to provide technicians with a broader range of technician skills (WS Schoen, attaching article by F. Morgan). These programs are mainly confined to acquisition of additional technical skills by employees already holding technical jobs as shown by the operation of the programs referred to in the record. Participants in the Methodist Hospital "Add-A-Comp" program which provides employees with laboratory, respiratory therapy, electrocardiograph, emergency medical technician, and similar skills are already licensed or credentialed and include employees having some of the listed skills (Stickler, 19-21 & Chi I 36). Although the Multi-Competency Technical Program at the University of Alabama provides training in medical office skills, it is basically designed to add basic x-ray skills or

extend laboratory skills for technicians who are already licensed (Stickler, 19-21, Chi I 36-38). There is no showing that students trained in medical office skills actually perform technical tasks.

Furthermore, the mere existence of the program does not show widespread participation, since the record fails to show there are many students involved (Stickler, Chi I 38-39). Moreover, even if these programs turn out a number of multi-competent graduates, they are generally employed in physicians' offices or outpatient facilities rather than in hospitals (Schoen, 5236 and WS Schoen, attaching article by F. Morgan) and their use therefore has little relevance to units in acute care hospitals.

We conclude from the record evidence that cross-training programs extending beyond the technical workforce are rare. Unskilled service workers cannot be readily trained to become technical employees because they lack the advanced education required and because of state licensure laws (AFL Br. 35-36; IUOE Br. 42, fn 5). Service workers cannot be easily trained for business office clerical jobs because of the specialized skills required in the business office (AFL Br. 57-58). Cross training from service to skilled maintenance or technical positions is virtually unknown (O'Cleireacain, 5467; McKinney, 5481). Business office clericals do not transfer into skilled maintenance positions (IUOE Br. 42). Nor are skilled maintenance employees being cross-trained into other job groups (Stickler, Chi I 9, 35-37). The few examples of individuals having interchange of functions (emergency technician starting IVs, RNs doing work after daytime hours normally performed by respiratory therapist or physical therapist, medical technologist trained to watch the heart monitor while RN is on break—Houston, 4026-27, 4042) are very limited. Evidence does show that separate RN units are compatible with limited interchange of function (ANA Br. 153, citing Houston, 4040.)

There is no evidence to support the industry's general claim that cross-training has been inhibited by collective bargaining in separate units (ANA Br. 151; IUOE Br. 45; Stickler, 45-49). The suggestion (Comment 142, St. Anthony's Health Corp.) that use of multi-competent workers would be hurt by turf battles between professional groups, separate bargaining unit designations, and existing legal restrictions on practice patterns is speculative and is undercut by finding that most multi-competent workers are

within one unit—the technical unit. Any problems raised by legal restrictions such as licensure requirements do not derive from the Board's proposal to allow multiple units. Industry testimony on interchange of functions between professionals and non-professionals (Donnelly, 4073-74; AHA Br. 11) is not relevant because the Act would not permit a unit combining professionals with non-professionals, absent a self-determination election by the professionals.

Countering the claim of increasing integration of health care employees is evidence of increasing fragmentation as a result of greater sophistication of work, decrease in the full time equivalent work force and rise in part-time and temporary jobs, increase in the use of subcontracting, growing gaps between patient care and non-patient care jobs (such as business office clericals), and growing gaps between RNs and other professionals because of the RN shortage (WS Schoen).

2. *Proliferation, strikes, jurisdictional disputes, and wage whipsawing.* There is little if any evidence that multiple units in the health care industry have resulted in any of the problems perceived to arise from proliferation such as strikes, jurisdictional disputes, and wage whipsawing.

First, the record shows that most hospitals that are organized have few units (Robfogel, Chi II 223; Comer, Chi II 329; Cammarata, 4424-4425). Logically, the potential for a number of units does not mean that every hospital will be faced with this number of organizing campaigns. Indeed, a successful organizing effort of one unit in a hospital does not appear to have had a ripple effect on further organization (Gilmore, 4894; Splain, 5252-53; IUOE Br. 69-70). Statistics over the last ten years show little organizing in residual units. Health care workers organize no more frequently in facilities where some workers are already engaging in collective bargaining than in facilities where no employees are represented (WS Splain at 14-17). A vast number of organized hospitals have only one unit (WS Schwarz at Table 1 & 264; Sockell, 4520; Shea, 5163). AFL analysis of all hospital contract renewal notices received by the FMCS from hospitals from 1983 to 1987 shows that 55% of all organized hospitals are party to only one collective-bargaining agreement; almost 80% negotiate no more than two contracts; and almost 90% negotiate no more than three contracts (AFL Exh. 5 p. 1). In an SEIU survey of 200 private hospitals, 74% have 3 or fewer

bargaining units (WS Shea, SEIU, Table 2).

Evidence shows that, with the exception of New York State, where pre-1974 practice was to permit each employee group to have its own unit, recognition of RN-only units has not led to organizing efforts by other professionals (King, Chi II 38: In Ohio there is only one unit in which professionals other than RNs are represented separately; Gilmore, 4894: No hospital represented by Maine State Nurses' Association has another professional unit in addition to RN unit). Existence of a physicians' unit is rare; some states, like Texas, do not permit physicians to be employees of health care facilities (IUOE Br. 64, 99; see section VI, Physicians, *infra*). There is no evidence that the existence of a separate skilled maintenance unit has led to the organization of other units (IUOE Br. 62-65 and section IX, Skilled Maintenance, *infra*).

Some witnesses' statements that multiple units lead to strikes, jurisdictional disputes, and wage whipsawing were, for the most part, general and speculative, and not supported by examples. See, for example, Graumann, 397, 409; Dauner, 3199; Corbett, 3369; Emanuel, 3503-04; Weinrich, 4254, 4256; Cammarata, 4403, 4405-06. The industry did not submit data with respect to the degree of organization, number of organized units per hospital, or incidence of strikes or sympathy strikes, nor evidence that a particular type of unit has proven to be strike prone (AFL Br. 118-19).

In fact, the evidence submitted by unions shows there is a low incidence of strike activity in the health care industry; the rate is lower than in other industries (IUOE Br. 75; NLRB Exh. 1; AFL Exh. 6). The ANA had a voluntary no-strike policy until 1968 (Shepard, 4931-32). The California Nurses' Association (CNA) offers binding arbitration (WS Absalom at 16). According to available data, only 3.3% of all contract negotiations, including nurse bargaining, resulted in strikes. From 1984-1987, strikes in the health care industry occurred substantially less often than in all other industries (FMCS data reprinted in WS Schoen at 28 and AFL Exh. 6). The minimal level of strike activity is confirmed by studies done by several health care unions. Since 1938, SEIU has had a strike incidence of 1.4% in over 2700 hospital contracts (WS Shea at 10). Of over 1,000 hospital contracts negotiated since 1975 by the NUHCE, only 43 involved strikes (Muehlenkamp, 4776). IUOE, which represents almost 300 hospital

bargaining units, has had only 25 strikes in its history (IUOE revised Exh. 2).

Industry witnesses who testified about collective bargaining experiences in the industry confirmed the infrequency of strikes (Comer, Chi II 320; Corbett, 3374-75; Henry, 3026, 3062, 3085-86). Indeed, Kaiser specifically stated that its observation that there is a greater likelihood of work stoppages in facilities with multiple units was limited to craft-specific units, not the broader, traditional unit groupings (Comment 311). The industry's claim that the Board should discount the lack of strike activity in professional units because few facilities have multiple units supports our finding that in fact few facilities have multiple units.

One study showed there is generally no correlation between the number of units in a hospital and the frequency of strikes (AFL Br. 118, fn citing FMCS study). Other evidence suggests, however, that the likelihood of strikes decreases as the number of units in a hospital increases (IUOE Exh. 2 revised). Strikes also tend to occur more frequently in units with more employees than in smaller units (AFL Exh. 5). For example, only 16.4% of hospital contracts covered 300 or more employees, yet these units account for 45.5% of all strikes, while 51.52% of all hospital contracts covered 100 or fewer employees, but accounted for only 17.7% of all strikes. The average size of a striking unit in the 1984-87 period was three times the size of a non-striking unit. (AFL Exh. 5 citing FMCS data.) See also WS Shea at 11-12 with similar variation in size of striking SEIU units. Strikes in broader units have the greatest impact on health care. Strikes in New York City by Local 1199 encompassing many worker classifications including other professionals, technicals, service, and clericals closed down most health care in the city. (Abelow, 229.) Strikes in broader units also draw in groups of employees who, if in their own smaller unit, might have no reason to strike (Dumpe, 3291: Strike over nurse practice issues would have no importance to other groups of employees; Viat, 3466; Shea, 5188: Skilled maintenance employees, technical employees enmeshed in strikes over issues related to other groups of employees).

The evidence shows that sympathy strikes are virtually nonexistent. No-strike clauses in hospital contracts forbid sympathy strikes, and the pattern in the industry is for covered employees to obey their contracts. (Schloop, Chi II

169; Sackman, 3585; Ahmed, 3708-09; Muehlenkamp, 4777.)

We cannot accept the argument that multiple strike notices alone, even absent actual strikes, are disruptive, since the purpose of the notice is to minimize possible disruptive impact by giving hospitals time to prepare for a strike. In any event, there was no showing of widespread frequency of strike notices and no evidence that notices caused disruption in health care delivery. Hospitals have not generally sought common expiration dates, which would be a possible solution to recurring near strikes. (Sackman, 3586; Schmidt, 3625; Willman, 4496; Muehlenkamp, 4771; Henry, 3074-75; Corbett, 3359-60; Weinrich, 4282).

Some hospitals' argument that they do not have the same defensive measures as do employers in other industries, for example, because it is difficult to replace striking professionals, is essentially an argument that hospital employees not be allowed to exercise their statutory right to strike. The record does not show in any event that they engage in strikes frequently.

Industry's general claim (AHA Br. 26-27) that multiple units will inevitably result in jurisdictional disputes is not supported by the record. The record shows a low frequency of jurisdictional disputes in hospitals and no correlation between the occurrence of disputes and the number of units. Jurisdictional issues that have arisen are often resolved on an informal basis without resorting to arbitration (Absalom, 3282-83; Sackman, 3585; Schmidt, 3625; Viat, 3471; IUOE Br. 78-79). There was no record evidence of jurisdictional disputes in hospitals between units of professional employees (Emanuel, 3503-4); such disputes are usually fought and resolved in the public arena (Absalom, 3282). Jurisdictional disputes between non-professional groups are rare, apparently because traditional unit lines separate functional groupings and the unit employees do not view the other units' duties as being within their purview (AFL Br. 124-25). The few disputes specifically referred to by the industry, such as accusations of mistakes on the job, and conflict between duties of RNs and LPNs assigned by the hospital (Krasovec, 413-415; Gibling, 5389-90; Graumann, 396-399, 408), encompassed disagreements that could arise even under all-professional and all non-professional units. The approval of an overall skilled maintenance unit, *infra*, should help reduce the risk of jurisdictional disputes between different skilled crafts.

The industry failed to support its general contention (Rhodes, 13) that

multiple units result in employees' competing for the best settlement, burdening negotiations, and inflating settlements. The record shows that wage whipsawing and leapfrogging rarely, if ever, occur in the hospital industry. This is apparently the result of separate labor markets for RNs, clericals, technicals, skilled maintenance, and doctors (ANA Br. 174; AFL Br. 37-38, 59-60, 86-88, 121-22; IUOE Br. 83 citing record), and the method of setting Medicare and Medicaid rates which limits the pass-through of spiralling wage increases (Friedman, 5044-45). In view of the unorganized nature of the health care industry as a whole, separate unit contracts tend to follow wage patterns set by non-union employers (WS Shea at 13).

3. *Costs.* Some unions question the relevance of costs in determining hospital bargaining units. In view of Congressional 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. However, to the extent the industry's contention regarding costs is an argument that employers cannot afford collective bargaining with their employees, we note that the health care amendments were passed in response to Congress' concern with low wages and poor working conditions in the hospital industry. *Beth Israel Hospital v. NLRB*, 437 U.S. 483, 497 (1978). It was anticipated by Congress that the amendments might lead to increased union organizing and bargaining which in turn might improve employee wages and working conditions. Costs associated with these anticipated improvements are not relevant to the Board's decision as to appropriate bargaining units.

Some commentators claimed that multiple units would increase costs by increasing expenses for contract negotiations, wage and benefit increases, administration and legal fees, grievances, supervision, and accounting (Comment 62, St. Mary's Hosp.; Comment 153, Sturdy Memorial Hosp.; Comment 140, Park City Hosp.; Comment 130, St. Vincent's Hosp., Birmingham; Comment 224, St. Luke's/Roosevelt; Comment 311, Hosp. Council of Southern Calif.). There was no empirical or specific evidence showing comparative labor costs in hospitals with different numbers of units. For example, one witness stated that facilities in Ohio with three or more

units devoted more time and resources to collective bargaining than hospitals with fewer units, but had no specific examples (Weimer, Chi II 7, 65-66, 77-79). Another industry witness testified generally that increased costs were associated with negotiating in multiple units in Pennsylvania, but gave no specifics (Cammarata, Hosp. Council of W. Pa., 4392-4430). In fact, studies have found minimal cost impact, 3%-5%, of labor unions on hospital costs. This rate is low when contrasted with the overall rate of health care cost inflation (WS Schoen at 31). The example relating to the costs for negotiations at a public hospital in Massachusetts with eight bargaining units (Robfogel, Chi II 222-23, 228, where out-of-state as well as local attorneys appeared for each negotiating session) was not shown to be typical.

The industry contends that small hospitals are particularly vulnerable to increased costs and cannot afford the money and staff resources needed for dealing with multiple units. However, we were not provided with empirical data for comparison. We note also that few health care facilities have more than two or three units.

The industry's claim that hospitals generally treat each bargaining unit as a separate cost accounting center, thereby adding to the complexity of operating a hospital, is unsupported in the record (Dauner, 3233-34), and in any event is irrelevant.

One witness claimed that multiple units would limit an employer's ability to secure significant cost reductions in employee benefits available now by marketing large groups of employees to third party providers and that the cost of administering multiple employee benefit plans is higher. No specific examples were cited of increased costs (Cammarata, 4402-03). Moreover, benefits may be negotiated across-the-board even in multiple units (Jacquin, 5366-68).

The claim by some that multiple units will result in limiting opportunities for job advancement and security are not supported by the record; neither is the claim that multiple units hamper affirmative action because departmental seniority and separate bargaining deter hiring and career development. To the contrary, there is record evidence (set forth in Sec. V, Registered Nurses and other sections), that there is limited career movement in hospitals regardless of whether or not the hospital is organized because promotions, layoffs, etc. are done by department and because of the distinct skills and education of the various groups of employees which restrict interchange

and mobility. There is also evidence that in organized facilities, unions have sought career ladders, training, and upgrading, and have not acted to limit movement among workers. (WS Schoen at 15; Supplemental Statement of Schoen.)

Some employers argue that multiple contracts limit their flexibility in job assignments, scheduling, and performance evaluation. This appears to be an argument that the industry does not wish to have to bargain since bargaining limits the employer's flexibility. However, the statute gives employees the right to bargain for more favorable terms of employment, and employers have the opportunity at the bargaining table to seek terms giving them flexibility.

Arguments that multiple contracts will result in confusion for management as to which contract covers which employees (Comment 104, St. Francis Hosp., Hartford), that it would be hard for employees to understand and deal with many units (Comment 51, O'Bleness Memorial Hosp.), and that multiple units work against cohesiveness among smaller groups like business office clericals (Comment 138, Rice Memorial Hosp.) were not supported by specific examples.

Finally, the record demonstrates some countervailing considerations to any increased costs as a result of multiple units. At least some of the administrative costs of unit determinations come from the hospitals' opposition to organizing. In 1981 Congress banned the use of Medicare funds for anti-union consultants on estimates that this activity cost \$30 million dollars a year (WS Shea at 15, citing Medicare Manual). There are presently industry costs for prolonged hearings and appeals in many units, which we are confident rulemaking will substantially reduce. Bargaining in large units may prolong negotiations and increase costs as employees are involved who would otherwise have no interest in certain demands (WS Shea at 15). Employers can face increased costs even if there is only one unit, since there may be separate negotiations for different major employee classifications (Owley, 4375-76) or separate contract provisions (Emanuel, 3499-3501). Costs might be contained by combining separate units for bargaining purposes or having common expiration dates for contracts, but the record shows lack of employer support for such union proposals (See Sec. IV(B)(2), *supra*).

### *C. Broad Units Militate Against Health Care Employees, Organizing and Bargaining, Contrary to Congress' Intent*

1. *The impact of broad units on organizing and bargaining is a relevant consideration.* As shown above, Congress passed the health care amendments, in part, to improve conditions for health care industry employees by extending to them the rights of the National Labor Relations Act which permits organizing and collective bargaining. *Masonic Hall v. N.L.R.B.*, *supra*, 699 F.2d at 634. While, as the industry correctly contends, the extent of union organization cannot be controlling in unit determinations, it is a factor, and in view of Congress' concerns, the ability of health care employees to organize and bargain is an important consideration in determining whether more than two units are appropriate in the industry.

2. *Historically, health care workers organize and engage in initial bargaining in occupationally homogeneous units.* The evidence shows that broad units militate against organizing by health care workers (AFL Exh. 4, AHA Report on Union Activity in the Health Care Industry). Although there were examples of broad-based bargaining, particularly in New York City, the record shows that organizing and initial bargaining among health care workers has historically been by occupationally-homogeneous units (AFL Appendix A; WS Shea, Table 1, SEIU Survey; and section V, Registered Nurses; section VI, Physicians; and section VII, Other Professionals). For example, in the AFL survey of all private sector hospitals in which an AFL affiliate has organized one or more units, there were 920 homogeneous non-professional units, and only 104 heterogeneous units (AFL Br. Appendix A). The ANA constituent state nurses' associations represent 363 all-RN bargaining units; only 4 all-professional units were organized before *St. Francis II* (Comment 240, ANA, Stull Affidavit). Evidence prepared by the industry confirmed that occupationally diverse bargaining units are found only in a minority of contracts (AFL Exh. 1, [Hospital Industrial Relations Information Services, p. 5]).

The industry contends that unions have requested or agreed to all-professional and all non-professional units, have successfully organized and bargained in these units, and that therefore a Board decision to find appropriate only two broad units (plus guards) would not negatively impact on organizing and bargaining. The record

shows that most union requests for broad-based units occurred after *St. Francis II*, at a time when the Board would have rejected most occupationally-homogeneous units. Broad bargaining, where it does occur, appears to develop over time, after individual employee unit concerns are addressed and the bargaining relationship has matured (WS Shea at 8; WS Pastreich; Friedman, 5046). Even then, the record shows that employers may meet separately with one or more subunits on their concerns and that there may be separate contract provisions for different concerns. See e.g. section VIII, Technicals; section X, Business Office Clericals. Thus, in New York City, where Local 1199 engages in citywide bargaining with the League of Voluntary Hospitals on behalf of its Professional, Technical, and Clerical Division (professionals other than RNs), Hospital Division (service and maintenance employees) and Drug Division (pharmacists, social workers, therapists), the individual units in these divisions were separately organized and negotiated their first contracts separately; joint bargaining of these divisions developed over twenty years (Olson, 4694-4700, 4706, 4716-19; Ratner, 3710, 3725-33, 3738). Proposals are submitted by each separate division; each classification has at least one representative at the bargaining table; and there are local negotiations for specific issues at some hospitals after the master negotiations (Ratner, 3739, 3742, 3757-59; Olson, 4702; Muehlenkamp, 4782). At Michael Reese Hospital, the service and maintenance unit and the business office clerical unit bargain jointly but have separate committees, contracts, and stewards (WS Gray).

There is no evidence of a trend toward coordinated bargaining (Shea, 5217-18). In New York City, there has been some movement away from the citywide approach of Local 1199; there is pressure to go back to each hospital after the master agreement to get separate provisions on local issues (Ratner, 3739).

Although some industry commentators now request broad-based units, there are a number of instances in the record in which employers sought, for example, to have RNs in a broad unit with other professionals, and then raised the question of effectiveness of bargaining representation, or appropriateness of unit. See section V, Registered Nurses, *infra*. To the extent that employees represented in different units may wish a number of years later to re-group as a single larger entity for

purposes of conducting negotiations, nothing in the rule would interfere.

In sum, the record fails to demonstrate that finding a limited number of occupationally-homogeneous units to be appropriate would inhibit functional integration on the job, increase strikes, jurisdictional disputes, or wage whipsawing, or substantially increase costs to industry or to workers. Rather, we believe that finding only two broad units appropriate would unduly hamper organizing and effective bargaining, and would not carry out Congress' intent in the health care industry.

## V. Registered Nurses

### A. Introduction

In the Notice of Proposed Rulemaking, the Board tentatively determined that RNs constituted a separate appropriate bargaining unit in acute care hospitals having more than 100 beds. 52 FR 25146. Among the reasons assigned were that RNs:

- (a) Work around the clock, 7 days a week;
- (b) Have constant responsibility for direct patient care;
- (c) Are subject to common supervision by other nurses;
- (d) Share similar education, training, experience and licensing not shared by other employees;
- (e) Have the most contact with other RNs; and
- (f) Have a lengthy history of separate organization and bargaining.

Much of the evidence taken at the rulemaking hearings concerned the RN classification. As discussed in more detail *infra*, we have decided not to differentiate between hospitals having more than 100 beds and those having fewer. However, in other respects, after carefully considering the evidence amassed, we have determined that RNs appropriately constitute a separate bargaining unit.

### B. The Record Supports a Finding That RNs Constitute a Separate Appropriate Unit

1. *Work schedules.* There was some evidence of selected other professionals who, at certain hospitals, might be scheduled to work evening and nighttime shifts (Comment 72, McCarthy; Comment 82, Humana). However, the evidence was overwhelming that only RNs have a professional responsibility which requires them as a group to be on duty 24 hours a day, 7 days a week (Chow, 3107-08; Ballard, 55; Schauer, 3155; Ratner, 3735; Graham, 4841-42). They are the only professionals regularly required to work overtime, including as much as two 8- or 12-hour

shifts (Bachus, Chi I 144; Wilson, 5074, 5091).

2. *Responsibilities.* Each professional classification obviously possesses its own singular job function and responsibility. However, whereas other professionals specialize, and have intermittent contact with patients, nurses are unique in that their profession demands continuous interaction with patients (Dumpe, 3277-78; Chow, 3108; Ballard, 55, 57-58, WS at 7; Foley, 446). Nursing practice involves the nursing process by which nurses assess patients, as reflected in the nursing practice acts (Comment 240, ANA, Kalisch; WS Foley at 4; WS Ballard at 9-10). RNs continually monitor all patients to be sure that physicians' orders are being carried out and that treatment procedures are not proving harmful (Ballard, 55-56; Bullough, 4627-30). RNs must be alert for errors made by other professionals; for example, if another professional, e.g. a pharmacist, dispenses medication in an improper dosage, the overall responsibility rests with the RN who, if she administers it, is also responsible (Reierson, 3606-07; Sackman, 3586). The RNs' special responsibility is based on a cluster of knowledge which they possess, as opposed to a single skill (Bullough, 4629-30). One 1982 study by Posavac showed that the "perception of nursing care is the single most crucial aspect in the overall rating of hospitals by patients" (Fine, 3143).

3. *Supervision.* All acute care facilities have an organized department of nursing, and that department is supervised by a nurse (Ballard, 52-53). For this reason, the vast majority of nurses in hospitals are ultimately responsible to the director of nursing (Ballard, 67; Lipari, 3703; Gilmore, 4909-10; Comment 293(b), Jones: 3 RNs out of 99 not in nursing department; Comment 293(g), Soltis: 11 out of 200 not in nursing department). The evidence did indicate that in some instances nurses work in departments other than nursing and are subject to supervision by these other departments, such as ambulatory services, discharge planning, home health care, and anesthesiology (Graybill, 4149; Comment 139, S. Baltimore Hospital). However, even in the few instances where a nurse might be hired into another department and report to someone other than the director of nursing, the director of nursing is still responsible for the delivery of nursing care (Ballard, 67-68; Indelicato, 3680).

Product line management is a system of organization by type of service and in response to the DRG method of payment

(Dalstrom, 332; Houston, 4024; Kennedy, 5552). It is argued that, with this type of structure, nurses have more in common with those in their product line than with other RNs with whom they have little contact (Dalstrom, 336-339). Ordinarily however, it results in some RNs' being responsible to a functional manager of a project and to nursing heads for clinical issues (Comment 293(i), Feldsine, at 2-3). Product line management is a financial tool; it does not result in changes in interaction among hospital workers (Kennedy, WS at 6-7). As noted *supra*, nurses overwhelmingly continue to report to nurses (Dalstrom, 335: Only 10% of RNs not members of nursing division, but no showing that not supervised by an RN).

4. *Wages.* The labor market for nurses is distinct from that for other professionals (Gonzalez, 4356). Thus, nurse salaries are low, even within the framework of hospital compensation (Corbett, 3332, 3335). There is no pressure from outside the hospital industry forcing up wages, as for example is the case with pharmacists (ANA Br. 97). Moreover, the overwhelming percentage of nurses are women, and there is evidence that this has contributed to the separateness of the RN wage structure and the distinctiveness of their concerns (Muehlenkamp, 4779; Saporta, 5114-15). When nurses and employers bargain about wages, they look to wages of RNs at other hospitals, not at wages of other professionals (Patek, Chi I 78-79; Absalom, 3316-18). Finally, RN career ladders are very short in terms of pay, quickly levelling out after relatively brief experience (Rosen, 4671). Hospitals recognize the separate RN market by having nurse recruiters; no similar position exists for other professionals (Ballard, 65; Reiersen, 3608-09).

Nurses traditionally conduct wage negotiations from these unique disadvantages despite the demand for their services (ANA Br. 99). In fact an employer may insist on a separate wage scale for RNs in an all-professional unit (Comment 51, Castrop: employer re-opened wall-to-wall contract at O'Brien to increase RN wages only).

5. *Wage whipsawing or leapfrogging.* The record evidence based on actual experience shows that wage leapfrogging has not occurred in the hospital industry (Ratner, Local 1199, 3744; Friedman, Local 1199, 5041, 5045; Absalom, CNA, 3316-3317; Muehlenkamp, NUHCE, 4775; Twomey, WS at 6, Hosp and Prof Allied Employees of NJ; Schmidt, Oregon Federation of Nurses, AFT, WS at 4; Shea, SEIU, WS at 13-14). The one

example offered by the industry as evidence of leapfrogging (involving RNs) occurred 20 years ago in California and concerned the adjustment of wages for RNs who had been underpaid for a long period of time as compared to other hospital employees (as found by a fact-finding panel appointed by the governor). Even this adjustment did not result in any disruption of patient care. Moreover, other professionals did not obtain higher wages or benefits thereafter as a result of the RN unit adjustment (WS Absalom, at 7-8; 3286-87).

The fact that RNs are in a different labor market mitigates against leapfrogging (Shepard, 4959-60). Special considerations such as the nursing shortage, recruitment, and retention are not concerns of other professions and have not been carried over into other units (Absalom, 3316-3318). In addition, there are certain limitations or rigidities in the financing system which preclude the pass-through of spiraling wage increases. A significant limitation is found in the Medicare and Medicaid reimbursement rates. These rates play a prominent role in the economics of hospitals, and are set in a regional area in accordance with the general wage pattern set by the most influential local union and its employers. Thus, there is little incentive for unions to engage in whipsaw strikes and efforts to leapfrog the pattern of wage increases. (Friedman, 5044-45.) Finally, it appears that concern about the potential for leapfrogging could be ameliorated by uniform contract expiration dates. However, the evidence shows that hospitals have declined to accept union proposals to this end. (Henry, 3074-76; Absalom, 3318-19; Sackman, 3586; Willman, 4480-82; Clark, 4685.)

6. *Education, training, experience and licensing.* All professions require specialized education and training (AHA Br. 15; Mixon, Chi II 274), and are subject to prescribed standards of practice (California Health And Safety Code Sec., cited in AHA Br. 15; Comment 248, Cedars-Sinai Medical Center). However, in addition, nurses must pass state licensing exams, which are uniform throughout the country, after graduating from an accredited nursing school. A candidate who passes the exam is competent to practice throughout the country. (Reiersen, 3597.) Nurses are required to follow, *inter alia*, state nurse practice acts, and no other health care worker may function as a nurse under nurse practice acts (Ballard, 56, 57).

RNs' licensing requirements may actually conflict with the requirements

and practices of other professions. For example, as previously indicated, RNs fill out incident reports on mistakes in medication dosages made by other workers (Reiersen, 3603; Sackman, 3586). This type of responsibility may result in antagonism between the RNs and other professionals which might impede collective bargaining by the professionals as a group.

Several states mandate continuing education for nurse licensure. Only social workers and pharmacists are subject to such requirements in more states than RNs. (ANA Br. 48; Ballard, 54; Lumpkin, 87.)

7. *Interaction.* RNs work in close and continuous contact with one another within the same hospital (WS Foley; Owley, 4377-78). Moreover, sometimes RNs at different hospitals have more contact with one another than with the other professionals in their own institutions (Owley, 4378; Schauer, 3156-58). With respect to RNs' interaction with non-nurse professionals, while there is some contact, it is not regular and recurring. There are a variety of factors which help to explain why interaction among RNs and non-nurse professionals is limited. For one thing, while there was testimony that there is a crossover of duties between RNs and other professionals (Thompson, Chi II 55-58), there was also testimony that licensing and other regulations clearly prevent RNs from doing much of the work of other professionals and other professionals from doing RN work (Lipari, 3702; WS Dumpel & 3279). Moreover, non-nurse professionals generally are located away from patient units where RNs are located. For example, in Local 1199-organized hospitals, most pharmacists are located in self-contained units, usually in the hospitals' basements. (Crisafulli, 3712-14.) Moreover, RNs typically have different working hours (Indelicato, 3681; Ahmed, 3707). As noted by the ANA, the contact RNs may have with respiratory therapists is not material since respiratory therapists consistently have been found to be non-professionals. See for example *Samaritan Health Services*, 238 NLRB 629, 638 (1978); *Barnert Memorial Hospital Center*, 217 NLRB 775, 779 (1975).

The point is made that RNs in many cases have more frequent contact with other professions than those other professions that the Board proposes to place together have among themselves (AHA Br. 20-21, citing *Long Island Hospital*, 256 NLRB 202 (1961), and other Board cases). However, this point militates more against grouping of the

different professionals than it does toward grouping the RNs with other professionals.

8. *The team concept.* Much evidence was offered during the proceeding concerning the team concept. See also section IV (B)(1), *supra*. After carefully considering this evidence and the parties' arguments in connection therewith, we conclude that the fact that some hospitals utilize the team concept does not detract from the separate appropriateness of RN units.

There are two types of teams found in hospitals. The first is the nursing team which consists of RNs, LPNs, and aides. This type of team is found throughout the industry. However, as this team contains only nurses and non-professionals, and the Act provides that professionals are entitled to a separate unit if they choose, the nursing team is not relevant to the issue presented.

The second type is the multidisciplinary team which contains various classifications of professionals and non-professionals and has been utilized in the health care industry since the early 1900's. Employers unsuccessfully relied on the existence of teams in an attempt to defeat the 1974 Amendments. (ANA Br. 126, citing Ohio Hospital Association testimony.) The team concept remains non-persuasive for several reasons. First, the evidence at the hearing established that many hospitals do not even use the team concept (e.g., McCullough 4819; Gilmore 4910). Moreover, except for some specialized hospitals, e.g., children's hospitals (Sokatch 4194, 4199; Gallagher, 3539, 3543-46), those hospitals with teams often have no more than six or seven teams (Thompson, Chi II 14-15; Mixon, Chi II 294-96; Graybill 4172-86; Comment 283, Leavenworth), with two to eight members on a team (Thompson, Chi II 72; Mixon, Chi II 277; Gallagher, 3543-45). Thus, within the limited number of hospitals that use teams, only a minority of nurses and other professionals participate on the teams (Bachus, Chi I 129-132, most teams are on the management level). Although one comment stated generally that the downsizing of staff has led to more teamwork (Comment 263, Huntsville Mem. Hosp), this was not supported by other specific examples.

While members of teams may have daily interaction and weekly formal meetings (Comment 78, Greater Cincinnati; Comment 238, Graybill, Children's Medical Center, Akron), there was also testimony that the interaction of RNs and other professionals is limited in certain ways. For example, team members only interact with the few other members on their teams.

Additionally, other duties of RNs may prevent or limit their actual participation in an assigned team program (Schmidt, 3627, 3635; Bachus, Chi I 129-130; Reiersen, 3609-10). More importantly, the fact that the RNs may interact and work with other professionals on teams does not alter the separateness of their identity. The team approach is a process to ensure that the elements of patient care are organized. The evidence was uncontradicted that it does not alter each licensed professional's responsibility for his or her individual scope of practice. (Ballard, 56; Twomey, 131; Wilson, 5095; Bachus, Chi I 129-130.) Nor does participation by some RNs in team care affect wages, hours, benefits, training, skills, or functions of RNs on or off the teams (Graybill, 4174-75; Houston, 4044-45).

Conversely, separate RN units were not shown to have interfered with team care (Gallagher, City of Hope, 3540; Bullough, 4651 and 4653; Houston, Sacred Heart, 4031, 4038, 4048). The industry offered only unsubstantiated speculation that team care would be adversely affected; e.g., one witness testified that the amount of interplay, the exchange that goes on minute-to-minute in critical situations, could be damaged significantly (4185-86). However, at City of Hope, a specialized cancer hospital with a large number of teams and a separate RN unit, the teams remained able to deliver a very high level and quality of care. (Gallagher, 3540 & 3543; Bullough, 4653. See also Thompson, Chi II 9, 86-87; no evidence that separate RN representation at her Ohio hospital has made nurses less able to function as a team.)

9. *Cross-training and interchange.* Because of licensure limitations, cross-training does not take place between RNs and other employees (Lipari, 3702; Dumpel, WS & 3279). Hospital codes also preclude replacement of RNs by other professionals (Rosen, 4666). It logically follows that the extent of interchange between RNs and other non-nursing professionals is limited not only because of RN licensing limitations but also because of the licensing requirements of other professional employees. There was testimony that RNs will perform functions of other "professionals" when the latter are not available, e.g., moving patients instead of physical therapists, or doing respiratory therapist work at night and on weekends (Comment 78, Greater Cincinnati; Comment 198, Marshalltown Medical Center). With respect to the first example, the performance of non-professional tasks such as transferring patients to wheelchairs is not relevant

to interchange between professionals. Similarly, respiratory therapists consistently have been held by the Board to be non-professionals. Finally, other examples of interchange, such as medical technologists' watching the heart monitor while a nurse is on break (Houston, 4041-42, 4026-27), appear to be minimal. It was also stated that both pharmacists and RNs dispense drugs and medications; however, pharmacists typically formulate medications and advise on proper medications while RNs administer them (Thompson, Chi II 55-58).

10. *History of representation and collective bargaining.* The ANA, representing RNs, stated that the RNs' desire to be organized to protect their interests as well as their patients' interests began nearly 100 years ago, and persisted through the onset of collective bargaining and the original Taft-Hartley exclusion of employees of non-profit hospitals from federal labor law (ANA p. 74; see Comment 240, attachment, Kalisch, Twelve Key Steps in the Process of Professionalization of American Nursing, 1854-1967; Comment 293, ANA, Flanagan). AHA contends that separate bargaining by RNs does not reflect a freely established pattern because, prior to the 1974 amendments, it was to some degree based upon considerations of the then-current law in each state and because collective bargaining primarily existed only in a few isolated parts of the country and thus could not be deemed representative. Moreover, the AHA contends, subsequent to the 1974 amendments such bargaining was established pursuant to the direction of the Board.

Regardless of what might first have provided the impetus, RNs have for many years exhibited a strong desire for separate representation. Even during the period following *St. Francis II*, RNs consistently sought separate RN units but were forced to organize into units with other professionals or face lengthy, costly, and fruitless litigation (Saporta, 5127-28; Splain, 5273-74; Muehlenkamp, 4764-67; Wilson 5069). Although forced to include other professionals, the organizing drives were strikingly similar to prior nurses-only campaigns. Testimony indicates that the campaigns were led by nurses, issues prompting organization were nurses' issues, and the bargaining was performed by nurses, often with no participation by other hospital professionals. (Gonzalez 4356; Splain, 5293; Lumpkin, 99-100; Patek, Chi I 54-55; Chow, 3108; McCullough, 4811; Gilmore, 4894; Shepard, 4927.) Moreover, comments from a number of hospitals

indicated they have not had problems bargaining with separate RN units (Comment 79, Baptist Hospital; Comment 105, Mass. Hosp. Assn: 2 examples; Comment 121, Central Michigan).

The AHA makes the point that the more recent history of collective bargaining shows that all-professional units nonetheless are viable, and the record offers some support for this position. Thus, even some RN-only unit proponents have testified that the interests of all professional groups have been adequately represented in bargaining for an all professional unit.<sup>21</sup> (AHA Br. 24.) However, while bargaining could undoubtedly proceed in any one of a number of configurations, this does not necessarily answer the question whether a separate unit of RNs might not also be appropriate; or better reflect the wishes, needs and interests of RNs, other professionals, and perhaps even health care providers themselves.

The testimony shows that not only have the RNs desired separate representation (Saporta, 5127-28; Splain, 5273-74; Muehlenkamp, 4764-67; Wilson, 5069), but other professionals do not appear to react favorably to their inclusion with RNs. As noted *supra*, the other professionals often do not participate in the organizing campaigns and are hostile to being included in bargaining units with RNs. As an example, when Capitol Hill Hospital demanded inclusion of other professionals, the other professionals complained, became hostile, and some even requested separation (Gonzalez, 4351-53). In Langlade Memorial Hospital, Wisconsin, other professionals forced into a unit with RNs tried to decertify the union but were outvoted by the RNs (Owley, 4376).

The main concern of the non-nursing professionals is of being overwhelmed by the large number of nurses and not having their concerns given priority. RNs are the largest professional group in any hospital. In fact, RNs constitute approximately 23% of the hospital workforce (WS Schoen, Table 1, citing data from AHA publication and BLS Hospital Wage Survey.) They may outnumber other professionals by a ratio of 4 to 1 or more. (AFL Br. 92; Twomey, 123-125, 128-129; Gafni, 133-135; Thompson, Chi II 58.) The non-nurse

professionals are also concerned that RNs could ignore their interests when they conflict with RNs' (Comment 134, American Physical Therapists Assn). A number of non-nursing professionals who testified at the hearings confirmed the lack of interest which RNs exhibited toward their circumstances, and the fact that, despite their different professions, they were able to achieve collective bargaining in all-professional units, excluding RNs and physicians. See section VII, Other Professionals, *infra*. Evidence showed that even when made part of a unit which wins an election, other professionals sometimes do not participate in negotiations or come to union meetings (Schauer, 3154; Wilson, 5070; Patek, Chi I 54, 55-67 and WS 6-7). Issues discussed during bargaining tend to be those of interest to nurses (Wilson, 5073). Moreover, most grievances at one hospital were from nurses on nurse issues (Bachus, Chi I 122). There is a concern that if forced into units with RNs and RNs do not want representation, other professionals would not have enough votes to obtain representation (Owley 4376-77; Ahmed, 3707-08).

The AHA argues that the size of the RNs' group relative to other professionals should not be a consideration in determining whether to have an all-inclusive unit, and that this is a clear departure from the Board's general unit determination analysis in which the Board routinely has included small ancillary groups in units with one or more large classifications that constitute the bulk of the unit. We acknowledge that units frequently are an amalgam of other special interest categories. See, e.g., *Airco*, 273 NLRB 348 (1984). Nonetheless, the Board routinely also finds appropriate separate groups whose interests have been shown to be sufficiently distinctive. See, e.g., *Pacesetter Corp.*, 241 NLRB 1150 (1979) (separate unit of over-the-road drivers found appropriate); *Newburgh Mfg. Co.*, 151 NLRB 762 (1965) (separate unit of garment cutters found appropriate.)

Some employers argued that the real reason unions want separate RN units is that their constitution and by-laws do not permit them to organize other professionals (Comment 306, Herrin). However there was testimony that some nurses' associations have amended their by-laws to allow organization and representation of other professionals (Gonzalez, 4362; Sackman, 3578). In addition, there was testimony that some employers' true concern with allowing separate RN units is not unit fragmentation but defeating unions. Several witnesses testified that their

employer demanded inclusion of other professionals with nurses when nurses wanted separate representation, but then told the RNs they should not include other professionals who did not have their interests. These same employers told the other professionals that they should vote against the "nurses'" union because they would be a minority and nurses could not adequately represent them, thus contradicting the argument of many employers in this proceeding. (Gonzalez, Capitol Hill Hospital, 4351-53; Gilmore, 4896-97; Absalom, 3315; Saporta, 5134, Sackman, 3580-84; WS Splain at 18-19; Wilson, 5096-97.) Employers have also requested the inclusion of lab technicians with RNs, then challenged their inclusion (Wilson, 5087-89).

In several instances, employers who earlier had insisted on the inclusion of all professionals later opposed bargaining with the RNs and other professionals in a single unit when the nurses' union was selected as bargaining representative of an all-professional unit. For example, after the D.C. Nurses Association won an election in a broader unit demanded by the employer, the employer at negotiations proposed removal of non-RNs from the agreement, saying its earlier position had been based on "tactics." (Gonzalez, Capitol Hill Hospital, 4355; see also Lumpkin, Shands Hospital, 95: hospital asked to amend unit to separate RNs from non-RNs; because of problems with recruiting and retaining RNs, the employer needed to set innovative scheduling, overtime pay for shifts, premium pay.)

**11. Collective bargaining interests.** There are a number of issues of unique concern to nurses in collective bargaining (See Comment 240(b), submission of David Martin, RN, ANA senior staff specialist for labor relations, affidavit analyzing 190 RN-only unit contracts representing nearly every such contract negotiated in 1986). While there may be examples of how special concerns of the RNs have been addressed in all-professional units, this does not necessarily demonstrate that RNs and other professionals have large numbers of common interests. Nurses can emphasize these issues in bargaining regardless of the concerns of non-RN professionals because RNs would constitute 80% or more in a typical unit (WS Shea at 22), and often 100% of those willing to participate in bargaining (Gonzalez, 4355-4356).

Moreover, that unions are capable of addressing special concerns of the RNs in all-professional units does not negate

<sup>21</sup> That other professionals have not filed unfair labor practice charges or grievances against unions where nurses predominate, charging breach of duty of fair representation, does not mean other professionals are satisfied with representation. A breach of the duty of fair representation is found only where conduct is arbitrary, discriminatory or in bad faith. *Vaca v. Sipes*, 386 U.S. 171, 190 (1967).

the fact that many of these issues are unique to RNs and that separate representation would frequently provide a more efficacious and just means for responding to their concerns. For example, RNs alone have recurring concerns with respect to floating, i.e. being temporarily transferred from one unit to another to cover understaffed units (Schauer, 3115). RNs have bargained for mandatory orientation both in their own unit and before floating to other units (Schauer, 3115; Comment 240(b), Martin affidavit; orientation provision found in 83 of 1986 contracts). Some organizations representing nurses have created "Assignment Despite Objection" forms to be used when nurses are asked to work in a unit or perform a function for which they feel unprepared (Graham, 4827; Shepard, 4929-31). Floating and orientation generally do not concern other hospital professionals since they typically are not required to float to areas where they may be unqualified (Saporta, 5114; Indelicato, 3681). Moreover, other hospital professionals are not as concerned with staffing in general because they do not have constant patient care responsibilities like the RNs and because they are not in critically short supply (Gonzalez, 4364; at Capitol Hill, staffing was a major concern for RNs, not at all for other professionals).

The evidence shows that scheduling issues are of much greater concern to RNs than to other non-nursing professionals. RNs are virtually alone in their concerns with respect to mandatory overtime and double or rotating shifts, or evening, night and weekend shifts, all of which are said to increase the likelihood of nurse error. (Bachus, Chi I 144; Lipari, 3697; Korn 4860-61; Chow 3111, Ballard, 62, 75.) There were only isolated examples of non-nurse professionals working late shifts or weekends. Many other professionals, like social workers, work primarily day shifts during the weekdays. (Roth, 3151: no pharmacist, social worker or physical therapist at night, skeleton crew for respiratory therapy; WS Foley at 6-9: social work, physical therapy, doctors, offices are all closed by 6 p.m., some evenings only RNs provide primary care.)

Collective-bargaining agreements have addressed these issues by, e.g., attempting to limit mandatory overtime, rotating shifts, etc. (Comment 240(b), Martin affidavit; Chow 3110-11.) Collective bargaining agreements covering other professionals do not usually include such provisions (Friedman, 5055: Local 1199 contracts for

medical technologists do not prohibit mandatory overtime).

Hospitals have difficulties attracting nurses to work the less desirable evening and night shifts. Ninety-eight percent of contracts in the ANA study provided higher wages on evening and night shifts; 57% offer some form of alternative scheduling designed to attract RNs. (Comment 240(b), Martin affidavit.) Other professionals generally view issue of premium pay and alternative scheduling as less important or irrelevant. This in part is due to the fact that non-nursing professionals usually do not work night shifts and many do not work evening shifts (Patek, Chi I 55: non-RN professionals had grave concerns about bargaining over premium pay for fear that this would mean that they would be required to work shifts they had not worked before. See also WS Lumpkin, supra at 8: re: innovative scheduling for RNs; Gilmore, 4907.)

12. *Education.* Nearly every surveyed contract has provisions for continuing education which is mandated in 15 states (Comment 240(b), Martin affidavit). Continuing education typically presents different issues for nurses, who work around-the-clock schedules and have difficulty attending the courses, which are often given evenings, nights, or weekends. Thus, other professionals typically bargain about continuing education by seeking more money; RNs seek time off to attend as well as tuition. (Lumpkin, 86-88; Foley, 449-450.) This in itself would not justify a separate unit as such concerns could, of course, be accommodated in larger-unit bargaining; however, they are but one of a congeries of concerns and special problems that make nurses a substantial, unique group.

13. *RN bargaining units and strikes.* There is testimony that there have been many strikes by nurses (King, Chi II 41, 46, 28; Whelan, Chi II 59-61, 85; Comment 304: one-third of 20 strikes at Kaiser since 1974 amendments are in RN-only units), and that some of these strikes have lasted for a long time (e.g., Ashtabula Hospital, Ohio, 572 day strike; King, Chi II 28, 59-61). However, according to available FMCS data, only 3.3% of all health care contract negotiations, including nurse bargaining, resulted in strikes. The strike percentage in any given year never exceeded 5.1% and fell below 2% in several years. Moreover, during the 1984-1987 period, strikes in the health care industry occurred far less often than in other industries, 1.5% v. 2.4%. (WS Schoen at 28; AFL-CIO Exh. 6.)

There was testimony that RN strikes are particularly disruptive because RNs constitute the largest group of hospital employees. For example, there was a strike of 6,000 nurses in Minneapolis-St. Paul in 1984 over job security (Patek, MNA, Chi I 51, 63). But there was also testimony that where strikes occurred, the hospitals continued operation (Whelan, Chi II 59-60; Viat, 3471). Moreover, we must also be mindful that in an all-professional unit, RNs, because of their predominance, could generally obtain an affirmative strike vote even if all the other professionals were opposed. Because such a strike would involve all professionals in the hospital, greater disruption of hospital services would result than with a separate RN unit. (ANA Comments 173.) Finally, for 18 years ANA had a no-strike policy (Shepard, 4931-32; Comment 293(k), Flanagan, *Collective Bargaining and the Nursing Profession* at 14-15), and CNA has adopted a standing policy that in the event of an impasse in arbitration, it will offer binding arbitration before resorting to strike action (Absalom, WS at 8-9, 12-13, 15-16 & 3286-98: 1974 strike resolved by FMCS; 1978 shift rotation disagreement resolved by advisory arbitration; 1980 disagreement on nursing shortage resolved by mediation-arbitration).

The AHA argues that the history of the RN-only unit bargaining does not support a conclusion that potential work disruptions are not increased by creation of multiple professional bargaining units, since the overwhelming majority of facilities where RN units exist have no other professional units (AHA Br. 24). However, because in all likelihood the latter phenomenon would continue to exist, this argument is not entitled to great weight.

Some commentators argued that multi-professional units may lead to sympathy strikes (Bennett, 3045; Comment 13, Corkin). However, most no-strike clauses in hospital contracts forbid sympathy work stoppages, and there was evidence it is common for RNs to cross picket lines set up by non-nurse health care workers (Sackman, 3585; Lipari, 3696; Korn, 4889; Roth, 3152-53). If sympathy strikes were a problem, it appears that they could be significantly reduced by mandating common expiration dates for all hospital contracts, a proposition which, the evidence showed, hospitals frequently or even universally have rejected (Absalom, 3318-19: Affiliated Hospitals refused to allow new expiration date to coincide with expiration of other contracts; Clark, 4683-85: no common

expiration dates for initial contracts; Abelow, 249-50: no push from any parties to coincide RN contract expiration with master contract of League of Voluntary Hospitals; Lipari, 3697: employer opposes common expiration dates).

14. *Jurisdictional disputes.* The record does not reveal a single jurisdictional dispute between unions of professional employees (Fine, 3156-3158). Witnesses who asserted that such jurisdictional disputes would arise did not substantiate their claims (Dalstrom, 339; O'Connell, 440; Dauner, 3199; Emanuel, 3503-04; WS Cammarata at 7). In fact, the most typical job duty issues involving jurisdictional lines are between RNs and nonprofessionals, i.e., LPNs and nurses' aides (WS Shea at 14). These types of issues would arise even if the RNs were placed in an all-professional unit.

As was the case with regard to strikes, the AHA argues that an assessment of the impact of multiple professional units on jurisdictional disputes can only exist where there are two or more units represented by labor organizations in a facility, and there are very few such instances (AHA Br. 24). For this same reason, we believe the argument that there is a potential for jurisdictional disputes among professionals where a separate RN unit is given, is speculative. To the extent the record deals with this matter, it shows that any issues regarding the possible overlapping duties of professionals have in the past been fought out in the public arena. For example, attempts by other groups to perform some of the nurses' duties under their scope of practice in California were dealt with by the legislature. (Dumpe, 3278-79.) In any event, as noted *supra*, (see subsection (B)(9) on cross-training and interchange), interchange of duties between professionals appears minimal.

15. *Nursing shortage.* It is common knowledge, and the record substantiated, that currently there is an unprecedented and severe nursing shortage (Absalom, 3295; Shea, 5235; WS Schoen at 16, citing ANA Report on Hospital Nursing Supply). Some hospitals have delegated some traditional RN functions, not reserved to RNs by law, to employees with no RN training. Additionally, hospitals currently have more seriously ill patients (higher acuity) than historically reported. Less qualified nurses, and fewer nurses, will be forced to attend to more seriously ill patients, leading to a lower level of care and more stress for the remaining RNs who may then opt

out of nursing. (ANA Br. 101, and articles cited therein.)

Nurses testified that they view collective bargaining, in their own unit, as the vehicle for improvement in their working conditions and for allowing them a voice in patient care (Ballard, 72; Lumpkin, 85-86). Additionally, hospitals are trying innovative proposals for nurses: opening contracts for them alone, raising wages, setting weekend differentials. Some think that if other professionals are included in units with RNs, problems could arise if such changes are also not implemented for non-nursing professionals. (Wilson, 5071; Saporta, 5116.)

It has been argued that the Board should not give special consideration to a group in temporary crisis or other groups will also make demands for separate units (Comment 65, Milford Hospital). However, while the evidence establishes that the situation is a serious one and appears to be growing more serious with time (ANA Br. 100-101, and articles cited therein), we view this as only one valid factor in determining the appropriateness of a unit limited to RNs. The concern that this will lead other professionals to follow suit is speculative, and insufficient reason to deny RNs, who have already established their unique concerns and a highly separate identity, a separate bargaining unit.

16. *Proliferation of units.* As has been documented elsewhere, the evidence in the record does not support the assumption that the recognition of RN-only units will lead to a demand by other professional groups to organize as separate units. In fact, as previously indicated, the AHA acknowledges in its brief that in the overwhelming majority of facilities where RN units exist, other professionals have not been represented in separate units. (AHA Br. at 24.) SEIU health care organizing director Splain concluded that 10 years of statistics show relatively little organizing in residual hospital units. There are 16 hospitals in Ohio that have a separate RN unit, and only one unit in which professionals other than RNs are represented separately. (King, Chi II 38-39; Shepard 4927.) Health care workers organize no more frequently in facilities where some workers engage in collective bargaining than they do in facilities where no bargaining units have been represented (WS Splain at 14-17). One witness testified that a typical hospital has an RN unit, an LPN unit or technical unit, a service and maintenance unit, and sometimes an operating engineers unit (WS Patek at 4).

### C. Conclusion

We have carefully considered the evidence in the hearings as to how a separate RN unit, or, in the alternative, an all-professional unit including RNs, might fare, based on the realities of hospital operations, organizing, and collective bargaining. We conclude based on this evidence and the arguments advanced that a separate RN unit is appropriate for collective bargaining purposes.<sup>22</sup>

For many years, RNs, who constitute a significant portion of the health care workforce, have demonstrated their commitment both to their careers in the health care industry as well as their patients' well-being. During the time period following *St. Francis II*, it appears that RNs consistently desired separate RN units but were compelled to organize into all-professional units in order to avoid prolonged litigation. However, even when the RNs were forced to include other professionals in their units, the organizing drives were quite similar to prior nurses-only campaigns.

Moreover, it is apparent from testimony taken at the hearings that non-nursing professionals did not wish to be included in a unit with RNs. If we ignore the perspective of the smaller, non-nursing professionals group, i.e., the animosity expressed toward their inclusion with RNs as well as their concern that their "voice" will not be heard, then we are disregarding, at least in part, one of our major objectives. As previously indicated, the Board seeks to avoid finding too large a unit appropriate, as this may result in "too diversified a constituency which may generate conflicts of interest and dissatisfaction among fringe groups, making it difficult for the union to represent \* \* \*." See section III, Standard To Be Applied, *supra*. This

<sup>22</sup> In making our decision on this issue, we have considered *St. Vincent Hospital and Health Center*, 285 NLRB No. 64 (Aug. 19, 1987), a fairly recent case in which we held in an adjudicatory proceeding that a separate RN unit was inappropriate. In so doing we found, *inter alia*, that all of the employer's professional employees "share common personnel policies and procedures and fringe benefits and have sufficient contacts and interaction to support the finding that the smallest appropriate bargaining unit is one consisting of all of the Employer's professional employees." *Id.*, slip op. at 13. Having now had the opportunity to consider the substantial empirical evidence adduced in this rulemaking proceeding, we have a far better understanding of the RNs' training, functions, interests, and involvement in hospital operations, and of the actual and potential ramifications of each type of unit. For the reasons stated in this section, we were to apply the empirical evidence presented in these hearings, we might well reach a different result in *St. Vincent*.

latter point appears to be a concern of nursing and non-nursing professionals alike, and is one reason we have decided to permit RNs to seek bargaining rights apart from other health care professionals.

There was also testimony that would lead us to believe that some hospital employers' true concern with prohibition of separate RN units was not possible fragmentation but rather defeating organization. This was demonstrated by evidence of, *inter alia*, employer opposition to bargaining with the RNs and other professionals in one unit when an all-professional unit was finally certified, despite these same employers' earlier efforts to require that all professionals be included.

The distinct functions and collective bargaining interests of RNs compel the conclusion that a separate RN unit is warranted. RNs are a unique group in that their profession demands continuous interaction with patients. Additionally, because of licensure limitations, other professionals may not perform RN work and vice versa. RNs have a separate labor market, and scheduling issues are more of a concern. These factors and others discussed *supra* support a finding that collective bargaining by RNs as a separate unit should be permitted.

The industry has contended that adverse consequences would follow having separate RN units, such as strikes, jurisdictional disputes, and proliferation of units. The testimony proffered at the hearings has satisfactorily alleviated any concern we had over these possibilities.

Finally, we are mindful of the growing problem involving the nursing shortage. While separate representation for the RNs does not provide the complete solution to this problem, we believe that it is an important step toward making the nursing profession a more attractive employment opportunity as the separate concerns of RNs are addressed more directly in a separate RN unit.

## VI. Physicians

In our Notice of Proposed Rulemaking, we provided for separate units of physicians in acute care hospitals having more than 100 beds. Although we did not anticipate the formation of many such units, we stated we would permit them because of physicians' separate education, training, and skills, and particularly because of physicians' unique position as the ultimate supervisors of patient care.

As discussed *infra*, we have decided not to differentiate between hospitals having more than 100 beds and those having fewer. However, as with RNs,

see section V, *supra*, the evidence produced during this proceeding supported the proposed separate unit of physicians.

Doctors have considerably more training than other professionals, i.e., four years of medical school plus two to six years of post-graduate residence training, working as student residents in hospitals under the tutelage of licensed physicians (WS Cornfield).

Doctors have the singular responsibility of directing all other patient care employees; the JCAH charges doctors with overall responsibility for the quality of professional services (Robinson, 3650-51; WS Todd at 4-5, citing 1987 Accreditation Manual). Malpractice claims are filed against doctors because they are responsible for medical treatment (Robinson, 3652). The AHA contends that all professionals are held responsible for malpractice (AHA Br. 30); while we do not doubt the truth of this assertion in some circumstances, the AHA offered no details.

It is common knowledge that doctors earn substantially more than other professionals. They are frequently salaried, entering into individual employment contracts with hospitals rather than having an overall wage scale applied to them. (Comment 94, Somers; Robinson, 3652; NYS Federation of Physicians' and Dentists' position paper Exh. D.)

Supervision of doctors is limited and is generally done by other doctors (Robinson, 3651; Comment 293, Feldsine). While we recognize that other professionals are also commonly supervised by their peers (Comment 71, Kowalski, St. Mary's Hospital), as indicated doctors are ultimately responsible for the care given patients.

Doctors, of course, work with other employees, particularly on teams, or committees (Comment 137, McDonough Hospital; Mixon, Chi II 291; Comment 248, appending statement from Spitzer of Cedars-Sinai). However, we are persuaded by the evidence that the team approach does not change the duties of doctors, which are limited by law. Other employees are not permitted to do work within doctors' scope of practice. (Todd, 4348; Comment 269, Todd, AMA.)

Aside from the other factors noted, doctors have particular interest in bargaining about medical education, malpractice insurance, and input into patient care decisions (Robinson, 3655). They have little interest in the issues of special concern to RNs, such as floating, per diem, uniform allowances, overtime, etc. (NYS Federation of Physicians' and Dentists' position paper, Exhs. B, D, E, and F), and are outnumbered by nurses

at a ratio of at least 15:1 (Todd, 4324, 4328), and perhaps 20:1 (AHA Br. 28). We are concerned that if doctors were forced to be included in the same unit with nurses and other professionals, doctors' interests would be overwhelmed (Todd, 4324). Florida, after 10 years, removed doctors from an all-professional unit in state facilities because of money considerations (Lumpkin, 100, 111-12). In one wall-to-wall unit including doctors, the hospital wanted raises just for doctors because of recruitment problems; the union opposed this because it would give raises just to one group in the unit (Robinson, 3654-55). A number of employers similarly expressed concerns about putting physicians in units of other professionals (Comment 94, Somers, attorney to many health care facilities; Comment 304, Kaiser Permanente; Comment 1, Lancaster Fairfield Community Hosp.; Comment 17, Middletown Regional Hosp.; Comment 48, St. Vincent's Medical Center, Bridgeport; Comment 141, Ayres). A wall-to-wall unit at O'Bleness Hospital did not include doctors (AHA Exh. 8D).

While the number of doctors employed in hospitals is small, and the percentage of employed doctors compared to other employees remains about the same, the actual number of employed doctors is increasing (Todd, 4335), and there is some evidence that doctors are organizing at increasing rates (AFL Exh. 4).

We are persuaded that the evidence weighs in favor of a separate unit for physicians, where sought. Thus, to include them with RNs and other professionals seems likely to lead to divisiveness and quite possibly to conflicts of interest. We have found no evidence that to grant doctors a separate unit would lead to repetitious bargaining, frequent strikes, or jurisdictional disputes. We believe the proper balance is struck in favor of a separate unit for all physicians, where requested.

## VII. Other Professionals

In our original Notice of Proposed Rulemaking, we tentatively provided for a separate unit of all professional employees, excluding registered nurses and physicians, in acute care facilities having over 100 beds. We noted that section 9(b)(1) of the Act mandated separate representation for professional employees unless a majority of those employees vote for inclusion in a unit with non-professionals. In view of the provision for separate RNs' and physicians' units, it was and continues

to be necessary to provide for a separate unit of professionals excluding these two classifications although, as noted *supra*, we have decided to abandon the proposed 100-bed differentiation.

A number of so-called "other professionals" appeared in person at the hearings to testify. In general, they confirmed the lack of interest which RNs exhibited towards their circumstances, and the fact that, despite their different professions, they were able to achieve collective bargaining in all-professional units, excluding RNs and physicians. (Indelicato, social worker, 3673, 3678; Ahmed, laboratory technologist, 3705-06; Crisafulli, pharmacist, 3711, 3737.) In a comment, physical therapists expressed a preference for their own separate unit, but if placed with other professionals they would prefer that unit did not include RNs (Comment 134). Some fear was expressed that, because of their numbers, RNs (and also technicals) would overwhelm the other professionals if included in the same unit with them (Ratner, 3731-32; WS Cornfield, Table 1).

A number of "other professional" classifications work relatively independently, and have no immediate direct supervision (Ratner, 3735). They generally work the day shift, on weekdays (Indelicato, 3681), though some work on other shifts (see, e.g., Comment 275, Presbyterian Hospital). As a group they have high prestige within the hospital because of their superior education and training (WS Cornfield, Table 6).

Despite the desire expressed by some other professionals for their own separate units, and despite some history of separate representation of each profession, mainly in New York (see, e.g., Friedman, 5038), it seems clear to us that to provide for such additional units might create the proliferation which Congress meant to avoid. Moreover, despite the existence of some units combining technicals with other professionals (see, e.g., Willman, 4480, 4483, 4485, 4486; Shea, 5208; Robfogel, Chi. II, 224), Sec. 9(b)(1) of the Act prohibits such a combined unit, unless the professionals separately vote for inclusion with the non professionals. Accordingly, based on the above, we affirm the appropriateness of a separate unit of all professional employees, other than RNs and physicians.

## VIII. Technicals

### A. Introduction

In our Notice of Proposed Rulemaking, we tentatively determined that technical employees constituted a separate

appropriate bargaining unit. Among the reasons we expressed were:

(a) That, in comparison with other non-professionals, they typically have significantly higher levels of skill and training, and are paid substantially more;

(b) That it has been the Board's consistent practice to approve separate units of technical employees; and

(c) That these separate units generally have met with approval from the courts of appeals.

After carefully considering the evidence presented during the rulemaking proceedings, we have determined that technical employees appropriately constitute a separate bargaining unit.

### B. Technical Employees Are Separate and Distinct From Other Non-Professional Employees

1. *Education, licensing, training, and skills.* Technical employees are found in major occupational groups including: medical laboratory, respiratory therapy, radiography, emergency medicine, and medical records.<sup>23</sup> (WS McKinney, 2.) The evidence presented at the hearings demonstrates that technical employees perform jobs involving the use of independent judgment and specialized training, as opposed to service and maintenance employees who generally perform unskilled tasks and need only a high school education (AFL Br. 32, citing *Southern Maryland Hospital Center*, 274 NLRB 1470 (1985); McKinney, 5502-03, 5523-24; Colbert, 5020; WS Shea at 20). Testimony indicated that the gap between technical employees and service and maintenance workers actually is widening, with higher levels of technical skills more closely aligned to professional job categories rather than to other non-professional categories (WS Shea at 20; WS Schoen at 14 and 5175-76). Thus, technical employees occupy a high-prestige status distinct from other categories of non-professional employees because of the training requirements for their jobs (WS Cornfield at 12-13).

Technical employees further are distinguished by the support role they play within the hospital, and by the fact that they work in patient care. Examples of their work include: routine clinical tests performed by medical laboratory technicians; general respiratory care

administered by respiratory therapists; and x-rays, ultrasound procedures, and CAT scans performed by various technicians. (WS Briguglio at 3.)

Contrary to the AHA's statement that "no evidence of separate or distinct employment attributes of technical employees was presented at the hearings" (AHA Br. 33), the evidence shows that all health care technical employees have significant additional education and/or training beyond high school, including: community college associate degree programs which provide math and science background beyond that which high schools offer (WS McKinney at 5); vocational training programs run by hospitals (WS McKinney at 7); programs at accredited schools of technology (WS Briguglio at 2); and, in some fields, a full 4-year college degree (Schoen, 5176; McKinney, 5477).

Further, the evidence indicates that most hospital technical employees are either certified (usually by passing a national examination), licensed, or required to register with the appropriate state authority (Willman, 4474), although laws regarding such licensure, registration, training and qualifications vary throughout the country (Ahmed, 3709-11).

There was evidence that some deskilling is occurring in the technical categories, reducing the need for higher skills in operating some equipment; however, the evidence further shows that it is not across-the-board (McKinney, 5485). Further, hospitals must purchase expensive and complicated equipment to deskill a task (McKinney, 5486); and where, for example, a technologist's work may be deskilled, it then would be performed by a technician rather than by a service worker (McKinney, 5513-14; Berliner, 5633-34).

2. *Wages, hours, and working conditions.* Although, in general, hospitals apply similar benefit and labor relations policies to technical and other non-professional employees, the evidence shows that the wages and hours of technical employees differ significantly from those of the other non-professionals (Mass. Hospital Assn., Comment 105). Technicians were shown to occupy the middle ranks in the hierarchy of health care workers, and the evidence presented regarding hospital pay scales reflects this standing (WS Schoen at 15). On the average, technicians earn \$2,000 per year more than service workers in this industry (WS Schoen at 15, Table 1; Henry, 3084-85). While the wages of service workers are tied to the unskilled labor market,

<sup>23</sup> Although we note that historically, those employees who enter and decode patient data in medical records have been placed in service and maintenance units or overall non-professional units (see e.g., *Levine Hospital of Hayward*, 219 NLRB 327 (1975); *Duke University*, 226 NLRB 470 (1976)), the inclusion of "medical records technicians" in a separate technical unit may be litigated as a unit placement issue when it arises, on a case-by-case basis.

and those of business office clericals and skilled maintenance workers are similar to those of comparable jobs outside the industry, technicians' wages are tied to the earnings of the more highly skilled technologists with whom they work, and they generally earn approximately 75% of what the technologists earn (WS McKinney at 12-13, & 5479). Thus, management needs to provide higher entry wages for technicians than for service workers (Shea, 5238-39; Briguglio, 5300-01; Henry, 3084-88).

Technical employees work daytime hours, with evening, night, and weekend skeleton crews, while business office clericals work daytime hours and service and maintenance employees are staffed on a 24-hour basis (Colbert, 5016-17).

3. *Supervision.* The evidence indicates that technical employees usually have separate supervision from other non-professional employees; however, this may differ from facility to facility. For example, a supervisor of some technical employees may also supervise business office clericals; or a laboratory manager who supervises technical employees also may supervise some service and maintenance employees. (Mass. Hosp. Assn., Comment 105; Briguglio, 5300.)

4. *Contact with other employees.* Technical employees typically perform their work in laboratories or in technical departments, and not in patient care areas (AFL Br. 41; Booth, 3693), although the AHA's brief states that more hospitals are beginning to locate some laboratory facilities in patient care areas and technicals may have direct and continuing involvement with other categories of employees as well as with patients (AHA Br. 33). The tasks that technicals perform, such as processing and reviewing patient specimens, taking x-rays, EKGs and EEGs, are considered ancillary services, diagnostic in nature (AFL Br. 41). Technicals have no contact with business office clericals, and only minimal contact with service employees, but in a typical laboratory, work with doctors, technologists, clericals, and messengers (WS Briguglio, 4-5; Colbert, 5017-18; AHA Br. 33). The evidence shows that LPNs do work in patient care areas and provide direct patient care; however, the Board has found them to be appropriately included with technicals in light of their skill level and the requirement that they be licensed (AFL Br. 41 citing NLRB Exh. 5, revised).

5. *Cross training.* There is no temporary interchange, and little permanent interchange between technical employees and other non-professionals because of the difference in skills, the specialized functions of the

technicals, and the differences in their education (Shea, 5221-22). Service workers typically have only a high school education or less and cannot be placed in technical positions in the absence of elaborate training programs (McKinney, 5481). Contrary to statements of industry witnesses who maintain that a service worker could take a six-week training program and be able to read EKG equipment (King, 5488), we are persuaded that technical training requires full or nearly fulltime education, and a high school education does not provide the mathematics and science background necessary (WS Shea at 21).

The evidence shows that cross-training programs are being offered at some hospitals and colleges; however, training programs and funds to provide classroom instruction for hospital employees are rare in hospitals that are not unionized (Schoen Supplemental Statement). Thus, the majority of cross-training that occurs is among the technical categories themselves (LPNs doing EKG work formerly done by EKG technicians; medical technologists administering blood gases previously administered by respiratory technicians) (St. Anthony's Health Corp., Comment 142; St. Joseph Mercy Hospital, Iowa, Comment 243). Moreover, new technology has brought about a decline in technician jobs requiring only minimal training, while increasing the need for more intensely-trained technicians, thus widening the gap between technical employees, who are becoming more skilled and sophisticated, and service and maintenance workers (WS Schoen, 14-15; WS Shea at 21).

6. *Career paths and the labor market.* Technical employees have a separate career path and labor market. They do not seek to transfer into other types of non-professional jobs; rather, technicians may seek to become technologists in the same line of technical work; or LPNs may seek to become RNs. (O'Cleireacain, 5426; Ryan, 4738-39.) While some LPNs may become RNs through training programs, progression to technologist is more difficult for technicians because of the 4-year college requirement for many technological positions (WS Schoen at 15; McKinney, 5477). Their existing training is not considered a "building block" toward technologist status, without successful negotiations with licensing and accreditation boards (Schoen, Supplemental Statement). Thus, in addition to little mobility in their immediate workplace, it is also difficult for technicians to move out of that workplace. As long as they wish to

practice their specialties, they must remain in the health care industry. (WS McKinney at 12.) Statistics show that 100% of job placements from technical programs are in health care occupations (Ryan, 4744). In contrast, business office clericals and skilled maintenance workers have great mobility outside the industry, as do unskilled service employees (O'Cleireacain, 5427; Marshall, 4018-19).

Evidence presented at the hearings shows that the labor market for technicians, which until recently was expanding steadily, is contracting (McKinney, 5474, 5478). Witnesses testified that with the introduction of cost containment techniques into the industry, the future of technical workers is in a state of flux. Further, even though new technology and equipment continue to be developed, at the same time hospitals are seeking to save on labor costs by replacing expensive, skilled employees, closing laboratories, and contracting out laboratory services. (WS McKinney at 13; Berliner, 5598.) Certificate of Need programs impose limits on the addition of new technology, further reducing the need for new technicians. For all of these reasons, training programs have become an important bargaining issue. (Schoen, Supplemental Statement.)

### C. Organizing and Bargaining

The health care industry's bargaining unit proposals in 1973-74 would have allowed a separate unit for technical employees in hospitals (AFL Br. 31); and since 1974, the Board has continued to find separate technical units appropriate (NLRB Exh. 5, revised; *Southern Maryland Hospital Center*, 274 NLRB 1470 (1985)). As we noted in our proposed rule, court decisions have approved the Board's determinations as to technical units. See, e.g., *Watsonwan Memorial Hospital v. NLRB*, 711 F.2d 848 (8th Cir. 1983); *NLRB v. Sweetwater Hospital Association*, 604 F.2d 454 (6th Cir. 1979). See also *Vicksburg Hospital v. NLRB*, 653 F.2d 1070, 1075 (5th Cir. 1981). Further, the evidence shows that technicals choose to organize in technical groups and not with other non-professionals (Booth, 3686-88). In the 588 hospitals in which a union affiliated with the AFL represents at least one bargaining unit, there are 311 separate technical units (including LPN units), and only 52 units in which technical employees and other non-professionals are combined into a single bargaining unit (AFL Br. 44 and Appendix A; Booth, 3688-90). In addition, LPNs organize with technicals who have the same training, education, licensure, and

certification requirements (Muehlenkamp, 4787).

Organizing drives are initiated by employees with specific concerns and grievances (WS Splain at 4; Sackman, 3592; Schmidt, 3628; Muehlenkamp, 4784). Other interests include professional conferences, training, and rotations (Colbert, 5019). At the hearings, no union organizer who was asked could recall any situation in which technical employees sought to include business office clericals or unskilled service workers, or vice versa (Olson, 4718; Muehlenkamp, 4784).

Technical employees generally choose to have separate initial contracts; however, they may agree, after the initial agreement expires, to engage in joint bargaining, but retain separate delegates for negotiations and for presenting separate issues (Booth, 3688; Colbert, 5021-22). Although industry witnesses maintain that the fact that technical employees organize and bargain their first contract as a separate unit does not justify finding a separate technical unit appropriate where subsequent bargaining history shows that they now bargain in broader units (St. Luke's/Roosevelt, Comment 224; AHA Br. 32-33), there is evidence that difficulties have arisen occasionally where technicals have been included with maintenance employees and clericals because of their different training, duties, and wages (Logan, Comment 150, pp. 3-4).

#### D. Proliferation

Technical units generally encompass a wide range of classifications, including LPNs, and they constitute approximately 17% of the health care work force—a substantial complement of workers (WS McKinney at 2; WS Schoen at 3, 5). What evidence there is shows that strikes involving technical employees alone are rare. In New York City, for example, strikes involving technical employees occur in broader units of clericals, service and maintenance, and professional employees. (Long Island Jewish (LIJ) Medical Center, Comment 270.)

#### E. Other Issues

The label "technical" may no longer define a particular group of jobs, and indeed, the union witnesses who appeared at the rulemaking hearings often did not distinguish between technicians and technologists (Schoen, 5175; Ahmed, 3709-11; McKinney, 5471-79; WS Briguglio at 2-3). Technologists often have been included as professional employees in professional-only units. See, e.g., *Children's Hospital of Pittsburgh*, 222 NLRB 588 (1976);

*Mercy Hospitals of Sacramento*, 217 NLRB 765, 769 (1975). Although industry witnesses urge the Board to consider the practical effect of the difficulties of resolving issues of unit placement, and caution that there may be "intense litigation" over unit placement which could be avoided by the inclusion of technicals in a broad non-professional unit (AHA Br. 34), we note that, even with such inclusion, litigation could continue to occur over which technicians were professional employees. Individual placement issues always have been present in the consideration of health care and other cases. In our opinion, their existence should not deter the Board from taking the first step, i.e., determining the threshold appropriateness of a separate technical unit.

#### F. Conclusion

For the above reasons, we determine that separate technical units are appropriate for collective bargaining. The evidence clearly demonstrates that the varied technical employees employed in the health care industry are appropriately grouped into a single unit by virtue of their education, training, and specialized skills, and do not constitute a unit so large as to be overly diversified and hence unwieldy for organizing and collective bargaining.

### IX. Skilled Maintenance

#### A. Introduction

In the Notice of Proposed Rulemaking, the Board tentatively determined that service and maintenance employees constituted a separate appropriate unit and that skilled maintenance employees should be included in that unit rather than represented in separate skilled maintenance units. Among the reasons we expressed for including skilled maintenance employees in the broader service and maintenance units were:

- (a) That their skill levels do not, at times, greatly exceed those of other service and maintenance unit employees;
- (b) That they work throughout hospital's facilities, and thus frequently come into contact with other service and maintenance employees;
- (c) Their inclusion in broader units will help to prevent unit proliferation; and
- (d) As a practical matter, the Board's approval of separate maintenance units had fared poorly in the courts.

After carefully considering the evidence amassed during the rulemaking hearings, we have determined that, contrary to our earlier impressions, skilled maintenance employees can and should constitute a separate appropriate bargaining unit.

#### B. Relationship to Other Employees

1. *Functions and skill level.* Evidence from the rulemaking hearings shows that skilled maintenance employees perform functions apart from those of unskilled service, maintenance, and clerical employees in that these employees deal with highly complex and sophisticated systems and equipment (Carrick, 3448-3450; Jacquin, 5354-55; Lake, 146-148). While they occasionally perform routine, unskilled tasks, skilled maintenance employees are generally engaged in the operation, maintenance, and repair of the hospital's physical plant systems, such as heating, ventilation, air conditioning, refrigeration, electrical, plumbing and mechanical (Lake, 150-151; Viat, 3457-59, 3476-77; Hach, 5318; Giblin, 5382-83). Work on these systems requires abstract skills and knowledge at levels considerably higher than those of other non-professional hospital employees (Marshall, 4010-4012; Hammond Exh. 1, pp. 340-45, 580-623; Cornfield, 5698; WS Cornfield at 4-6, citing Dictionary of Occupational Titles of U.S. Employment and Training Administration). Skilled maintenance employees are rated more highly, for example, even than physicians on the manipulation of "things" (WS Cornfield at 5). Skilled maintenance employees are frequently required to have postsecondary training in their field, such as vocational or trade school. Even the lower skilled maintenance employees in plant operations and maintenance are required to have higher skills than those required of service employees. (Jacquin, 5363-64, 5374, 5377; Viat, 3459-60; Giblin, 5384.)

2. *Education, licensing, and training.* Contrary to virtually all nonsupervisory service classifications, which require only a grade school education, skilled maintenance classifications require completion of high school; at least some trade or vocational school experience, if not graduation therefrom; completion of formal or informal apprenticeship programs, which may take several years; or an associate's or bachelor's degree (Hammond, 5404-05, 5409-12; AHA Health Care Occupations: A Comprehensive Job Description Manual pp. 340-45, 385-88, 394-402, 499-501, 561-62, 567-70, 573-74, 580-623; Marshall, 4010). Skilled maintenance employees also need continuing education to keep abreast of technological changes in building maintenance, such as computers and remote controls (Carrick, 3454; Marshall, 4011-12; Schloop, Chi II 165; Schwemm, Chi II 186-89; Hammond, 5408; WS

Schwemm, Exh. 5-9; WS Fowler at 4; WS Denevi at 7-9). Moreover, the amount of training available in skilled maintenance classifications compares favorably to that offered in various technical classifications, such as lab technician and medical records technician (WS McKinney at 6-7), and access to the programs and the upward mobility they bring provide a common concern to employees largely unshared by those outside the skilled maintenance group (Schloop, Chi II 165; Ryan, 4739). Another distinction between skilled maintenance and unskilled service employees is that at least seven skilled maintenance classifications, but no service classifications, require licenses. (Hammond, 5404-06; WS Cornfeld, at 6-8)

3. *Supervision.* The distinct nature of skilled maintenance functions is underscored by the frequent placement of skilled maintenance employees in separate departments, usually coinciding with the hospitals' plant engineering or maintenance departments (Carrick, 3448; Viat, 3457, 3478; Marshall, 4014; Hach, 5342, 5354). Thus, skilled maintenance employees frequently have their own supervision (Hammond, Exh. 1, pp. 581-590). Moreover, skilled maintenance employees are not supervised by any supervisors from outside their own departments (see, e.g., WS Fowler at 8).

4. *Wages, hours, working conditions.* While it appears that certain terms and conditions of employment, i.e., fringe benefits and personnel policies, are similar among non-professional employees (Jacquin, 5368-70; Comer, Chi II 326-29; Comment 129, Hall), wage rates paid to skilled maintenance employees underscore their higher skills and training. Thus, the most recent Industry Wage Survey: Hospitals, Aug. 1985, BLS of the DOL, shows that skilled maintenance employees in private hospitals in 23 metropolitan areas averaged \$11.89/hour whereas, in comparison, employees in six service classifications averaged \$6.84/hour, office clericals in five classifications averaged \$7.56/hour, and employees in ten technical classifications averaged \$9.89/hour. (Lake, 154-55; IUOE, Exh. 4.) Thus, on the average, skilled maintenance employees earn 25% more than technicians, almost 60% more than business office clericals, and 76% more than service employees. Moreover, the wage rate of lesser skilled maintenance employees, while lower than that of the most skilled maintenance employees, almost always exceeds that of even the highest-paid service employees and

often exceeds the rate of employees in other classifications as well.

5. *Interaction with other employees.* Though they primarily work in maintenance areas, skilled maintenance employees do perform work throughout the hospitals (Kelly, Chi II 178; Carrick, 3453; Hach, 5330). As a result, skilled maintenance employees have contact with just about every other employee in a hospital. However, these contacts are brief, limited, and incidental as it appears that the only employees with whom skilled maintenance employees actually work are others from the maintenance department (Carrick, 3453-54; Jacquin, 5360; Kelly, Chi II 212-13), and that the contacts with non-maintenance employees typically consist of other employees' identifying the maintenance problem to the skilled maintenance employees (Kelly, Chi II 178, 213; Jacquin, 5360; WS Fowler at 8).

6. *Labor market and career paths.* Skilled maintenance employees have separate labor markets and highly mobile cross-industrial career paths as the operation and maintenance of physical plant systems are the same no matter in which industry they are performed (Marshall, 4014; Schloop, Chi II 183; Kelly, Chi II 177; Fox, 3436-37; O'Cleireacain, 5427; WS Denevi at 4). Easy mobility in skilled maintenance classifications tends to orient these employees toward their skills rather than the industry in which they are employed (Lake, 144, 490; Marshall, 4010, 4019). The external skilled maintenance labor market also affects the hiring and wage scales in the health care industry since hospitals compete with other industries, such as hotels and office buildings, for these employees (Berliner, 5645; Hach, 5344-45; WS Schoen at 23; Corbett, 3344-45).

Skilled maintenance employees are in a separate internal labor market within the hospital in terms of career path, training, and promotion. There are formal and on-the-job training programs to permit lower level maintenance employees who have acquired skills and knowledge to move into more highly skilled positions; yet, there is virtually no transfer of clerical or service employees into maintenance classifications. (Schloop, Chi II 204-05; Kelly, Chi II 216-17; Giblin, 5400; O'Cleireacain, 5427, 5488; WS Shea at 18.) Even entry level jobs are filled by those with skilled maintenance backgrounds (Hach, 5327; Schloop, Chi II 203-04).

#### C. History of Representation

The appropriateness of separate skilled maintenance units is supported by a history of separate representation,

especially by labor organizations specializing in the separate representation of skilled maintenance employees (IUOE Exh. 2 revised; Holland, Chi II 305-09; Friedman, 5036, 5040-41; Peters, Chi II 131-34; Comer, Chi II 320, 327-28; Hach, 5328; Giblin, 5395). For example, the IUOE currently represents at least 237 separate skilled maintenance units in both private and public health care institutions nationwide (IUOE Br. 56). Twenty percent of IUOE health care units date from the 1940's and '50's, and 85% of them predate the 1974 amendments (IUOE Exh. 2 revised). Admittedly, there are skilled maintenance employees represented in combined service and maintenance units, or in a handful of broader non-professional units, but inclusion of skilled maintenance employees with these other employees does not necessarily show a voluntary grouping as some combined units are the result of stipulations so that elections could be held without further delay, or are atypical situations (Stickler, Chi I 16-26; Twomey, 131-34; Emanuel, 3497; Ratner, 3728; AHA Exh. 4-9; Willman, 4491-92; Muehlenkamp, 4767; Friedman, 5041; King, 4244, 4249, 4251-52). In addition, the evidence regarding combined units is equivocal in that the "maintenance" employees in "service and maintenance" units are frequently unskilled rather than skilled maintenance employees (Silberman, 5651; IUOE Br. 58; Shea, 5227-28; Splain, 5302-04).

#### D. Organizing and Bargaining Interests

1. *Organizing.* Though clearly not impossible, it appears that because of the variety of personal interests involved it is more difficult to organize larger, combined units than to organize separate smaller units of employees (Viat, 3465; Sackman, 3578; Schwarz, 265; WS Schwarz; Koziara study pp. 1, 4, Figure 1; Delaney, 4517-18, 4525; Silberman, 5686; AFL Exh. 2). Larger heterogeneous units deter decertifications of unions as well (Delaney, 4523). In addition, skilled maintenance employees usually do not wish to organize with other groups, and it is unusual for different groups of non-professional employees to seek to organize in the same unit (Muehlenkamp, 4785; Olson, 4698-99; Ratner, 3730). There is evidence that, where combined units are sought, separate interests of the diverse groups may make it difficult, or impossible, to hold organizing meetings of the entire group (Viat, 3465).

2. *Bargaining interests.* While all employees have some similar bargaining

concerns, i.e., wages, hours, and fringe benefits, skilled maintenance employees have additional interests different from those of other non-professional employees. They seek wage levels commensurate with those of skilled maintenance employees in other industries; access to craft-related education and training programs; tool supply allowances; safety equipment and practices; portable pensions, because of their cross-industrial mobility; and input with respect to subcontracting of work. (Kelly, Chi II 175; Marshall, 4011; Willman, 4492-93; Schloop, Chi II 164-65; Schwemm, Chi II 209; Viat, 3466-67; Giblin, 5388.) Service employees and business office clericals have specialized bargaining interests as well (Schloop, Chi II 168; Viat, 3466-67; Gregory, 5746). These differences lead to difficulties in bargaining in a heterogeneous group, and may result in the smaller group of skilled maintenance employees getting lost in the shuffle in negotiations relating to the more numerous lesser skilled employees (Schloop, Chi II 168-69; Olson, 4729-30; Viat, 3465; Willman, 4492; Ratner, 3734; Shea, 5187; Muehlenkamp, 4795-96). Negotiating in a broader unit may also serve to broaden the scope of labor disputes by involving employees whose personal interests are not of concern in disputes relating to the interests of other unit employees (Viat, 3466). For example, in one hospital in which two unions jointly represented a combined unit of service, skilled maintenance, technical, and plant clerical employees, the skilled maintenance employees were forced to join other employees in a strike over unresolved bargaining issues that affected only the other employees even though all issues involving the skilled maintenance employees had already been settled (Viat, 3466).

#### E. Proliferation

Contrary to our concern, as expressed in our NPR, there was no evidence adduced at the rulemaking hearings that establishing a separate unit of skilled maintenance employees will lead to proliferation of bargaining units in the industry (Kelly, Chi II 180; Gilmore, 4894; Splain, 5252). No labor organizations have sought or demonstrated the appropriateness of other small units (IUOE Br. 64-65). Moreover, the skilled maintenance employee unit may be viewed as a consolidation of specialized employees inasmuch as it combines such employees as carpenters, painters, plumbers, and electricians (IUOE Br. 65). The only employee classification performing work similar to that performed by traditional craft or trade-type maintenance employees are

biomedical technicians (Marshall, 4018-20; Hach, 5346-49; Jacquin, 5377; Viat, 3480-81; Giblin, 5396-98). Biomedical technicians work on and repair sophisticated computer-based equipment, and because of both their skills and training share a community of interest with other skilled maintenance employees and in many instances have already been included in some such units (Fox, Exh. 1 and 2; Hammond, Exh. 12; Viat, 3458, 3460, 3480; Giblin, 5495-97; Marshall, 4019-20; McKinney, 5497, 5525; Hach, 5347-49; Jacquin, 5377; Schloop, Chi II 203-04; Carrick, 3448).

#### F. Strikes, Sympathy Strikes, Jurisdictional Disputes, and Wage Leapfrogging or Whipsawing

1. *Primary strikes.* The evidence taken at the rulemaking hearings shows that the presence of separate skilled maintenance units has not resulted in a large number of strikes by these units (Lake, 157; IUOE Exh. 2; Viat 3468; Schloop, Chi II 169; Kelly, Chi II 180; Hach, 5323; Giblin, 5389; Hammond Exh. 12, attached affidavits). The hospitals contend that the number of strikes is low because the number of employees involved is small and therefore the cost of a strike exceeds the potential increase in labor costs of the union's demands thereby making it more likely that hospitals will give in to those demands. Nonetheless, the fact remains that in the 237 skilled maintenance units represented by the IUOE, in which hundreds of contracts have been negotiated, there have been only about 25 strikes ever (Lake, 157; IUOE Exh. 2). In addition, the incidence of strikes by skilled maintenance employees has not increased in proportion to the number of other represented units of hospital employees (IUOE Exh. 2; Viat, 3468-69; Fox, 3442). The few strikes that have occurred have been almost exclusively in support of bargaining demands, and have not been disruptive to health care delivery; indeed, skilled maintenance employees have offered to provide skeleton crews to assure uninterrupted service in the event of a work stoppage (Henry, 3059; Fox, 3442; Viat, 3467-68, 3470; Hammond Exh. 12, affidavits of Bess, Tighe, and Scheb.) Moreover, other hospital employees, whether represented or not, generally have not engaged in work stoppages in support of striking skilled maintenance employees (Hammond Exh. 12, affidavits of Bess, Tighe, and Scheb).

2. *Sympathy strikes.* While the strike rate in the health care industry in general is low (Subrin, Chi I 119-20; Schoen, 5181; Silberman, 5659), there is evidence that hospitals have not availed themselves of the opportunity to limit

the possibility of successive multiple strikes by supporting union proposals for common contract expiration dates of different units' contracts; indeed, hospitals have opposed such proposals. (Henry, 3075; Absalom, 3318-19; Corbett, 3359-60; Schmidt, 3625; Weinrich, 4274; Muehlenkamp, 4771, 4774). Moreover, there have been virtually no sympathy strikes by skilled maintenance employees in support of other striking hospital employees (Schloop, Chi II 169; Kelly, Chi II 180; Fox, 3442; Friedman, 5060; Hach, 5323; Jacquin, 5361; Giblin, 5389; WS Fowler at 7; Hammond Exh. 12, affidavits of Bess, Tighe, and Chambers). No-strike clauses, which are generally honored, appear to have contributed to the infrequency of such strikes (Fox, 3442; Friedman, 5060-61). And, while the evidence shows that bargaining in broad, heterogeneous groups may serve to expand the scope of a strike by involving employees whose personal interests are not of concern in disputes relating to the interests of other unit employees (Viat, 3466; see above discussion in subsection (d)(2), Bargaining Interests), it also shows that the absence of sympathy strikes in the industry makes it unlikely that such expansions of strikes will occur where employees with separate and distinct interests are represented in separate units.

3. *Jurisdictional disputes.* In general, industry witnesses were unable to support the allegation that allowing separate skilled maintenance units would increase the number of jurisdictional disputes in the industry (Graumann, 409; Weinrich, 4254, 4281; Cammarata, 4406). Instead, the evidence shows that jurisdictional disputes over work assignments involving skilled maintenance employees are, like those in the hospital industry in general, rare and nondisruptive (Roth, 3153; Muehlenkamp, 4775; WS Shea at 14). Moreover, we are persuaded that the types of jurisdictional disputes which do arise, i.e., disputes over job classification, content, and responsibility, occur regardless of whether the employees are represented in one unit or several different units (Krasovec, 420-22; Hach, 5324; Giblin, 5389-90; WS Shea at 14). Finally, the few disputes which have arisen have been resolved informally, minimizing disruption of normal operations (Schloop, Chi II 170-71; Kelly, Chi II 181, 206, 207; Fox, 3442-43 & Exh. 2; Viat, 3471; Hach, 5323; Jacquin, 5361; Giblin, 5389).

4. *Wage whipsawing and leapfrogging.* Wage whipsawing or leapfrogging virtually never occurs with

skilled maintenance units inasmuch as the wages of skilled maintenance employees are generally based on the wages of skilled maintenance employees in other industries, rather than on the wages of other health care industry employees (Corbett, 3344; Hach, 5344-45).

### G. Changes in the Industry

The alleged trend toward specialized hospitals and integration of employee functions would appear to have no impact on skilled maintenance units because the physical plant systems will essentially remain the same and will require skilled maintenance employees to operate and maintain them (Viat, 3470). Any move toward interdisciplinary teams also appears to have had no effect on skilled maintenance employees as virtually every team that was described by the industry included only health care personnel (Mixon, Chi II 275; Gallagher, 3541-42; Houston, 4025, 4050-55; Donnelly, 4064, 4080; Sokatch, 4195; Weinrich, 4268-69; Comment 62, Achterhof; Comment 78, Olman Greater Cincinnati Hospital Council). The one example provided at the hearings of skilled maintenance employees' participating on a team involved the skilled maintenance employees' voluntarily critiquing vocational training projects of rehabilitation patients (Coney, 165). This one example of an incidental function undertaken by a maintenance group at one hospital is, so far as we know, unique, but in any event does not involve direct patient care and is clearly insufficient to obliterate their distinct functions. Finally, the industry gave no examples of skilled maintenance employees being cross-trained into other job groups such as clericals or service employees and, cross-training from service to skilled maintenance positions or technical positions is virtually unknown. (Stickler, Chi I 9, 33-37; Houston, 4026; O'Cleireacain, 5467-68; McKinney, 5481.)

### H. Other Issues

1. *Costs of multiple units with reference to skilled maintenance.* Assuming the relevance of the potential cost to the industry of negotiating in additional units, the evidence does not support the conclusion that units of skilled maintenance employees would necessarily have any adverse effect on hospitals' expenses. The evidence there is shows that contract negotiations for skilled maintenance units tend to be relatively short, which means relatively inexpensive (Comer, Chi II 328; Viat, 3469; Jacquin, 5378).

2. *Congressional admonition against proliferation.* The admonition against proliferation of units was directed toward problems that could be caused by having many separate bargaining units, i.e., substantial numbers of strikes interfering with the delivery of health care services, wage whipsawing, and jurisdictional disputes. As shown above, there is little or no evidence that the existence of separate skilled maintenance units has resulted, or would in the future result, in these problems. As a practical matter, permitting separate skilled maintenance units would not necessarily result in the creation of still additional bargaining units since most hospitals have substantially fewer organized units than the number proposed by either the Board or the unions. (Schwarz, 264, WS Table 1; Robfogel, Chi II 223; Comer, Chi II 329; Cammarata, 4425; Delaney, 4520; Muehlenkamp, 4770-71; Shea, 5163.)

During the 1973 legislative hearings on S. 794, the fear expressed by a number of witnesses was that Board precedent might permit a separate unit for each trade or craft found in hospitals. Thus, e.g., Sidney Lewine, testifying on behalf of AHA, and Richard V. Whelan, Jr., representing the Ohio Hospital Association, noted with apprehension the proliferation that would result if the Board were to grant a separate unit to each construction craft such as stationary engineers, carpenters, plumbers, electricians, pipefitters, and painters. (Coverage of Nonprofit Hospitals Under National Labor Relations Act, 1973, Hearings on S. 794 and S. 2292, at 128-29, and 465-66, respectively.) The Board's proposal directly takes into account this concern, which was called to Congress' attention, by putting all such separate skilled crafts into one skilled maintenance unit.

3. *The most recent Board decision.* In *St. Francis Hospital*, 286 NLRB No. 123 (Nov. 30, 1987) (*St. Francis III*), the Board held that a separate maintenance unit was inappropriate. In so doing, the Board found that the hospital's maintenance employees constituted less than 10% of the hospital's 438 service and maintenance employees, and spent approximately 80-95% of their time working throughout the hospital, thus bringing them in frequent contact with all other hospital employees. The Board further found that the hospital used independent contractors to perform difficult work, and that the sought employees shared the same basic terms and conditions of employment as service employees, including departmental supervision. The Board also noted that its finding that these

particular maintenance employees did not constitute a separate appropriate unit was based on the particular facts of the case and was in no way an expression of its view concerning the appropriateness of maintenance units in general. Based on the evidence obtained during the rulemaking hearings, it is unlikely that we would reach the same result. Thus, the evidence from the hearings shows that, in virtually all health care facilities which were the subject of testimony at the hearings, skilled maintenance employees constitute a discrete and distinct group of employees. They perform functions apart from those of unskilled service, maintenance, and clerical employees. Skilled maintenance employees were shown to be highly skilled as evidenced by higher educational, licensing, and training requirements. While they share some common terms and conditions of employment with other hospital personnel, these employees uniformly have higher wages than service and clerical employees and have a number of bargaining interests separate and distinct from those of non-maintenance employees, such as access to craft related education and training programs, tool supply allowances, safety equipment and practices, portable pensions, and the like. Moreover, while skilled maintenance employees do work throughout the entire hospital, their contact with non-maintenance employees is brief and limited. Finally, the hearing evidence shows that transfers are rare in the industry and that skilled maintenance employees have a separate internal and external labor market.

### I. Conclusion

For the above reasons, we find that a unit of skilled maintenance employees is separately appropriate for collective bargaining purposes. Although the number of employees in such a unit will be relatively small, their work bears little relationship to that of other hospital employees. It is, essentially, a non-health care occupation involving skills, interests, and job markets largely separate from the hospital itself. For that reason, to require unions to organize and represent skilled maintenance employees as part of a larger group of unskilled employees performing health-related jobs within the hospital is both unrealistic and inefficient. Hence, we have decided that the final rule should provide for separate skilled maintenance units.

The IUOE contends (IUOE Br. 9), and we find, that skilled maintenance units should generally include all employees

involved in the maintenance, repair, and operation of the hospitals' physical plant systems, as well as their trainees, helpers, and assistants. However, evidence from the hearings shows that it may not always be possible to identify in advance those employees properly included in this unit, partly because employees performing essentially the same functions are classified differently in different hospitals. Thus, for example, in Los Angeles and San Francisco all employees represented by the IUOE in skilled maintenance units are classified as stationary engineers regardless of their particular job functions (Viat, 3457-58; Hach, 5318) whereas in Chicago, New York, and New Jersey most health care employers have retained craft titles for their employees. (Schloop, Chi II 203; Schloop affidavit; Hach, 5318; Giblin, 5383.) In addition, many skilled maintenance classifications are subdivided by skill or experience level, e.g., master level, journeyman level, apprentice, and/or helper. Among the employee classifications which should generally be included in such units are carpenter, electrician, mason/bricklayer, painter, pipefitter, plumber, sheetmetal fabricator, automotive mechanic, HVAC [heating, ventilating, and air conditioning] mechanic, maintenance mechanic, chief engineer, operating engineer, fireman/boiler operator, locksmith, welder, and utility man. (Health Care Occupations: A Comprehensive Job Description Manual, Chapter XXXII; Hammond, Exh. 12, affidavits of Bowen, Tighe, Chambers, Scheb, McWade, Scadden, Kelly, Schloop, Gindorf, Fox, Lane, Belfi, and Bess.) As noted above, sometimes relatively unskilled utility workers are included, either if they are involved in the maintenance, repair, and operation of hospitals' physical plant systems (Viat, 3460), or if they are part of a separate maintenance department. This list is not exhaustive; rather, it is illustrative of the types of employee classifications exhibiting the characteristics which the rulemaking record shows are typical of employees included in skilled maintenance units. Because of this variation, in some instances it may be necessary to decide by adjudication the unit placement of individuals in particular job classifications. However, this is also true with respect to technical and business office clerical units, for example. It does not defeat the basic appropriateness of the unit as found in this rulemaking proceeding.

## X. Business Office Clericals

### A. Introduction

In the Notice of Proposed Rulemaking, the Board tentatively determined that business office clericals should be included in a unit of service and maintenance employees, rather than represented in a separate unit. 52 FR 25147. Among the reasons for including business office clericals in the broader service and maintenance unit were that they:

- (a) Often share many terms and conditions of employment with service and maintenance employees;
- (b) Have regular and frequent contact with service employees;
- (c) Are engaged in recordkeeping as are ward clericals, technicians, nurses, and physicians;
- (d) Have not been represented historically by labor organizations specializing in representing business office clericals; and
- (e) Their inclusion in the broader unit will help unit proliferation.

After carefully considering the evidence amassed during the hearing, contrary to our tentative determination we have concluded that for the following reasons the business office clericals constitute a separate appropriate bargaining unit.

### B. The Record Supports a Finding That Business Office Clericals Constitute a Separate Appropriate Unit

1. *Job duties and functions.* Evidence from the rulemaking hearings shows that although many hospital employees perform some recordkeeping functions, business office clericals perform substantially different functions from those performed by other employees (WS Holtz at 8-9; WS O'Neil at 1 & 5526-29). Business office clericals are primarily responsible for a hospital's financial and billing practices (WS Winn at 6-7), and deal with Medicare, DRGs, varying price schedules, multiplicity of insurance types, and new reimbursement systems (WS Schoen at 9; Berliner, 5599-5600). Increasing computerization of financial management has led to specialization and has reduced the clerical duties of other hospital employees (WS Schoen at 11).

One argument advanced by some employers is that many different professional and non-professional classifications use computers; 2/3 of the hospitals are considering information systems technology which will enable nurses to enter and read programs reporting patients' test results, medication, and scheduling (AHA Br. 45 citing article in *Modern Healthcare*). Unlike these employees, however,

business office clericals do not engage in any form of patient care and are not responsible for the patients' physical or environmental health (Wilkinson, 4973-76; Bryant, 116-118). Moreover, although other clerical and professional employees may be utilizing information systems technology and video display terminals (VDTs), and despite the existence at the University of Alabama (Birmingham) of a training program for "clerical technicians" who learn to do billing, perform blood tests, and take x-rays (AHA Br. attachment 5), it has not been shown that service workers or clinical technicians perform functions similar to those performed by the business office clericals, i.e., they are responsible for selecting, completing, or interpreting business forms using computers, keyboard terminals, and typewriters. Nor was it shown that the University of Alabama program was duplicated elsewhere in the country, or that any person from the program was ever placed in a hospital. (AFL Br. 77). Moreover, the evidence indicates that this program was clearly intended for technical employees (Stickler, Chi I 37-38).

2. *Education.* Business office clericals generally are required to have a higher level of education than service and maintenance employees, i.e., a high school diploma and specific clerical skills, and a majority of business office clericals have some college background and formal clerical training (WS Nussbaum at 2; WS Cornfield at 8). Moreover, because of the increased complexity of the hospitals' financial operations, including the introduction of DRGs, hospitals have begun to require more training for business office clericals, and to require skills in such areas as programming, coding, abstracting, and billing procedures (WS Schoen at 9; WS Ryan at 1-2). By contrast, service workers have minimal educational requirements, prior work experience is unnecessary, and they are not required to possess special business-oriented skills (AFL Br. 53; WS Cornfield at 8). There is some evidence that admitting clerks and medical records librarians receive vocational training at many of the same business or trade schools as purchasing clerks and accounts receivable clerks (WS Coney at 5). However, no specific evidence was provided regarding the type of training each receives. The fact that some employees are attending the same schools does not establish that they are receiving identical training. Consequently, we do not place great weight on this factor; in any event, whether some of these other

classifications are also business office clericals is a matter we do not here decide. Further, business office clericals undergo constant retraining to update current skills or acquire new skills as financial operations are updated (WS Holtz at 5, 9-10).

3. *Terms and conditions of employment.* Although clericals often share some terms and conditions of employment with non-professional employees, especially benefits, evidence from the rulemaking proceeding clearly shows other, significant differences between the business office clericals' terms and conditions of employment and those of the service and maintenance employees. Salaries paid to business office clericals reflect their higher skills and training; a 1985 BLS wage survey shows that business clericals on average earn \$2,000 more than the top service jobs (WS Schoen at 12; WS O'Neil at 3). Unlike service and maintenance employees, business office clericals may be permitted to smoke and eat at work stations, and have different dress requirements and health and safety concerns. In addition, unlike most service employees who work varying shifts and weekends, business office clericals generally work one shift, 5 days per week. (AFL Br. 59; WS Nussbaum at 5; Bryant, 116-118; Booth, 3688; WS O'Neil at 2.)

4. *Supervision.* The differences in skills and functions are underscored by the separate supervision of business office clerical departments, which has resulted from the almost universal centralization of business office functions (Berliner, 5597; WS Schoen at 9-10 & 5173). The SEIU survey of 250 facilities showed that at 100% of the facilities, business office clericals have separate supervision. Although clericals occasionally may share supervision with other non-professionals (Briguglio, 5300), the evidence establishes that business office clericals regularly have a separate supervisory hierarchy; ultimate supervisory responsibility generally rests with financial administrators as compared to the ultimate supervisory authority for service employees which rests with administrators overseeing patient care (WS O'Neil at 2; WS Holtz at 4, 6-7). Two examples were given in which clericals and other employees report to the same individual (Briguglio, 5300; Comment 157, Halifax Medical Center). Nevertheless, we are persuaded that, with few exceptions, business office clericals are separately supervised. Moreover, in one important respect, the nature of the supervision received by the business office clericals is unlike the traditional supervision

received by service and maintenance employees. Technology enables supervisors to monitor closely the output of the business office clericals, measured in keystrokes, paper output, volume of bills processed, time on terminals, and phone calls; this monitoring increasingly is used for purposes of discipline. (WS Holtz at 6-7; WS Nussbaum at 2-3.)

5. *Interaction.* Contrary to our original impression, the evidence shows that business office clericals are physically isolated from other non-professional employees and, therefore, have little contact or interaction with them. (Dretchan, 5002; Bryant, 116-118; Booth, 3689-90; WS Nussbaum at 4). The ballooning costs of new construction, as well as increased technology, have resulted in many instances in hospitals' moving administrative offices outside the health care facility into existing buildings at other locations (Berliner, 5602; WS Schoen at 10). Of 250 hospitals surveyed, 35% of the business offices are located in a separate building, 25% are located in a separate wing of the hospital, and 28% are located on a separate floor (WS Shea at 17; WS McKenna at 3-4). Further, centralized processing of information and the increasing use of computerized communication of data continue to reduce even further the potential for physical interaction (WS Schoen at 14).

6. *Career paths and job mobility.* Business office clericals have few avenues of advancement within health care facilities; rather, they have a separate and increasingly well-defined external labor market (Wilkinson, 4980; WS Ryan & 4749-50). Business office clericals are hired almost exclusively from the external labor market, and hospitals hire business office temporaries as replacements rather than using other hospital personnel. The external market also influences salary scales since hospitals compete with other industries for these employees. (WS Schoen at 11-12; hospitals use BLS wage surveys in determining salaries for business office clericals.) Consequently, while service employees generally remain in health care facilities (WS Berliner at 9-10), business office clericals look elsewhere for other positions if they are dissatisfied.

There is minimal interchange, either permanent or temporary, between employees in service, maintenance, technical or professional jobs and those in business office clerical positions (Ryan at 1-2). Moreover, although one witness testified generally that some clericals receive training to provide direct patient care (Stickler, 16-17 & WS

Rhodes at 7), there were no examples of instances where this had actually occurred. There would appear to be little cross-over from clerical positions to patient care positions. Further, the evidence reveals that job mobility between service employees and business office clericals is basically nonexistent and, with the upgrading of skills and additional training received by business office clericals, it is becoming even less feasible (WS Lewis at 2-3; WS Blake at 2; WS O'Neil at 2; WS Berliner at 7). In some hospitals, admitting clerks and medical records librarians, and purchasing clerks and accounts payable clerks are interchangeable and may substitute for each other, and technicals and professionals may handle clerical operations on the night shift (WS Coney at 5; Comment 263, Huntsville Memorial Hospital). Nevertheless, for the most part, even clinical clerical workers cannot shift into business office clerical positions without a substantial degree of retraining and reskilling (WS Berliner at 7). There was testimony that hospitals prohibit or discourage bidding between the business office clerical and service and maintenance positions; however, even where hospital-wide posting of vacancies is required and employees use their seniority to bid, there is little cross-over between service and maintenance employees and business office clericals (WS Shea at 18; WS Roitman at 1.)

7. *History of representation.* The appropriateness of separate business office clerical units is supported by a history of representation separate from service and maintenance employees. For example, at 250 hospitals surveyed by SEIU, business office clericals sought representation in 71 hospitals, of which 46 were separately organized, compared with service employees who organized in 195; a survey conducted by NUHCE of 200 post-1974 elections in 100-plus bed hospitals showed 37 involved business office clericals, of which 33 were separate units (WS Shea at 15-16; Muehlenkamp, 4767-70). There are 92 separate business office clerical units represented by AFL affiliates in private sector hospitals. (AFL Br. App. A). Local 1199 had no combined non-professional units until *St. Francis II* (Friedman, 5035-41). Although there are business office clericals represented in combined service and maintenance units (Stickler, Chi I 23-31 giving examples), some combined units may have resulted from an effort to minimize delay or to comply with *St. Francis II* (AFL Br. 70). The weight of the evidence establishes that business office clericals predominantly have been separately represented.

8. *Bargaining interests.* While all employees have some similar bargaining concerns, i.e., wages, hours, and fringe benefits, business office clericals have a number of different interests, e.g., pay equity, performance monitoring, productivity standards, career mobility, automation, and VDT stress, as opposed to concerns of service employees such as job security, subcontracting, economic survival, supplies, shift rotations, infectious disease, injuries, and patient care (WS Nussbaum at 3; WS Lewis at 2; WS Holtz at 12-13; WS Barton at 1; AFL Br. 64-65).

Despite the differences, in some instances business office clericals have bargained jointly with other non-professional employees and contracts have covered both non-professional employees and business office clericals. In 1987, Mercy Hospital negotiated a contract which included over 50 classifications in one overall non-professional unit (AHA Br. attach. 15) (One classification included such jobs as accounting clerk and lab department secretary and both received identical wage rates and wage increases for the duration of the contract). See also Comment 162, AMI; Saporta, 5142; Comment 154, Michael Reese Hospital, for other examples. However, in some cases where business office clericals negotiated together with service employees and the resulting contract provided for identical terms and conditions of employment, wages and upgrade negotiations often remained separate, and clericals had different bargaining representatives. In one instance incentive bonuses tied to receivables were offered only to business office clericals, and in others the contracts contained separate wage schedules for business office clericals. (WS Holtz at 10; WS McKenna at 3-4.) At Roosevelt Hospital, although the union bargained jointly for clericals, technicians, and service and maintenance employees, the clericals had their own bargaining delegates, contracts for business office clericals and service and maintenance employees were administered separately, and there was no interchange of delegates or exchange of grievance handling (Colbert, 5020-22).

9. *Proliferation.* Contrary to our concern, as expressed in the NPR, there was no evidence adduced at the rulemaking hearings indicating that a separate unit of business office clericals will lead to the proliferation of bargaining units in the industry. The admonition against proliferation of units was directed toward problems that might be caused by having many

separate bargaining units, i.e., substantial numbers of strikes interfering with the delivery of health care services, wage whipsawing, and jurisdictional disputes. There is no evidence that the existence of a separate unit of business office clericals would result in such problems. There were no examples of sympathy strikes by business office clericals in support of service and maintenance employees, and no examples of leapfrogging because of a separate business office clerical unit. (WS Wynn at 3.) In one hospital as to which there was testimony about separate units, there was no evidence of jurisdictional disputes. (WS Gray at 4; Michael Reese Hospital). One argument advanced was that because a business office clerical unit will not include all clerical classifications, e.g., ward clerks, there is a potential for conflicts between clerical groups. There was no evidence of specific examples, and we accord no weight to the theoretical possibility of a conflict.

10. *Legal Precedent.* Legal precedent supports finding separate business office clerical units appropriate. The Board has recognized the appropriateness of separate business office clerical units in every other industry covered by the Act, and until *St. Francis II*, in the health care industry. See e.g., *Armour & Co.*, 15 NLRB 268 (1939); *Legal Services for the Elderly Poor*, 236 NLRB 485 (1978); and cases cited in AFL Br. pp 71-72. From 1974-1984, the Board did not find any business office clerical unit to be inappropriate (See NLRB Exh. 5, revised). Moreover, Senator Taft's industry-sponsored bill would have explicitly provided for separate office clerical units.

In *Baker Hospital*, 279 NLRB No. 38 (Apr. 16, 1986), the Board required the inclusion of business office clericals in a unit of service and maintenance employees. In so doing, the Board found that business office clericals and service and maintenance employees received the same fringe benefits and were covered by the same personnel, salary, promotion, seniority, transfer, and disciplinary policies. The Board also found that there was a significant amount of contact between clericals and unit employees. The Board held, therefore, that there was an insufficient disparity of interests between business office clericals and service and maintenance employees to justify excluding the clericals from the unit. After considering the substantial empirical evidence adduced in the rulemaking proceeding, we find it unlikely that we would reach the same

result. The evidence from the hearings shows that business office clericals constitute a distinct group of employees. They perform substantially different functions, have a greater degree of education and training, utilize different skills, are separately supervised, receive higher wages, have a number of distinct bargaining interests, have little or no interaction or interchange with other employees, and frequently are located in geographically separate offices.

11. *Identification of business office clericals.* The evidence from the hearings indicates that there may be other clericals, e.g., ward clericals, medical records clericals, physicians' secretaries, and admitting office clericals who perform functions similar to those performed both by service employees and business office clericals or else perform a combination of functions such that they cannot be readily classified as one or the other. To date, however, the Board has decided the placement of these categories of employees on a case-by-case basis, generally excluding these classifications of employees from business office clerical units. See *Mercy Hospital of Sacramento*, 217 NLRB 765 (1975). There, the Board found a separate unit of business office clericals appropriate, and placed ward clericals in another unit because their work was more closely related to the function performed by personnel in the service and maintenance unit. The precise placement of particular classifications which may be disputed in a particular case is, for the time being, left to the case-by-case adjudicative approach.

### C. Conclusion

Business office clericals share some terms and conditions of employment with all other service and maintenance employees, have occasionally participated in joint bargaining, and may even have been covered by the same contracts. However, we are more persuaded by the evidence developed at the hearing as to their separate supervision, their different and specialized skills and education, their minimal interchange and contact, their different career paths and job markets, their maintenance of a separate identity even where bargaining was in a larger group, and, finally, the recent development whereby more and more business office clericals are being moved out of the hospital to different buildings or facilities. We believe that the weight of the evidence strongly supports finding separate business office clerical units appropriate.

## XI. Other Non-Professionals

Based on our analysis of the evidence adduced, we have found appropriate separate units of technicals, business office clericals, and skilled maintenance employees. All remaining service and non-professional employees<sup>24</sup> shall, therefore, constitute a separate appropriate unit, where requested.

## XII. One Hundred Bed Distinction

The proposed rule suggested establishing a different unit configuration for hospitals over 100 beds than for those of 100 beds or fewer based on the Board's belief that hospital size (as determined by the number of beds) was correlated with integration of labor, and that smaller hospitals were more functionally integrated than larger hospitals, and could function with fewer, broader units. However, the record does not support that belief, and the Board has concluded that its rule regarding units in acute care hospitals should apply regardless of hospital size.

The vast majority of representatives of both unions and employers appeared to agree that hospital size is not well correlated with integration or division of labor, and opposed a rule differentiating between large and small hospitals. Examples of unions opposing the distinction were: AFL Br. 139-140; ANA 4919-20; SEIU, 5215; Hospital Professionals and Allied Employees of New Jersey, 125. Over 40 employers registered specific or general criticism of use of a 100 bed distinction, including AHA, Br. 48; League of Voluntary Hospitals, 226-229, 254; Hospital Council of Western Pennsylvania, 4395; Comment 5, Holy Redeemer Health Systems; Comment 15, Methodist Health Systems; Comment 25, Bradley Memorial Hospital; Comment 78, Greater Cincinnati Hospital Council; Comment 82, Humana, Inc.; Comment 104, St. Francis Hospital. Experts in the field agreed with the parties' position (Rosen, 4663; McKinney, 5519-20). Only a handful of commentators supported the use of any distinction based on the number of beds. For example, Comment 11, National Rehabilitation Hospital; Comment 105, Mass. Hosp. Assn.

A survey by UFCW comparing the number of beds and the staffing in hospitals of varying sizes in five states showed a wide variation in staff size (UFCW Exh. 6-11). For example, in New York State, among 46 hospitals surveyed with 20-100 beds, one hospital with 20 beds had over 200 employees, one with

21 beds had 50 employees, one with 20 beds had 209 employees, while another with 129 beds had 181 employees. (UFCW Exh. 11). In California, one hospital with 107 beds had 1011 employees, while another with 110 beds had 299 (UFCW Exh. 6). In Illinois, hospitals with 77 and 91 beds had 279 and 429 employees, respectively, while another hospital with 129 beds had 126 employees (UFCW Exhs. 5, 6). Similar variations, and lack of correlation, appeared throughout the exhibits.

Lack of correlation between number of beds and number of employees may be attributable to specialization or the amount of outpatient services (UFCW Exh. 1-11; WS Willman & 4500; Rosen, 4663; AFL Exh. 20). Thus, it appears that staffing size and patterns might correlate more closely with the nature of services than with bed number (AHA Br. 47; New Jersey Society for Health Care Human Resources Administrators, 439).

The AHA correctly noted that the Board's proposal for a 100 bed distinction did not clarify how it defined the term "bed" (AHA Br. 47). The record shows that there are several meanings of the term in health care facilities. A bed may be licensed or unlicensed; if licensed a bed may be occupied or unoccupied (AHA Br. 47; Comment 52, Hillcrest Baptist Medical Center). Hospitals may change the number of licensed beds more than once a year (California Association of Hospitals and Health Systems, 3229). Occupancy rates vary; a hospital may have occupancy substantially below the number of its licensed beds (Comment 1, Lancaster Fairfield Hospital; Comment 115, National Healthcare, Inc.: rural areas may have only 25-30% patient census). The number of staffed beds (based on average projected occupied beds and patient acuity) can differ from the number of occupied beds (Comment 186, Hiawatha Community Hospital; Comment 191, Trinity Lutheran Hospital.) Beds may also include swing beds (beds that swing between acute care and nursing or long-term care) (Missouri Hosp. Assn., Chi II 265).

The Board also notes that to the extent unions and employers addressed the standard to be used if the Board determined to have a bed-number distinction, they rejected the use of 100 beds as an appropriate bed measure but did not reach a consensus as to the appropriate number of beds to use. For example, some unions suggested using the definition of small hospitals employed by the U.S. Department of Health and Human Services in calculating reimbursements under Medicare, which is those hospitals with

fewer than 50 licensed beds. (AFL Br. 141; WS Sweeney.) The AHA suggested a 400 bed cutoff (AHA Br. 141), but other employers suggested 250 beds (Comment 169, Columbus Hospital); 300 beds (Comment 126, Arlington Memorial Hospital); 450-500 beds (Comment 1, Lancaster Fairfield Hospital); and 500 beds (Comment 11, National Rehabilitation Hospital).

The Board's decision to drop the 100 bed distinction is based on the evidence provided by the parties regarding the lack of correlation between bed number and hospital staff, the multiplicity of definitions for the term "bed" in health care, the lack of consensus on the number of beds dividing large and small hospitals, and the parties' general opposition to use of a distinction based on the number of beds.<sup>25</sup>

## XIII. Nursing Homes

The only health care facility, other than hospitals, covered by our proposed rule was nursing homes. In so doing, we tentatively determined that the appropriate bargaining units for this type of health care facility should be the same as that for small hospitals, i.e., (1) all professionals, (2) all technicals, (3) all service, maintenance, and clericals, and (4) all guards. After careful consideration of all the evidence presented at the hearings, however, we have concluded that the rule should not apply to nursing homes.

To a larger extent than acute care hospitals, nursing homes vary both in size and type of service rendered. Generally speaking, there are three basic types of nursing home facilities: skilled nursing, intermediate care, and residential care. Skilled nursing homes provide 24-hour inpatient nursing care to chronically ill or stable convalescent patients, are state licensed, and are eligible for both Medicare and Medicaid. Intermediate care facilities also provide 24-hour inpatient care, but care is less intensive and more oriented to daily living. These homes are also state licensed or certified but are eligible only for Medicaid. Residential care facilities meet only social needs, not medical, and are not licensed. (Durham, 3164-66, 69, 71, 83; Comment 155, Indiana Healthcare Assn. (IHA).) The facilities range in size from 10-500 patients (Harris, 4294; Comment 284, Ryan). One-third have a capacity for fewer than 50 residents,

<sup>25</sup> We note, parenthetically, that the information we have acquired as to the relationship between staffing and number of beds most likely would not have been acquired in an adjudicatory proceeding, and provides further evidence of the value of rulemaking in obtaining industry-wide information unavailable in a case-by-case approach.

<sup>24</sup> Excepting guards, of course, who must be placed in a separate bargaining unit. See section 9(b)(3) of the Act.

one third for 50-99, and one-third for over 100 (Harris, 4304).

Unlike hospitals, nursing homes are populated primarily by the elderly and provide long term care rather than medical treatment of a specific illness. Consequently, nursing home staff are concerned not only with their residents' physical well-being but also their social and psychological needs. Accordingly, there is less diversity in nursing homes among professional, technical and service employees, and the staff is more functionally integrated. (Harris, 4294-95; Willman, 4501-02.) Generally, nurses provide a less intensive, lower level of care to patients in skilled and extended care facilities, and thus receive lower salaries than that paid in acute care hospitals (AHA Br. 6-7 citing *Modern Healthcare*, Jan. 3, 1986). In addition, RNs in most nursing homes never administer oxygen or assist in surgery, and therefore generally have no interest in or need for acute care pay differentials or for specialization (Comment 155, IHA; Shepard, 4962). Also, there is for the most part little difference in the duties of LPNs and nurses' aides (Comment 155, IHA). Both are primarily responsible for providing nursing care to patients (Comment 155, IHA, affidavits of Miller and Price; AHA Br. 6 citing *Modern Healthcare*, Jan. 3, 1986). Indeed, almost no aspect of nursing home care is in the exclusive domain of any one group of employees (Harris, 4295). Thus, there appears to be a greater overlap of functions as well as a greater work contact between the various nursing home non-professionals (Willman, 4501-02; Comment 155, IHA, affidavits of Townsend and Turner-Simpson).

Skilled care homes also differ from hospitals in that a ratio of 50 patients per nurses' station is ideal for nursing homes, whereas the typical ratio for acute care units is half that number (AHA Br. 7 citing *Modern Healthcare*, Jan. 3, 1986).

Also unlike hospitals, there are few professionals employed at nursing homes, and of those, most are RNs who serve as head nurses or charge nurses primarily performing administrative duties (Durham, 3190; Willman, 4501-02; Saporta, 5145-46; Bullough, 4656-57; Comment 155, IHA, affidavits of Davy, Townsend, Turner-Simpson, and Higdon). There are also few business office clericals. In a typical 100 bed nursing home, the business office will have one or two employees. In a 100 bed acute care hospital, the office consists of payroll employees, accounts receivable and payable employees, data processing

employees, and others. (Comment 155, IHA.)

Greater differences in the size and purpose of nursing homes have resulted in greater differences in their organization, regulation, and staffing patterns. For example, in very large homes, business office clericals may be physically separated from the home, and have little employee or patient contact. In very small homes, the business office is located next to the patient care areas and there is continuous contact with the patient care staff. (Comment 155, IHA; Durham, 3166-67.) Duties of staff also vary with the size of the institution. In a small, 10-resident facility, the staff will have overlapping responsibilities, and thus an overall unit would be appropriate. In a large, skilled care facility with specialized units (see *infra*), more than one unit might be appropriate (Harris, 4298). In an intermediate care facility which also cares for the mentally disabled as a result of trauma, there may be a separate group of employees, such as psychiatrists, who have distinct supervision and little contact with other professionals (Durham, 3170).

Although most homes are regulated by the state, regulations with respect to staffing patterns and employee qualifications vary widely from state to state (Harris, 4296-97; Comment 284, Ryan). For example, Connecticut requires more skilled nursing care than Iowa, and in some states, skilled nursing facilities must have 24-hour RN coverage. Seventeen states have mandated nurses aide training programs ranging from 20 hours to over 100 hours. A majority of states have no specific training requirements. In Massachusetts, the activity director and the social service director must have baccalaureate degrees; in other states, their formal qualifications are less than those of a nurses' aide. (Harris, 4297; Comment 284, Ryan; Comment 155, IHA.) Also in Massachusetts, as in other states, homes must be staffed by LPNs or RNs, and they are required to provide substantial direct patient care. In contrast, in Indiana, with lesser staffing requirements, nurses' aides provide direct patient care, and LPNs perform RN-type duties such as distributing medication and assisting doctors. (Comment 155, IHA.)

The nursing home industry is also in a period of rapid transition. It is currently undergoing enormous growth as the population of older persons increases and family responsibility for older parents lessens. In addition, many long term facilities will increasingly offer nontraditional specialized services, i.e.,

head and spinal cord injury units, intensive rehabilitation, sub acute care, Alzheimers, respiratory therapy, hospice care, nutrition, AIDS, home health care, and care for ventilator dependent patients. (Harris, 4299; Comment 284, Ryan; Durham, 3161; AHA Br. 6 citing *Modern Healthcare*, Jan. 3, 1986.) These services require different staffing needs. For example, in most Alzheimers' units, nurses' aides receive psychological training in order to respond properly to their patients' behavior, and LPNs are required to perform recreational, educational, and social activities that are normally done by service employees such as recreational aides. A head injury unit requires many more professionals than are usually present in a nursing home facility. An AIDS facility might need more counselors. (Harris, 4300-4301; Comment 284, Ryan.) The professional and technical staff in a specialized service area such as a coma unit may also be far more integrated than RNs and LPNs who work in the nursing area (Comment 306, Harris).

For some or all of the reasons discussed above, numerous witnesses were opposed to applying the rule to nursing homes (Durham, 3179; Harris, 4293-94; Comment 284, Ryan; Comment 155, IHA; Comment 155, IHA, affidavit of Miller; Comment 3, Jefferson Davis Nursing Home). Three witnesses would support a two unit approach (Comment 22, Louisiana Nursing Home Assn; Comment 27, Jefferson Manor Nursing Home; Comment 34, Lewisburg United Methodist Homes). Several commentators thought the Board lacked sufficient experience with respect to nursing homes to formulate a rule as to such facilities (IUOE Br. 2, fn 1; Durham, 3179; Harris, 4304). Board statistics show that only 20% of the elections in the health care industry have involved long term care facilities (Harris, 4302). Also, case-by-case determinations of appropriate units in nursing homes have not caused undue litigation (Comment 155, IHA). In fact, to the best of our knowledge there is not a single published case since the health care amendments in which the Board had to decide appropriate units in nursing homes, and no party testified that it had experienced problems with case-by-case determinations as to this issue.

In view of the evidence set forth above, we have decided to exclude nursing homes from the rule. The evidence shows that there are not only substantial differences between nursing homes and hospitals but also significant differences between the various types of nursing homes which affect staffing patterns and duties. In the absence of a

measure of uniformity of operation, it would be difficult to establish uniform rules with respect to appropriate bargaining units. It also appears that there is no need at this time for a rule with respect to nursing homes as there has been no prolonged litigation and no party has expressed any problems in this area. We, therefore, conclude that it is best to continue a case-by-case approach with respect to nursing homes. For those facilities which provide both hospital and nursing home services, if the facility is primarily an acute care hospital, it will be treated in its entirety as a hospital; if primarily a nursing home, it will be considered a home, and outside the rule. To do otherwise would further fractionalize bargaining within the facility, and cause more, rather than less, proliferation.

#### XIV. Specialized Hospitals

Some employers suggested that the Board make a separate rule for specialty hospitals, arguing that they are neither acute care hospitals nor nursing homes (Comment 172, New England Sinai Hospital; King, 4230-31). The evidence with regard to most of the specialty hospitals which participated in the rulemaking did not support a conclusion that there are fewer traditional distinctions between employee groups. However, the evidence demonstrated that psychiatric hospitals, are, for a number of reasons, in a category apart, and the Board has decided to exclude psychiatric hospitals from application of the rule.

Initially, the industry's claimed trend toward one-specialty hospitals is not supported by statistics. The AHA classifies 90% of U.S. private, acute care hospitals as general; of these, 98% are general medical and surgical hospitals and only 2% are pediatric or rehabilitation hospitals. Nine of the remaining ten per cent are psychiatric, a category apart. (AFL Exh. 7, 8.) In California, where the industry contends the trend is particularly strong (Dauner, 3206), there are relatively few specialized hospitals (Silberman, 3209-12).

Most of the comments submitted to the Board from specialty hospitals apart from psychiatric hospitals did not argue that these hospitals should be treated differently from general acute care hospitals. See for example, Comment 4, Le Bonheur Children's Medical Center; Comment 10, National Rehabilitation Hosp.; Comment 123, Children's Memorial Hosp.; and Comment 303, Children's Medical Center, Akron, regarding children's hospitals. Although Children's Medical Center of Dallas (Comment 276) states that in that

hospital RNs integrate patient care with some other professionals, and Cardinal Glennon Children's Hospital (Comment 271) discusses use of the team approach, neither suggests that children's hospitals differ from general acute care hospitals for purposes of rulemaking. While Shriners Hospitals For Crippled Children (Comment 238) were unique in their method of obtaining funds and charging patients, they operate like other acute care hospitals, subscribing to the same rules of licensure and accreditation.

Two hospitals, Children's Hospital of Dayton and Children's Hospital of Cincinnati presented more details regarding the operation of children's hospitals (Testimony of Graybill, Sokatch; Comment 288, Graybill). There is evidence that children's hospitals have higher acuity and outpatient activities than general acute care hospitals, and as a result have more full time equivalent positions and higher budgets than comparably sized general acute care hospitals (Comment 288). There is also evidence that RNs have a somewhat higher level of interaction with other professionals, for example, interacting with respiratory therapists on ICU units and transports (Graybill, 4183), working on special teams like bone marrow transplants, interacting with pharmacists regarding allergies, and tube sequencing (Comment 288). Even assuming that respiratory therapists are professionals, a status the Board has rejected on some occasions, (see for example, *Samaritan Health Services*, 238 NLRB 629, 638 (1978)), the interaction of RNs with other professionals, including presence on teams, is similar to that shown in other hospitals, and RNs' duties were not shown to be different merely because they may work on teams. As in other acute care hospitals, most nurses in children's hospitals are directly or indirectly supervised by other nurses (Graybill, 4147-48, 4164).

Comments from rehabilitation hospitals show similar arguments to those made by general acute care hospitals: that there is increased contact between RNs and other professionals, that there is some cross-training and utilization, that teams are used, that a hospital has across-the-board personnel policies (Comment 172, New England Sinai Hospital; Comment 131, The Institute for Rehabilitation and Research). These commentators did not request special treatment for their hospitals. Of course, to the extent rehabilitation hospitals may be long term, they will not fall within the parameters of the Board's rule, *infra*,

which applies only to hospitals whose average patient stay is less than 30 days.

Nor was there a suggestion made by commentators of other, non-psychiatric, single specialty hospitals that their type of hospital merited special rules. For example, the Board received evidence from Springfield General Hospital (Comment 201) and Oklahoma Osteopathic Hospital (Comment 300), both osteopathic hospitals, in opposition to the rulemaking, but not claiming a special status for specialty hospitals.

As noted above, the evidence received on psychiatric hospitals supports an exception for this specialty. Psychiatric hospitals constitute a substantial portion (9%) of private hospitals in the U.S. (AFL Exh. 7). Even the AFL, the only union which took a position on psychiatric hospitals, provided a mixed case for including these hospitals under the rule. Thus, while the AFL argued that psychiatric hospitals which provide short term care are acute care hospitals, it recognized that there is evidence to suggest that at least some professionals play different roles in psychiatric hospitals than in acute care hospitals (citing Albanese/Caswell, Chi I 148-165). Further, the AFL noted that the Board has treated psychiatric facilities differently from other hospitals. Thus, *Mt. Airy Psychiatric Center*, 253 NLRB 1003 (1981), was the only pre *St. Francis II* case in which the Board refused to find appropriate a separate RN unit. Finally, even the AFL acknowledged that the Board might wish to exclude exclusively psychiatric facilities from the rule. (AFL Br. 140, fn.)

The two main industry representatives who presented evidence on psychiatric hospitals strongly urged that psychiatric hospitals not be considered acute care hospitals for purposes of rulemaking. Most of the evidence submitted with regard to psychiatric hospitals came from the National Association of Private Psychiatric Hospitals (Comment 307, Thomas) and from Charter Medical Corporation (Albanese/Caswell, Chi I 148-165). The National Association represents a substantial majority of private psychiatric hospitals in the U.S. Charter Medical represents about 60 psychiatric hospitals. Therefore, the Board considers their evidence to be representative of psychiatric hospitals in general. The other employers representing psychiatric hospitals agree that psychiatric hospitals operate in a distinct manner (Comment 110, Charter Lakeside Hosp.; Comment 35, Massachusetts Chapter of the National

Association; Comment 29, Glen Eden Hospital; Comment 120, HCA Belle Park Hospital; Comment 168, Camelback Hospitals; Comment 298, Palo Verde Hospital).

The evidence showed that unlike other acute care hospitals, psychiatric hospitals do not provide patient care for the physically ill. RNs are not the primary facilitators of health care in psychiatric hospitals. Many professionals participate hands-on with patients. Regardless of which of three basic models a psychiatric hospital follows: medical, milieu, or combined, the programs are highly integrated. RNs' work is closely integrated with the work of clinical psychologists, counselors, social workers, and various types of therapists in a treatment plan as designated by doctors and program coordinators.

There are more professionals other than doctors and RNs in psychiatric facilities than in other acute care facilities. The ratio of RNs to other professionals is about 1:1 regardless of facility size. It appears that non-RN professionals would not have the same concerns about being outnumbered in an all-professional unit as they have expressed regarding organization in acute care hospitals.

Psychiatric hospitals also differ from other acute care hospitals in that there are more paraprofessionals (mental health workers), and all employees are specially trained in relating to the patients as all employees' actions have an impact on patient treatment.

Further, the evidence shows that Congress has distinguished between acute care general and psychiatric hospitals under Medicare by setting special Medicare certification requirements with respect to staffing, treatment planning, teams, etc.

For all these reasons, the Board has decided to exclude "primarily" psychiatric hospitals from its rule for units in acute care hospitals and to proceed as to them on a case-by-case basis. A number of acute care hospitals have psychiatric sections, however, and such hospitals are not thereby excluded from application of the rule unless the psychiatric sections predominate. Nor do we adopt the suggestion of the AFL that the exclusion be limited to hospitals that are "exclusively" psychiatric, as we deem such an exclusion to be too limited. See the definition of "psychiatric hospital" contained in 42 U.S.C. 1395 x (f).

#### XV. Partially Organized Facilities

In the first Notice of Proposed Rulemaking, we limited the applicability of the rule to petitions for initial

organization, and commented that "historically the Board has required decertification petitions to be filed in the certified or recognized unit." (52 FR at 25145). By way of further explanation, the Board added that "when institutions are partially organized we assume that petitions for new units will follow the proposed rules, insofar as possible." (*Id.*)

As indicated *infra*, in Sec. XIX, Combined Units, the principle of *Campbell Soup Co.*, 111 NLRB 234 (1955), will continue to apply to decertification petitions. See also *Westinghouse Electric Corp.*, 115 NLRB 530 (1956). With respect to other types of petitions in partially organized facilities, we wish to amplify our previous remarks.

In the Second Notice of Proposed Rulemaking, "insofar as practicable" language [changed from "insofar as possible"] is now part of the proposed rule. However, there are two different possible situations we can envisage:

(1) Where existing units are in conformity with the new proposed final rule, we can foresee no reason that new petitions, for the same or other units, should not also be in conformity with the new rule.

(2) Where existing units are not in conformity with the new proposed final rule, we can anticipate a number of questions arising with respect to the applicability of the new rules. Where units smaller than those permitted by the rules already exist, may the incumbent petition for a residual unit? May another labor organization? What will be the continued viability of the principles enunciated in *Levine Hospital of Hayward*, 219 NLRB 327 (1975)? In Comment 304, Kaiser Permanente raised a number of these questions, claiming that "many health care employers, including Kaiser Permanente, currently have bargaining relationships with unions in units that are narrower than those set forth in the proposed rules." These issues have not been extensively addressed during the rulemaking proceeding, and it is the Board's judgment that their resolution should, for the time being, be deferred pending the adjudication of particular cases that present these issues. The Board will, in the adjudication of cases, attempt to apply the new rules to these situations insofar as practicable.

#### XVI. Facilities Covered

The Board stated in its proposed rule that the rule would apply to acute care hospitals, but did not define the term. Noting the concern of some commentators during the Board hearings with the absence of a specific definition,

the Board has carefully reviewed a variety of sources in order to reach a definition. In particular, the Board has extensively searched Federal health care legislation, agency regulations, legislative history, industry reference materials, and hearing testimony for an authoritatively based and commonly understood distinction suitable to the goals of rulemaking in the health care industry. Research reveals that there is a commonly understood distinction between acute and long term care facilities, but that the terms are not statutorily defined as such.

The Public Health Service, for example, draws a distinction between acute care and long term care facilities for the purpose of administering special projects and grants (42 U.S.C.S. 296k(a)(4) and (7) (1985)), and for administering grants to nurse practitioners and midwife programs (42 U.S.C.S. 296m(a)(2)(A) (1985)). Various sections of the Social Security Act make the same distinction: e.g., for purposes of determining the scope of review of peer group organizations (42 U.S.C.S. 1320c-3(a)(4)(A) (1986)), and for determining the application of payment in accordance with state reimbursement control systems (42 U.S.C.S. 1395ww(c)(1)(A) (1983)). Despite the repeated use of the terms acute care and long term care, however, no statutory definition is provided.

In regulations promulgated by the Department of Health and Human Services, the agency principally responsible for administering health care legislation, there is also a distinction between acute and non-acute care facilities. The term "like [similar] hospital", for example, is used in reference to the special treatment given sole community hospitals and is defined as a "hospital furnishing short-term, acute care." (42 CFR 412.92(c)(2) (1987)).

Finally, a review of the extensive legislative proceedings surrounding health care legislation and related issues likewise reveals regular use of the acute care/long term care distinction, with the terms "short term hospital" and "acute care hospital" used interchangeably. Here again, though, the use of these terms is so commonplace that no specific definition is provided.

In light of this commonplace usage, but lack of statutory or legislative definition, the Board has adopted the definition of an "acute care hospital" provided by the Dictionary of Health Services Management, edited by Thomas Timmreck, Ph.D., 1982, National Health Publishing, Owings Mills, Maryland.

The Dictionary of Health Services Management defines an "acute care hospital" as a short term care hospital with an average length of patient stay of less than 30 days. This definition was also referred to with apparent approval by the AFL in this proceeding and is used by the American Hospital Association (AFL Exh. 20, AHA Guide to the Health Care Field, 1987).

The definition of a "psychiatric hospital" for the purposes of this rule shall be that set forth in 42 U.S.C. 1395x(f). According to that definition, a psychiatric hospital is an institution which:

(1) Is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;

(2) Satisfies the requirements of paragraphs (3) through (9) in the definition of a "hospital" in that statute [§ 1395x(e)];

(3) Maintains clinical records on all patients; and

(4) Meets certain staffing requirements found necessary by the Secretary.

Coverage for the purpose of this rule, then, will include all acute care hospitals as defined. A hospital is covered if its primary service is acute care, regardless of the presence of other non-acute care units at the same facility. Psychiatric hospitals, defined above and dealt with in section XIV, are specifically excluded from coverage. Also excluded are nursing homes.

As previously indicated, rehabilitation and drug-alcohol hospitals that meet the 30-day standard are tentatively included as the Board did not receive sufficient information during the proceedings to distinguish these facilities for the purposes of this rulemaking.

#### XVII. Decisions To Which Rule Applies

The NPR suggested that the Board's new health care rule would be effective "on a prospective basis only, for petitions filed on and after (30 days after publication of the final rule)." In *St. Vincent Hospital and Health Center*, 285 NLRB No. 64 (Aug. 19, 1987), the Board indicated that while its proposed rulemaking procedure was pending, it would continue to make unit determinations in health care cases on a case-by-case basis utilizing the criteria set forth in *St. Francis Hospital*, 271 NLRB 948 (1984) ("*St. Francis II*"). The Board also reiterated that it would apply its new rule prospectively only to cases in which petitions were filed after the rule became effective. Based on comments received in the record, and upon further consideration, the Board has concluded that its rule regarding appropriate units in the health care industry shall apply to all decisions

made on and after the effective date of the rule.

Representatives of unions urged the Board to revise the proposed prospective application of the new rule. One union suggested that the rule should be effective for all cases decided after the rule was published, even if the petition was filed prior to that date (ANA Br. 197). Unions suggested that it would be unsound, if not arbitrary, to disregard the rule in pending cases, considering the vast body of knowledge the Board now possessed by virtue of its rulemaking proceedings (ANA Br. 198, AFL Br. 145-146). The AFL asserted that to apply preexisting law would deny employees the right of self organization. The AFL noted that applying the rule retroactively would not have an ill effect on pending representation cases. The AFL also noted that the Board recently gave retroactive application to its decision in *John Deklewa & Sons*, 282 NLRB No. 184 (Feb. 20, 1987), *enfd. sub nom Iron Workers Local 3 v. NLRB*, 843 F.2d 770 (3d Cir. 1988). Further, the AHA and AFL noted that the Board applied its *St. Francis II* decision retroactively, and remanded many bargaining unit cases to regional directors for further consideration. (AHA Br. 203-204; AFL Br. 145.) ANA also noted the incongruity that could result if the Board enacted a rule that conflicted with pre-rule standards, e.g., finding a unit inappropriate that previously was appropriate. (ANA Br. 204 at n.115.)

The Board has decided that its rule on appropriate bargaining units in the health care industry should be applied to all decisions made on and after the effective date of the rule, which will be 30 days after publication of the final rule in the *Federal Register*. See APA, 5 U.S.C. 553(d). The Board agrees that it would be incongruous to apply the rule as originally stated; that is, only to petitions filed 30 days after publication. Such a rule would arbitrarily affect petitions filed just 1 or 29 days after the rule is published, and could conceivably lead to vastly different results based solely on the timing of the petition. However, the Board will apply its pre-rule standards to cases that issue prior to the effective date of the rule. As we indicated in *St. Vincent*, we deem it unwise either to decline to take any action on pending petitions, or to promulgate a new standard while rulemaking proceedings are pending. We continue to deem it contrary to statutory policy to hold cases pending effectuation of the Board's new rule. Accordingly, all cases that issue prior to the effective date of the rule will be analyzed under *St. Vincent*. If cases currently pending before the Board do

not issue prior to the rule's effective date, the Board will not apply the rule *de novo* to such cases. Rather, the Board will, where necessary, remand such pending cases to regional directors to determine the need for a hearing or other appropriate course of conduct in order to permit parties to address the rule.

#### XVIII. Non-Conforming Stipulations

In the initial proposed rule, the Board stated that it would approve consent agreements providing for elections in accordance with the units set forth in the rule, and that no other agreements would be approved. Several commentators urged the Board to permit stipulated units even when they do not comport with those specified in the rule. We have been persuaded that permitting non-conforming stipulations, which are not prohibited by the Act, may, in many instances, better serve the interests of the parties, and perhaps even the Board. The Board therefore has tentatively decided to allow its regional directors to approve stipulations providing for elections in units not provided for in the rules.

It is the Board's established practice in other areas to permit parties to stipulate to the appropriateness of units and to various inclusions and exclusions if the agreement does not violate any express statutory provision or established Board policies. See, e.g., *SCM Corporation*, 270 NLRB 885, 886 (1984). This policy on stipulated units was extended to the health care industry in *Otis Hospital*, 219 NLRB 164 (1975). The Board there reasoned that it is consonant with the design of the Act to give the parties in representation proceedings the broadest permissible latitude to mutually define the appropriate unit. The Board stated that when the parties' perceptions coincide regarding unit appropriateness, in the absence of a statutory command or policy considerations within the Board's expertise, the Board is not the better judge. The Board noted in *Otis Hospital* that the legislative history of the 1974 health care amendments supports the application of general policy regarding stipulated units to the health care industry.

Our expertise acquired throughout this rulemaking proceeding gives us considerable pause with regard to stipulations not in accordance with our proposed rules. Thus, stipulations in conformity with these rules would surely be preferable. However, we recognize the possibility that the parties have their own reasons for preferring to bargain in some other configuration.

Moreover, we note that the majority of certifications issued in representation cases in the health care industry following enactment of the amendments followed either a consent or stipulated election and that these elections gave rise to challenges less often than directed elections. Annual Reports of the National Labor Relations Board, Tables 9, 11B. In view of Congress' concern with stability in health care labor relations, the importance of reducing unnecessary litigation, and expeditiously proceeding with elections, permitting stipulations, even when they do not conform to the Board's explicitly drawn units, seems warranted. For these reasons, we have decided that the reasoning of *Otis Hospital* should remain applicable despite this rulemaking proceeding.

To the extent a stipulation may later result in the creation of a residual group of unrepresented employees, the Board will address their representation concerns as it would those of other groups of residual employees present in partially organized acute care hospitals—on a case-by-case basis applying the rules insofar as practicable.

Despite our tentative decision to accept non-conforming stipulations, we expressly invite any interested party to comment further on this problem during the period provided for comments.

#### XIX. Combined Units

The Notice of Proposed Rulemaking provided that, in addition to the specified units, "any combination will also be appropriate, at the union's option and so long as the requirements of section 9(b) (1) and (3) are met." The reason for the reference to the union's option was that the union, as petitioner,<sup>26</sup> need seek only an appropriate unit. *Morand Brothers Beverage Co.*, 91 NLRB 409, 417-18, enfd. on other grounds 190 F.2d 576 (7th Cir. 1951); *Parsons Investment Co.*, 152 NLRB 192, 193 at fn. 1 (1966). It does not benefit an employer to have the option of showing that another unit, perhaps a combined unit, is also appropriate, or even more appropriate, since the appropriateness of an alternative unit is not the issue. *Parsons Investment Company*, supra; *Federal Electric Corporation*, 157 NLRB 1130, 1131-32 (1966). We therefore reject arguments by some employers that it is unfair to give

<sup>26</sup> If the employer is the petitioner (RM petition), its petition must seek the unit requested by the union. *Wm. Wood Bakery*, 97 NLRB 122 (1951); *Restaurant & Tavern Owners Association of Salem*, 125 NLRB 671 (1980). If the petition seeks decertification, it must be filed in the certified or recognized unit. *Campbell Soup Co.*, 111 NLRB 234 (1955).

only unions the option of combining units. (See, e.g., AHA Br. 49; Comment 258, Durham, attorney for California Association of Health Facilities.)

However, upon reflection, we believe that we defined too broadly a union's option to seek, alternatively, combined units. In the NPR, as indicated, we implied that any combination of the enumerated units would also be appropriate; after giving this matter further thought, we believe that we have insufficient evidence at this time to say that, *per se*, all combinations will be found appropriate. We believe this is a matter we will have to decide in the course of individual cases, by adjudication. While there are some combinations that, while not required under these rules, would obviously be appropriate, such as all professionals, or all non-professionals, there may be other, more unusual combinations that need to be examined for appropriateness. We meant to say only that combinations of the enumerated units are not thereby precluded, and we have therefore modified the rule to provide that combinations "may" be appropriate.

#### XX. Extraordinary Circumstances Exception

The Board has, in order to ensure satisfaction of parties' due process rights,<sup>27</sup> included in both the proposed rule and the final rule an exception for "extraordinary circumstances." The exception has been provided to allow for the possibility of individual treatment of uniquely situated acute care hospitals, so as to avoid accidental or unjust application of the rule.<sup>28</sup> However, the Board wishes to emphasize that while the rule does not, therefore, conclusively establish invariable parameters of bargaining units in the industry, our intent is to construe the extraordinary circumstances exception narrowly, so that it does not provide an excuse, opportunity, or "loophole" for redundant or unnecessary litigation and the concomitant delay that would ensue. The Board has considered fully and at length all evidence presented and

<sup>27</sup> See *Chemical Manufacturers Assn. v. Natural Resources Defense Council*, 470 U.S. 116, 133 n.25 (1985); *Heckler v. Campbell*, 461 U.S. 458, 467 (1982); *FPC v. Texaco, Inc.*, 377 U.S. 33, 40 (1964); *United States v. Storer Broadcasting Co.*, 351 U.S. 192, 205 (1956); *National Broadcasting Company v. United States*, 319 U.S. 190, 225 (1943); *WAIT Radio v. FCC*, 418 F.2d 1153, 1157 (D.C. Cir. 1969); 1 C. Koch, *Administrative Law and Practice* § 4.112 at 321-23 (1985).

<sup>28</sup> Cf. *National Nutritional Foods Assn. v. FDA*, 504 F.2d 761, 764 (2d Cir. 1974), cert. denied 420 U.S. 946 (1975), citing *The New England Divisions Case*, 261 U.S. 184, 204 (1923).

arguments submitted at the rulemaking hearings and during the comment period. None of the referred-to variations between acute care hospitals, some of which are enumerated below, are matters which would qualify for litigation under the special circumstances exception; rather, they are merely minor differences, inherent in the industry due to the multifariousness of individual constituent institutions. The Board deems such variations to be ordinary, and hence by definition not extraordinary,<sup>29</sup> even in situations in which such variations may be highly unusual.<sup>30</sup>

Among the variations in acute care hospitals illustrated at the hearings and considered by the Board are arguments relating to: (1) Diversity of the industry, such as the sizes of various institutions, the variety of services offered by individual institutions, including the range of outpatient services provided, and differing staffing patterns among facilities (as, for example, a particular facility employing a larger or smaller number of RNs than generally employed by similarly situated hospitals); (2) increased functional integration of, and a higher degree of work contacts between, employees as a result of the advent of the multi-competent worker, increased use of "team" care, and cross-training of employees; (3) the impact of nation-wide hospital "chains"; (4) recent changes within traditional employee groupings and professions, e.g., the increase in specialization among RNs; (5) the effects of various governmental and private cost-containment measures; and (6) single institutions occupying more than one contiguous building. Except as specifically noted elsewhere (e.g., exclusion of psychiatric hospitals and nursing homes from coverage by the rule), the Board has concluded that none of the arguments raised in the course of the rulemaking procedure, including those listed above,<sup>31</sup> alone or in combination, constitutes an "extraordinary circumstance" justifying an exception from the rule.

The Board is well aware that facilities will, and do, differ in some respects; however, as we observed in the NPR (52 FR 25144), it is the Board's considered judgment, after issuing health care decisions by adjudication for more than

<sup>29</sup> See *Bollman v. Indianapolis Machinery Co.*, 150 Ind. App. 296, 276 N.E.2d 606, 613 (1971); *Black's Law Dictionary* 527 (rev. 5th ed. 1979), and cases cited therein.

<sup>30</sup> See *Kugler v. Helfant*, 421 U.S. 117, 125 (1975).

<sup>31</sup> The arguments listed were selected by way of example and not by way of limitation, and were chosen merely as being illustrative of the Board's intent.

13 years, that acute care hospitals do not differ in substantial, significant ways relating to the appropriateness of units.<sup>32</sup> Moreover, to the extent that the rulemaking hearings demonstrated that at least in some respects acute care hospitals do vary, the Board has made a judgment that, in this area of establishing appropriate units, "[d]etailed analyses of all the facts of the particular case are just not that enlightening,"<sup>33</sup> and that the policies of the Act would better be effectuated by the establishment of appropriate units in the enumerated segments of this industry by exercise of the Board's section 6 rulemaking authority.<sup>34</sup>

To satisfy the requirement of "extraordinary circumstances," a party would have to bear the "heavy burden" to demonstrate that "its arguments are substantially different from those which have been carefully considered at the rulemaking proceeding,"<sup>35</sup> as, for instance, by showing the existence of such unusual and unforeseen deviations from the range of circumstances revealed at the hearings and known to the Board from more than 13 years of adjudicating cases in this field, that it would be unjust<sup>36</sup> or an abuse of discretion<sup>37</sup> for the Board to apply the rules to the facility involved.

The Board, contrary to some industry representatives (e.g., Comment 148, Mississippi Hosp. Assn.), anticipates that litigation under the "extraordinary circumstances" exception will be rare; the AHA, representing the largest group of health care employers in this proceeding, has indicated it understands that the Board intends to limit exceptions to "truly extraordinary situations" (AHA Br. 55-56), and neither the AHA nor any other employer (or

union) representative has raised objections to the Board's stated intent.

In most instances, should a facility claim it comes within the "extraordinary circumstances" exception, it should present an offer of proof to the Hearing Officer, who will then either permit the requested evidence to be adduced or, we anticipate far more commonly,<sup>38</sup> refer the offer to the Regional Director, and, if requested, ultimately to the Board, for ruling.

#### XXI. Proliferation

As set forth in considerable detail, *supra*, the evidence taken during the rulemaking proceeding has convinced the Board, contrary to its earlier belief, that eight possible units (seven plus guards) should be found appropriate in acute care hospitals. In reaching this conclusion, the Board has carefully considered the Congressional admonition against proliferation set forth in the legislative history of the 1974 health care amendments as well as its own strongly-held view that the number of units found appropriate should not be so many as to lead to a splintering of the workforce into the myriad of occupations and professions found within the industry. The Board has examined the units found appropriate to ensure they are not so numerous as to create a never-ending round of bargaining sessions, and that each unit represents truly distinctive interests and concerns. A number of groups of employees found appropriate have separate labor markets. A thorough examination of the record in this rulemaking proceeding has satisfied us that the health care units established by the Board do not constitute proliferation either in terms of the legislative history of the amendments or in the context of the history or realities of the industry.

We believe that Congressional and industry concern with proliferation was directed towards the fifteen to twenty plus units that had arisen in the health care and other industries prior to the amendments and the possibility of scores of units if each hospital classification were permitted to organize separately. IUOE Br. 96-97: Legislative History of the Coverage of Non-Profit Hospitals Under the National Labor Relations Act at 113-114 (Senator Taft); Hearings on S. 794 and S. 2292 Before the Subcommittee on Labor and Public Welfare, 93rd Cong., 1st Sess. 1973 at 175 (David Brekke, Colorado Hospital Association), 181 (O. Ray Hurst, Texas Hospital Association), 188 (William

Whelan, California Hospital Association), Sidney Lewine, 138-139 (American Hospital Association), 563-564 (exchange between Senator Taft and Andrew Biemiller of the AFL-CIO). See also testimony in 1971 and 1972 hearings, cited in IUOE Br. 96-97.

By 1974, a number of state and agency decisions with respect to non-profit hospitals, and Board decisions with respect to proprietary hospitals, had permitted each profession, and in some cases each craft, to form a separate bargaining unit (See discussion in AFL Br. 2-3, 28). As stated in Senator Taft's proposal, Congress feared that patterns such as developed in construction and newspaper industries—wherein units were permitted for each craft, resulting in 15-20 or more units—would result in separate units for the equally, if not more, numerous classifications in a hospital. We find no evidence that Congress opposed a smaller number of units. Thus, Senator Taft's proposal, containing special rules for the health care industry, would have established five units as presumptively appropriate: Technical, clerical, service and maintenance, all professional, and guards, two more than the statutorily mandated three units (professional, non-professional, and guards). The Board's addition of three units, RNs, physicians, and skilled maintenance, raising the total number of proposed possible units to eight, still constitutes half or fewer of the number of units that seem to us to have concerned Congress.

Furthermore, the record shows that the hospital industry understood proliferation to mean a much greater multiplicity of units than is proposed here. The League of Voluntary Hospitals of New York, an association of 54 nonprofit medical centers, hospitals, and nursing homes, and the largest organization of its kind in the country, supported the 1974 amendments because the League wished to remove itself from New York State health care coverage under which there were potentially 15-20 or more units in a health care facility (WS Abelow). Indeed, the American Hospital Association proposed a five-unit configuration: Professional, technical, clerical, service and maintenance, and guards. Hearings on S. 794 and S. 2292 Before the Subcommittee on Labor and Public Welfare, 93rd Cong., 1st Sess. 1973, Sidney Lewine, 140.

There is little evidence that the number of units proposed by the Board will result in proliferation or in the problems perceived to arise from proliferation. The units proposed by the Board are only potential units. Indeed,

<sup>32</sup> See, e.g., NLRB Exhibit 5, revised, showing that for the 13 years since passage of the health care amendments, variations among facilities and their methods of operation had virtually no effect on the Board's ultimate decisions reached following frequently lengthy, case-by-case adjudications as to appropriate units.

<sup>33</sup> Subrin, *Conserving Energy at the Labor Board: The Case for Making Rules on Collective Bargaining Units*, 32 Lab. L.J. 105, 107 (1981).

<sup>34</sup> See *Cummins v. Schweiker*, 670 F.2d 81, 83 (7th Cir. 1982).

<sup>35</sup> *Basic Media, Ltd. v. FCC*, 559 F.2d 830, 834 (D.C. Cir. 1977). Accord, *P & R Temmer v. FCC*, 743 F.2d 919, 930 n.11 (D.C. Cir. 1984); *Industrial Broadcasting Co. v. FCC*, 437 F.2d 680, 683 (D.C. Cir. 1970). See also *WAIT Radio v. FCC*, 459 F.2d 1203, 1207 (D.C. Cir. 1972), cert. denied 409 U.S. 1027 (1972); *WAIT Radio v. FCC*, 418 F.2d 1153, 1157 (D.C. Cir. 1969).

<sup>36</sup> *National Nutritional Foods Assn. v. FDA*, 504 F.2d 761, 763 (2d Cir. 1974), cert. denied 420 U.S. 946 (1975).

<sup>37</sup> *P & R Temmer v. FCC*, 743 F.2d 919, 929 (D.C. Cir. 1984); *Ashland Exploration, Inc. v. FERC*, 631 F.2d 817, 823 (D.C. Cir. 1980).

<sup>38</sup> See 1 C. Koch, *Administrative Law and Practice* section 4.112 at 323 (1985).

two of the units, physicians and guards, are rarely sought. A successful organizing effort in one unit in a hospital does not appear to have a ripple effect causing further organization. The record shows that from the 1974 health care amendments until the Board's 1984 decision in *St. Francis II*, most health care units fell into the categories now proposed by the Board. However, the majority of organized hospitals only had one unit, and about 80% had three or fewer units. (AFL Exh. 5 p. 1; SEIU, WS Shea, Table 2.) Nor, as detailed *supra*, was there a showing that the configuration of units proposed by the Board have resulted in an increased number of strikes, jurisdictional disputes, or other disruptions in the delivery of health care services.

Finally, as shown above, the empirical evidence submitted in these proceedings strongly supports the appropriateness of each of the units proposed by the Board.

For all the above reasons, we conclude that our proposal for seven units plus guards is not only well within our discretion, but also consistent with both our own and Congress' concerns about proliferation.

#### XXII. Docket

The docket is an organized and complete file of all the information submitted to or otherwise considered by the NLRB in the development of this proposed rulemaking. The principal purposes of the docket are: (1) To allow interested parties to identify and locate documents so they can participate effectively in the rulemaking process; and (2) to serve as the record in case of judicial review. As provided in the first NPR (52 FR 25148), the docket, including a verbatim transcript of the hearings, the exhibits, the written statements, and all comments submitted to the Board, is available for public inspection during normal working hours at the Office of the Executive Secretary in Washington, DC.

#### XXIII. Regulatory Flexibility Act

As required by the Regulatory Flexibility Act, 5 U.S.C. 601 *et seq.*, the Board certifies that the proposed rule will not have a significant economic impact on small entities. Prior to this rule, parties before the Board were required to litigate the appropriateness of a unit for election purposes if they could not reach agreement on the issue. Upon enactment of this rule, parties will no longer be required to engage in litigation to determine the appropriateness of units, thereby saving all parties the expense of litigation before the Board and the courts. To the extent that organization of employees

for the purpose of collective bargaining will be fostered by this rule, thereby requiring small entities to bargain with unions, and that employees may thereby exercise rights under the National Labor Relations Act, as amended (29 U.S.C. 151 *et seq.*), the Board notes that such was and is Congress' purpose in enacting the Act and the health care amendments thereto.

#### XXIV. Regulatory Text

##### List of Subjects in 29 CFR Part 103

Administrative practice and procedure, Labor management relations.

For the reasons set forth in the prior pages, it is proposed to amend 29 CFR Part 103 as follows:

##### PART 103—OTHER RULES

1. The authority citation for 29 CFR Part 103 is revised to read as follows:

Authority: 29 U.S.C. 151, 156; 5 U.S.C. 500, 533.

2. Subpart C, consisting of § 103.30, is added to read as follows:

##### Subpart C—Appropriate Bargaining Units

Sec.

103.30 Appropriate bargaining units in the health care industry.

##### Subpart C—Appropriate Bargaining Units

§ 103.30 Appropriate bargaining units in the health care industry.

(a) This portion of the rule shall be applicable to acute care hospitals, as defined in paragraph (f) of this section: Except in extraordinary circumstances and in circumstances in which there are existing non-conforming units, the following shall be appropriate units, and the only appropriate units, for petitions filed pursuant to section 9(c)(1)(A)(i) or 9(c)(1)(B) of the National Labor Relations Act, as amended, except that various combinations of units may also be appropriate:

- (1) All registered nurses.
- (2) All physicians.
- (3) All professionals except for registered nurses and physicians.
- (4) All technical employees.
- (5) All skilled maintenance employees.
- (6) All business office clerical employees.
- (7) All guards.
- (8) All nonprofessional employees except for technical employees, skilled maintenance employees, business office clerical employees, and guards.

(b) Where there are existing non-conforming units in acute care hospitals, and a petition for additional units is filed pursuant to section 9(c)(1)(A)(i) or

9(c)(1)(B), the Board shall find appropriate only units which comport, insofar as practicable, with the appropriate units set forth in paragraphs (a) (1) through (8) of this rule.

(c) Nothing shall prevent the Board from holding additional hearings concerning the specific job classifications to be included in, or excluded from, each of the above units, and from establishing additional rules about such matters.

(d) The Board will approve consent agreements providing for elections in accordance with paragraph (a) of this section, but nothing shall preclude regional directors from approving stipulations not in accordance with paragraph (a), as long as the stipulations are otherwise acceptable.

(e) This rule will apply to all cases decided on or after the effective date of the final rule.

(f) For purposes of this rule, the term "acute care hospital" is defined as a short term care hospital in which the average length of patient stay is less than thirty days. The term "acute care hospital" shall include those hospitals primarily operating as acute care facilities even if those hospitals provide such services as, for example, long term care, outpatient care, or psychiatric care, but shall exclude facilities that are primarily nursing homes or primarily psychiatric hospitals. The definition of "psychiatric hospital" shall be as set forth in 42 U.S.C. Sec. 1395 x (f), Social Security Act. A "non-conforming unit" shall be defined as a unit not in conformity with paragraphs (a) (1) through (8) of this rule.

(g) Appropriate units in all other health care facilities: The Board will establish appropriate units in other health care facilities, as defined in section 2(14) of the National Labor Relations Act, as amended, on a case-by-case basis.

#### XXV. Dissenting Opinion

Member Wilford W. Johansen, dissenting:

As amply documented in the Notice of Proposed Rulemaking in the *Federal Register* on July 2, 1987, there has been no universal acceptance in the circuit courts of a standard for formulating appropriate units in the healthcare industry. Some courts have simply substituted their own judgment for that of the Board on the question of what constitutes an appropriate unit. Frequently a court has apparently supported its conclusion by a selective reading of portions of the legislative history of the 1974 Amendments. The

Board in turn has reacted first by trying to explicate that the differences might be "largely semantic" (*Newton-Wellesley Hospital*, 250 NLRB 409 (1980)), then by reversing field and adopting the test advocated by the Ninth Circuit (*St. Francis Hospital*, 271 NLRB 948 (1984) (*St. Francis II*)). That course in turn was roundly criticized by the D.C. Circuit. (*Electrical Workers IBEW Local 474 v. NLRB (St. Francis Hospital)*, 814 F.2d 697 (1987)). The Board's reaction was to try yet a different approach—i.e., rulemaking.

With all due respect, I disagree. Rulemaking in regard to healthcare units is neither desirable nor appropriate.

First, it is my view that the appropriate method for resolution of questions surrounding the interpretation of Congress' intent, the proper scope of review, and the Board's duty and authority under the statute, is to submit these questions to the Supreme Court, which is the final arbiter on issues of this nature. Submission to the Court is especially appropriate in this area. Second, the Board has received criticism from the courts at both ends of the spectrum. Most of the criticism and disagreement has centered around application of the traditional community of interest standard, versus a separately derived "disparity of interest" test for evaluating units in the healthcare industry.

Thus, the Ninth Circuit, in an early *St. Francis* hospital case, faulted the Board for applying what the court deemed a too rigid presumption *in favor* of a registered nurses unit; and enunciated a "disparity of interest" standard which it deemed necessary for assessing healthcare units. More recently, after the Board itself decided to adopt the disparity of interest standard, the District of Columbia Circuit in yet another *St. Francis* case, severely criticized the Board's action, and strongly "suggested", that some form of the historically accepted community of interest standard is required. Hence the Board is faced with some courts which have indicated a definite preference for the so-called "disparity of interest"

analysis. Other courts are equally adamant that nothing in the 1974 Amendments indicates that the Board was to abandon the community of interest standard which had served well for the previous forty years, and of which Congress was cognizant at the time of the Amendments.

It is apparent that the disagreements involve questions concerning the meaning of the statute, analysis of the legislative history, and the deference to be properly accorded to the Board's reading and interpretation of the Act, which is the Board's primary function and responsibility. These questions are all particularly appropriate for submission to, and final resolution by, the Supreme Court. This avenue is also the one which best serves the interests of the parties, the general public, and the Board itself.

Section 9(b) of the Act provides that

The Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this Act, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof \* \* \*

I do not read the above language as permissive. It is mandatory. The Board cannot satisfactorily fulfill its statutory obligation by relegating its specialized decisional function in this area to rulemaking procedures. That is not to suggest that I disapprove of rulemaking *per se*. On the contrary, I agree that rulemaking is desirable, and even a necessary part of the Board's function, in some areas. This is not one of those areas. I believe it is important to keep in mind that Congress did *not* amend Section 9 when it enacted the Healthcare amendments in 1974. Had Congress intended that the Board abandon the decisional approach and utilize a wholly new procedure for determining appropriate units in the healthcare industry, Congress would have told us so explicitly. It did not. Nor did it even implicitly suggest such action. The rule changes cited by the majority (e.g. contract bar, *Excelsior* list, etc.) in support of this radical departure

from 50 years of Board precedent, (a) were arrived at decisionally, and; (b) did not involve unit determinations.

There are additional factors which make rulemaking on particular units, at best, inadvisable. Units established by rulemaking will continue to be criticized by courts that deem the Board's approach to healthcare unit determinations to be too rigid. Indeed, as unit specifications derived from a predetermined set of rules are inherently less flexible than those arrived at by decision in individual cases, criticism by some courts may even intensify on the ground that the Board has not arrived at a result through the application of its institutional expertise to a particular fact pattern.

Contrary to the stated expectations of my colleagues, setting unit configurations by rulemaking will not in fact substantially reduce the amount of litigation in this area. It may serve to change part of the focus of that litigation, while at the same time creating more. The amount of evidence produced in rulemaking is not the point. The difficulties encountered over the last several years have not been for lack of evidence. Rather, they have revolved around differing interpretations of the statute and, particularly, the legislative history and the deference to be accorded the Board and its expertise in its role as the primary decision maker under the Act. I do not see that announcing rules by administrative fiat will resolve the divergent views on these fundamental questions. We still will not have obtained a definitive resolution of the basic issues which is so sorely needed.

I would, therefore, vacate the notices of proposed rulemaking and submit the extant issues to the Supreme Court for resolution.

Dated, Washington, DC, August 25, 1988.

By direction of the Board.

National Labor Relations Board.

John C. Truesdale,

Executive Secretary.

[FR Doc. 88-19688 Filed 8-31-88; 8:45 am]

BILLING CODE 7545-01-M