

St. Francis Hospital and International Brotherhood of Electrical Workers, Local Union No. 474, AFL-CIO. Case 26-CA-10060

13 August 1984

DECISION AND ORDER

BY CHAIRMAN DOTSON AND MEMBERS
ZIMMERMAN, HUNTER, AND DENNIS

Upon a charge filed by the Union on 21 January 1983, the General Counsel of the National Labor Relations Board issued a complaint on 1 February 1983 against the Company, the Respondent, alleging that it has violated Section 8(a)(5) and (1) of the National Labor Relations Act.

The complaint alleges that on 5 January 1983, following a Board election in Case 26-RC-6109, the Union was certified as the exclusive collective-bargaining representative of the Company's employees in the unit found appropriate. (Official notice is taken of the "record" in the representation proceeding as defined in the Board's Rules and Regulations, Secs. 102.68 and 102.69(g), amended Sept. 9, 1981, 46 Fed.Reg. 45922 (1981); *Frontier Hotel*, 265 NLRB 343 (1982).) The complaint further alleges that since 17 January 1983 the Company has refused to bargain with the Union. On 8 February 1983 the Company filed its answer admitting in part and denying in part the allegations in the complaint. The Respondent admits being served with the charge, its status as a health care institution, the Union's status as a labor organization, and that it meets the Board's jurisdictional standards. The Respondent denies that the employees designated as the appropriate bargaining unit by the Board in its Decision on Review constitute an appropriate unit. The Respondent admits that the Union was duly certified as the exclusive bargaining representative of all the employees in the unit, that the Union has requested and is requesting bargaining, and that it has refused and continues to refuse to bargain with the Union. However, the Respondent denies that by its refusal to bargain it has violated Section 8(a)(5) and (1) and Section 8(d) of the Act.

On 22 February 1983 the General Counsel filed a Motion for Summary Judgment. On 28 February 1983 the Board issued an order transferring the proceeding to the Board and a Notice to Show Cause why the motion should not be granted. The Respondent filed a response and requested oral argument.¹ Thereafter, the American Hospital Asso-

¹ The Respondent has requested oral argument. The request is denied as the record, exceptions, and briefs in the underlying representation case adequately present the issues and the positions of the parties.

ciation filed a brief amicus curiae in support of the Respondent's position.

Ruling on Motion for Summary Judgment

In its response to the Notice to Show Cause, the Respondent contends that special circumstances exist which require the Board to reexamine its decision in the underlying representation proceeding.² The Respondent maintains that, in deciding that a bargaining unit comprised solely of its maintenance employees is appropriate, the Board majority failed to give proper weight to the congressional admonition to avoid undue unit proliferation in the health care industry. The Respondent cites several circuit court opinions which disagree with Board decisions finding that units comprised of health care maintenance employees are appropriate for bargaining and argues that the Board should defer to judicial interpretation of this issue.³ The Respondent also points to Member Hunter's dissent in the underlying representation case in support of its contention that the majority's determination cannot stand.

For the reasons set forth below, we have decided to vacate our earlier Decision on Review and Direction. We recognize that the arguments presented by the Respondent warrant a more complete response than we have given up to this point, particularly with regard to the criticisms directed at the Board from the courts of appeals. With the benefit of many years of thoughtful and often conflicting analyses among the Board members, courts of appeals, and legal commentators, we have formulated a revised health care employee unit approach which we believe will fulfill our dual obligations of adhering to the legislative intent behind enactment of the 1974 health care amendments⁴ to the Act and guaranteeing the representational interests of health care employees.

Review of the record reveals that in Case 26-RC-6109 the petition was filed by the Union on 28 September 1979. On 5 November 1979 the Regional Director issued his Decision and Direction of Election, in which he found, inter alia, that the petitioned-for maintenance employees, plus employees in two less skilled classifications not included in the petition,⁵ share a community of interest sufficient

² *St. Francis Hospital*, 265 NLRB 1025 (1982) (*St. Francis II*).

³ *Mary Thompson Hospital v. NLRB*, 621 F.2d 858 (7th Cir. 1980); *NLRB v. Mercy Hospital Assn.*, 606 F.2d 22 (2d Cir. 1979), cert. denied 445 U.S. 971 (1980); *NLRB v. West Suburban Hospital*, 570 F.2d 213 (7th Cir. 1978).

⁴ Pub. L. 93-360 §§ 1-4, July 26, 1974, 88 Stat. 395-397, 29 U.S.C. §§ 152 (14), 158(d) and (g), 169, 183.

⁵ The unit found appropriate consisted of:

Continued

to warrant representation within their own unit. On 19 November 1979 the Respondent filed a request for review of the Regional Director's decision, in which the Respondent questioned the Regional Director's use of the community-of-interest analysis, citing the unique statutory treatment of the health care industry as well as judicial criticism of the Board's traditional approach to health care employee unit determinations. The Respondent also disputed certain facts contained in the Regional Director's decision. On 4 December 1979 the Board granted the Respondent's request for review and directed that the ballots cast in the scheduled election be impounded. The election was conducted on 7 December 1979 and the ballots were impounded. On 16 December 1982 the Board issued its Decision on Review and Direction, with the majority finding that the unit in which the election was held was appropriate for bargaining and directing that the impounded ballots be opened and counted. The tally of ballots revealed that, of 43 eligible voters, 23 ballots were cast for the Union, and 20 votes were cast against the Union; there were no challenged ballots. On 5 January 1983 the Regional Director certified the Union as the exclusive collective-bargaining representative of the employees in the unit found appropriate.

Following a written bargaining request by the Union about 10 January 1983 the Respondent, by letter dated 17 January 1983, refused to recognize or bargain with the Union as the exclusive representative of the employees in the certified unit.

It is well settled that in the absence of newly discovered and previously unavailable evidence or special circumstances, a respondent in a proceeding alleging a violation of Section 8(a)(5) is not entitled to relitigate issues that were or could have been litigated in a prior representation proceeding. See *Pittsburgh Glass Co. v. NLRB*, 313 U.S. 146, 162 (1941); Secs. 102.67(f) and 102.69(c) of the Board's Rules and Regulations. However, this prohibition against relitigation of representation issues in a subsequent technical 8(a)(5) refusal-to-bargain situation applies to the *parties*—the employer and the union—and does not preclude the Board from reconsidering its own earlier action. In view of the

All maintenance employees, including communications technicians, painters, carpenters, maintenance helpers, x-ray processor mechanic, refuse and linen collectors, utility operators, cabinet makers, painter/vinyl hanger, HVAC trainee, HVAC mechanic, boiler operators, electronics technicians, electricians, general maintenance mechanics, pneumatic tube mechanic, groundskeeper, utility mechanic, refrigeration mechanic, and plumber employed by the Employer at its hospital at 5959 Park Avenue, Memphis, Tennessee, excluding all other employees, including office clerical employees, Bio-Medical Engineering Department employees, service employees, guards and supervisors as defined in the Act. The two classifications not sought by the Petitioner Union, but included by the Regional Director, are the groundskeeper and the linen and refuse collectors.

history of controversy surrounding the issue of appropriate bargaining units in the health care field—and noting particularly the frequency with which courts of appeals have disagreed with our unit determinations—we have decided to reconsider our earlier decision.⁶

In the underlying representation case, the majority⁷ set forth a two-tiered analytical paradigm to be applied in all health care unit determinations. After a discussion of the legislative history of the health care amendments and a review of both pre- and post-amendment cases involving health care bargaining units, the majority identified seven groups of employees which were deemed “potentially appropriate” for bargaining in the health care field. These seven are: physicians, registered nurses, other professional employees, technical employees, business office clerical employees, service and maintenance employees, and skilled maintenance employees. The majority stated that, with few exceptions, these seven classifications could accommodate the entire employee complement at most health care facilities. The majority further stated that it had derived these seven groups through case-by-case application of its traditional unit determination principles, tempered by the congressionally recognized special consideration of avoiding unit multiplicity in the health care field. Because these “potentially appropriate” units were in its view nearly all-encompassing, the majority concluded that, by limiting health care units to these seven, undue proliferation would be prevented and employees' representational interests would also be insured.

Accordingly, the majority stated that, when a petition presented a request for one of these units, the Board would apply a community-of-interest test to the employees comprising the unit and, if a community-of-interest was shown to exist, the unit request would be granted. If no community-of-interest were demonstrated the petition would be dismissed. On the other hand, if a petitioner sought a

⁶ See *NLRB v. West Suburban Hospital*, 570 F.2d 213 (7th Cir. 1978); *NLRB v. HMO International*, 678 F.2d 806 (9th Cir. 1982); *Beth Israel Hospital v. NLRB*, 688 F.2d 697 (10th Cir. 1982), reaffirming en banc 677 F.2d 1343 (10th Cir. 1981); *St. Anthony's Hospital Systems v. NLRB*, 655 F.2d 1028 (10th Cir. 1981), reaffirmed en banc at 688 F.2d 697 (1982); *NLRB v. Frederick Memorial Hospital*, 691 F.2d 191 (4th Cir. 1982); *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450 (10th Cir. 1981), modified on different grounds by 688 F.2d 697 (1982); *Mary Thompson Hospital v. NLRB*, 621 F.2d 858 (7th Cir. 1980); *Allegheny General Hospital v. NLRB*, 608 F.2d 965 (3d Cir. 1979); *NLRB v. Mercy Hospital Assn.*, 606 F.2d 22 (2d Cir. 1979), cert. denied 445 U.S. 971 (1980); *NLRB v. St. Francis Hospital*, 601 F.2d 404 (9th Cir. 1979); and *St. Vincent's Hospital v. NLRB*, 567 F.2d 588 (3d Cir. 1977).

⁷ The full Board participated in *St. Francis I*, with Member Zimmerman and former Members Fanning and Jenkins in the majority, and Member Hunter and former Chairman Van de Water each filing a dissent.

unit not among these seven, only the existence of extraordinary circumstances could overcome the presumption that such unit is inappropriate for bargaining in the health care industry. In the underlying case, the majority examined the composition of the requested maintenance unit, as modified by the Regional Director, found that the employees shared a community-of-interest separate and apart from other employees, and concluded that the unit was appropriate.

However, Member Hunter and then Chairman Van de Water, in separate dissents, disagreed with both the approach used and the result reached by the majority. Each discussed the unique societal role of health care institutions and Congress' concern about preventing disruptions in delivery of health care services, citing the special statutory requirements and limitations imposed on the industry under Section 8(d) and (g) of the Act.⁸ Both dissents also referred to the now well-known legislative admonition that the Board should avoid unit proliferation in the health care field⁹ because of the

⁸ Sec. 8(d) of the Act describes the duties of the parties in fulfilling their collective-bargaining roles. The special provisions applicable to the health care industry read as follows:

Whenever the collective bargaining involves employees of a health care institution, the provisions of this section 8(d) shall be modified as follows:

(A) The notice of section 8(d)(1) shall be ninety days; the notice of section 8(d)(3) shall be sixty days; and the contract period of section 8(d)(4) shall be ninety days.

(B) Where the bargaining is for an initial agreement following certification or recognition, at least thirty days' notice of the existence of a dispute shall be given by the labor organization to the agencies set forth in section 8(d)(3).

(C) After notice is given to the Federal Mediation and Conciliation Service under either clause (A) or (B) of this sentence, the Service shall promptly communicate with the parties and use its best efforts, by mediation and conciliation, to bring them to agreement. The parties shall participate fully and promptly in such meetings as may be undertaken by the Service for the purpose of aiding in a settlement of the dispute.*

* Pursuant to Public Law 93-360, 93d Cong., S. 3203, 88 Stat. 396, the last sentence of Sec. 8(d) is amended by striking the words "the sixty-day" and inserting the words "any notice" and by inserting before the words "shall lose" the phrase ", or who engages in any strike within the appropriate period specified in subsection (g) of this section." In addition, the end of paragraph Sec. 8(d) is amended by adding a new sentence "Whenever the collective bargaining . . . aiding in a settlement of the dispute."

Sec. 8(g) states:

(g) A labor organization before engaging in any strike, picketing, or other concerted refusal to work at any health care institution shall, not less than ten days prior to such action, notify the institution in writing and the Federal Mediation and Conciliation Service of that intention, except that in the case of bargaining for an initial agreement following certification or recognition the notice required by this subsection shall not be given until the expiration of the period specified in clause (B) of the last sentence of section 8(d) of this Act. The notice shall state the date and time that such action will commence. The notice, once given, may be extended by written agreement of both parties.

⁹ At S. Rep. 93-766, 93d Cong., 2d Sess. 5 (1974), reprinted in "Legislative History of the Coverage of Nonprofit Hospitals Under the National Labor Relations Act, 1974" at 12; H. Rep. 93-1501, 93d Cong., 2d Sess. 6-7 (1974), id. at 274-275. Hereafter this shall be referred to as Legislative History.

potentially disruptive effects which could be created by competing bargaining interests. Both dissents also focused on the many circuit court decisions critical of the Board's repeated determinations that units comprised solely of hospital maintenance employees and units of registered nurses are appropriate. The Board's continued adherence to long-established community-of-interest standards is one factor often cited by these courts as indicative of the Board's failure to adapt its processes to the special circumstances of the health care field¹⁰ and both dissents suggested that using a "disparity-of-interests" test instead could result in more favorable treatment before the circuits.

In the months since that split decision issued, we have availed ourselves of the opportunity to reflect on and reconsider the analyses and perspectives offered by the Board Members and by the discussion of several courts of appeals which reviewed these unit determinations. After careful and thorough consideration we are persuaded that the majority approach in *St. Francis I* is contrary to the intent of Congress and that the adoption of a disparity-of-interests test can best effectuate our statutory obligations in health care unit determinations.

The dissents in *St. Francis I* emphasized that in 1974 when the health care amendments were enacted and the exemption of nonprofit hospitals was removed, the Act was not amended by merely removing the exclusion of nonprofit hospitals from the definition of "employer" in Section 2(2). Congress was concerned "that the needs of patients in health care institutions required special consideration in the Act,"¹¹ and therefore imposed certain restrictions not applicable to other industries.¹² Thus, the health care amendments curtailed the right to engage in strikes and picketing and contained special provisions regarding contract termination and mediation.¹³

In addition, Congress recognized that the paramount public interest in maintaining uninterrupted accessibility to health care facilities required that further protection and special care would have to be taken to avoid the "ultimate disruptions in health care institutions caused by organization drives and related activities such as strikes and slow downs."¹⁴ Congress concluded that the object of minimizing work stoppages resulting from

¹⁰ See, e.g., *Allegheny General Hospital v. NLRB*, 608 F.2d 965 (3d Cir. 1979); *NLRB v. HMO International*, 678 F.2d 806 (9th Cir. 1982); *NLRB v. Mercy Hospital Assn.*, 606 F.2d 22 (2d Cir. 1979), cert. denied 445 U.S. 971 (1980); *Mary Thompson Hospital v. NLRB*, 621 F.2d 858 (7th Cir. 1980).

¹¹ Leg. Hist., above at 10.

¹² Id. at 143, Statement by Senator Dominick.

¹³ See fn. 8, above.

¹⁴ Leg. Hist., supra at 142, Statement by Senator Dominick.

initial organizational activities, jurisdictional disputes, and sympathy strikes could best be achieved, and thus the likelihood of disruptions to health care reduced, by minimizing the number of units appropriate in the health care industry. Accordingly, the House and Senate Committee Reports contained the following directive to the Board:

EFFECT ON EXISTING LAW BARGAINING UNITS

Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 208 NLRB [403] (1974), and *Woodland Park Hospital*, 205 NLRB [888] (1973), as well as the trend toward broader units enunciated in *Extencicare of West Virginia*, 203 NLRB [1232] (1973).¹

¹ By our reference to *Extencicare*, we do not necessarily approve all of the holdings of that decision.¹⁵

Previous Board and court decisions have set forth at length various statements by Congressmen and Senators regarding this directive. Virtually every Senator and Representative speaking in regard to the passage of the amendments admonished the Board to avoid a proliferation of bargaining units and directed the Board to make every reasonable attempt to accommodate broader units in the health care industry.¹⁶

In particular, Senator Taft, a principal cosponsor of the nonprofit hospital bill, in an attempt to clarify any misunderstanding as to Congress' intent, stated:

Certainly, every effort should be made to prevent a proliferation of bargaining units in the health care field and this was one of the central issues leading to agreement on this legislation. In this area there is a definite need for the Board to examine the public interest in determining appropriate bargaining units. *N.L.R.B. v. Delaware-New Jersey Ferry Co.*, 128 F.2d 130 (3rd Cir. 1942).¹⁷

¹⁵ Leg. Hist., supra at 12.

¹⁶ See, e.g., Leg. Hist., supra at 142-143, Statement by Senator Dominick; at 255, Statement by Senator Taft; at 363, statement by Senator Williams; 120 Cong. Rec. E4849-4850 (daily ed., July 2, 1974); statement by Representative Ashbrook, 120 Cong. Rec. 16900.

¹⁷ Leg. Hist., supra at 255.

Our dissenting colleague suggests that because Senator Taft was unsuccessful in adding language to the health care amendments which would have limited the number of bargaining units to four—professional, technical, clerical, and service and maintenance—our current use of the disparity-of-interests analysis somehow distorts congressional intent. Member Zimmerman apparently infers from the alleged rejection of the Taft proposal that Congress viewed four units as too few and that application of a disparity-of-interests analysis will invariably result in even fewer than

Immediately prior to the final vote approving the amendments, Senator Williams, another cosponsor, also attempted to clarify Congress' admonition to the Board:

While the Board has, as a rule, tended to avoid an unnecessary proliferation of collective bargaining units, sometimes circumstances require that there be a number of bargaining units among nonsupervisory employees, particularly where there is such a history in the area or a notable disparity of interests between employees in different job classifications.

While the Committee clearly intends that the Board give due consideration to its admonition to avoid an undue proliferation of units in the health care industry, it did not within this framework intend to preclude the Board acting in the public interest from exercising its specialized experience and expert knowledge in determining appropriate bargaining units. (*N.L.R.B. v. Delaware-New Jersey Ferry Co.*, 128 F.2d 130 (3d Cir. 1942).)¹⁸

As indicated by the legislative history and by the circuit courts¹⁹ Congress clearly intended that, in determining appropriate units in the health care area, the Board should apply a stricter standard than its traditional community-of-interest analysis. As pointed out by the Third Circuit in *St. Vincent's Hospital v. NLRB*, 567 F.2d 588, 592 (1977):

The legislative history of the health care amendments . . . makes it quite clear that Congress directed the Board to apply a standard in this field that was not traditional. Proliferation of units in industrial settings has not

four units. The mere fact that the Taft proposal was not included in the enacted legislation may not properly be attributed to its being perceived as numerically too restrictive. There is no evidence as to whether the lawmakers viewed the proposal as too broad, too rigid, too narrow, or simply unnecessary. See *NLRB v. HMO International*, above, 678 F.2d 806 at 808, and *Trustees of the Masonic Hall and Asylum Fund v. NLRB*, 699 F.2d 626, 636 (2d Cir. 1983). Also the analysis we set forth today establishes neither a minimum nor maximum number of appropriate bargaining units, but rather permits the determination to be made on the facts of the particular facility involved. We believe that this approach comports with Congress' intent that the Board be free to exercise flexibility in dealing with unit determinations on a case-by-case basis.

¹⁸ Leg. Hist., supra at 363.

¹⁹ *Southwest Community Health Services v. NLRB*, 726 F.2d 611 (10th Cir. 1984); *NLRB v. HMO International*, 678 F.2d 806 (9th Cir. 1982); *Beth Israel Hospital v. NLRB*, 688 F.2d 697 (10th Cir. 1982), reaffirming en banc *Beth Israel Hospital v. NLRB*, 677 F.2d 1343 (1981), and *St. Anthony's Hospital Systems v. NLRB*, 655 F.2d 1028 (1981) reaffirmed en banc at 688 F.2d 697 (1982); *NLRB v. Frederick Memorial Hospital*, 691 F.2d 191 (4th Cir. 1982); *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450 (10th Cir. 1981), modified on different grounds in 688 F.2d 697 (1982); *Mary Thompson Hospital v. NLRB*, 621 F.2d 858 (7th Cir. 1980); *Allegheny General Hospital v. NLRB*, 608 F.2d 965 (3d Cir. 1979); *NLRB v. Mercy Hospital Assn.*, 606 F.2d 22 (2d Cir. 1979), cert. denied 445 U.S. 971 (1980); *NLRB v. St. Francis Hospital*, 601 F.2d 404 (9th Cir. 1979); *NLRB v. West Suburban Hospital*, 570 F.2d 213 (7th Cir. 1978); *St. Vincent's Hospital v. NLRB*, 567 F.2d 588 (3d Cir. 1977).

been the subject of congressional attention but fragmentation in the health care field has aroused legislative apprehension. The Board therefore should recognize that the contours of a bargaining unit in other industries do not follow the blueprint Congress desired in a hospital.

The majority in *St. Francis I* recognized that the Board had not complied with Congress' intent and the courts' concerns and attempted to remedy the problem by continuing to adhere to its traditional community-of-interest test but adding a preliminary "screening" step to its unit determination. That approach was designed to "limit" the number of potentially appropriate units to seven except for so-called exceptional cases. Furthermore, Section 9(b) of the Act requires an additional unit of guards. Thus despite the screening step referred to in *St. Francis I*, the results and the methods utilized to reach those results remain basically the same. The traditional community-of-interest test that the Board applies in the industrial setting is used and the same units that have been repeatedly rejected by the courts of appeals are found potentially appropriate. This large number of Board-sanctioned units can hardly be what Congress, concerned with minimizing disruptions in patient care, envisioned. We therefore find that the majority approach in *St. Francis I* fails to meet the standards desired by Congress, established by the Act, and required by the courts.

While courts of appeals have largely rejected the Board's approach to health care unit determination and have emphasized the Board must take into account the congressional admonition against unit proliferation, they have not been unified upon a proper standard for deciding appropriate units in this industry. The principal division is between the Ninth²⁰ and Tenth²¹ Circuits, which advocate a "disparity-of-interests" test, and the Second,²² Eighth,²³ and Eleventh²⁴ Circuits which, although acknowledging the necessity to restrict health care units, disagree with that test.

The Ninth Circuit, in *St. Francis Hospital*, above, refused to enforce a bargaining order based on a determination that a registered nurses unit was appropriate, and remanded the case to the Board.

²⁰ *NLRB v. St. Francis Hospital*, 601 F.2d 404 (1979); *NLRB v. HMO International*, 678 F.2d 806 (9th Cir. 1982).

²¹ *Southwest Community Health Services v. NLRB*, 726 F.2d 611 (1984); *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450 (1981), modified on different grounds in 688 F.2d 697 (1981); *St. Anthony's Hospital Systems v. NLRB*, 655 F.2d 1028 (10th Cir. 1981), reaffirmed en banc at 688 F.2d 697 (1981); *Beth Israel Hospital v. NLRB*, 677 F.2d 1343 (10th Cir. 1981), modified on different grounds en banc 688 F.2d 697 (1981).

²² *Trustees of the Masonic Hall v. NLRB*, 699 F.2d 626 (1983).

²³ *Watsonwan Memorial Hospital v. NLRB*, 711 F.2d 848 (1983).

²⁴ *NLRB v. Walker County Medical Center*, 722 F.2d 1535 (1984).

The court referred to the previously quoted remarks of Senator Williams in outlining the meaning of "disparity-of-interests," as follows:

[H]is statement was that "a notable disparity of interests between employees in different job classifications" [emphasis added by court] could sometimes require a number of bargaining units. We view that language and the remaining legislative history of the 1974 Amendments to the Act as requiring the Board to determine not the similarities among employees in the same job classification . . . but instead the "disparity of interests" among employee classifications which would prevent a combination of groups of employees into a single broader unit thereby minimizing unit proliferation. . . . By focusing upon the disparity of interests between employee groups which would prohibit or inhibit fair representation of employee interests, a balance can be made between the congressional directive and the employees' right to representation.²⁵

In adopting the same view, the Tenth Circuit distinguished the "disparity-of-interests" test from the "community-of-interest" standard in the following manner:²⁶

It is not the similarity of employees' training, hours, conditions and activities which determine the appropriateness of the unit. It is, rather, the dissimilarity of interests relevant to the collective bargaining process that determines which employees are not to be included in a proposed unit. The proper approach is to begin with a broad proposed unit and then exclude employees with disparate interests. One should not start with a narrow unit, such as registered nurses, and then add professionals with similar interests.

The Ninth Circuit later cited this interpretation with approval, stating,²⁷ "Separate bargaining units in the health care field must be justified in terms of a disparity that precludes combination, not an internal consistency within a class that could justify separation."

Subsequently, however, the Second Circuit, upholding a Board-approved service and maintenance unit (excluding technical and business office clerical employees) in a nursing home, took issue with what it termed the "rigid disparity-of-interests test" developed by the Ninth Circuit.²⁸ Such a method

²⁵ 601 F.2d at 419.

²⁶ *Presbyterian/St. Luke's Medical Center*, 653 F.2d at 457 fn. 6.

²⁷ *HMO International*, 678 F.2d at 812 fn. 17.

²⁸ *Trustees of the Masonic Hall*, 699 F.2d at 641 (emphasis added).

of analysis, according to the court, "suggests that a union has some obligation to petition to represent wall-to-wall units,"²⁹ and "would unnecessarily restrict the employees' right to choose their bargaining representative."³⁰ The court, relying on its earlier decision in *NLRB v. Mercy Hospital Assn.*³¹ (rejecting a unit limited to hospital maintenance employees), described the correct legal approach as follows:³²

When the National Labor Relations Board

makes a unit determination for health care institution employees, traditional community of interest factors "must be put in balance against the public interest in preventing fragmentation in the health care field." *St. Vincent's v. NLRB*, supra, 567 F.2d at 592. The Board in its decision must specify "the manner in which its unit determination . . . implement[s] or reflect[s] that admonition . . ." *NLRB v. West Suburban Hospital*, supra, 570 F.2d at 216.

Similarly, the Eighth Circuit refused to follow the "disparity-of-interests" standard used by its sister circuits, and approved a technical employee unit in *Watonwan Memorial Hospital*.³³ According to the court, "in resolving bargaining unit questions in the context of health care institutions, the Board may utilize its community of interest approach, but it must also give express consideration to the 1974 congressional directive concerning unit proliferation."³⁴

We are persuaded that the phrase "disparity-of-interests" properly emphasizes that more is required to justify a separate unit in a health care institution than in a traditional industrial or commercial facility. That is to say, the appropriateness of the petitioned-for unit is judged in terms of normal criteria,³⁵ but 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 be established to grant the unit. Requiring greater disparities in the usual community-of-in-

terest elements to accord health care employees separate representation must necessarily result in fewer units and will thus reflect meaningful application of the congressional injunction against unit fragmentation.³⁶

At the same time, however, we believe the Second Circuit was correct in *Trustees of the Masonic Hall* that application of a "rigid disparity-of-interests" standard would be unwarranted. More precisely, it has been argued that the Ninth Circuit's decision may be construed as holding that no unit narrower than all professionals or all nonprofessionals is permissible unless it can be shown that the interests of the petitioned-for employees are so divergent that fair representation for them would be "prohibit[ed] or inhibit[ed]" without separate representation.³⁷ So stringently defined, it is difficult to envision circumstances that would allow more than two units in a health care facility. As observed by the Eighth Circuit, the test apparently "always requires the Board to select the largest appropriate bargaining unit."³⁸

In sum, we decline to substitute what borders on a per se approach finding two units appropriate for our previous position which automatically resulted in as many as eight possible units.³⁹ The courts, as our review of their decisions has shown, have always been cognizant of the congressional mandate against unit proliferation in health care institutions, and yet, where justified by the particular circumstances, have upheld units limited to technical employees⁴⁰ and service and maintenance employ-

²⁹ See *NLRB v. West Suburban Hospital*, 570 F.2d 213, 215 (7th Cir. 1978) ("[T]he traditional criteria employed in making bargaining unit determinations must be weighed in the context of Congress' admonition. . . ."). Accord: *Trustees of the Masonic Hall*, above; *Mercy Hospital Assn.*, above; *Watonwan Memorial Hospital*, above; *St. Vincent's Hospital v. NLRB*, 567 F.2d 588, 592 (3d Cir. 1977).

³⁰ 601 F.2d at 419.

³¹ *Watonwan Memorial Hospital*, 711 F.2d at 850. It is not certain this is what the Ninth Circuit itself intended. In *HMO International*, 678 F.2d at 812 fn. 17, the court stated that the disparity-of-interests standard was simply "[a]nother way of saying . . . that . . . the Board must make clear to the reviewing court the definite manner in which [it is] implementing the nonproliferation mandate." (Emphasis in original.)

³² Despite this explanation the dissent fears that the majority nevertheless harbors a "predilection for only two basic units—professional and nonprofessional." We emphasize again that we are *not* establishing a rigid disparity-of-interests test that would always result in two broad units. We will reach our unit determinations on a case-by-case basis, focusing on the differences shown by the petitioned-for unit from other employees and the similarities among the proposed unit members. The diverse nature of today's health care industry—including nursing homes, small hospitals, large medical centers, blood banks, outpatient clinics, etc.—precludes any generalization as to the appropriateness of any particular bargaining unit. However, despite these diversities, the disparity-of-interests test can and will be applied to all these facilities. We anticipate that after records have been developed and a number of cases decided from these records, certain recurring factual patterns will emerge and illustrate which units are typically appropriate.

³³ *Watonwan Memorial Hospital*, above; *NLRB v. Hillview Health Care Center*, 705 F.2d 1461 (7th Cir. 1983); *NLRB v. Sweetwater Hospital Assn.*,

Continued

²⁹ *Id.* at 641.

³⁰ *Id.* at 642.

³¹ 606 F.2d 22 (1979), cert. denied 455 U.S. 971 (1980).

³² 699 F.2d at 632.

³³ 711 F.2d 848.

³⁴ *Id.* at 850.

³⁵ The Board evaluates employees' wages, hours, and working conditions; qualifications, training, and skills; frequency of contact and degree of interchange with other employees; frequency of transfer to and from the petitioned-for unit; commonality of supervision; degree of integration with the work functions of other employees; area practice and patterns of collective bargaining; and collective-bargaining history. See in general *Kalamazoo Paper Box Corp.*, 136 NLRB 134 (1962); J. Abodecely, R. Hammer & A. Sandler, *The NLRB and the Appropriate Bargaining Unit*, 13-83 (rev. ed. 1981).

ees.⁴¹ We caution, however, that no unit is per se appropriate and that separate representation must be justified upon each factual record in light of the disparity-of-interests test as we have refined it.

Turning to the instant facts, approximately 39 employees in the requested unit are divided among 4 of the hospital's 90 departments. They represent a small minority of the 438 service and maintenance employees.⁴²

The maintenance workers perform their duties throughout the hospital (80 to 95 percent of the time). They have significant and frequent work contact with nearly all categories of health care employees, particularly service employees. They do not perform functions requiring a high degree of skill: there are no journeymen level employees, and independent contractors are hired to do difficult work.⁴³

The service and maintenance employees are subject to the same hourly pay plan and are eligible to receive the same fringe benefits. Labor relations policies at the hospital are centrally controlled, and there is a uniform discipline and discharge system.⁴⁴ Maintenance employees are subject to departmental supervision, as are service employees. Finally, there have been seven transfers between the service and maintenance departments in recent years.

The facts thus disclose that the Employer's maintenance employees are lesser skilled individuals, who work closely with and share the same basic terms and conditions of employment as the much larger group of service employees. The present record thus fails to demonstrate a disparity of interests between the maintenance employees and other nonprofessionals adequate to justify separate representation. Nevertheless, we have decided, in the exercise of our discretion, to remand this case to permit the parties to adduce further evidence bearing upon the issue. We do this because, at the time the case was litigated several years ago, the Board's approach to unit determination was quite different from what it is today, and the parties proceeded without the benefit of our current analysis.⁴⁵

604 F.2d 454, 458 (6th Cir. 1979) (the congressional policy "does not mean that all non-professional hospital employees must be covered by a single unit"); *Bay Medical Center v. NLRB*, 588 F.2d 1174 (6th Cir. 1978).

⁴¹ *Trustees of the Masonic Hall*, above.

⁴² The total employee complement is 1300.

⁴³ The Employer's chief engineer testified that half of the maintenance budget is spent on outside contractors and that in-house employees merely "take care of the basic nontechnical skills of repairing and maintenance to all equipment and structures within and outside the hospital."

⁴⁴ Personnel records are also centrally maintained.

⁴⁵ For the reasons stated in his dissent in *St. Francis I*, Member Hunter finds on the basis of the record here that the petitioned-for unit fails to satisfy the disparity-of-interest test. Member Hunter notes that in *St. Francis I* he would have dismissed the petition. In the present circum-

In reaching our decision to accept the "disparity-of-interests" standard by adjudication in this case, we have considered the alternative of establishing the appropriate units in the health care field through rulemaking as suggested by Member Dennis.⁴⁶ The critical question addressed in today's decision—congressional intent regarding hospital bargaining units—has been the subject of prolonged litigation before the Board and in the courts. The principles announced here represent a clear rejection of Board precedent to this point since the 1974 health care amendments. Were we now to establish an overly rigid formulation of appropriate units in the health care field without the development of sufficient experience under the new standards, we risk the danger of entering a second decade of litigation in this field. As stated by the Supreme Court in *S.E.C. v. Chenery Corp.*, 332 U.S. 194, 202 (1974), and appropriately relied on in *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 294 (1974):

Not every principle essential to the effective administration of a statute can or should be cast immediately into the mold of a general rule. Some principles must await their own development, while others must be adjusted to meet particular, unforeseeable situations.

Accordingly, we deny the General Counsel's Motion for Summary Judgment.

ORDER

It is ordered that this case be remanded to the Regional Director for Region 26 for further consideration consistent with this Decision and Order, including, if necessary, reopening the record in the underlying representation case.

MEMBER DENNIS, further concurring.

I agree that the Board to this point has not observed the congressional injunction against unit proliferation in the health care field. I therefore join my colleagues in promulgating the "disparity-of-interests" standard, as refined in this case, in an effort to give effect to the will of Congress. I would have preferred, however, that the Board

stances, however, Member Hunter is willing to join his majority colleagues in remanding the case for further hearing, if the parties so desire, on the ground that the Board here is establishing an important new legal standard.

The dissent charges that the majority has failed to provide parties with sufficient guidance as to the types of units which may be found appropriate. We have in this decision announced the test which will apply to all health care cases—a disparity-of-interests analysis using community-of-interest elements—and have applied this test to the extent possible on the record now before us. Based on that record, no sufficient disparity of interests is demonstrated for the maintenance employee unit.

⁴⁶ Member Dennis does not join in this paragraph.

clearly define a limited number of appropriate health care units, after full consideration of the positions and interests of all elements of the industry, through its rulemaking authority. Such an approach, in my view, would have provided health care labor relations with immediate stability and certainty, and obviated continued litigation before the Board and courts. I note with approval the recent statement of the Seventh Circuit:

[W]hile 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 . . . awakened its dormant rulemaking powers for the purpose of particularizing the application . . . to the medical field. [*NLRB v. Hillview Health Care Center*, 705 F.2d 1461, 1466 (1983).]

Under the "disparity-of-interests" standard we adopt today, it is not possible to give as much guidance to health care employers and unions as I would like, for each case must be judged on its own particular facts. I believe, however, that a disparity of interests may be demonstrated most readily in a large, diversified health care institution, yielding four appropriate units (professionals, service and maintenance employees, technicals, and business office clericals). In a small, functionally integrated facility it may be that a disparity cannot be demonstrated, and two units (professional and nonprofessional) would therefore be appropriate.

MEMBER ZIMMERMAN, dissenting.

Less than a hundred words of legislative history warning against the proliferation of bargaining units in the health care industry have sparked a legal debate that has now raged for 10 years.¹ In abstract terms, this debate concerns whether a "community-of-interests" or "disparity-of-interests" test better serves the vague statutory limitation on the number of appropriate bargaining units at a health care facility. Regardless of the test used, however, sharp differences of opinion among Board Members and between the Board and certain courts of appeals have actually involved the propriety of only two of several commonly petitioned-

for units—a unit restricted to skilled maintenance employees and a unit exclusively composed of registered nurses. Nevertheless, the continuing lack of definitive guidelines for appropriate units has gradually paralyzed the processing of all Board representation cases in the industry. Consequently, thousands of employees have been denied their right to choose or reject collective-bargaining representation.

It is clear that there must be an end to the debate. The proliferation of litigation has undermined the stability of labor relations in health care facilities at least as much as any potential proliferation of bargaining units. Yet, the majority today has produced a decision far more likely to exacerbate this problem than to settle it.

Two years ago, the Board attempted to resolve the unit debate in the representation stage of this case.² In *St. Francis I*, the majority set forth an extensive analysis of legislative history and precedent; specifically identified seven potentially, but *not* presumptively, appropriate health care bargaining units; held that units beyond those seven were presumptively inappropriate, absent a showing of extraordinary circumstances; and further held that the appropriateness of any of the seven units, when petitioned for, would be decided on a case-by-case basis by application of the Board's traditional community-of-interests test.

The effort to produce definitive unit guidelines in *St. Francis I* was stillborn. My colleagues in the majority have successfully prevented that case and any case relying on it from seeing the light of day.³ As of today, the *St. Francis I* standard has never received a full review in any court of appeals. Whether that standard would have satisfied the criticisms voiced by several of the courts cannot be known with certainty, but it at least addressed those criticisms fully.

The majority has now replaced *St. Francis I* with a new "disparity-of-interests" test. This new test is the consequence of change in Board membership and in views regarding the purposes of the Act.⁴

¹ S. Rep. 93-766, 93d Cong., 2d Sess. 5 (1974), reprinted in "Legislative History of the Coverage of Nonprofit Hospitals Under the National Labor Relations Act, 1974" at 12; H. Rep. 93-1051, 93d Cong., 2d Sess. 6-7 (1974), *id.* at 274-275.

Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 208 NLRB [403] (1974), and *Woodland Park Hospital*, 205 NLRB [888] (1973), as well as the trend toward broader units enunciated in *Extencare of West Virginia*, 203 NLRB [1232] (1973).¹

¹ By our reference to *Extencare*, we do not necessarily approve all of the holdings of that decision.

² *St. Francis Hospital*, 265 NLRB 1025 (1982), hereafter identified as *St. Francis I*.

³ Case processing information from the Board's Office of the Executive Secretary indicates that no cases presenting an issue of the appropriateness of health care units have issued since *St. Francis I*. As of 20 June 1984, the Board had 80 pending health care cases, the largest single category of cases in the Board's overall case backlog.

⁴ As I recently stated in a dissenting opinion in *Sub-Zero Freezer Co.*, 271 NLRB 47 (1984), an unrelated case before the Board on a motion for summary judgment:

The sole reason that relitigation is being permitted here is a change in the composition of the Board from the time the representation case was litigated to the time the test of certification occurred. Certainly the Act allows for shifts in the law when the composition of the Board changes, and undoubtedly Congress intended for the

Continued

Although I would reaffirm *St. Francis I* here, I am also guided by the wisdom of Justice Brandeis' remark that, "It is usually more important that a rule of law be settled, than that it be settled right."⁵ Regrettably, my colleagues' new test is neither right *nor* settled. Faced with reasonable alternatives of settling the issue by testing *St. Francis I* before the courts, by modifying *St. Francis I* to reduce the number of specific potentially appropriate units to as few as four, by reviving the Board's underutilized rulemaking powers, or by seeking certiorari from the Supreme Court, the majority rejected them and has instead chosen an approach which raises more questions than it answers. Beyond hinting at the appropriateness only of one unit for all professionals and another for all non-professionals, the majority's disparity-of-interests test is so bereft of necessary specifics that it guarantees continued debate and renewed litigation, thereby denying the finality needed by employees, labor, and management in the health care industry.

Under the majority's disparity-of-interests test:

[T]he appropriateness of the petitioned-for unit is judged in terms of normal criteria, but 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 be established to grant the unit. Requiring greater disparities in the usual community-of-interest elements to accord health care employees separate representation must necessarily result in fewer units and will thus reflect meaningful application of the congressional injunction against unit fragmentation.⁶

The majority also contends that it is not adopting a rigid application of the disparity-of-interests test which would be the equivalent of a *per se* rule delineating only two units as appropriate.

The faults of this test are several: (1) It really says nothing about what evidence would prove or disprove a disparity of interests. (2) There is less of a basis in legislative history or in judicial precedent for a disparity-of-interests test than there is for a

community-of-interests test. (3) Most importantly, if this new test is not in reality a two-unit standard, then it reveals little about what parties in the health care industry need most to know: what number and kind of bargaining units will generally be found appropriate.

First, an analysis calling for "sharper than usual" disparities gives no practical guidance to petitioners, employers, or Board personnel designated to process election petitions. It gives no predictability either as to which community-of-interests elements may be more significant than others or as to the degree of distinction for each factor that will prove the critical "sharper than usual" difference. It simply is not clear at what point a difference between employee classifications in level of benefits, working hours, training and skills, or other traditional community-of-interests factors becomes significant. Absent clarification, parties in dispute about the appropriateness of a unit will be constrained to litigate the employment details of every employee classification in a facility.

Second, I reject the majority's rationale that a disparity-of-interests test better satisfies the congressional admonition against unit proliferation than a community-of-interests test. On its face, "disparity of interests" is no magical incantation somehow more deserving of deference than "community of interests." In application, I would agree with the Eleventh Circuit that disparity of interests can actually be no more "than a semantic inverse of community of interest."⁷ The appropriate unit under either a community-of-interests or disparity-of-interests test, properly applied, will be determined by reference to the same employment factors which are used both to separate and to aggregate employee classifications. A far more restrictive application, however, unnecessarily distorts the congressional intent of the 1974 amendments.⁸

I have no doubt that fewer units will result from my colleagues' application of their disparity-of-interests standard because that is precisely the outcome they wish to achieve. Nevertheless, I find no mention in the legislative history of any specific admonition to the Board to find the fewest possible number of health care bargaining units. On the contrary, although Senator Taft attempted to limit the number of appropriate units to four,⁹ the en-

Board to respond to changing times and conditions. It is, therefore, inevitable that a certain degree of instability in Board law will arise as new Members enter into the decision-making process. At the same time, however, such changes undermine the goals stated by a long succession of Board Members of maximizing the voluntary settlement of cases and minimizing the litigation of labor disputes. Those goals call for giving due regard for both stability in the law and finality in litigation. Avoiding unnecessary instability and uncertainty is critical to the efficient administration of the Act.

See also my concurring opinion in *Bravos Oldsmobile*, 254 NLRB 1056 (1981).

⁵ *Di Santo v. Pennsylvania*, 273 U.S. 34, 42 (1927).

⁶ Footnote omitted.

⁷ *NLRB v. Walker County Medical Center*, 722 F.2d 1535, 1539 fn. 4 (11th Cir. 1984).

⁸ E.g., *NLRB v. HMO International*, 678 F.2d 806 (9th Cir. 1982). The court there defined a strict disparity-of-interests test that would permit the Board to find not more than two units appropriate in any health care facility.

⁹ S. 2292. See Leg. Hist. at 457-458.

acted amendment contained no such restriction.¹⁰ What a remarkable distortion of context it is to insist on disparity of interests, a phrase attributable to Senator Williams, an advocate of the bill who sought to promote union representation in health care facilities, to mean that the Board should restrict the number of bargaining units to fewer than would have been permitted by Senator Taft.

The majority claims that its test will satisfy those courts which have criticized the Board's unit determinations. As previously mentioned, the courts have chastised the Board only for its decisions concerning registered nurses and maintenance employees units.¹¹ Even those courts which have dealt with registered nurse unit issues have not all rejected the Board's previous approach of utilizing community-of-interests factors weighed against concern for nonproliferation in health care units.¹² There has been little controversy as to units limited to all professional,¹³ technical,¹⁴ clerical, or service and maintenance employees,¹⁵ the same four units Senator Taft proposed.

More importantly, several circuits which have denied enforcement of Board orders in unit cases have not necessarily criticized the Board's use of a community-of-interests test as much as they have admonished the Board to define better its acknowledgement and application of the congressional warning against undue splintering of health care units.¹⁶ The principal dispute is now between the Ninth¹⁷ and Tenth Circuits¹⁸ which have adopted

the disparity-of-interests test, and the Second¹⁹ and Eleventh Circuits²⁰ which have rejected the strict disparity-of-interests test.²¹

Third, although the majority gives lip-service to the Second Circuit's criticism of a strict disparity-of-interests test, it stops short of demonstrating in what ways its new "sharper than usual" disparity test will differ from the test used by the Ninth and Tenth Circuits. For the present, this ambiguity leaves my colleagues' true intent largely to speculation. Future cases, however, may well demonstrate what is only suggested today—that the two tests are indistinguishable in result.

In rejecting a per se approach, the majority reluctantly acknowledged that separate units of technical, and service and maintenance employees have been upheld by the circuits.²² Yet, in applying their new standard to the facts of the instant case, the majority did not compare the employment factors of maintenance employees only to the group of all service and maintenance employees. Instead, the majority stated that "the present record thus fails to demonstrate a disparity of interests between the maintenance employees and other nonprofessionals adequate to justify separate representation." This comports with the majority's initial description of its new test which states that greater than usual differences between employees in the requested unit "and those in an overall professional or nonprofessional unit must be established to grant the unit." Consequently, the majority's analysis provides no basis for concluding that there are any circumstances in which judicially accepted service and maintenance units would be found appropriate by the Board.

The majority's predilection for only two basic units—professional and nonprofessional—is not refuted by its disclaimer of any desire to follow either a rigid disparity-of-interests test or to adopt a per se approach, as evidenced by application of the new test here. If there is any meaningful difference between my colleagues' approach and that set forth by the Ninth and Tenth Circuits, they have done the Act and the health care industry a disservice by failing to identify other employee units which may be appropriate.

The approach taken by the Board majority in *St. Francis I* stands in sharp contrast to the majority's approach here. In *St. Francis I*, the Board recognized that some prior decisions were susceptible to misinterpretation by the courts concerning the

¹⁰ Additionally, a standard similar to the disparity-of-interests test was proposed in congressional hearings, but was never adopted. William Whelan, representing the California Hospital Association, proposed that the "appropriate bargaining unit shall be the largest reasonable unit of employees of an employer." *Coverage of Nonprofit Hospitals Under National Labor Relations Act, 1973: Hearings on S. 794 and S. 2292 before the Subcommittee on Labor of the Senate Committee on Labor and Public Welfare, 93d Cong., 1st Sess. 200.*

¹¹ *NLRB v. Frederick Memorial Hospital*, 691 F.2d 191 (4th Cir. 1982); *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450 (10th Cir. 1981); *Mary Thompson Hospital v. NLRB*, 621 F.2d 858 (7th Cir. 1980); *Allegheny General Hospital v. NLRB*, 608 F.2d 965 (3d Cir. 1979); *NLRB v. St. Francis Hospital of Lynwood*, 601 F.2d 404 (9th Cir. 1979); *NLRB v. Mercy Hospital Assn.*, 606 F.2d 22 (2d Cir. 1979); *NLRB v. West Suburban Hospital*, 570 F.2d 213 (7th Cir. 1978); *St. Vincent's Hospital v. NLRB*, 567 F.2d 588 (3d Cir. 1977).

¹² *NLRB v. Walker County Medical Center*, above. In that case, the court enforced a Board order finding, inter alia, that a unit comprised solely of RNs was appropriate.

¹³ *NLRB v. Community Health Services*, 705 F.2d 18 (1st Cir. 1983).

¹⁴ *Watsonwan Memorial Hospital v. NLRB*, 711 F.2d 848 (8th Cir. 1983).

¹⁵ *Trustees of the Masonic Hall v. NLRB*, 699 F.2d 626 (2d Cir. 1982).

¹⁶ See, e.g., *St. Elizabeth Hospital v. NLRB*, 715 F.2d 1193, 1197 (7th Cir. 1983). The unit in this case included 31 maintenance, laundry, and linen department employees out of 100 other service employees. The court denied enforcement of the Board's order not because the court found the unit inappropriate, or that the community-of-interests test was improper, but because the Board had "failed to demonstrate how it considered the congressional directive, or why it concluded the directive had been satisfied."

¹⁷ *NLRB v. HMO International*, above.

¹⁸ *Presbyterian/St. Luke's Medical Center v. NLRB*, above.

¹⁹ *Trustees of the Masonic Hall v. NLRB*, above.

²⁰ *Watsonwan Memorial Hospital v. NLRB*, above.

²¹ *NLRB v. Walker County Medical Center*, above.

²² *Watsonwan Memorial Hospital v. NLRB*, above; *Trustees of the Masonic Hall v. NLRB*, above.

Board's methods of determining appropriate health care units.²³ In response, the majority set forth a straightforward analysis premised first on the identification of seven potentially appropriate units. These were neither presumptively nor per se appropriate, but provided the parties with some specific guidance as to the usual scope and number of health care units. Such guidance is vital if the Board is to effectuate the employees' right to exercise their fullest freedom of choice in selecting or rejecting a collective-bargaining representative.

As a second step, *St. Francis I* required a showing that employees in one of the potentially appropriate units also possess a "distinct community of interest, separate and apart from other hospital employees."²⁴ Under this analysis, "the long-established community-of-interest criteria are balanced against the legislative concern about over-proliferation of health care bargaining units."²⁵ For the reasons more fully expressed in the *St. Francis I* majority decision, this is the better approach to accommodate both the representational rights of health care employees and the congressional concern about unit multiplicity. As I believe that *St. Francis I* adequately addressed the criticism cited by the various courts of appeals, I would have at least put this test to judicial review before discarding it. Regrettably, my colleagues have rejected this course of action.

Equally regrettable, they have chosen an obfuscatory legal approach which is far worse than several reasonable alternatives to *St. Francis I*. In this decision they could have set forth a reasoned rejection of *St. Francis I* on the basis of the overriding need to find a solution to the unit issue most likely to be accepted by reviewing courts. They could have adopted a disparity-of-interests test which would have been clear and not wholly at odds with the Board's traditional community-of-interests criteria which were nowhere rejected by the Congress in 1974. They could have given reasonably clear guidance to the parties and to agency personnel reducing the number of and specifying the composition of all potentially appropriate units in health care facilities. Had they done so today, I could well have joined them despite my prior approval of *St. Francis I*, because of the overwhelming need for the Board to take the initiative in resolving this 10-year-long dispute.

It is clear now more than ever that the parties deserve a final resolution of the standard which will be used to prevent undue proliferation of health care bargaining units. By today's decision,

however, the majority has demonstrated the futility of this Board's attempts to resolve this issue through traditional case-by-case adjudication. Rule-making could provide an acceptable and feasible means to end the 10-year controversy. It would give the Board a chance to evaluate the industry's experiences under the law and to end the uncertainty over how to implement the congressional injunction against unit proliferation.²⁶ The Board could formulate comprehensive and specific rules tailored to the needs of different types and sizes of facilities. This would give parties predictability, guidance, and assurance that the rules would be settled unless or until they were modified. Finally, rules based on a broad range of information and comments from interested parties would have greater inherent credibility and should therefore lead to more judicial deference to Board decisions.

The Board could also seek certiorari to resolve the nonproliferation dispute. The Board has not petitioned for certiorari since *Mercy Hospital*, when certiorari was denied in 1980.²⁷ That request for certiorari preceded the sharp division of opinion in the courts of appeals about community of interests versus disparity of interests as the health care unit standard. Given the split in the circuits, the health care unit controversy is now ripe for review.

In summary, the disparity-of-interests test announced today fails to persuade me to abandon the approach taken by the Board in *St. Francis I*, particularly in light of the majority's rejection of any of the constructive alternatives I have discussed. The ambiguity of this new test is a setback for the Board's basic statutory mandate to provide stability, certainty, and promptness in its rulings. Those goals are critical to effectuating the rights of employees to fully exercise their freedom of choice in selecting a collective-bargaining representative. The only beneficiary of the new rule is likely to be the legal profession due to profit from increased litigation to define the rule's true meaning. If future cases do demonstrate that appropriate health care units will be reduced in the Board's view to only two, professional and nonprofessional, this result would represent a gross and unnecessary overreaction to criticism from courts of appeals, which are not universally opposed to the Board's balancing of community of interests against health care industry peculiarities. Moreover, the new test may confuse those courts which have already rejected a disparity-of-interests test.

²³ 265 NLRB at 1026.

²⁴ 265 NLRB at 1031.

²⁵ 265 NLRB at 1026.

²⁶ For example, the Board has no information showing any correlation between the number of bargaining units in health care facilities and the incidence of disruptive work stoppages in such facilities.

²⁷ *NLRB v. Mercy Hospital Assn.*, 445 U.S. 971 (1980).

For all of these reasons, I would adhere to the two-step analysis set forth in *St. Francis I* and find the maintenance unit here appropriate.