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RULEMAKING: THE NATIONAL LABOR RELATIONS BOARD'S PRESCRIPTION FOR THE RECURRING PAINS OF THE HEALTH CARE INDUSTRY

Americans spend more of their income on health care than do the citizens of any other nation in the world, in both absolute and relative terms.¹ The annual health care bill in the United States is estimated at $650 billion.² Health care costs are increasing annually at two to three times the rate of inflation³ and are predicted to reach $1.5 trillion before the year 2000.⁴ In fact, health care costs claim an exorbitant share of our national wealth—12% of the gross national product—a share that is on a growth curve of amazing proportions.⁵ Every sector of the American population is affected by the burden of these ever-increasing costs.

Some commentators emphasize that health care spending is a major burden on the public fisc and a contributing factor to economic recession.⁶ In the private sector, analysts argue that the increased cost of providing health care services is passed on to the consumer in the form of higher prices.⁷ Other commentators theorize that the “healthy” consumer is indirectly paying the increased costs of health care through higher health care insurance premiums.⁸ Still others believe that these costs are recouped by employers in

³. Id.
⁵. Verespej, supra note 2, at 38. In 1950, health care costs consumed 4.5% of the gross national product. Bernstein, supra note 1, at 19. The figure was 7.3% in 1970. Id. At this rate, health care costs will represent 19.1% of the gross national product in twenty years, approximately what is now spent in education, agriculture, and defense combined. Id.
⁶. See, e.g., Julie Kosterlitz, The Growth Industry, 48 NAT’L J. 2917, 2917-19 (1991). The public sector cannot pass costs on to workers or consumers and is therefore caught between rising demands to provide health services and taxpayer resistance to new revenue-raising measures. Id. at 2919.
⁷. Id. at 2918. In the mid-1980s, former Health, Education and Welfare Secretary, Joseph A. Califano, Jr., speaking as advisor to Chrysler Corporation, argued that the cost of employer-provided health care benefits was adding $500 to $700 to the cost of each Chrysler car. Id.
⁸. Id.
the form of lower wages paid to all employees. All interested parties would agree, however, that the plight of the thirty-seven million Americans who are without health insurance is in large part a tragic result of the increased cost of health care and health insurance, and that this tragedy only worsens the malady of the system.

Health care is big business. In 1989, U.S. merger and acquisition activity in the health service industry culminated in 141 mergers with a market value of $28.5 billion. In the midst of a prolonged economic downturn and with unemployment on the rise, the health care sector stands out as a prime example of a recession-proof industry. According to the Bureau of Labor Statistics, from 1989 to 1990, employment in the private health care sector grew more than three times as fast as in the private sector as a whole. The industry, however, is struggling nonetheless. Early in 1991, Fortune magazine characterized the health care industry as “infirm” with a grim prognosis for recovery, in large part due to the burden of expenses that continue to outpace inflation. Although industry revenues increased by 10.9% in 1990, industry expenses increased by a greater margin of 11.1% in the same year.

Increased competition from HMOs and nonhospital providers such as urgent care centers, outpatient surgery centers, outpatient birthing centers, diagnostic centers, and companies that deliver intravenous feedings and

9. Id. Any employer with a population of unionized employees has difficulty accepting this argument. Wages and benefits packages that are agreed upon in collective bargaining negotiations are typically memorialized in a three-year contract.

10. Bernstein, supra note 1, at 19.


12. Kosterlitz, supra note 6, at 2917. The health care sector handles economic difficulties better than most other business sectors because people continue to get sick and injured regardless of business cycles. Id. at 2919.

13. Id.


15. Id.

16. Lawrence Wu, Hospitals End 1990 with Negative Patient Margin in Aggregate, HOSPITALS, May 5, 1991, at 34, 34. All health care providers are not losing money, however. Jacob & Neumeier, supra note 14, at 80. A Salomon Brothers analyst expected earnings at Humana, the largest publicly held hospital company, to increase by a healthy 16% in 1991. Id. “The company operates a lucrative group insurance business that refers cases to its hospitals.” Id.

17. A 1985 study showed that hospital admissions from health maintenance organization members are 40% lower than those for a typical fee-for-service group. Dean C. Coddington et al., Strategies for Survival in the Hospital Industry, HARV. BUS. REV., May-June, 1985, at 129, 132. This is attributed to the HMO’s philosophy of preventative medicine, its careful screening of the subscriber and his or her physician prior to admission into the hospital, and its close monitoring of patients while hospitalized. Id.
medications at home, is adding salt to the already deep wounds of the skyrocketing expenses of hospitals. These alternative providers are aggressively competing for patients, and their ability to provide care at a lower cost than hospitals makes them very appealing to employers and insurers. In fact, a 30% growth rate was predicted for these non-hospital providers in 1991. In addition, hospitals continue to lose money on programs such as Medicare, which in 1990 reimbursed hospitals less than ninety-five cents on the dollar. Because hospitals derive one-half of their revenues from such programs, the impact of these losses is considerable.

“We have a system that nobody’s happy with: not the government, not business, not the hospitals.” Although many strategies are available as potential solutions to the interrelated problems of the increasing costs of providing and of receiving health care, the most popular strategy attacks the expense side of the equation, seeking to provide services at the lowest possible cost.

Health care is labor intensive. Labor costs, in fact, constitute 60% of total hospital costs and, therefore, represent an area of great financial concern for hospital administrators and an expense that requires precise and constant monitoring. The labor intensity of the industry is increasing and the costs of labor, along with other expenses, have risen. In 1950, the typical hospital hired approximately two employees per inpatient bed. Only a small number of these employees were college graduates. Most were women who were underpaid, largely due to long-perpetuated stereotypes.

18. Id. at 131-32; see also Jacob & Neumeier, supra note 14, at 80.
19. Hospitals, as the average American knows them, represent approximately 40% of the health care industry as a whole. Jacob & Neumeier, supra note 14, at 80.
20. Coddington et al., supra note 17, at 131-32.
22. Id.
23. Id.
24. Id.
25. Id. (quoting Alexander Williams, III, senior vice president of the American Hospital Association).
26. Coddington et al., supra note 17, at 133. “[I]t is clear that if hospitals are to survive, they must operate more efficiently.” Id. at 134. “Just as business cannot compete if its products are [of] poor or [in] quality and its manufacturing facilities inferior, America can no longer afford inefficient hospitals . . . .” Verespej, supra note 2, at 38.
27. Royce Diener, Controlling Hospital Costs: Government Rationing or the Voluntary Effort, NAT’L J., June 2, 1979, at 929, 933. In perspective, the health care sector provides approximately 8.3 million Americans with jobs, nearly 9% of all of the nation’s private sector employment. Kosterlitz, supra note 6, at 2919.
28. See infra notes 29-36 and accompanying text.
29. Bernstein, supra note 1, at 20.
30. Id.
31. Id.
Today, a typical urban hospital may have as many as four employees per bed. 32 Most positions require that the employee have at least an undergraduate degree and, therefore, pay at or near competitive wages. 33 As the market for skilled labor qualified to meet the demands of increased health care technology tightens, hospitals are forced to increase their wages dramatically in order to remain competitive in the job market. 34 In fact, health care wages overall have risen faster than all other wages over most of the past fifteen years. 35 Without question, "[l]abor is . . . the most important element of health care inflation." 36

I. MANAGEMENT'S PERSPECTIVE OF COLLECTIVE BARGAINING

Despite the fact that labor costs are closely monitored by hospital administrators, many of the factors that contribute to the expense of labor may not be completely within management's control. The great jurist, Oliver Wendell Holmes, wrote while serving on the Supreme Judicial Court of Massachusetts in 1896:

One of the eternal conflicts out of which life is made up is that between the effort of every man to get the most he can for his services, and that of society, disguised under the name of capital, to get his services for the least possible return. Combination on the one side is patent and powerful. Combination on the other side is the necessary and desirable counterpart if the battle is to be carried on in a fair and equal way. 37

Although ahead of its time, this proclamation accurately expresses the philosophy that has long guided the labor relations policy of the United States: the affirmative support by the federal government of unionism and collective bargaining among workers who choose to be represented by a union. 38 It also aptly describes the typical relationship between management and organized labor as a battle, albeit one of economic warfare. Union avoidance is a familiar strategy employed by the management teams who are faced with the threat of unionization. The health care industry is no exception.

Initially, the union-management conflict is sparked by frustration. Employers are not likely to welcome the presence of a third and arguably disi-

32. Id.
33. Id.
34. Id.
35. Kosterlitz, supra note 6, at 2920.
The major source of employer opposition to unionization, however, is undoubtedly its cost to the employer. Union organization campaigns, the process by which unions typically gain initial employee support prior to a representation election, cost employers much time, effort, and money. Employers must wage an equally effective campaign in order to attempt to secure a nonunion status through the votes of what the employer hopes to be contented and well-informed employees. Unionization inevitably increases administrative costs and most likely means increased labor costs due to higher wages and more expensive benefits.

These costs are further inflated when a newly elected union begins to participate in the collective bargaining process. New unions typically file a greater number of grievances and seek to bargain over a greater number of issues in order to justify their presence and to assure the employees that they made the right decision in electing the union as their representative. Effectively counteracting this union-initiated activity is not only "cumbersome, time consuming and very frustrating for administrators," but also very expensive.

In addition, when an employee population is represented by more than one union, management fears "the whipsaw effect," whereby two or more unions play against each other to gain a bargaining advantage over the employer. For example, assume that an employer's workforce is represented by two different unions, union A and union B. Assume further that union A has recently negotiated pay increases and improved benefits over the next three years. Sometime in the near future, when union B comes to the bargaining table, its representatives may demand concessions greater than those in union A's collective bargaining agreement. When several unions employ this strategy, "management gets caught in a never-ending battle for advantage."

Another source of tension is the fact that unionization typically reduces

39. Todd Stein, Healthcare Unions Flex Newfound Legal Muscle, Bus. J. (Sacramento), June 3, 1991, at 19, 28. At its most pessimistic, management's view is represented by the following statement: "Communication is already tough enough; now management has to go through a middle person every time they want to talk with an employee. That makes employee relations very difficult." Id. (quoting Floyd Palmer, a labor attorney for hospitals and a partner in Littler, Mendelson, Fastiff & Tichy).

40. Id. "When people pay dues to a union, they're looking for a return on their investment," said Christine Hall, general counsel for California Association of Hospitals and Health Systems. Id.

41. Id.

42. Id.

43. Id.

44. This hypothetical is based on one presented by Stein, supra note 39, at 19, 28.
management's decision-making flexibility because job duties, wages, scheduling, and other conditions of employment are predetermined and set forth in the collective bargaining agreement. This creates a special challenge for hospital executives. To illustrate, one analyst advises that hospitals, by more effective deployment of their human resources, could reduce their labor costs by 30%. An increasing number of hospital executives already condemn the health care industry's affinity for a "caste-like" system of employment and the resulting "turf-conscious work force" that is composed of too many types of technicians, all of whom are in short supply. In response, some hospital administrators treat both ailments, increased costs and labor shortages, with one remedy: cross-training, a relatively simple notion that employees who have been trained to perform multiple tasks may be deployed more efficiently. Such innovation is made more difficult when wages, job duties and scheduling requirements have been negotiated in advance and are set forth in a binding agreement. Finally, management fears the potential for labor unrest, which can affect both the cost and the quality of services rendered, especially when it results in work stoppages or strikes.

In consideration of the pressures created by the inherent tensions between organized labor and management, the financial difficulties facing hospitals, and the need for effective national labor relations policies in the health care industry, the National Labor Relations Board (the Board) recently issued a substantive rule mandating the appropriateness of petitioned-for collective bargaining units in the health care industry. Following a discussion of the history of the National Labor Relations Act and its impact on the health care industry, this comment reviews the Board's rulemaking endeavors and

45. Linda Perry, Staff Cross-Training Caught in Cross-Fire, MOD. HEALTHCARE, May 6, 1991, at 26, 27 (quoting Steven Cohn, President of Medical Management Planning, in Calabasas, Cal.).
46. Id. at 26.
47. Id. Health care executives have borrowed this concept from employers in the high-tech manufacturing industry. "Motorola, for example, trains its employees for as many as a dozen tasks, moving them from station to station in its manufacturing plants as the production process warrants it." Id. According to a 1988 study conducted by the National Multiskilled Practitioner Clearinghouse at the University of Alabama in Birmingham, 25% of 546 hospitals had trained employees to perform more than one job. Id. at 27. The cross-training trend, however, is a recent one. Id. The survey showed that 70% of the cross-trained workers had learned their second skill within the past five years. Id. The most popular plan is to teach a second clinical skill to experienced clinical workers. Id. Other models teach a clinical skill to a clerical worker and teach a second, lower-level skill to clinical workers. Id. at 27-28.
48. A bargaining unit is a group of employees that has been targeted by a union or that has sought union representation. It may be composed of virtually any combination of employees. Unions and employers are in near constant disagreement as to appropriate makeup of these units. See infra notes 68-71 and accompanying text.
considers the merits of the health care industry's vehement opposition to the rule that the American Hospital Association\(^5\) took to the Supreme Court.\(^5\) This comment examines the Supreme Court's decision to uphold the Board's rulemaking authority and its approval of the Board's rule as promulgated. This comment then considers some recent cases that the Board has addressed since the Supreme Court's decision, focusing on the likely effect that the rule will have on future disputes over the appropriateness of petitioned-for bargaining units. This comment concludes with an assessment of the likely success of the rule at obtaining the Board's asserted goals and the rule's probable impact on future union representation cases.

II. THE NATIONAL LABOR RELATIONS ACT AND COLLECTIVE BARGAINING UNITS

The National Labor Relations Act (the "Act") was enacted on July 5, 1935.\(^5\) This statute declared the United States' policy of encouraging the practice and procedure of collective bargaining "by protecting the exercise by workers of full freedom of association, self-organization, and designation of representatives of their own choosing . . . ."\(^5\) The Act also established the National Labor Relations Board (the "Board") as the administrative body that enforces the policy and provisions of the Act.\(^5\) The Board consists of five members appointed by the President for staggered five-year terms.\(^5\) The Board has the power to determine the appropriateness of the unit of employees for which representation is sought.\(^5\)

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\(^5\) The American Hospital Association (the AHA), headquartered in Chicago, Ill., is an association of individuals and health care institutions including hospitals, health care systems, and pre- and postacute health care delivery organizations that was founded in 1898 and presently has some 54,500 members. ENCYCLOPEDIA OF ASS'NS, Vol. 1, Part 2, Entry 12,769 (Deborah M. Burek ed., 26th ed. 1991). The AHA represents hospitals in national legislation; carries out research and educational projects; offers programs for institutional effectiveness review, technology assessment, and administrative services to hospitals; and conducts educational programs for and furnishes educational materials to its members. Id.

\(^5\) American Hosp. Ass'n v. NLRB, 111 S. Ct. 1539, aff'd 899 F.2d 651 (7th Cir. 1990).


\(^5\) Id. § 151.

\(^5\) Id. §§ 153-55.

\(^5\) Id. § 153.

\(^5\) 46 N.L.R.B. ANN. REP. 31 (1981). Thereafter, the Board has the power to formally certify a collective bargaining representative upon the basis of the results of a Board-conducted election. Id. The Senate Report accompanying the Act explained rather cryptically that the Board was empowered under section 9(b) of the Act to determine appropriate units because "there can be no choice of representatives and no bargaining unless units for such purposes are first determined. And employees themselves cannot choose these units, because the units must be determined before it can be known what employees are eligible to participate in a choice of any kind." S. REP. NO. 573, 74th Cong., 1st Sess. 1679 (1935), reprinted in LEGISLATIVE
Section 9(b) of the Act broadly defines an appropriate collective bargaining unit as one that assures to employees "the fullest freedom in exercising the rights guaranteed by . . . [the Act]."\textsuperscript{57} Appropriate bargaining units typically consist of groups of employees with the same or related job functions.\textsuperscript{58} Once a unit has been determined to be appropriate, a representation election may be held among the employees who comprise that unit.\textsuperscript{59} Under section 9(a) of the Act, the collective bargaining representative that has been designated or selected by the majority of the employees in an appropriate unit is the exclusive representative of all the employees in that unit "for the purposes of collective bargaining in respect to rates of pay, wages, hours of employment, or other conditions of employment."\textsuperscript{60}

Guided by the Act's general statement of purposes and standards, the Board has formulated certain criteria over the past forty years that are applicable to the determination of the appropriate unit.\textsuperscript{61} In so doing, the Board applies either a "community of interests" or a "disparity of interests" standard to the facts of the particular case.\textsuperscript{62} Under the traditional community-of-interests test, the Board examines the unit to determine if the employees share a community of interest with respect to their wages, hours, and conditions of employment.\textsuperscript{63} If a separate and distinct community of interests exists that is unique to the petitioned-for unit of employees, that unit is found appropriate, and an election is then directed in that unit.\textsuperscript{64} The Board held in 1984, however, that it could better effectuate its statutory obligations in health care unit determinations by adopting the disparity-of-interests test.\textsuperscript{65} This standard judges the appropriateness of a unit using the traditional criteria; however, "sharper than usual differences (or 'disparities') between the wages, hours and working conditions, etc., of the requested employees and those in an overall professional or nonprofessional unit must

\textsuperscript{57} 29 U.S.C. § 159(b).
\textsuperscript{59} 46 N.L.R.B. Ann. Rep. 31 (1981). The Board may conduct such an election after a petition has been filed by or on behalf of the employees or by an employer who has been confronted with a claim for recognition from an individual or labor organization. \textit{Id.}
\textsuperscript{60} 29 U.S.C. § 159(a).
\textsuperscript{61} See supra notes 13-15 and accompanying text.
\textsuperscript{64} \textit{Id.}; see, e.g., Dahl Oil Co., 221 N.L.R.B. 1311, 1312 (1975) (approving a unit having found a community of interests among the unit employees evidenced by common terms and conditions of employment, supervision and overlapping duties).
be established to grant the unit." In fact, the Board has recognized that these two tests are not significantly different, holding that the disparity-of-interests standard, to a great extent, embodies the community-of-interests approach.

In all cases, the Board considers the totality of circumstances surrounding the employment of the members of the proposed unit, yet, in certain situations, its determination is limited by provisions of the amended Act. Congress, however, by prescribing that each case be decided on its own facts, afforded the Board broad discretion to determine appropriate employee units for the purposes of collective bargaining.

Labor and management are continually at odds over the appropriate composition of the bargaining unit that is to participate in a representation election. Organized labor would generally prefer to organize and represent a greater number of small units; however, from the employer's perspective, a lesser number of large units of employees is the more manageable of the two evils. Nonetheless, as a practical matter, the parties routinely take a posi-

66. Id. at 953. See, e.g., Park Manor Care Ctr., Inc., 305 N.L.R.B. 1, 2 (1991) (stating that the disparity-of-interests test requires sharper than usual differences in wages, hours, and working conditions between unit and nonunit employees before the requested unit will be approved).


68. Id. For example, the Board has considered employees' wages, hours, and working conditions; qualifications, training, and skills; frequency of contacts and extent of interchange with other employees; 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. Id.

69. "Professional employees," "guards," and "supervisors" are defined in the statute. 29 U.S.C. §§ 152(12), 159(b), 152(11), respectively. Supervisors and independent contractors are expressly excluded from the definition of employees covered by the Act and may not be included in any bargaining unit. 29 U.S.C. § 152(3). No unit that includes both professional and nonprofessional employees will be found appropriate unless a majority of professional employees vote for inclusion in such a unit. 29 U.S.C. § 159(b). In addition, guards who enforce rules to protect the property of an employer or to protect the safety of persons on that employer's premises must be included in a separate and distinct unit. Id.


From organized labor's standpoint, generally the more units there are the better. This is because the smaller and more homogeneous a bargaining unit is, the easier it will be for the members to agree on a mutually advantageous course of collective action, and therefore the more attractive union will be, unionization being the vehicle for collective action by employees. . . . The diversity of . . . interests of the members of a large and heterogeneous unit . . . make[s] collective action difficult, [and makes it] hard for a union to gain majority support in such a unit . . . . [T]he employer's perspective is different. The more units there are, the more costly it will be
tion on the scope of a unit based not on an esoteric interpretation of Board precedent, but rather on their best prediction of which particular configuration will more likely produce winning election results for their side. In making unit determinations, the Board is required to strike a balance among the competing interests of unions, employees, employers, and the public at large. The precise balance among these competing interests is not explicitly defined in the Act; the Board determines the appropriate balance based on the particular facts and circumstances of each case.

III. RULEMAKING AND ADJUDICATION

Throughout its history, and despite its statutory rulemaking power, the Board has chosen to formulate national labor policy almost exclusively through the process of adjudication, the case-by-case determination of the appropriate solution for each different set of facts. This aversion to rulemaking survived a 1947 congressional reaffirmation of the Board's rulemaking authority in the Taft-Hartley Amendments. In the two decades that followed, as the use of rulemaking in other federal agencies grew, and as a growing body of commentary and judicial opinions developed that encouraged rulemaking and sought to improve its processes, the Board continued to embrace adjudication as its preferred method of operation.


73. *American Hosp. Ass'n*, 899 F.2d at 654. The Seventh Circuit recognized that the interests of the employees are not always identical to those of unions. Id.

74. *Id.* at 654 (citing Continental Web Press, Inc. v. NLRB, 742 F.2d 1087, 1090 (7th Cir. 1984); NLRB v. Res-Care, Inc., 705 F.2d 1461, 1469 (7th Cir. 1983); 29 U.S.C. §§ 151-169 (1988)).

75. 29 U.S.C. § 156. "The Board shall have the authority from time to time to make, amend, and rescind, in the manner prescribed by subchapter II of chapter 5 of title 5 [(the Administrative Procedure Act)], such rules and regulations as may be necessary to carry out the provisions of [the Act]." *Id.*

76. MARK H. GRUNEWALD, *THE LABOR BOARD'S FIRST RULEMAKING: AN EXERCISE IN PRAGMATISM* 1 (1991) (a report prepared for the consideration of and published by the Administrative Conference of the United States). There are some exceptions to the exclusivity of adjudication. The Board used rulemaking to establish jurisdictional standards for private colleges and universities and for symphony orchestras. 29 C.F.R. §§ 103.1-103.2 (1992). The Board also used rulemaking in deciding not to assert jurisdiction over the horseracing industry. 29 C.F.R. § 103.3 (1992).


78. GRUNEWALD, *supra* note 76, at 3.
Finally, in 1969, the Supreme Court declared that the Board had, in effect, promulgated a rule, although in doing so, the Board had violated the Administrative Procedure Act.\textsuperscript{79} Relying on this case, the Second Circuit Court of Appeals later argued that the Board was required to proceed by rulemaking, rather than by adjudication, when it proposes to "reverse a long-standing and oft-repeated policy" in representation cases.\textsuperscript{80} The Supreme Court, however, subsequently disagreed, holding that the Board has the discretion to proceed either by adjudication or by rulemaking in effecting a change in policy, as long as the Board's holding does not amount to an abuse of its discretion.\textsuperscript{81}

In 1978, Congress considered legislation that would have required the Board to employ rulemaking in several areas.\textsuperscript{82} Although this legislative attempt was unsuccessful, the Senate committee that had endorsed the legislation made a noteworthy observation that "there [was] no labor relations issue on which there [was] such a strong consensus of scholarly opinion as on the proposition that the Board should make greater use of its [statutorily authorized] rulemaking authority."\textsuperscript{83}

The Board's authority to fashion rules through common law, case-by-case adjudication is clear.\textsuperscript{84} The Board, throughout its history of case-by-case adjudication, however, has moved closer and closer to the establishment of

\textsuperscript{79} NLRB v. Wyman-Gordon Co., 394 U.S. 759 (1969). In this case, the Board, pursuant to its previous decision in Excelsior Underwear, Inc., 156 N.L.R.B. 1236 (1966), ordered a representation election among the employees and directed the employer to furnish a list of names and addresses of those employees who were determined to be members of the appropriate bargaining unit for distribution to the parties interested in the election. Wyman-Gordon, 394 U.S. at 761. The Supreme Court rejected the Board's suggestion that, without complying with the requirements of the Administrative Procedure Act (the APA), "commands, decisions, or policies announced in adjudication are 'rules' in the sense that they must, without more[,] be obeyed by the affected public." Id. at 764-66. The APA requires, among other things, publication in the Federal Register of notice of proposed rulemaking and of hearing; opportunity to be heard; a statement in the rule of its basis and purposes; and publication in the Federal Register of the rule as adopted. 5 U.S.C. § 553 (1988). The Court, however, also recognized that adjudicated cases may "serve as vehicles for the formulation of agency policies, which are applied and announced therein." Wyman-Gordon, 394 U.S. at 765. "They generally provide a guide to action that the agency may be expected to take in future cases." Id. at 765-66. Justice Black, joined by Justices Brennan and Marshall, concurred, explaining that the Board's use of the term "rule" in applying the so-called "Excelsior rule" implied a rule of law such as would be announced in a court opinion and not necessarily the kind of a rule required to be promulgated in accordance with the rulemaking procedures of the APA. Id. at 769 n.1. For the sake of clarity, Justice Black thereafter made reference to the Excelsior "requirement". Id.


\textsuperscript{83} S. 2467, 95th Cong., 2d Sess. (1978).

\textsuperscript{84} Textron, Inc., 416 U.S. at 290-95.
“relative fixed rules” or “principles” that have come to guide the parties in union representation cases. Because these principles are developed through Board precedent and are not promulgated in accordance with the Administrative Procedure Act, the principles are themselves subject to potential judicial review each time the Board applies them to cases before it. For this reason, case-by-case adjudication has been a source of frustration not only for the Board, but also for at least one circuit court. In 1987, Professor Charles Morris, Editor-in-Chief of The Developing Labor Law, a well-respected and frequently cited treatise on labor law, opined that substantive rulemaking pursuant to the Administrative Procedure Act and the National Labor Relations Act was “probably the most important thing the Board [could] do to effectuate its process, economize its time, and advise the people who need to know—most of whom are not lawyers—what the law requires.”

IV. LABOR RELATIONS IN THE HEALTH CARE INDUSTRY

The Act as originally enacted in 1935 did not contain an exemption for health care institutions. The Board was granted discretion in its exercise of jurisdiction, and it initially asserted that jurisdiction over all health care

85. Subrin, supra note 72, at 110; see, e.g., the “contract bar rules” discussed in Appalachian Shale Prods. Co., 121 N.L.R.B. 1160, 1163-64 (1958); the “Excelsior rule” enunciated in Excelsior Underwear Inc., 156 N.L.R.B. 1236, 1239-42 (1966); and the “Peerless Plywood rule” explicated in Peerless Plywood Co., 107 N.L.R.B. 427, 429-30 (1953).

86. Subrin, supra note 72, at 110 (citing NLRB v. Saint Francis Hosp., 601 F.2d 404 (9th Cir. 1979); Pacific Southwest Airlines v. NLRB, 587 F.2d 1032 (9th Cir. 1978); NLRB v. Mercy-Memorial Hosp. Corp., 575 F.2d 1196 (6th Cir. 1978)). In cases in which the Board indicates that application of a previously established principle will require a weighing of certain case-specific factors, “reviewing courts are tempted to look over the Board’s shoulder and do their own weighing, especially if it appears that the Board is finding ‘X’ unit appropriate 99 per cent of the time.” Subrin, supra note 72, at 110. In fact, by 1987, the Third, Fourth, Seventh, Ninth, Tenth, and Eleventh Circuits had all held that the legislative history of the Act warranted a different approach to fashioning health care bargaining units from the traditional community-of-interest criteria. Stickler & Nelson, supra note 63, at 128-29.

87. Out of a sample of 25 post-1976 circuit court decisions that reviewed Board unit determinations in the health care industry, approximately two-thirds of those decisions have been unfavorable to the Board and either refused to enforce Board orders or remanded to the Board for further consideration. Kathleen A. Curran, Note, The National Labor Relations Board’s Proposed Rules on Health Care Bargaining Units, 76 VA. L. REV. 115, 130-31 (1990).

88. See NLRB v. Res-Care, Inc., 705 F.2d 1461, 1466 (7th Cir. 1983) (expressing frustration with repeated case-by-case analyses on a charge nurse-supervisory issue and stating that although “the Board is entitled to some judicial deference in interpreting its organic statute as well as in finding facts, it would be entitled to even more if it had awakened its dormant rulemaking powers for the purpose of particularizing the application . . . to the medical field!”).


employers.\textsuperscript{91} When Congress passed the Taft-Hartley Act of 1947,\textsuperscript{92} it exempted not-for-profit hospitals by excluding from the definition of "employer" any corporation or association operating a hospital if no part of the net earnings inured to the benefit of any private shareholder or individual.\textsuperscript{93} In 1960, the Board exercised its jurisdictional discretion and decided that all hospitals should be removed from coverage.\textsuperscript{94} This position was reversed seven years later when the Board held that only not-for-profit hospitals and their employees should be exempt from the coverage of the Act.\textsuperscript{95} Early in the first session of the 93rd Congress in 1973, Congress, in response to predictions that organized labor was intending to make a strong effort to secure the repeal of the statutory exemption for not-for-profit hospitals,\textsuperscript{96} considered a bill that would have extended the Act's coverage to all private health care institutions, including not-for-profit hospitals.\textsuperscript{97} "The proposed legislation was highly controversial, largely because of the concern that labor unrest in the health care industry might be especially harmful to the public."\textsuperscript{98} This bill did not pass.\textsuperscript{99}

By the second session of the 93rd Congress, the staffs of the House and Senate Labor Committees, representatives of the health care industry, and organized labor officials had already been involved in considerable discussion of these issues. Consideration of health care amendments to the Act scattered sections of 29 U.S.C.) (amending the National Labor Relations Act to extend its coverage and protection to employees of "health care institutions").

\begin{footnotes}
\item[95] Butte Medical Properties, 168 N.L.R.B. 266, 268 (1967).
\item[96] Taft, supra note 91, at 2.
\item[97] S. 2292, 93d Cong., 1st Sess. § 2 (1973). This bill also sought to place a limit of five on the number of bargaining units in not-for-profit health care institutions. Id. § 9.
\item[98] American Hosp. Ass'n v. NLRB, 111 S. Ct. 1539, 1544 (1991). These public policy concerns were recently addressed by the Seventh Circuit:

[T]he work force of a hospital . . . tends to be at once small and heterogeneous. . . . If the desirability (from the union standpoint) of homogeneous units is stressed, even a hospital of average size might have ten or twenty or even more units, each with a bare handful of workers. The cost of the institution's labor relations and the probability of work stoppages would soar. Wages might soar, too. . . . Work stoppages, heavy bargaining costs, soaring wages, labor unrest—all these are matters of concern in a period of high and rising costs of health care.

\item[99] S. 2292, 93d Cong., 1st Sess. (1973); see Taft, supra note 91, at 2.
\end{footnotes}
recommenced. The proponent of the legislation agreed that in this session it would be advisable to stay as close as possible to the number of units proposed in the first session, to minimize political opposition from unions and the health care industry, and to grant the Board the flexibility it needed to avoid bargaining unit proliferation on a case-by-case basis. Senator Taft stressed the need for the Board to consider the public interest, especially the increasing cost of health care, in determining appropriate units. After much debate, the National Labor Relations Amendments of 1974 were enacted. The health care amendments represented a congressional compromise between the truly incompatible interests of two of its important constituencies: the health care industry and organized labor. The amendments subjected all acute care hospitals, both profit and not-for-profit, to the coverage of the Act but did not specifically address the appropriate number and scope of bargaining units or the Board's authority to make such unit determinations on a case-by-case basis.

The health care industry, however, in an apparent attempt to influence subsequent Board decisions, succeeded in persuading the members of both the House and Senate committees to include in their reports an admonition

100. Taft, supra note 91, at 2.
101. Id. at 3.
102. 120 CONG. REC. 12,944 (1974).

[T]he Board should . . . consider the issue of the cost of medical care. Undue unit proliferation must not be permitted to create wage "leapfrogging" and "whipsawing." The cost of medical care in this country has already skyrocketed, and costs must be maintained at a reasonable level to permit adequate health care for Americans from all economic sectors.

The committee, in recognizing these issues with regard to bargaining unit determination, took a significant step forward in establishing the factor of public interest to be considered by the Board in unit cases. Id. at 12,945.
103. In the period between the Taft-Hartley Amendments of 1947 and the health care amendments of 1974, there was very little organizational activity among health care workers. Accordingly, there were very few reported Board decisions regarding appropriate health care bargaining units. The absence of relevant case law posed a considerable challenge for those involved in the drafting of the amendments. Taft, supra note 91, at 2.
106. "Acute" is defined as: "[h]aving a sudden onset and a short, but rather severe, course opposed to chronic, which designates a relatively slow onset and a protracted, but mild, course." SCHMIDT'S ATTORNEY'S DICTIONARY OF MEDICINE A82 (1991). Acute care hospitals are in-patient hospitals with relatively short overnight patient stays.
107. Pub. L. No. 93-360, 88 Stat. 395 (1974). In addition, the Act was amended to require ten-day advance notification of a strike and to increase the notification requirements of a desire to modify or terminate a collective bargaining unit. Id.
to the Board against proliferation of bargaining units in the health care industry.108 The initial impact of the Committee Reports’ admonition upon subsequent Board decisions involving bargaining unit determinations in the health care industry was considerable.109 In 1989, however, the Board expressed its view that the admonition itself should not be afforded great weight in its unit determinations.110 This declaration came shortly after a concession by the Board that its intention was “at all times to be mindful of avoiding undue proliferation111 [of bargaining units in the health care industry] not only because this desire was expressed in the legislative history, but also because it accords with [the Board’s] view of what is appropriate in the health care industry.”112

The Seventh Circuit has characterized the congressional admonition as an

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108. Both reports contained the following caveat: “Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry.” S. REP. No. 766, 93d Cong., 2d Sess. 5 (1974); H.R. REP. No. 1051, 93d Cong., 2d Sess. 6 (1974).

109. Shelton, supra note 58, at 164. For example, in two decisions issued within a year of the passage of the Amendments, the Board referred to the admonition in support of the avoidance of the proliferations of units in the health care industry. Mercy Hosps. of Sacramento, Inc., 217 N.L.R.B. 765, 766 (1975) (considering the admonition in determining the appropriateness of the units of registered nurses and nurse permittees, professional employees excluding registered nurses, medical laboratory technologists, service and maintenance employees, clerical employees and supplemental employees); Shriners Hosps. for Crippled Children, 217 N.L.R.B. 806, 807 (1975) (rejecting the appropriateness of a unit of stationary engineers that represented five of the employer’s eighty-eight employees based on the admonition).

110. Collective-Bargaining Units in the Health Care Industry, 54 Fed. Reg. 16,336, 16,346 (1989). The Board reasoned that “in the decade between 1974 and 1984[,] ... [d]espite continual uncertainty as to the proper standard, there was considerable organizational activity, and ... there were virtually none of the disruptive consequences which concerned Congress during the 1974 debates.” Id. at 16,346.

111. Some emphasis has been put on the fact that the Committee Report uses the language of preventing proliferation rather than preventing undue proliferation. See Legislative History of the Coverage of Nonprofit Hospitals Under the N.L.R.A., H.R. 11,357, 93d Cong., 2d Sess. 105 (1974). The word “undue” appears nowhere in the committee reports. Id.

Inexplicably, the Board began using the term ["undue"] in certain health care bargaining unit cases decided in 1975. Unfortunately, this mistake has been compounded through the years. Indeed the phrase undue proliferation [has been used by the Board] in an apparent attempt to justify greater tolerance than Congress intended for an increased number of health care bargaining units in health care institutions. Taft, supra note 91, at 5 (footnotes omitted); see, e.g., Saint Catherine's Hosp. of Dominican Sisters, 217 N.L.R.B. 787, 788 (1975).

112. Collective-Bargaining Units in the Health Care Industry, 53 Fed. Reg. 33,905 (1988). Notwithstanding the above discussion, the Board believes that “Congressional and industry concern ... [is] directed towards the 15 to 20 plus units that had arisen prior to the amendments and the possibility of scores of units if each hospital classification were permitted to organize separately.” 53 Fed. Reg. 33,933. Current Board Chairman, James Stephens, has implied that the legislative history of the amendments indicated to him that proliferation would exist only if the number of bargaining units in an acute care hospital were in the double digits. 56 Daily Lab. Rep. (BNA) A-3 (Mar. 24, 1989).
example of the oxymoron\textsuperscript{113} of post-enactment legislative history, calling it a “sneaky device for trying to influence the interpretation of a statute, in derogation of the deal struck in the statute itself among the various interests represented in the legislature.”\textsuperscript{114} Judge Posner warned that “[c]ourts must be careful not to fall for such tricks and thereby upset a legislative compromise.”\textsuperscript{115} Consistent with the most recent view of the Board, he rejected the validity of any influence exerted by the admonition and reiterated a basic tenet of American government: “Congress legislates by passing bills and sending them to the president for his signature. It does not legislate by issuing committee reports.”\textsuperscript{116} The final word came from the Supreme Court, which ultimately declared without qualification that the admonition does not have the force of law.\textsuperscript{117} It is merely “an expression by the Committees of their desire that the Board give ‘due consideration’ to the special problems that ‘proliferation’ might create.”\textsuperscript{118}

V. PROMULGATION OF THE RULE

The 1974 health care amendments set in motion the impetus that compelled the Board eventually to break with tradition and to engage in rulemaking; however, the immediate catalyst was a March 1987 decision by the United States Court of Appeals for the District of Columbia Circuit that has come to be known as \textit{St. Francis III}.\textsuperscript{119} The court held that the Board’s reliance on the legislative history of the 1974 amendments and its interpretation of them as requiring the disparity-of-interests analysis constituted an abuse of its discretion.\textsuperscript{120} On May 4, 1987, the Board held rare oral argument regarding \textit{St. Francis III} to determine which test the Board should utilize in determining health care bargaining units generally.\textsuperscript{121} In June of that same year, the Board held several meetings to consider rulemaking.\textsuperscript{122}

Berton Subrin, the Director of the Office of Representation Appeals of the

\textsuperscript{113} American Hosp. Ass’n v. NLRB, 899 F.2d 651, 657 (7th Cir. 1990) (“[T]he history of an event lies in its past, not its future.”), \textit{aff’d}, 111 S. Ct. 1539 (1991).
\textsuperscript{114} \textit{Id.} at 657 (citing \textit{Covalt v. Carey Canada, Inc.}, 860 F.2d 1434, 1438-39 (7th Cir. 1988); \textit{In re Tarnow}, 749 F.2d 464, 467 (7th Cir. 1984)).
\textsuperscript{115} \textit{Id.}
\textsuperscript{116} \textit{Id.}
\textsuperscript{118} \textit{Id.} “In any event, we think that the admonition . . . is best understood as a form of notice to the Board that if it did not give appropriate consideration to the problem of proliferation in this industry, Congress might respond with a legislative remedy.” \textit{Id.}
\textsuperscript{119} Stickler \& Nelson, \textit{supra} note 63, at 128 (referring to \textit{International Bhd. of Elec. Workers, Union No. 474 v. NLRB}, 814 F.2d 697 (D.C. Cir. 1987)).
\textsuperscript{120} 814 F.2d at 714.
\textsuperscript{121} Stickler and Nelson, \textit{supra} note 63, at 128.
\textsuperscript{122} \textit{Id.}
National Labor Relations Board, called for broader use by the Board of its rulemaking authority seven years prior to the Board's decision to do so. Mr. Subrin woefully admitted that "Board volumes [were] replete with decisions containing lengthy narratives as to whether the plant manager can hire or fire or schedule or grant overtime, which parking lot or restrooms various groups use . . . or which employees wear common uniforms." The pressing need for a solution to the health care unit issue, the Board's desire to improve relations with its labor constituency, and outspoken staff initiative (such as that exemplified by Mr. Subrin's article) all influenced the Board's consideration of rulemaking on the health care issue.

On July 2, 1987, the Board announced its decision to engage in rulemaking. The Board signalled its apparent agreement with Mr. Subrin that the two prime considerations of unit determination, at least in the health care industry, should be predictability and clarity. The Board was optimistic that rulemaking would be "a valuable long-term investment, paying dividends in the form of predictability, efficiency, and more enlightened determinations as to viable appropriate units, leading ultimately to better judicial and public acceptance."

Although the notice and comment procedures of section 553 of the Administrative Procedure Act required only that the Board provide an opportunity for written comments on the proposed rule, the Board decided to hold public hearings, to receive both oral and written comments, and to per-

123. Subrin, supra note 72 at 112-13. Mr. Subrin's article discusses the advantages to the Board and to the labor relations community of utilizing rulemaking on the subject of appropriate bargaining units generally.
124. Id. at 106.
125. GRUNEWALD, supra note 76, at 35.

[I]n light of the fact that, after 13 years, we are no further along in achieving consensus . . . than we were in 1974, and since . . . we are convinced that laborious, costly, case-by-case recordmaking and adjudication in this remarkably uniform field has proved to be an unproductive expenditure of the parties' and the taxpayers' funds, we have decided to engage in rulemaking.

52 Fed. Reg. 25,142, 25,144. The decision to embark on rulemaking was 3-2: Members Babson, Stephens, and Cracraft for rulemaking; Chairman Dotson and Member Johansen against. Stickler & Nelson, supra note 63, at 128.

127. In Mr. Subrin's opinion, "[T]he units deemed appropriate are than that they be known in advance, with clarity." Subrin, supra note 72, at 107.
129. "After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation." 5 U.S.C. § 553(c) (1988) (emphasis added).
mit limited cross-examination. The detailed and exhaustive evidence received by the Board at the hearings and during the comment period substantially exceeded what the Board expected.

Industry opponents of the proposed rule put forth many arguments. In short, the health care industry objected to any rule that required recognition of more than the statutory minimum of three units, namely, professional employees, nonprofessional employees, and guards. The Board considered all of the arguments, emphasizing the contentions that the proposed rule would lead to increased organizing by unions; that multiple units would result in strikes, repeated strike notices, jurisdictional disputes, and other

130. 52 Fed. Reg. 25,142, 25,148 (1987). In undertaking this new method of policy formulation, the Board assured the affected parties that there would be full opportunity to participate since there was concern that without oral testimony and cross-examination the Board would only receive the kinds of legal arguments that it traditionally heard in adjudications. Grunewald, supra note 76, at 18. This form of dialogue was consistent with the model of labor-management relations that the Board and its constituencies generally accepted. Id. In addition, this method was intended to minimize the likelihood of legal challenge to the action on procedural grounds. Id.

131. Collective-Bargaining Units in the Health Care Industry, 53 Fed. Reg. 33,900 (1988). The first hearing was held in Washington, D.C. on August 17 and 18, 1987. Id. Twenty witnesses appeared and 496 pages of testimony were taken. Id. The second hearing was held in Chicago, IL on August 31 and September 1, 1987. Id. Twenty-seven witnesses appeared and 521 pages of testimony were taken. Id. The third hearing was held in San Francisco, CA on September 14, 15, and 16, 1987. Id. Thirty-nine witnesses appeared, and 762 pages of testimony were taken. Id. The final hearing was held in Washington, D.C. on October 7, 8, 9, 13, 14, 15, and 16, 1987. Id. Fifty-eight witnesses appeared and 1,766 pages of testimony were taken. Id. At the hearings, any party who wished to testify or ask questions of the various witness was given an opportunity to do so. Id. The comment period was extended three times upon the request of various parties. Id. In addition to the 144 witnesses who testified, the Board received 315 written comments from individuals and organizations representing diverse points of view totalling approximately 1500 pages. Id. The Board proved serious its contention that there would be full opportunity for all interested parties to participate.

132. Collective-Bargaining Units in the Health Care Industry, 54 Fed. Reg. 16,336, 16,336-37 (1989). The list of arguments that were put forth against rulemaking generally and against the Final Rule in particular includes: (a) the health care industry is unfairly being singled out for rulemaking; (b) rulemaking is contrary to the language of § 9(b) of the Act, requiring a case-by-case approach; (c) the particular units proposed are inappropriate; (d) the implementation of the proposed rule will lead to increased litigation; (e) the Board should consider an alternative to a rule, such as a Board panel deciding health care issues; (f) the rule will expedite the Board's election process and result in insufficient time for an employer to respond to a union's organizing campaign; (g) hospitals will lose needed flexibility; and (h) if the Board establishes units, there should be only two units, professionals and nonprofessionals, plus guards. Id. Some commentators also argued that although the Board was procedurally within its jurisdiction to adopt appropriate rules as set forth in § 6 of the Act, that this particular rule, due to its extreme rigidity, did not provide an opportunity for meaningful adjudication "in each case", and, therefore, fell on its own weight. Stickler & Nelson, supra note 61, at 130.

133. American Hosp. Ass'n v. NLRB, 899 F.2d 561, 654 (7th Cir. 1990), aff'd, 111 S. Ct. 1539 (1991). In other words, since no rule is necessary to confer rights already granted by the Act, the industry objected to the promulgation of any rule at all. Id.
disruptions of health care; and that health care costs would substantially increase as a result of strikes, work rules, and bargaining and contract administration. 134

The Board, upon careful consideration of each of the opponents' contentions, either rejected the argument as inconsequential or invalid, or adapted the rule based on what it accepted as a legitimate concern. 135 The Board, however, emphasized that empirical data in the record revealed that between 1974 and 1984, there were eight distinct units recognized throughout the industry as appropriate under Board precedent. 136 In addition, the Board considered that the incidence of strike activity in the health care industry had been lower than in all other industries. 137 The Board also rejected outright any cost-consideration arguments, noting that the 1974 health care amendments were passed in response to congressional concerns regarding low wages and poor working conditions in the health care industry. 138 The Board justified its position by concluding that the beneficial objectives of collective bargaining upon which the Act was based must necessarily be obtained at some financial cost. 139

The Board discussed protracted litigation as another possible motivation for the health care industry's objection to the rule. Employers initiate protracted litigation in order to produce "lengthy delays and great difficulties in organizing." 140 Under existing Board standards, hospitals could delay union elections by challenging the composition of the group of employees

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134. 54 Fed. Reg. 16,336, 16,336-37 (1989). The District Court for the Northern District of Illinois later provided a valid opposing argument that case-by-case adjudication may actually be more appropriate to the Board's function because, in many situations, it is "more amenable to the unique circumstances of employers and employees in diverse settings, and perhaps, a necessary burden for a labor policy which will extend to employees the fullest freedom to exercise their rights." American Hosp. Ass'n v. NLRB, 718 F. Supp. 704, 713 (N.D. Ill. 1989), rev'd, 899 F.2d 651 (7th Cir. 1990), aff'd, 111 S. Ct. 242 (1991).

135. See generally 53 Fed. Reg. 33,900 (1988) and 54 Fed. Reg. 16,336 (1989) (both discussing the Board's consideration of these and other arguments both favoring and opposing rulemaking generally and specifically in the arena of the determination of health care bargaining units).


being targeted as a bargaining unit. Subsequent Board hearings on the legitimacy of the unit, including arguments as to the greater appropriateness of one group over another, or the inclusion or exclusion of a specific job classification, or even the status of a specific employee, could be prolonged for months or years, possibly dooming the union's chances for a successful election. Management predicted that the proposed rule would replace this lengthy process with a rubber stamp, thereby destroying the only legal roadblock to union elections.

The Board recounted a reported admission by a management-side consultant that the delays brought about by contesting health care unit determinations were frequently an important part of management's strategy in union avoidance. In contrast, some hospital executives claimed that the pre-election hearings were encouraged by legitimate concerns that unions were trying to organize employees into units that were either too small or too large to be effective for the workers. Unions were skeptical. "By the time the NLRB finally settled an issue, all those employees who originally wanted an election could be fired or retired or dead," said Gary Robinson, executive administrator of the Oakland-based American Union of Physicians and Dentists. 'It was just a cynical attempt by hospitals to manipulate the rules in their favor.'

Not all members of the health care management community were diametrically opposed to rulemaking. One individual with prior experience as a department head in several hospitals observed that rulemaking might actually reduce costs in the industry since both the unions and management would spend fewer dollars and less time on legal maneuvering and on or-

141. Stein, supra note 39, at 19.
142. Id.
143. Id.
144. 53 Fed. Reg. 33,900, 33,902 (1988) (citing [Current Developments] Daily Lab. Rep. (BNA) A-2 (BNA) (Aug. 6, 1987), which reported that at a workshop on unions, consultant Raymond Mickus predicted that the Rule would spark increased union activity). He predicted faster elections, adding that employers would not have access to the hearings or briefs that they were accustomed to using to delay the proceedings. Id. Another health care industry representative agreed, stating, "The greater the time between the initial union petition and the election, the less chance there is that the union will win." Id. (citing [Current Developments] Daily Lab. Rep. (BNA) (Sept. 29, 1987), which quoted the vice president of labor relations for Mount Sinai Medical Center addressing management's typical strategy though not necessarily advocating it himself).
145. Stein, supra note 39, at 19.
146. Id.
147. 53 Fed. Reg. 33,900, 33,902 (1988). Holy Redeemer Health System predicted that rulemaking would be a "welcome relief" from the existing situation in which unit determinations were confusing and hard to follow. Id. Kaiser recognized the disadvantages to both parties of protracted litigation. Id.
organizing campaigns.\textsuperscript{148}

Finally on April 29, 1989, after several drafts had been presented for public review and commentary, the Board announced its intention to issue the final rule.\textsuperscript{149} This notice included the complete version of the final rule (the Rule).\textsuperscript{150} In short, the Rule provides that the Board will recognize the fol-


\textsuperscript{149} 54 Fed. Reg. 16,336 (1989). The Board ultimately concluded that, in the health care industry, "establishing bargaining units by rulemaking [would] 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." \textit{Id}. One of the five members of the Board, Wilford W. Johansen, dissented from the Rule, characterizing rulemaking as "neither desirable nor appropriate" in this situation. 53 Fed. Reg. 33,900, 33,934-35 (1988).

\textsuperscript{150} 54 Fed. Reg. 16,336, 16,345. The Rule provides, in pertinent part, as follows:

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 . . . except that, if sought by labor organizations, 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.

\textit{Provided That} a unit of five or fewer employees shall constitute an extraordinary circumstance.

(b) Where extraordinary circumstances exist, the Board shall determine appropriate units by adjudication.

(c) Where there are existing nonconforming units in acute care hospitals, and petition for additional units is filed pursuant to sec. 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 unit set forth in paragraph (a) of this section.

(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 . . . .

(f) For purposes of this rule, the term:

(2) Acute care hospital is defined as: either a short term care hospital in which the average length of patient stay is less than thirty days, or a short term care hospital in which over 50% of all patients are admitted to units where the average length of patient stay is less than thirty days . . . . The term "acute care hospital" shall include those hospitals operating as acute care facilities even if those hospitals provide such services as, for example, long term care, outpatient care, psychiatric care, or rehabilitative care, but shall exclude facilities that are primarily nursing homes, primarily psychiatric hospitals, or primarily rehabilitation hospitals.
lollowing, and only the following, eight bargaining units for employers of acute care hospitals: (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; and (8) all nonprofessional employees except for those specifically listed as appropriate above.151 The Rule recognizes three exceptions: cases that present extraordinary circumstances,152 cases in which nonconforming units already exist,153 and cases in which labor organizations seek to combine two or more of the eight specified units.154 The extraordinary circumstances exception applies automatically to hospitals in which the eight unit rule will produce a unit of five or fewer employees.155 The rule is limited to acute care hospitals but does not differentiate among them by size or location.156

VI. LITIGATION CHALLENGING THE RULE

In a series of articles published prior to the promulgation of the Rule, the American Hospital Association (the AHA) expressed a great number of concerns on behalf of the health care industry. The AHA claimed that the immediate effect of the Rule would be an increase in union-organization efforts and successes "by splintering employee groups within hospitals into unrealistically delineated bargaining units."157 They worried that as a result, health care providers would be faced with a multiplicity of organizing campaigns, contract negotiations and arbitration administration as well as increased potential for the disruption of services occasioned by strikes and

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151. 29 C.F.R. § 103.30(a) (1992). Interestingly, and quite possibly in contradiction, the Board argued in the course of its rulemaking proceedings that Congress had not intended for the Board to answer the question of whether any given number of units found appropriate was proliferative "in the abstract—as if, for example, 'x' number of units are automatically proliferative, but 'y' are not." 54 Fed. Reg. 16,336, 16,345 (1989).
152. 29 C.F.R. § 103.30(b) (1992).
153. 29 C.F.R. § 103.30(c) (1992).
154. 29 C.F.R. § 103.30(a) (1992).
155. Id.
156. Id.; 29 C.F.R. § 103.30(f) (1992).
work stoppages. They were also concerned that management's ability to respond to change would be severely restricted. The AHA asserted that the Board had ignored the "interdependence, integration, and coordination of services among health care employees" in arriving at its ultimate unit determinations. The AHA predicted that joint ventures, mergers, and affiliations would be hampered or impeded by having to face and negotiate with different labor organizations representing different employee groups "each with its own political aspirations and economic needs." The Rule, declared the AHA, represented "a threat to the delivery of effective and cost-efficient health care in this country."

By contrast, unions viewed the Rule as offering hope at a time when despair was the norm. According to union representatives, the union movement had fallen on hard times in recent years as a result of the decreasing employment rates of most U.S. industries. The health care industry, by contrast, was vital and expanding, making it an attractive target for union organization.

The AHA ultimately challenged the facial validity of the Rule in the District Court for the Northern District of Illinois. The district court agreed with the AHA's position that the Rule violated the congressional admonition to the Board to avoid the proliferation of bargaining units in the health care industry and the court accordingly enjoined enforcement of the Rule. On appeal, the Court of Appeals for the Seventh Circuit found no merit in any of the AHA's arguments, reversed the district court's decision, vacated

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158. Stickler & Nelson, supra note 63, at 130.
159. Id.
161. Stickler & Nelson, supra note 63, at 130.
162. Rhodes, supra note 158, at 2.
163. Stein, supra note 39, at 28.
164. Id.
165. Id.
167. American Hosp. Ass'n, 718 F. Supp. at 716. The AHA also argued that the Rule is arbitrary and capricious as written and that section 9(b) of the Act requires the Board to make a separate bargaining unit determination "in each case" and, therefore, plainly prohibits the Board from using general rules to define bargaining units. Id. at 705. These arguments were later rejected by the Supreme Court. 111 S. Ct. at 1541-47.
the injunction, and entered judgment for the Board.\textsuperscript{168} The Supreme Court granted certiorari\textsuperscript{169} due to the importance of the case and, in a unanimous decision written by Justice Stevens, affirmed the decision and endorsed the reasoning of the Seventh Circuit Court of Appeals.\textsuperscript{170}

The immediate reaction to the Supreme Court’s decision from organized labor was predictable. “‘Many [union] groups with large healthcare membership are gearing up right now to take advantage of the new rules. There will be a lot of [collective bargaining unit] petitions filed and a lot of elections won over the next few years.’”\textsuperscript{171} “‘We think there’s more of an interest in union representation than ever before.’ ‘Now its really going to be the decision of the employees, not the hospital lawyers, which is what the law intended in the first place.’”\textsuperscript{172} Management’s dismay was no less surprising. “‘We expect it to have a dramatic impact. . . . It’s going to have a domino effect on the cost of labor in the industry.’”\textsuperscript{173}

VII. PRACTICAL APPLICATION OF THE RULE

The Rule affects only those health care facilities that are “acute care hospitals” as defined by the Rule.\textsuperscript{174} All health care facilities that are not acute care hospitals are excluded from the Rule’s mandated unit determinations; appropriate unit determinations in those other facilities will continue to be made by case-by-case adjudication.\textsuperscript{175} The Board’s research revealed a traditionally accepted and commonly understood distinction between acute

\begin{footnotes}
\footnote{168}{American Hosp. Ass’n v. NLRB, 899 F.2d 651, 655-60 (7th Cir. 1990), rev’d, 718 F. Supp. 704 (N.D. Ill. 1989), aff’d, 111 S. Ct. 1539 (1991).}
\footnote{169}{American Hosp. Ass’n v. NLRB, 111 S. Ct. 242 (1990). The AHA’s petition for Supreme Court review was not opposed by the Board, the party intervenors, the American Nurses Association, or the AFL-CIO.}
\footnote{170}{American Hosp. Ass’n v. NLRB, 111 S. Ct. 1539, 1541-47 (1991), aff’d, 899 F.2d 651 (7th Cir. 1990).}
\footnote{171}{Stein, supra note 39, at 28 (quoting Gary Robinson of the American Union of Physicians and Dentists). \textit{Id.}}
\footnote{172}{\textit{Id.} (quoting Maureen Anderson, spokeswoman for the California Nurses Association). \textit{Id.}}
\footnote{173}{\textit{Id.} at 19 (quoting Tom Luevano, vice president of human resources and governance for the California Association of Hospitals and Health Systems).}
\footnote{174}{29 C.F.R. § 103.30(a) (1992).}
\footnote{175}{29 C.F.R. § 103.30(g) (1992). The Board used the following statistics in deciding to apply the Rule only to acute care hospitals: Of the 4381 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. 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.}
\end{footnotes}
care and long-term care facilities.\textsuperscript{176} It appeared to the Board that there had been relative uniformity of workforce configurations and job classifications among acute care hospitals throughout the industry.\textsuperscript{177} The Board proclaimed that rulemaking was a response to a perception that the workforce of acute care hospitals is particularly susceptible to rules of general applicability regarding the contours of bargaining units.\textsuperscript{178} Based on the record presented before it, the Supreme Court agreed.\textsuperscript{179}

The Rule, however, does not conclusively establish invariable parameters of bargaining units even when acute care hospitals are involved.\textsuperscript{180} The Rule does not affect existing nonconforming units.\textsuperscript{181} The Rule does not preclude combinations of the eight prescribed units or regional approval of agreements between unions and employers that stipulate the appropriateness of units that differ from those mandated by the Rule.\textsuperscript{182} The Board has also excepted from the coverage of the Rule any employer who can make a showing that extraordinary circumstances exist.\textsuperscript{183} The Board wished to “allow for the possibility of individual treatment of uniquely situated acute care hospitals so as to avoid accidental or unjust application of the [R]ule.”\textsuperscript{184} The Board has proclaimed its intent, however, to construe this exception very narrowly, so that it does not provide a loophole for redundant or unnecessary litigation and the concomitant delay that typically ensues.\textsuperscript{185}

In a report prepared for the consideration of and later published by the Administrative Conference of the United States, Mark H. Grunewald, Professor of Law of the Washington and Lee University School of Law, opined that the prognosis for the Rule was good.\textsuperscript{186} Yet he recognized one likely

\textsuperscript{176} Id. at 33,930.
\textsuperscript{177} Id.
\textsuperscript{179} American Hosp. Ass’n v. NLRB, 111 S. Ct. 1539, 1546 (1991). “The Board’s conclusion that, absent extraordinary circumstances, ‘acute care hospitals do not differ in substantial, significant ways relating to the appropriateness of units,’ was based on a ‘reasoned analysis’ of an extensive record.” Id.
\textsuperscript{181} 29 C.F.R. § 103.30(a) (1992).
\textsuperscript{182} 29 C.F.R. §§ 103.30(a), (d) (1992).
\textsuperscript{183} 29 C.F.R. § 103.30(a) (1992).
\textsuperscript{184} 53 Fed. Reg. 33,900, 33,932 (1988) (footnote omitted). This exception was provided in order to ensure satisfaction of all parties’ due process rights. Id.
\textsuperscript{185} 53 Fed. Reg. 33,900, 33,932 (1988). “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.” 53 Fed. Reg. 33,900, 33,933 (citations omitted).
\textsuperscript{186} GRUNEWALD, supra note 76, at 36. “The terms of the [R]ule are clear and straightforward; the [R]ule establishes appropriate units; it does not merely set standards for units or presume certain units to be appropriate.” Id. In preparation for his report, Grunewald thoroughly researched the history of the Rule and interviewed Board officials, members of the
problem: the potential for a shift in the focus of litigation from the question of the appropriateness of particular units to the question of the "placement" of employees in what are concededly appropriate units. In his dissent, Boardmember Johansen also recognized the potential for a shift in litigation, intimating that it would defeat the Rule's stated purpose of election facilitation.

One of the Board's earliest stated rationales for its decision to venture into substantive rulemaking was to facilitate the election process. The Board anticipated that rulemaking would ultimately bring about less, rather than more, litigation over the boundaries of particular units, notwithstanding its recognition that there still would be litigation on the issue of the placement of individual job classifications within the eight broadly defined units. Although the Rule is still in its infancy, and its effectiveness may not accurately be assessed for many years, a review of some of the cases considered by the Board after the Supreme Court's decision in American Hospital Association provides insight into the Rule's potential consequences.

A. Saint Margaret Memorial Hospital

In Saint Margaret Memorial Hospital, the first published opinion of a decision arising under the provisions of the Final Rule, the employer averred that the unit of skilled maintenance employees for which the union petitioned was not an appropriate unit for collective bargaining under section 9(b) of the Act. The Rule specifically includes skilled maintenance employees as one of the eight prescribed units. Although the employer agreed that the petitioned-for unit conformed to the prescriptions of the labor-management bar, and representatives of the affected parties, including labor organizations who had participated in the rulemaking. Id. at 2 n.8.

187. Id. at 36. Although there may be less litigation on the issue of which units are appropriate, there may be new litigation on the issue of which employees belong in each of the eight units.

188. 53 Fed. Reg. 33,900, 33,935 (1988). Reduced litigation facilitates elections. "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." Id.

189. 52 Fed. Reg. 25,142 (1987). "In order to facilitate the election process, the . . . Board proposes to amend its rules to include a new provision specifying which bargaining units will be found appropriate in various types of health care facilities." Id.


192. Id. at 2-3. The union sought to represent in a single unit of "all skilled maintenance employees, including stationary engineers, electricians, HVAC mechanics, carpenters, painters, maintenance mechanics, electronic technicians and HVAC electronic technicians . . . ; excluding all business office clerical employees, all technical employees, and professional employees, guards and supervisors as defined in the Act, and all other employees." Id. at 2.

193. 29 C.F.R. § 103.30(a) (1992).
Rule, it argued that "'extraordinary circumstances' exist[ed] within the meaning of the Rule" that justified a specific determination by the Regional Director of the appropriateness of the unit for its facility.\textsuperscript{194} The employer asserted that, if permitted to do so, it could and would submit evidence to establish that the skilled maintenance employees share a community of interest with other nonprofessional employees and do not have wages, hours, or other terms and conditions of employment distinct enough from other non-professional employees "so as to justify representation in a separate collective-bargaining unit."\textsuperscript{195} The employer therefore suggested that the appropriateness of the unit must be adjudicated.\textsuperscript{196}

In this case, the Board was given its first opportunity to enforce its earlier declaration that the extraordinary circumstances exception would be narrowly construed. The Board denied the Employer's Request for Review stating that it "raise[d] no substantial issues warranting review," and, issuing no opinion of its own, adopted the Regional Director's Decision and Direction of Election in the case.

The Regional Director pointed out that each of the employer's arguments had been raised in the course of the rulemaking proceedings and that the Board had carefully considered each of them in reaching its conclusion that a separate unit of skilled maintenance employees was appropriate for the industry.\textsuperscript{197} The Regional Director found no support for the contention that extraordinary circumstances existed that warranted adjudication of the unit's appropriateness.\textsuperscript{198} The Regional Director ordered an election among the skilled maintenance employees in the petitioned-for unit, as mandated by the Rule.\textsuperscript{199}

Unit determinations are not a new subject of litigation.\textsuperscript{200} The determination of when extraordinary circumstances exist, thereby meriting Board review under the Rule, however, is a novel result of the Rule as written.\textsuperscript{201} The Board has explained that this provision was included and designed in order to satisfy due process requirements by permitting litigation when the circumstances of the case are truly extraordinary; the Board has cautioned, however that the Rule is intended to preclude litigation when the issues presented are repetitive of considerations entertained by the Board in the

\textsuperscript{194} Saint Margaret Memorial Hosp., 303 N.L.R.B. No. 146 at 4.
\textsuperscript{195} Id. The employer also pointed to such factors as functions and skill levels; education, licensing and training; and interaction with other employees. Id. at 6.
\textsuperscript{196} Id. at 5.
\textsuperscript{197} Id. at 6.
\textsuperscript{198} Id.
\textsuperscript{199} Id. at 8-9.
\textsuperscript{200} See supra notes 61-74 and accompanying text.
\textsuperscript{201} 29 C.F.R. § 103.30(a), (b) (1992).
rulemaking proceedings. It is evident, then, that this type of litigation was a pre-established element of the Rule.

The employer, arguing the inappropriateness of the unit determination, presented an issue that was not ultimately decided by the Regional Director or the Board. The employer reminded the Regional Director of the existing binding precedent of the Court of Appeals for the Third Circuit, which holds that a collective bargaining unit that is limited to skilled maintenance employees is not an appropriate unit for bargaining in an acute care hospital. The employer argued that because the Supreme Court, deliberately avoiding any extended comment on the propriety of the specific unit determinations, did not expressly overrule any existing precedent in its American Hospital Association decision, the appropriateness of this unit must be adjudged in light of Third Circuit precedent. The Regional Director, in dicta, gave this argument careful consideration, noting Justice Stevens' explanatory remarks in American Hospital Association that the Court was silent "solely because these matters primarily concern the Board's exercise of its authority . . . ." The Regional Director also pointed to the Court's finding that the Rule was based on a "reasoned analysis" of the Board's rulemaking record and on the Board's years of experience in the adjudication of health care issues. In denying the Employer's Request for Review and adopting the Regional Director's Decision and Direction of Election, the Board tacitly agreed with Justice Stevens.

Although the Board found "nothing in the Supreme Court's decision to suggest that [the Supreme Court] had any reservations concerning the appropriateness of any of the eight separate bargaining units established by the Rule," the Board explicitly put on the record that it had reached its ultimate conclusion to deny review in this case "notwithstanding [the fact] that legal precedent concerning unit determinations which are contrary to the appropriateness of the eight separate units recognized by the Rule were not

203. Saint Margaret's Memorial Hosp., 303 N.L.R.B. No. 146 at 4-5.
204. Id.
205. Id. at 5. The Supreme Court had stated: "In this opinion, we have deliberately avoided any extended comment on the wisdom of the rule, the propriety of the specific unit determinations, or the importance of avoiding work stoppages in acute care hospitals." American Hosp. Ass'n v. NLRB, 111 S. Ct 1539, 1547 (1991).
206. Saint Margaret's Memorial Hosp., 303 N.L.R.B. No. 146 at 7. Justice Stevens had explained: "We have pretermitted such discussion not because these matters are unimportant but because they primarily concern the Board's exercise of its authority rather than the limited scope of our review of the legal arguments presented by the [AHA]." American Hosp. Ass'n, 111 S. Ct. at 1547.
207. Saint Margaret's Memorial Hosp., 303 N.L.R.B. No. 146 at 7.
208. Id.
expressly overruled by the Supreme Court's *American Hospital Association* decision.\textsuperscript{209}

**B. Child's Hospital, Inc.\textsuperscript{210}**

In *Child's Hospital, Inc.*, the Board was faced with an employer's Request for Review of a Regional Director's\textsuperscript{211} decision that the petitioned-for unit of registered nurses was appropriate at its facility.\textsuperscript{212} The employer characterized itself as an "amalgam type of institution."\textsuperscript{213} The employer argued that Child's Hospital is not an "acute care hospital" for the purposes of the Rule.\textsuperscript{214} In the alternative, the employer argued that there are nevertheless

\textsuperscript{209} *Id.* Although the employer's argument merited consideration by the Regional Director, no conclusions as to the validity of conflicting precedent were drawn. *Id.* The issue remains open to litigation.

\textsuperscript{210} *Child's Hosp., Inc.*, No. 3-RC-9734, NLRB Regional Director's Decision and Direction of Election (July 22, 1991) [hereinafter Regional Director's Decision in Child's Hosp., Inc.].

\textsuperscript{211} In fiscal 1961, the Board delegated its decisional powers with respect to representation election cases to its twenty-eight regional directors. NATIONAL LABOR RELATIONS BOARD 26TH ANNUAL REPORT 1 (1961). This delegation includes decisions as to whether a question concerning representation exists, determination of appropriate bargaining units, directions of elections to determine whether employees wish union representation and by whom, and rulings on other matters such as challenged ballots and objections to elections. *Id.* Actions taken by the regional directors are final and binding, subject to discretionary review by the Board in Washington, D.C. only on very restricted grounds: (1) when a substantial question of law or policy is raised because of (a) the absence of, or (b) the departure from, officially reported precedent; (2) when a regional director's finding on a substantial factual issue is clearly erroneous, and such error prejudicially affects the rights of a party; (3) when the conduct of the hearing in an election case or any ruling made in connection with the proceeding has resulted in prejudicial error; (4) when there are compelling reasons for reconsideration of an important Board rule or policy. *Id.* at 2.

\textsuperscript{212} Regional Director's Decision in Child's Hosp., Inc., *supra* note 213, at 2 n.3. The petitioned-for unit included all full-time, part-time and per diem employees licensed or otherwise lawfully authorized to practice as registered professional nurses employed by the employer to perform registered professional nursing. *Id.* at 1.

\textsuperscript{213} *Child's Hosp., Inc.*, No. 3-RC-9734, Employer's Request for Review at 6 (Apr. 15, 1992) [hereinafter Employer's Request for Review in Child's Hosp., Inc.]. The employer is referring to 54 Fed. Reg. 16,344 (1989), in which the Board recognized a distinction between an "amalgam type of institution" and a "primarily acute care" hospital. The Board deleted an initial reference to the primary purpose of a hospital in the Final Rule. *Id.*

The facility consists of a not-for-profit surgical care center, providing both inpatient and ambulatory (outpatient) services; a residential nursing home attached to the surgical care center; and a company that provides shared administrative and security services to both the hospital and the nursing home. Regional Director's Decision in Child's Hosp., Inc., *supra* note 213 at 2 n.2. The nursing home and hospital are not free-standing but are contained in a single structure. Employer's Brief at 4, Child's Hosp., Inc., (No. 3-RC-9734) (June 27, 1991). There are, in fact, a substantial number of common areas such as the kitchen, cafeteria, board room, etc. *Id.* at 5.

\textsuperscript{214} Regional Directors Decision in Child's Hosp., Inc., *supra* note 213, at 2 n.3.
extraordinary circumstances present that render the unit of registered nurses inappropriate for its operation.\textsuperscript{215}

The employer stressed that, whether viewed from a dollar volume, patient volume or activity basis, ninety-five percent of Child’s Hospital’s business involves outpatient surgery;\textsuperscript{216} that the hospital employs forty-two registered nurses while the nursing home employs twelve registered nurses;\textsuperscript{217} and that the average length of stay for hospital patients is 2.3 days.\textsuperscript{218} The Regional Director, however, noted that the Board has rejected using the percentage of inpatient beds as a basis for excluding an otherwise covered institution.\textsuperscript{219} He also quoted from an official state document a written statement by Child’s Hospital of its intent to become a “short-term stay care unit,” and he called that characterization “consistent with the definition of an acute care hospital.”\textsuperscript{220} Finally, the Regional Director called attention to the Rule’s definition of an “acute care hospital,” which has limited exclusions only for those institutions that are primarily either nursing homes, psychiatric hospitals, or rehabilitation hospitals.\textsuperscript{221}

Construing the language of the Rule, the Regional Director concluded that the Board “deliberately declined to exclude from coverage acute care hospitals which are primarily devoted to outpatient care, since the Board specifically referred to outpatient care in the same sentence [in which it thereafter enumerated the exclusions].”\textsuperscript{222} Based on his findings of fact and interpretation of the Rule, the Regional Director ordered that a representation election be held in the petitioned-for unit.\textsuperscript{223}

The employer appealed the Regional Director’s decision to the Board in Washington, D.C., and reminded the Board of its previous recognition that the diverse character of the health care industry precluded industry-wide generalizations about the appropriateness of any particular bargaining unit.\textsuperscript{224} The Board had also asserted that many of today’s hospitals have a number of types of units in addition to overnight, or acute care, units, “such as outpatient clinics, nursing care units, etc.,” and that the Board intended to exclude such hospitals from coverage of the Rule if any one of the ex-
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cluded ancillary services predominated. The employer argued that the Rule’s predetermination of units is based upon fundamental “assumptions flowing from the role of and services provided by the traditional inpatient hospital.” In addition, the employer pointed out that the Board justified its selection of the eight bargaining units by detailing factors that supported generalizations as to the appropriateness of the units. The employer viewed itself as a nontraditional inpatient hospital and therefore outside the coverage of the Rule.

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The definition of “acute care” or “hospital” does not fit the case at bar, because of the Rules’ clear purpose to distinguish “acute” from “long term” care such as provided at a nursing home. The administrative history of the Final Rule . . . belies any suggestion that a health care facility is “acute care” unless it is a nursing home, psychiatric or rehabilitation hospital, since [the Board provided] for the possibility that additional exclusions would occur when . . . ancillary services predominated.

On May 9, 1991, shortly after the Supreme Court’s decision in American Hospital Association, Jerry M. Hunter, General Counsel for the Board, issued to all Regional Directors a memorandum intended as a shorthand guide to the processing of hearings on unit determinations under the Rule. For the determination of a facility’s status as an “acute care hospital”, the General Counsel supplied the Regional Directors with a simple analysis, asking them to determine: (1) whether the facility is a hospital as defined by the Rule; (2) whether there is a sufficient number of patients receiving acute care, as calculated by their average length of stay; (3) whether the facility is primarily a nursing home, primarily a psychiatric hospital, or primarily a rehabilitation hospital, thereby excluding it from the coverage of the Rule. In addition, the memorandum explained that the term “acute care hospital” “shall include those hospitals operating as acute-care facilities

226. Employer’s Brief at 9-10, Child’s Hosp., Inc.
227. Id. at 10.
228. Employer’s Request for Review in Child’s Hosp., supra note 216, at 5-6. “Child’s is far closer to an ‘outpatient clinic’ than a traditional in-patient hospital. Child’s does not perform the full range of services appropriate to a ‘hospital’ [as defined in the Rule].” Id. This latter assertion is a reference to 29 C.F.R. § 103.30(f)(1) (1992).
229. Employer’s Brief at 11, Child’s Hosp., Inc.
230. Memorandum GC 91-3 from Jerry M. Hunter, General Counsel, NLRB, to all Regional Directors, Officers-in-Charge, and Resident Officers I (May 9, 1991) (on file with The Journal of Contemporary Health Law and Policy).
231. Id. at 2.
even if those hospitals provide such services as, for example, longterm care, outpatient care, psychiatric care, or rehabilitative care.”

The Regional Director's determination is entirely predictable given the Rule as written and the direction of the General Counsel's memorandum. On review, the Board supported the Regional Director's rejection of the employer's argument that "it is not an acute care hospital [merely] because it performs a high percentage of ambulatory surgery." The Board, however, also held that the Regional Director had erred in rejecting the employer's offer of proof because "other issues in the case [raised] substantial questions warranting a hearing." The case was remanded to the Regional Director for further hearing with instructions to "permit the parties to introduce such further evidence as is necessary for complete litigation... in view of the possibility the Board may ultimately find the employer is (a) taken in its entirety, not an acute care hospital, or (b) the subject of extraordinary circumstances.”

C. Duke University

On June 5, 1991, in another memorandum to Regional Directors regarding the Rule, the General Counsel reiterated one of the purposes of the Rule: “[T]o establish stable and consistent law with respect to appropriate health care units covered by the rule, so as to reduce the frequency and length of hearings.” He conceded, however, that there would "continue to be disagreements as to unit placement issues in some health care cases.” To assist the Board agents in handling union-management disagreements, the General Counsel attached research materials on over seventy-five frequently litigated health care unit classifications and set forth the Board's views as to which of the eight units established by the Rule encompassed each employment position, based on generally consistent, pre-existing Board precedent.

232. Id.
234. Id.
235. Id. at 2. Here, the Board must interpret the definition of "acute care hospital" as it applies to an "amalgam facility" and, again, must litigate the existence of extraordinary circumstances. Id.
236. Duke Univ., No. 11-RC-5779, NLRB Regional Director's Decision and Direction of Election (July 30, 1991) [hereinafter Regional Director's Decision in Duke Univ.].
237. Memorandum GC 91-4 from Jerry M. Hunter, General Counsel, NLRB, to All Regional Directors, Officers-in-Charge, and Resident Officers (June 5, 1991) (on file with The Journal of Contemporary Health Law and Policy).
238. Id.
239. Id. at 1-2. The General Counsel explained that the materials were offered for assist-
In *Duke University*, the petitioning union and the employer agreed that the University's Medical Center is an acute care hospital facility. The parties, however, disagreed on both the scope and the composition of the petitioned-for unit. The union petitioned for an election among full-time bus drivers. The employer argued that the unit of its full-time bus drivers was comprised of "[']health care employees['] who should be included in an all-encompassing non-professional unit within the health care facility" as mandated by the Rule. In the alternative, the employer contended that the only appropriate unit would be a unit composed of all of the employer's service employees.

Duke University is an educational institution that includes in its operations an undergraduate university with a school of nursing, a hospital (the "Medical Center"), and a school of medicine. Duke University Transit provides transportation to all of the university's students and employees, as well as to visitors to the campus and to the Medical Center. The Medical Center directly employs approximately 12,500 of the 19,000 Duke University employees. The full-time bus drivers are headquartered in a separate and distinct transportation building of the University along with the employer's operating engineers. In addition, "[a]ll hiring decisions relative to bus drivers are made within the [e]mployer's campus transportation department." The bus drivers are supervised, scheduled and disciplined by the transportation department. Full-time bus drivers wear distinctive uniforms. They routinely lunch together in the transportation building and have only limited interaction with other nonprofessional employees of the University.

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240. Regional Director's Decision in Duke Univ., *supra* note 239, at 3 n.1.
241. *Id.*
242. *Id.* There are approximately fourteen employees in this unit. *Id.*
243. *Id.*
244. *Id.*
245. *Id.* The Medical Center consists of two full-service hospitals. Duke Univ., No. 11-RC-5779, Employer's Request for Review at 15-16 (Aug. 13, 1991) [hereinafter Employer's Request for Review in Duke Univ.]. The hospitals have more than 36,000 admissions per year with over 850 acutely ill patients receiving care on a daily basis. *Id.*
246. Regional Director's Decision in Duke Univ., *supra* note 239, at 3 n.1.
248. Regional Director's Decision in Duke Univ., *supra* note 239, at 3 n.1.
249. *Id.*
250. *Id.*
251. *Id.*
252. *Id.* at 3-4 n.1.
Noting that the full-time bus drivers are directly employed by the campus transportation department and are only involved with Medical Center employees to the extent that those employees ride on buses, the Regional Director found that the full-time bus drivers are not health care employees. He applied pre-Rule precedent and found a distinct community of interest among the full-time bus drivers. He held that the full-time bus drivers comprise a separate collective bargaining unit appropriate for representation by the union of their choice, should they so decide.

The employer objected to what it characterized as the Regional Director's departure from Board precedent in his refusal to apply the Board's "fifty percent rule." "This approach directly contravenes well-established Board precedent which has historically required that an employee's health care status be determined by looking not at the employee's job duties or integration with other hospital personnel, but rather at the amount of time employees spend on health care related activities."

The employer's argument was presented quite succinctly. "The Medical Center is a unique acute care hospital . . . in that it is fully integrated with Duke University." The uncontroverted evidence indicated that the full-time bus drivers spend a majority of their time servicing the Medical Center. The fifty percent rule holds that the full-time bus drivers are, therefore, health care workers. As a result, the full-time bus drivers are subject to the provisions of the Rule that require special bargaining units for

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253. Id. at 4 n.1.
254. Id. He also pointed to their distinct occupational skills, as evidenced by a licensing requirement, and to their headquarters in a distinct facility. Id.
255. Id.
As far back as 1971, when non-profit hospitals were exempt from the Act, the Board determined that employees who, on an individual basis, "spend a majority of their time performing duties related to the patient care functions of the Hospital" were "health care" employees excluded from the Act. The Board later refined this rule to exclude those employees who, taken as a group, spent 50 percent or more of their time performing "hospital related work."


258. Id. at 4.
259. Id. at 11-12.
260. Id. at 10-12.
acute care hospitals.\textsuperscript{261} Relying upon Board precedent, the employer dismissed any suggestion that the fifty percent rule does not apply to employees whose duties seem to be far-removed from the health care facility.\textsuperscript{262}

The employer also pointed to the Board's decision in \textit{Kirksville College of Osteopathic Medicine, Inc.}, a pre-Rule decision in which the Board held that when a college and its hospitals are so highly integrated that their functions, administration, and workforce straddle both entities, the entire facility should be regarded as a health care institution within the meaning of the Act.\textsuperscript{263} In finding Kirksville College to be an integrated health care institution, the Board was concerned with the potential disruption of health care services.\textsuperscript{264} Duke University submitted uncontested evidence that the Medical Center is highly integrated with the whole of the University in terms of its administration, core functions, and workforce.\textsuperscript{265} Like the Kirksville College employees, many of Duke's employees, including the full-time bus drivers, service both the traditional university campus and the Medical Center.\textsuperscript{266} The employer contended that "the Medical Center completely depends on these employees and could not provide patient care without them."\textsuperscript{267}

Finally, the employer insisted that because this was a case of first impression under the Rule, the Regional Director's decision presented a substantial question of policy and, therefore, the Board should grant its request for review.\textsuperscript{268} The employer reminded the Board that during the promulgation of the Rule, the Board had stated an intention "at all times to be mindful of avoiding undue proliferation . . . because it accords with [the Board's] view of what is appropriate in the health care industry."\textsuperscript{269} The employer disdainfully predicted that the Regional Director's decision to exclude the full-time bus drivers from the Rule would result in the first of many small bar-

\begin{itemize}
\item \textsuperscript{261} \textit{Id.} at 4.
\item \textsuperscript{262} \textit{Id.} at 11. The employer is referring to the Board's application of the fifty percent rule to animal caretakers and housekeepers, parking lot attendants, and switchboard operators. \textit{Id.} (citing Georgetown University, 200 N.L.R.B. 215, 217 (1972); Duke University, 194 N.L.R.B. 236, 236 (1971); Duke University 217 N.L.R.B. 799, 800 (1975)).
\item \textsuperscript{263} \textit{Id.} at 12 (citing Kirksville College of Osteopathic Med., Inc., 274 N.L.R.B. 794, 795 (1985)).
\item \textsuperscript{264} Kirksville College of Osteopathic Med., Inc., 274 N.L.R.B. 794, 795 (1985).
\item \textsuperscript{265} Employer's Request for Review in Duke Univ., \textit{supra} note 248, at 13.
\item \textsuperscript{266} \textit{Id.} at 13. In \textit{Kirksville College}, the Board found that "the employees in several departments serve both the college and the hospitals in such an integrated fashion that their functions cannot be assigned to one or the other, and it is impossible to draw a line between them." Kirksville College, 274 N.L.R.B. at 795.
\item \textsuperscript{267} Employer's Request for Review in Duke Univ., \textit{supra} note 248, at 13 (emphasis omitted).
\item \textsuperscript{268} \textit{Id.} at 15.
\item \textsuperscript{269} \textit{Id.} at 15. \textit{See} 53 Fed. Reg. 33,900, 33,905 (1988).  
\end{itemize}
gaining units that would create a distinct threat to the hospital's vital operations. "Thus, the acute care hospital is left vulnerable to the very disruptions the Board sought to avoid, only because the drivers do not exclusively service its facilities."271

VIII. THE EFFECTIVENESS OF THE RULE

In the following situations, the Rule requires that the Board engage in adjudication in order to determine the appropriateness of bargaining units in acute care hospitals: when extraordinary circumstances exist, when application of the Rule results in a unit of five or fewer employees, when there are existing nonconforming units and a petition for additional units is filed, and when various combinations of units are sought by a labor organization.272 The General Counsel also points out that the Board left for adjudication the issue of the continuing validity of Board precedent regarding the treatment of residual units and that the Rule does not determine the placement of individual employees in specific units.273 A cursory examination of these situations reveals that they required adjudication prior to the promulgation of the Rule.274 Their determination was, therefore, left untouched by the Rule. In addition to those uncodified, pre-existing requirements of adjudication, it has been shown that the Rule also created new arenas for litigation.275 A number of other situations that have not yet come before the Board are

270. Employer's Request for Review in Duke Univ., supra note 248, at 16. "In order to provide such large scale patient care, [the Medical Center's] employees simply must get in to work. . . . The Medical Center completely depends on the bus drivers to bring its employees to work." Id.

271. Id. The Board has yet to rule on the issues presented by this most recent Duke University case. The employer's arguments are, however, formidable and arguably worthy of Board review and adjudication. Again, the Board is faced with the issue of the Rule's effect on Board precedent pre-dating the Rule and the issue of potential case-by-case adjudication of "acute care hospital."


274. This is most evident when it is considered that the Board's previous policy required adjudication of each and every unit determination on a case-by-case basis. See supra notes 53-67 and accompanying text.

275. See discussion supra notes 117-124 and accompanying text (discussing the need for litigation to determine, e.g., where a particular employee classification falls into the eight broadly defined categories of the Rule, the validity of contradictory circuit court precedent, the status of health care facilities that operate as a part of a larger institution or that offer a unique mix of services, the meaning of "acute care hospital" in certain circumstances, the existence of extraordinary circumstances that might exempt a hospital from the coverage of the Rule, and, should extraordinary circumstances be found to exist, the appropriateness of petitioned-for bargaining units for a given employer).
likely also to require litigation.\textsuperscript{276} Interestingly, the industry, once vehemently opposed to the Rule, is already using it as a part of its strategy to prevent, postpone, or minimize the effects of unionization.\textsuperscript{277}

There is no doubt that with regard to the determination of the appropriateness of bargaining units in the health care industry the need for case-by-case adjudication will continue. The Board, it seems, purposefully constructed a rule that leaves room for the exercise of discretion when appropriate. The Seventh Circuit has supported the Board's position, stating that "[t]he decision how much discretion to eliminate from the decisional process is itself a discretionary judgment."\textsuperscript{278} Arguably, the Board's careful consideration of the conflicting arguments and the Rule's resulting flexibility assisted the Board in defending against the American Hospital Association's attacks in the circuit court as well as in the Supreme Court. In any event, the AHA's prediction that the Rule would "foreclose virtually any type of case-by-case adjudication or consideration of the unique circumstances characterizing a hospital that is party to representation proceedings thereby foreclosing . . . any possibility of meaningful appellate review of the Board's health care unit determinations"\textsuperscript{279} appears to have failed to materialize.

When the dust settles, will there be less litigation than there was prior to the promulgation of the Rule? That was neither the sole nor the primary goal of the Board in its decision to embark on rulemaking in this arena; nor is such the Rule's sole or primary purpose at the present. More appropriate questions are: Does the Rule "facilitate the election process?"\textsuperscript{280} Does the Rule "reduce the . . . length of hearings?"\textsuperscript{281} Does the Rule "avoid unnecessary litigation?"\textsuperscript{282} Given that the Rule has conclusively established eight mandatory and exclusive bargaining units for acute care hospitals in most

\textsuperscript{276} Some possibilities include: (1) How should multi-skilled employees be handled? (2) Given that section 9(b) of the Act entitles guards to form their own separate unit, how should the Board handle a guard unit in an acute care hospital that has five or fewer members? (3) How has the promulgation of the Rule affected the standards that the Board applies in cases in which a health care provider is not an acute care hospital? (4) How does the Rule affect decertification petitions in which the employees vote to discontinue union representation?

\textsuperscript{277} Regional Director's Decision in Duke Univ., \textit{supra} note 239, at 3-4 n.1.

\textsuperscript{278} American Hosp. Ass'n v. NLRB, 899 F.2d 651, 660 (7th Cir. 1990) (citing Heckler v. Campbell, 461 U.S. 458, 467-68 (1983); Fook Hong Mak v. I.N.S., 435 F.2d 728, 730 (2d Cir. 1970); Midtec Paper Corp. v. United States, 857 F.2d 1487, 1501 (D.C. Cir. 1988)). In addition, the Seventh Circuit found that, although the Rule was not without room for improvement, "[t]he Board did [do] a reasonable job of weighing the conflicting arguments." \textit{American Hosp. Ass'n}, 899 F.2d at 660.

\textsuperscript{279} Taft, \textit{supra} note 91, at 1.


\textsuperscript{281} Memorandum GC 91-4, \textit{supra} note 240, at 1.

situations, it is safe to say that the Rule will in fact significantly reduce the litigation and subsequent delay that was inherent in the previously mandatory case-by-case adjudication of the appropriateness of petitioned-for health care bargaining units in most situations. This result will no doubt be lauded by Mr. Subrin who lamented that "[l]awyers, administrators, and judges have matters of higher significance to attend to than hearing each and every detail of the supervision or integration at Joe's grocery store before announcing . . . whether a meat department unit will or will not be deemed appropriate at Joe's." Mr. Subrin was not blind to the practical reality that rulemaking would not put an end to litigation of the issue. He predicted that, in any rulemaking endeavor, "[h]owever bright the lines that are drawn, there will inevitably remain some dimly lit penumbras requiring further illumination by adjudication." Yet he came to the conclusion that rulemaking was an appropriate direction for the Board to take. Consequently, the Board, a collection of five presidential appointees, is left with "more time for statesmanlike thinking about larger issues," and the parties to representation proceedings are "free to pursue their respective concerns, including, should the employees choose, a collective bargaining relationship.

The AHA's fear that the Rule would lead to increased, aggressive organizing efforts by unions seeking to represent the employees of acute care hospitals was not unfounded or zealously prejudicial. Indeed, the same result was anticipated by all of the parties to rulemaking, including the Board. To date, however, no dramatic change in the level of organizational activity has been observed by the Board. Although there is no conspicuous explanation for this improbable denouement, it is unlikely that an assessment of the Rule this early in the course of its application can be presumed to be a comprehensive review. The recovery period may be longer than anticipated. However, despite the legitimate concerns of the AHA, the promulgation of the Rule and its subsequent survival in the Supreme Court have not significantly affected the cost or availability of health care services in this country.

Notwithstanding the outcome of a future balancing of the Rule's ultimate

284. Subrin, supra note 72, at 108.
285. Id. at 113.
286. Id.
287. Id.
288. Id.
289. Subrin, supra note 72, at 108.
291. Id.
benefits and burdens, it may presently be declared that in the course of the
rulemaking endeavor, the Board’s efforts accomplished some of the major
putative purposes of rulemaking as a means of creating and implementing
policy. First, the Board accumulated an incredible volume of data that
would not have been available through the adjudication process. Second,
the process provided a degree of openness and broad scale participation by
all affected parties unmatched by the traditional Board proceedings. Fi-
nally, the Rule produces a degree of clarity and stability, however contro-
versial, for an area of policy that had been overwhelmed by subtlety,
complexity, and change.

Future changes to the Rule, if necessary, can be accomplished on an out-
patient basis, now that the major surgery has been declared a success. The Board has finally admitted itself in to the realm of major substantive
rulemaking. Having survived this bout, the Board should feel more at ease
to augment further the Act with predictability and clarity, operating with
the precise instruments of rulemaking that were prescribed for that very
purpose.

IX. POSTSCRIPT

Subsequent to the initial drafts of this comment, the Board issued opinions
in Child’s Hospital, Inc. and Duke University. A brief description of
the Board’s holding in each case follows.

292. GRUNEWALD, supra note 76, at 37.
293. Id. “[W]ere we to continue to decide the appropriateness of units . . . solely by adjudica-
tion, 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 ad-
is an organized and complete file of all the information submitted to or otherwise considered
by the NLRB in the development of [the] proposed rulemaking . . . 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, National Labor Relations Board, Washington, D.C.” 53 Fed. Reg. at
33,934.

294. GRUNEWALD, supra note 76, at 38.
295. Id.
[W]e are under no illusions that the answers we now provide will necessarily solve all
health care unit problems, for all time. . . . At some future date, after the rule has had
a fair trial, it may be appropriate to reexamine the rule to determine how well it has
worked, whether new developments have changed our underlying assumptions and
require different conclusions, and whether some other provisions might improve
those now promulgated.

Id.

In *Child's Hospital, Inc.*, the Board recognized the dilemma that the circumstances of Child's Hospital presented under the Rule:

The Board here is asked to determine the scope of a unit at a single facility composed of both an acute care hospital and a nursing home, both of which are substantial components of the overall facility. Acute care hospitals are expressly covered under the Rule; however, facilities that are primarily nursing homes are expressly excluded, both from the definition of acute care hospital and from the Rule itself.299

Careful to explain that this facility was of an “unusual nature,” and avoiding the issue of whether the hospital and nursing home together met the definition of “‘acute care hospital’ as set forth in the Rule (patient stay requirement of less than 30 days),” the Board held that “it would not be feasible or sensible to automatically apply the Rule.”300 The Board reasoned that “[t]o attempt to fit this hybrid facility within a rule that is designed to cover the more typical free-standing acute care hospital may, possibly, lead to an anomalous or impractical result . . . .”301

The Board remanded the case to the Regional Director with “directions to reopen the hearing to permit the parties . . . to adduce additional evidence on the unit issue should they desire to do so,” and with instructions to issue a supplemental decision, consistent with the Board’s decision in *Park Manor Care Center*,302 as to the appropriateness of the unit sought.303

In *Duke University*, the Board, rejecting the employer’s assertion that “employees who spend 50 percent of their time in support of the Medical Center . . . should be deemed health care workers,”304 the Board affirmed the Regional Director’s finding that the bus drivers were not health care workers.305 The Board distinguished *Kirksville College*:306 “At Kirksville College patient care was interwoven throughout the institution; most phys-

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299. *Id.* at 7-8. The Board found that the evidence established that all three facilities were “sufficiently integrated, both physically and operationally, as to require that they be treated as a single facility.” *Id.* at 7.

300. *Id.* at 8 & n.14.

301. *Id.* at 8.

302. 305 N.L.R.B. No. 135 (Dec. 18, 1991) (setting forth general principles applicable to unit determinations for health care facilities not covered by the Rule and discussing the reasons for excluding nursing homes from the definition of acute care hospital).

303. *Child’s Hosp., Inc.*, 307 N.L.R.B. No. 14, at 9-10. Because the Regional Director’s decision in *Child’s Hosp., Inc.* was decided prior to the issuance of the Board’s *Park Manor* decision, the parties had not “had an opportunity to address the appropriateness of the unit in light of the considerations set forth in Park Manor.” *Id.* at 9.


305. *Id.* at 2.

cians on the facility treated patients at the health care center, and the medical teaching process took place throughout the entire complex. That has not been demonstrated to be the case at Duke.\textsuperscript{307}

In addition, the Board supported the Regional Director's decision not to apply the fifty percent rule as enunciated in the Board's earlier \textit{Duke University}\textsuperscript{308} case.\textsuperscript{309} There, according to the Board, the fact that the switchboard operators spend a majority of their time handling calls for the Medical Center was "but one of a number of factors cited by the Board in finding that a unit limited to switchboard operators was not appropriate."\textsuperscript{310} In fact, the Board stated emphatically that "[s]ince the passage of the 1974 health care amendments, there is no continuing need for a breakdown of work duties by percentage in order to determine the Board's jurisdiction."\textsuperscript{311} The Board found that "the [Kirksville] operators' intimate involvement in the provision of medical care" was a more important consideration, and that, in that respect, they "were much more directly involved in medical care" than were the Duke bus drivers.\textsuperscript{312}

The Board dismissed "policy considerations such as a concern for the potential disruption of health care services in the event of a work stoppage" as "weigh[ing] in favor of treating the drivers as health care employees."\textsuperscript{313} The Board distinguished "'patient care situations' " from "'purely administrative health care connected facilities,'" holding that the bus drivers performed the latter function, a function that "could easily be replaced in the event of a work stoppage."\textsuperscript{314}

The Board concluded that "[i]nasmuch as the Board's Rule on collective bargaining units in the health care industry applies by its terms to acute care

\begin{footnotesize}
\begin{enumerate}
\item[310.] Id. at 9.
\item[311.] Id. at 9 n.10. The Board thus overruled the "inflexible, mathematical approach" of the fifty percent rule enunciated in the earlier \textit{Duke University}, 217 N.L.R.B. 799 (1975), and its progeny, to the extent that those cases suggested that other circumstances may be disregarded. Duke Univ., 306 N.L.R.B. No. 101, at 10 n.12.
\item[312.] Id. at 9, 10. According to the Board, the bus drivers' "only connection to the Medical Center is that the Medical Center employees and patients ride on buses." \textit{Id.} at 10 n.13. The Board did agree with the employer, however, that the Regional Director "improperly relied on the operators' physical location in the Medical Center as a basis for distinguishing" the earlier \textit{Duke University} case. \textit{Id.} at 10 n.11.
\item[313.] Id. at 7.
\item[314.] Id. at 7 & n.8 (citing Damon Medical Lab., 234 N.L.R.B. 333, 334 n.1 (1978) (which cited the legislative history of the 1974 health care amendments)).
\end{enumerate}
\end{footnotesize}
hospitals, and the drivers are not employees of an acute care hospital, their representational interests are not affected by the Rule."\(^{315}\)

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315. *Id.* at 11.