

McLean Hospital Corporation and Massachusetts Nurses Association, Petitioner. Case 1-RC-19750

June 30, 1993

ORDER DENYING REVIEW

BY CHAIRMAN STEPHENS AND MEMBERS
DEVANEY AND RAUDABAUGH

The National Labor Relations Board has considered the Employer's request for review of the Regional Director's Decision and Direction of Election (pertinent portions of which are attached), as well as the Petitioner's opposition brief. The request for review is denied as it raises no substantial issues warranting review.¹

¹ Review was requested of the Regional Director's findings that: (1) the petitioned-for unit, limited to the Employer's registered nurses, is an appropriate unit for bargaining, and (2) the Petitioner is not disqualified from representing the Employer's employees due to an asserted disqualifying conflict of interest. Only the portion of the Regional Director's decision addressing the first issue is attached.

APPENDIX

**REGIONAL DIRECTOR'S DECISION AND
DIRECTION OF ELECTION**

The Petitioner seeks to represent a unit limited to the Employer's nonsupervisory registered nurses. The Employer contends that the only appropriate unit is a unit containing approximately 160 classifications, consisting of all professional employees, including those professional employees employed by the Employer at the Adolescent Day Service and Adolescent Day Hospital. The Employer would also include in its proposed unit all psychiatrists-in-charge, medical interns, residents, and fellows, the facilities design coordinator, the research project operations supervisor, and three program coordinators at the Adolescent Day Service and Adolescent Day Hospital, but exclude all human resource department employees, information systems employees, security guards, confidential and managerial, and supervisors as defined in the Act. The Employer would further include in its proposed unit two attending physicians, Dr. Sinor and Dr. Livingstone.

McLean Hospital is a nationally recognized psychiatric hospital¹² and a major teaching hospital of the Harvard University Medical School. It is a subsidiary of Massachusetts General Hospital, a well-known general acute care hospital in Boston, Massachusetts. In addition to having clinical and teaching missions, McLean also serves as a research facility in the area of mental illness.

McLean is licensed by the Commonwealth of Massachusetts Departments of Mental Health and Public Health and accredited by the Joint Commission for Accreditation of Health Care Organizations as a psychiatric facility. On its

¹² McLean has been ranked by *U.S. News and World Report* as the best psychiatric hospital in the country.

240-acre campus in Belmont, Massachusetts, McLean provides inpatient, outpatient, partial hospitalization, and community residential services to severely mentally ill patients. It has 14 inpatient units with 273 inpatient beds and 13 community residences with 134 beds. Eight of the community residence programs are located on the Belmont campus; five are located in nearby communities. Also located on the Belmont campus are various research laboratories and the Arlington School, a high school for severely disturbed adolescents. Due in part to pressure from payors to contain health care costs, the average length of stay in McLean's inpatient units has dropped dramatically in the last few years from over 70 days to between 24 and 21 days at the end of 1991.¹³ Compared to 2 years ago, McLean is now admitting twice as many patients who stay for one-third the time they used to stay. As a result, the patients who are cared for on McLean's inpatient units are much more acutely ill than they were 3 to 5 years ago, and they require more intensive care. McLean expects this trend toward shorter lengths of stay and higher acuity to continue.

McLean employs approximately 2000 professional and nonprofessional employees. A bargaining unit of approximately 67 skilled maintenance employees is represented by the International Union of Operating Engineers, while the remaining employees are currently unrepresented.

McLean is headed by Dr. Steven Mirin, general director and psychiatrist in chief, and is organized in what McLean describes as a matrix fashion. Five associate general directors as well as the heads of the departments of nursing, psychology, rehabilitation services, and social work report directly to Dr. Mirin and oversee some 51 departments. In addition to the main clinical departments of nursing, social work, rehabilitation services, and psychology, there are numerous other departments which provide clinical support, such as the departments of internal medicine, admissions, quality assurance/utilization review, pharmacy, clinical lab, and chaplaincy. The vast majority of the registered nurses at issue in this case work for and report to the nursing department.

In addition to being organized along departmental lines, McLean's clinical employees are also organized into "programs," essentially, programs designate a continuum of services for patients with a certain type of diagnosis or for patients in a certain age grouping. For example, there are separate "programs" for patients with affective disorders, psychosocial disorders, psychotic disorders, and alcohol and drug abuse problems, as well as programs for geriatric patients and children, each headed by a program director who has clinical oversight across disciplines. Each program provides a continuum of services—inpatient, partial hospitalization, community residential, and outpatient—for the type of patients it serves, who may need varying levels of care depending on the acuity of their illness. Programs are staffed by various types of professionals, including nurses, physicians, psychologists, social workers, and rehabilitation workers. Nurses, social workers, rehabilitation workers, and some psychologists are simultaneously members of their respective departments and their respective programs. Each program carries out a clinical, research, and training mission.

¹³ The average length of stay in McLean's community residential treatment program, however, is well over 6 months.

The nursing department is headed by Nancy Valentine, administrator for nursing, who is assisted by Dorothy Tuttle, associate administrator for nursing, and three assistant administrators for nursing, Linda Ciulla, Linda Flaherty, and Karen Mainville. Below them in the nursing department hierarchy are 10 administrative nursing supervisors (ANS) who work out of the central nursing office deploying nurses and managing the department on all three shifts. In addition, there are 14 clinical nursing supervisors (CNS), each assigned to 1 of McLean's 14 inpatient units. Each CNS is the administrative and clinical supervisor for her particular unit and is responsible for hiring, evaluating, disciplining, terminating, and counseling the staff she supervises: RNs, mental health specialists, and administrative unit assistants.¹⁴ CNSs have no supervisory authority over the other professionals who work on their inpatient units. A CNS from one unit may cover for a CNS on another unit who is absent due to a holiday, vacation, or sickness. The above-described members of the nursing department have been stipulated by the parties to hold supervisory positions.

The vast majority of McLean's nonsupervisory registered nurses, approximately 250 employees, work as full-time or part-time staff nurses on 1 of McLean's 14 inpatient units. With the exception of eight nurses who "float" from unit to unit as needed, staff nurses are permanently assigned to a particular unit. Each unit has a psychiatrist-in-charge (PIC)¹⁵ and typically psychologists, social workers, and rehabilitation staff who are also permanently assigned to the unit. These professionals, along with the nurses, work together in multidisciplinary teams to provide patient care. The 14 units are located in several separate buildings on the McLean campus, with each building generally housing two patient units as well as other floors containing office space. Unit capacity ranges from 12 to 25 patients, all of whom are hospitalized for severe psychiatric illness. Because many of the patients may be in danger of hurting themselves or others, most of the units are locked and have security screens on the windows. Each inpatient unit has patient rooms, a common living room, dining room, and kitchen, a central nurses station which is enclosed and may be locked, and quiet rooms used to isolate patients when necessary.

Staff nurses, along with mental health specialists, provide coverage for McLean's inpatient units 24 hours a day, 365 days a year. Although there is some variation, nurses generally staff three core shifts: 7 a.m. to 3:30 p.m., 3 to 11:30 p.m., and 11:15 p.m. to 7:15 a.m. Each unit does its own scheduling. By and large, those nurses that work the night shift are permanently assigned to that shift; the remaining nurses rotate through the day and evening shifts, working about 50 percent of the time on each shift. Some nurses' schedules are changed from week to week. Once or twice a week nurses may be required to work a "turnaround," a schedule which requires them to work the 3 to 11:30 p.m. evening shift and then return to the hospital at 7 a.m. the next day for the day shift. Nurses are required to work every other weekend and holidays. As an incentive for staff nurses

to work weekends, McLean offers a "weekend package" under which staff nurses can work two 12-hour shifts on the weekend for 40 hours pay. Staff nurses who work as charge nurses, described below, may opt to work five 8-hour shifts or four 10-hour shifts, Monday through Friday.

Depending on the unit, two to five nurses are typically assigned to each day shift, two to three nurses work each evening shift, and one nurse generally covers each unit on the night shift. The staff nurses on the units are assisted by mental health specialists, the only other McLean employees who provide direct patient care 24 hours a day.

On most units, one nurse is assigned on a rotating basis to be charge nurse for the day and evening shifts.¹⁶ (Night nurses, who are usually the only nurse on their shift, also act in a charge capacity.) The assignment lasts for a month, and a nurse may be designated to be the charge nurse every 8 or 9 months. The charge nurse is generally responsible for seeing that the unit runs smoothly and is the primary conduit of information about the unit and its patients. She begins her shift by taking "report" from the outgoing charge nurse regarding the status of the unit. She then tours the unit with the previous charge nurse, observing the whereabouts of each patient. The two charge nurses also check and sign off that the "code cart" contains all equipment and supplies necessary in the event of a medical emergency. The charge nurse's duties include transcribing physicians' orders for periodic "safety checks," medications, lab tests, and privileges, obtaining physician's orders as needed, assigning the duties of the other staff nurses on her shift, reporting the status of the unit to the central nursing office and to the incoming shift, and relaying information about patients to the other professionals, e.g., abnormal lab reports or unusual behavior. Evening and weekend charge nurses also have their own patients for whom they are responsible during their shift; the day-shift charge nurses generally do not have their own patients but are responsible for attending rounds and team meetings, which take place two to five times a week. Rounds and team meetings, discussed further below, are meetings of the multidisciplinary staff of the unit during which the progress of each patient is discussed.

Nurses may be assigned other functional roles during their shift, such as medication nurse, vital signs nurse, admissions nurse, or nurse assigned to handle patients in seclusion or restraint. Nurses also rotate through these roles; i.e., a nurse may be assigned to be the medication nurse on one shift and the admissions nurse on her next shift. The medication nurse counts the narcotics on the unit with the prior shift's medication nurse. She pours and administers medications to all the patients on the unit who need them, first checking the doctors' order books to verify that medication orders are correctly transcribed on a medication chart sheet and making sure that no medications are given to those patients who are to have blood tests or vital signs checked first. Medications may be administered orally or by intramuscular or intravenous injection, and may only be administered by a physician, registered nurse, or licensed practical nurse.¹⁷

¹⁴ The parties stipulated at the hearing that the mental health specialists and administrative unit assistants are not professional employees.

¹⁵ In some instances a psychologist rather than a psychiatrist serves as the PIC of an inpatient unit.

¹⁶ Neither party contends that charge nurses are supervisory employees.

¹⁷ Neither party contends that the licensed practical nurses are professional employees or should be included in the unit.

The admissions nurse greets patients being admitted to the unit, checks their vital signs, does a body and belongings search, and interviews the patients to obtain their history and do a nursing assessment. Each admission takes about 2 hours to complete and is done together with a physician, who may be present all or part of the time, and who is the only professional authorized to sign a patient into the hospital. On some units one nurse is assigned to check all the patients' vital signs.

On some shifts one nurse may be assigned the task of monitoring patients who, because of their dangerous behavior, must be secluded in a quiet room and/or restrained, either physically or chemically. By law, only a physician may order chemical restraint, and only a physician or a licensed registered nurse may order physical restraints. Nurses are authorized to order physical restraint of assaultive patients for up to 1 hour, although a physician is supposed to arrive within 15 minutes to countersign the order. No other professionals at McLean authorize restraints. On some units there are typically two or three restraints per shift; on others, seclusion and restraint is rarely used, perhaps a few times a year. Patients in restraints must have periodic breaks to avoid circulation problems, and nurses must check patients in restraints every hour to monitor their vital signs and ensure sufficient fluid intake.

In addition to the functional roles described above, each nurse on a shift is typically assigned to care for three or four of her own patients. Nurses are responsible for preparing, implementing, and periodically updating a written "nursing care plan" for each patient, which is directed toward their nursing needs. Each patient also has a written "treatment plan" which is developed in collaboration with the other professionals on the unit. While nurses are not trained in formal psychotherapy, they do individual counseling with patients in the form of daily "staff talks" in which they assess the patient's clinical condition, and focus on the patient's day-to-day life and problems. Nurses report each patient's progress daily on "assessment flow sheets" and in "nursing notes." They also may lead or co-lead group therapy sessions, further discussed below. They are responsible for performing periodic "safety checks" in which they must observe patients at a specified interval ordered by a physician. While the minimum interval for checks is every 30 minutes, some patients must be checked as often as every 15 or 5 minutes, and some are ordered to be under constant observation. Nurses are also responsible for educating their patients about the medications they are taking. Nurses are responsible for preparing patients for lab tests or treatments they may undergo while hospitalized, such as electroconvulsive therapy. They may also assist patients with activities of daily living on the unit such as dressing, bathing, cooking, or doing laundry.

A few inpatient units at McLean use the so-called primary nursing model, under which a single nurse is assigned to perform all the nursing functions related to a single patient, and a nurse and doctor team are the patient's primary caregivers. On primary nursing units, nurses are not assigned the functional roles described above, and each shift has a "shift coordinator" rather than a charge nurse, who handles only administrative details. On those units, someone wishing to speak to a nurse regarding a particular patient would be directed to that patient's primary nurse rather than to the

charge nurse. While the nursing functions are divided up differently on primary nursing units, the functions are essentially the same as on those units that employ a more traditional model of nursing care.

Staff nurses interact primarily with the nurses, mental health specialists, and other professionals on their own unit. Most units have a staff meeting for nurses and the CNS once a week; on some units there is an additional weekly meeting for the CNS, staff nurses, and mental health specialists. Contact with staff nurses on other units is much less frequent. Nurses are occasionally assigned to work a shift on another unit. Nurses also have occasional contact with nurses from other units when patients are transferred from one unit to another or when a patient who needs to be secluded in a "quiet room" is temporarily "boarded" off the unit to another unit due to the lack of an available quiet room in his or her own unit. When a patient is boarded, the charge nurse from the sending unit generally calls the charge nurse from the receiving unit to discuss the need for boarding, as well as the patient's diagnosis and medications. Boarding occurs as often as every week in some units or as little as one to three times a month or rarely in others. Nurses from one unit may also be called to help another unit in emergency situations, such as a seclusion or restraint. This happens as often as three or four times a day in some units and once a shift on average. Less frequently, about every 2 months, a nurse may be called to another unit to assist with a medical emergency.

Patients are admitted to McLean for psychiatric rather than medical care, and the vast majority of a staff nurse's time is spent focusing on her patients' psychiatric illness. While the nursing care plan developed for each patient addresses both the patient's medical and psychiatric condition, the focus is on the psychiatric issues. Because McLean is not equipped to deal with medical conditions of a serious or emergency nature, patients who develop such conditions are transferred to a medical/surgical hospital for treatment. However, depending on the unit, anywhere from 20 to 75 percent of the patients may have concurrent medical problems which are also managed by the nursing staff. Medical conditions seen on the units include diabetes, seizures, pneumonia, hypertension, infections of various kinds, and adverse reactions to medications. McLean has nurse practitioners and internists whose function it is to diagnose and order treatment for patients' physical illnesses; staff nurses on the units are responsible for following through with the prescribed treatment. Annual training in CPR is mandatory for all nurses. All patients have lab work done on admission and about one-half continue to have lab work done throughout their stay. About half or more of the patients must have their vital signs checked one or more times a day, a function that can also be performed by mental health specialists. Some of the more traditional task-oriented nursing duties, such as transcribing doctors' orders, counting narcotics, checking the code cart, or touring the unit at the change of shift, take only a few minutes. Receiving report at the change of shifts can take anywhere from 15 to 30 minutes. Somewhat infrequently, nurses perform such medical tasks as changing dressings, catheterizing a patient, or monitoring fluid intake and output.

Many of the patients at McLean are treated with medications. While the vast majority of the medications administered are psychotropic drugs for treatment of mental illness, these drugs may have physical side effects. Although other

professionals may report their observations as to the effect of a medication on a patient, only doctors or nurses may administer them, and nurses are uniquely responsible for ensuring that the correct dosage is administered, assessing drugs for effectiveness and side effects, and teaching patients about their medications. Nurses spend about one-half hour daily teaching patients about medication. Dispensing medications on the alcohol and substance abuse unit, one of the units with the most medications, takes about 40 minutes each time.

In addition to staff nurses, the nursing department¹⁸ employs several other categories of nurses whom the parties concur should be included in any unit found appropriate.¹⁹ McLean has a medical clinic which provides physical care on a walk-in basis for patients on the inpatient units and in community residences, and also has a staff of internists and nurse practitioners who are assigned to provide medical care on the inpatient units. The medical clinic has two staff nurses. One is a half-time nurse who assists in the walk-in clinic giving injections, hearing, vision, and tuberculosis tests, enemas, and the like, and also assists the doctors with electroconvulsive therapy. The other is a full-time charge nurse who oversees the daily flow of activities in the clinic, communicates with the nurses and doctors on the units, does triage of emergencies by telephone, schedules appointments, and arranges for followup care. Both work daytime, weekday hours.

McLean also has six full-time and part-time nurse practitioners, some of whom split their time between various roles. Four of them work full- or part-time in the medical clinic and are assigned to various inpatient units where they go to see patients and consult with the staff nurses concerning care for patients' medical conditions. Two of them work as part-time occupational health nurses, providing routine medical care and physicals for employees. Two share the role of infection control nurse, consulting with nursing staff on how to manage patients with infectious diseases and developing policies and procedures relative to infection control.

Also employed by the nursing department are one full-time and two part-time clinical educators in nursing who are responsible for a 3-week orientation program for new staff nurses, mental health specialists, and administrative unit assistants. They also act as instructors for certain mandatory continuing education classes for nurses, present seminars to staff on topics as needed, and provide an orientation session on mental illness for new nonprofessional employees. They work weekdays, 8:30 a.m. to 5 p.m. Three nurses work as clinical specialists, two in the outpatient clinic and one in the

Arlington Day Service. These nurses do individual and group therapy and evaluate the need for medication in their respective settings and, like the nurse practitioners and clinical nurse educators, are more expert than staff nurses. Finally, one nurse works half-time as a staff nurse and half-time as a research coordinator reviewing research proposals by staff nurses.

In addition to registered nurses employed by the nursing department, McLean employs registered nurses in some other departments whom the parties agree should be included in any unit found appropriate. Five registered nurses work as utilization review coordinators and report to the director of the quality assurance department. Utilization review coordinators must be registered nurses, and all the incumbents are former staff nurses at McLean. Their function is to prove to insurers that the care provided by McLean in each case is necessary, and they regularly consult with staff on the unit, attend rounds, and review patient charts. Two clinical nurse specialists and two triage nurses report to the director of the admissions department and perform psychiatric assessment of patients presenting themselves for admission to McLean. The clinical nurse specialists, some of whom are former staff nurses, are master-level nurses who do a more in-depth assessment than that performed by nurses on the units. They work during the day. Triage nurses cover the admissions department during the night shift, floating out to units that receive a new admission and helping to stabilize patients. The community residential treatment program employs three nurses whose function is primarily to administer medications, as well as four master-level clinical nurse specialists who oversee medical treatment and work with community residential counselors to implement treatment plans. Most of these nurses work 8:30 a.m. to 5 p.m., weekdays; two clinical nurse specialists cover the night shift. Two staff nurses work for the research department providing patient care to patients who volunteer to be research subjects in the alcohol and drug abuse program. Their job duties and responsibilities are the same as those of a staff nurse on an inpatient unit.

All staff nurses at McLean must be licensed registered nurses, a state license which is obtained by passing an examination, and graduates of an accredited school of nursing. No experience is required. A degree in nursing may be obtained by completing a 2-year associate degree program, a 3-year diploma school program, or a 4-year bachelor's program. Nurse practitioners, clinical educators in nursing, and clinical nurse specialists are required to have a master's degree in nursing in addition. While nursing school may include a psychiatric rotation lasting several weeks, nursing students do not receive training in psychotherapy. On hire by McLean, nurses are required to go through a 3-week orientation program which is attended by new nurses from all units. Some of the classes during the orientation are attended only by registered nurses; some are also attended by mental health specialists. Nurses also annually attend mandatory training in CPR, CPI (intervention with dangerous or assaultive patients), patients' rights, and infection control.

McLean also employs numerous other categories of professionals throughout the hospital whom the Employer contends should be included in an all-professional bargaining unit with the registered nurses. Those who work most closely with the nurses in the petitioned-for unit are the psychiatrists, psychologists, social workers, and rehabilitation specialists

¹⁸ There was testimony that the chief of the internal medicine department, which runs the medical clinic, occupational health, and infection control services, has oversight over all the nurses and doctors in that department. However, the nursing department's assistant administrator for nursing and coordinator of medical nursing, Linda Ciulla, testified that she supervises the nurse practitioners and staff nurses in the medical clinic. Similarly, there appears to be dual supervision of the clinical nurse specialists who work in the outpatient clinic and Arlington Day Service described below; the nursing department's associate administrator for nursing, Dorothy Tuttle, is responsible for hiring, evaluating, and firing those nurses, but they receive supervision from their colleagues in those departments with respect to clinical issues.

¹⁹ The parties have stipulated that nursing students are not employees of McLean and should not be included in any unit found appropriate.

who work on the inpatient units. Psychiatrists, psychologists, social workers, and rehabilitation specialists are also employed by McLean's outpatient service, by its community residential treatment program, by the adolescent day service (ADS) program, and by the North Cottage Adolescent Day Hospital.

While there are about 450 physicians who are employed by or have some other kind of affiliation with McLean, there are only about 40 to 45 physicians whom McLean contends are nonsupervisory and properly belong in a professional bargaining unit, as well as about 40 to 50 interns, residents, and fellows, who are psychiatrists in various stages of their training. Most of the physicians at McLean are psychiatrists, i.e., medical doctors who have obtained their license to practice medicine after completing a 4-year bachelor's program, 4 years of medical school, and 1 year of internship, and who also have completed a 4-year residency in psychiatry. McLean also employs a few physicians who are not psychiatrists, including about five internists and a neurologist. All physicians must meet continuing education requirements imposed as a condition of renewing their license.

Psychiatrists at McLean evaluate and admit new patients, prescribe medications, order the frequency of checks, authorize patient privileges and, when necessary, seclusion and/or restraint, and engage in individual and group therapy. Of the 40 to 45 psychiatrists whom McLean would include in the bargaining unit, about 25 to 30 of them are psychiatrists-in-charge (PICs) of an inpatient unit. Each inpatient unit has two full-time equivalent PICs, in some cases two full-time individuals, and in some cases one full-time and two half-time doctors. PICs are responsible for clinical oversight of their unit and lead the clinical teams which provide patient care. They report to the clinical director of the program with which their inpatient unit is affiliated, generally another psychiatrist. PICs generally keep daytime hours, although their hours vary. They may leave work at 4 p.m. one day and 10 p.m. the next. They do weekend rounds and may be called to the hospital at night in the event of an emergency. The other doctors whom the Employer would include are staff psychiatrists who work on the units, most of them on a part-time basis. They report to the PICs, at least for clinical purposes.

Patients at McLean are also treated by some 40 to 50 residents and fellows, doctors being trained in the specialty of psychiatry. As licensed physicians, they admit and treat patients, prescribe medication, attend rounds, write orders, and give clinical direction to nurses. When assigned to an inpatient unit they report to the PIC of that unit. Residents spend the first year of their residence in a general hospital, getting experience in internal medicine, pediatrics, neurology, or emergency room medicine. Second, third, and fourth year residents rotate through McLean's various inpatient units, the outpatient service, and the admissions office. Residents' schedules vary considerably depending on the year of residency. Second year residents are required to act as "night float" 3 weeks of the year, during which they must be physically at the hospital from 10 p.m. to 8 a.m. Ten second year residents rotate acting as the weekend resident on call, each shift lasting from 8 a.m. to 8 a.m. Third and fourth year residents rotate being on call evenings from 5 to 10 p.m. Some residents volunteer to "moonlight" doing admissions evenings and weekends for extra pay. Residents spend about

half a day per week in classroom training. About half of the residents and more than half of the clinical fellows stay on after the completion of their residency or fellowship, but there is no guarantee that they will be able to stay.

The Employer employs about 40 to 45 nonsupervisory social workers throughout the hospital. Two are assigned to most inpatient units, while three or four are assigned to the Hall Mercer Center, McLean's inpatient unit for children. Social workers are also assigned to the admissions office, outpatient clinic, the ADS program, and to various community residences. With the exception of the social workers in the community residence treatment program, social workers are hired, evaluated, and promoted by the social work department and attend weekly social work staff meetings. However they are also considered to be affiliated with the program within which they work. Clinical social workers I, the entry level position, must have a master's degree in social work with one internship in a psychiatric setting. The master's takes 2 years to complete and provides graduate level training in psychotherapy. Entry level social workers must be licensed by the State as LCSWs or take the first licensing exam they are eligible to take after hire. Clinical social workers II are more experienced. Some social workers at McLean have an LICSW, a license which allows social workers to practice autonomously. An LICSW must have a master's plus 3 years of postmaster's experience, pass an exam, and meet certain other requirements. Both licenses require a certain number of hours of continuing education for relicensure.

Social workers do individual, couple, family, and group therapy. They focus in therapy on family issues and are the primary contact with patients' families. Their standard hours are 8:30 a.m. to 5 p.m. weekdays, although many stay longer. Social workers are on call for emergencies on a rotating basis, about one evening a month and three weekends a year. When on call they assist with admissions when there is a family member present and may be paged regarding problems on the units. Social workers have their own offices, usually, but not always, in the building that houses the unit to which they are assigned.

McLean employs roughly 40 to 50 full-time and part-time nonsupervisory psychologists in various titles throughout the hospital, including assistants in psychology, assistant psychologists, assistant child psychologists, associate psychologists, and associate child psychologists. Assistants in psychology are master-level clinicians and are not required to be licensed. The remaining psychologists are licensed by the state Board of Registration in Psychology. In order to be licensed, a psychologist must have a PhD in psychology, have 3200 hours of clinical experience in a health provider setting, and pass a national and state exam. It takes approximately 8 to 11 years of post-high school education to obtain a doctorate in psychology. McLean also has approximately 30 to 35 predoctorate-level interns and postdoctorate fellows who are in various stages of their training.

Psychologists engage primarily in individual and group psychotherapy in inpatient and outpatient services at McLean. There are six psychologists who do psychological testing throughout the hospital and are primarily affiliated with the psychology department. The balance of the psychologists are primarily affiliated with the unit and program in which they work rather than the psychology department.

Psychologists have their own offices and spend some time in their offices and some time on the patient units. They work day and evening hours and their schedules vary.

The Employer's rehabilitation services department employs about 40 nonsupervisory professionals in various titles who provide therapy that is focused on improving patients' daily living, vocational, and social skills. Each inpatient unit has an occupational therapist or rehabilitation coordinator. The department also has occupational therapists and clinical administrators who work in the outpatient clinic and community residential treatment program. These employees are generally master-level occupational therapists or rehabilitation counselors and are licensed by the State. Those who work on inpatient units meet with patients individually to assess them, attend rounds and team meetings to form a treatment plan, lead therapy groups, and plan after-care, which may include talking to a patient's employer to help with their posthospitalization adjustment. Rehabilitation program coordinators are certified recreation, art, or music therapists who are assigned to an inpatient or outpatient setting and spend about 75 percent of their time running group activities for patients.

The nonsupervisory rehabilitation employees all report to a clinical supervisor for each program who reports in turn to the director of the rehabilitation services department. The vast majority of them have offices in the rehabilitation building, but about one-third of those who are assigned to an inpatient unit have an office in the building in which the inpatient unit is located. Those who work on inpatient units spend about 75 percent of their time on the units. Rehabilitation employees who work in the outpatient clinic work a day shift, Monday through Friday. Program coordinators on the inpatient units work 10 a.m. to 8 p.m. Monday through Friday, although six of them work on Saturday as part of their schedule. Rehabilitation coordinators and occupational therapists on the inpatient units work days, Monday through Friday, and also work one evening a week at their discretion. Some rehabilitation coordinators who work on a per diem basis occasionally provide weekend coverage for the inpatient units when called in because of an unusually large number of admissions over the weekend.

The Employer employs other professionals who are also involved in patient care. The pharmacy department has eight registered pharmacists who work in the pharmacy filling prescriptions for inpatients and community residents. Medications are delivered to the units by messengers in locked cassettes. However, pharmacists do visit the inpatient units once a month to check for expired medications on the code carts and they may occasionally give inservice training to inpatient staff. Pharmacists must have a bachelor's degree and are licensed by the State. Continuing education courses are required to maintain their license. The pharmacy is open Monday through Friday, 8 a.m. to 10 p.m., Saturday 8 a.m. to 5 p.m., and Sunday 10 a.m. to 2 p.m. One pharmacist covers only Saturdays. The others rotate covering the day, evening, and Sunday hours. There is also one clinical pharmacist who has a PhD in pharmacy. The clinical pharmacist reviews medical records, sees patients on the units, and consults with physicians concerning such matters as drug interactions. She works weekdays, 8 a.m. to 4:30 p.m.

Other professional employees who provide patient care are a part-time physical therapist in the internal medicine depart-

ment and three clinical dieticians in the dietary department. The pharmacists and clinical dieticians occasionally consult with the treatment teams with respect to medication or nutritional issues.

Numerous other professionals are employed in other departments throughout the hospital. The admissions department has approximately seven admissions coordinators whose function is to receive the telephone calls from patients or their families requesting admission, take certain essential information, call the appropriate clinical staff to clear the admission, call the patient back to make admission arrangements, notify insurers, and arrange for patient records to be sent to McLean. They are required to have a bachelors degree plus 2 years of experience in a psychiatric setting and provide coverage 24 hours a day, 7 days a week. Two marketing representatives, both of whom are registered nurses, work out of the admissions suite expediting admissions in order to ensure that the institutions and professionals who regularly refer patients to McLean are satisfied.²⁰ Two discharge coordinators work in the discharge planning department making arrangements for patients' posthospitalization care.

In addition to doctors and nurses who do research, McLean employs in its research department approximately 50 nonsupervisory professionals in numerous categories with titles such as clinical research technologist, animal research technologist, laboratory research technologist, clinical assistant investigator, laboratory assistant investigator, etc.²¹ McLean engages in both basic research, which is primarily conducted in laboratories in its Mailman Research Center and its Alcohol and Drug Abuse Research Center, and in clinical research, which involves interviewing and working with actual patients, and is conducted in the buildings which house the inpatient units and outpatient clinics. Those employees who engage in clinical research are considered to be affiliated both with the research department and with the program in which they work, although their salaries are paid from grants rather than from clinical revenues. Research employees who work in the laboratories have bachelors or master's degrees in fields such as biology, pharmacology, or biochemistry, while those who do clinical research may be psychology majors. McLean also employs two research associates in its evaluative services unit who conduct patient surveys designed to evaluate patient satisfaction with the quality of care provided.

McLean's Hall Mercer Center, an inpatient unit for children, has five or six clinical educators who function as teachers for the younger children and also administer educational and psychological tests to the children. They have a bachelors or master's degree in special education and work weekdays. McLean also employs 10 teachers and a dean at the Arlington School, a private, independent secondary school for emotionally disturbed children ages 13 to 22, which

²⁰ It appears from the record and the posthearing briefs submitted by the parties, that neither party seeks to include the marketing representatives in an RN unit. Since, as discussed below, I find a unit limited to RNs to be appropriate, I shall exclude the marketing representatives from the unit.

²¹ The parties dispute the professional status of five categories of research employees: senior clinical research technician, senior animal research technician, research project administrative coordinator, research computer specialist, and senior laboratory research technician.

serves children who are inpatients and outpatients as well as children who live in McLean's community residences. Most of the Arlington School faculty work only during the school year, September through June, and take the traditional school vacations. The dean works year round, and a few faculty may work during the summer, depending on the patient census. The faculty spend 90 percent of their time at the school, but they may occasionally visit students on the inpatient units in connection with their schoolwork. The dean occasionally goes to the inpatient units for meetings regarding patients.

McLean employs several psychologists, a social worker, and a registered nurse in its ADS I program, ADS II program, and the North Cottage Adolescent Day Hospital, day treatment programs for adolescents who are being released from an inpatient unit or who are attending the Arlington School. Each of the three programs has a program coordinator who, in addition to carrying a caseload of patients like the other professional staff, also serves as contact person with outside agencies, inpatient staff, and community residential staff concerning referrals into or out of their respective programs. One of the program coordinators is a master-level registered nurse who works .25 fte (full-time equivalent) as the program coordinator for ADS I and .25 fte as a nurse for the North Cottage Adolescent Day Hospital, where she handles cases and runs a medication group. The other two program coordinators are doctorate-level psychologists. The four professionals who staff ADS I rotate being "on call" for a week, every fourth week, 24 hours a day. ADS II, a less intensive program, does not provide 24-hour on-call coverage.

The remaining professionals whom the Employer seeks to include in the bargaining unit are scattered throughout the hospital. Two accountants and two financial analysts work in the fiscal services department. A facilities design coordinator in the plant and operations department performs architectural and interior design services for hospital construction and renovation projects. The environmental health and safety department employs an industrial hygienist who implements programs designed to protect the hospital's environment from materials such as asbestos, radon, and hazardous materials used in the labs. The development office employs development officers and development associates who handle McLean's fund-raising activities. Professionals within the public affairs department include a public affairs writer who prepares copy for McLean's various newsletters, a publications editor who prepares McLean's annual report and other literature, and a special projects coordinator who coordinates special events and handles media relations for special events. Finally, McLean employs chaplains who meet the spiritual needs of its patients, librarians who staff the library used by researchers and clinicians, and an assistant archivist in the office of the registrar who is responsible for maintaining McLean's historical records.

While the staff nurses on the inpatient units have little or no contact with many of the professionals described above, they do have frequent interaction with the psychiatrists, psychologists, social workers, and rehabilitation professionals on the inpatient units who, together with the nurses, constitute the members of the multidisciplinary teams. Each patient is required to have a multidisciplinary treatment plan. Each unit holds team meetings about two to three times per week for

about 2 hours which are attended by all members of the multidisciplinary teams—the PIC, psychiatric resident, CNS, charge nurse, other nursing staff if they are available, social worker, rehabilitation personnel, and, occasionally, staff from utilization review or other consultants. At these meetings the team members share information, discuss the progress of each patient, and collaborate to develop an appropriate treatment plan. In addition, most units have multidisciplinary "rounds," brief meetings to discuss what happened on the unit the night before, three to five times per week. While the day shift charge nurse or shift coordinator always attends these meetings, other staff nurses on the day shift attend somewhat less frequently, about half of the time on some units, because of their patient care responsibilities. Rounds and team meetings are never held during the evening, night, or weekend shifts.

Staff nurses also work with other professionals in group therapy and other meetings with patients. Each unit has a weekly community or "hall" meeting which is attended by patients and staff of all disciplines for the purpose of discussing issues and events of common interest. Many units also have a weekly "contract" meeting attended by patients and multidisciplinary staff in which patients make a contract to achieve certain goals by the next meeting. Most units have numerous therapy groups which meet once or twice a week for about 45 minutes; many are led by one discipline alone, but in some cases nurses co-lead groups with psychiatrists, psychologists, social workers, or rehabilitation staff. In addition to weekly staff meetings for nurses, some units have a multidisciplinary staff meeting once a week.

Outside of meetings, the other professionals with whom staff nurses have the most contact are physicians, with whom they collaborate in determining the appropriateness of medications, the frequency of checks, and the need for continued seclusion or restraint. Because nurses are in a position to observe patients minute to minute, they frequently contact physicians to report changes in patients' conditions and recommend changes in their orders. Individual contact with the other professionals during the day varies in frequency, but typically consists of brief conversations to inform the nurses that a patient is being taken off the unit for some purpose, e.g., a group activity or therapy session, and to report afterward how the patient did. Such contacts occur several times a day in some instances, but some nurses interact with a social worker, for example, about twice a week for a couple of minutes. Nurses have daily contact by phone with the pharmacists, concerning patients' medication. Staff nurses' contact with other professionals is much less frequent on the evening and night shifts, as most of the other professionals leave for the day by 5 or 6 p.m., and few professionals other than nurses and physicians work weekends.

Twenty-one registered nurses currently employed by McLean have transferred from one nursing position to another. For example, four utilization review coordinators, two triage nurses and two clinical specialists in the admissions department, two nurses in the medical clinic, and five nurses in the community residential treatment program are former staff nurses. No registered nurses have ever been employed in any other professional positions at McLean, nor have any other professionals ever transferred into registered nurse positions.

McLean has a human resources department which recruits for all positions except doctors. A human resources employee sometimes referred to as a "nurse recruiter" and sometimes referred to as an "employment specialist," recruits and screens nurses as well as some other nonprofessional employees such as administrative unit assistants and mental health specialists, but no other professional employees. A clinical nursing supervisor in the nursing department interviews and makes the final hiring decision for nursing positions, and the nursing department evaluates and disciplines nurses, as do the supervisors in other departments for their employees.

Physicians at McLean are recruited by the hiring department rather than human resources and are hired as "joint appointees" of McLean and Harvard Medical School.²² As a condition of appointment to the "professional" staff at McLean, physicians, psychologists, and fellows go through a credentialing process under which they submit their curriculum vitae, licensure, and malpractice information to the program or training director who has recommended them. Their applications are then reviewed in turn by the credentials committee, the joint executive committee of professional staff, and, finally, McLean's board of trustees, which has the final vote. The appointment carries with it certain clinical privileges, which usually include authorization to practice independently. Residents are selected through a national program which matches graduating medical students with institutions all over the country. As members of the professional staff, physicians and psychologists must be recertified every 2 years and are bound by bylaws applicable only to professional staff.

Social workers who have an LICSW may, but are not required to, go through a similar credentialing process pursuant to McLean's bylaws applicable to allied health professionals. On being credentialed, social workers are entitled to engage in psychotherapy without supervision, both in the course of their employment and in private practice. Not all social workers at McLean have an LICSW, but, as a rule, those who do have an LICSW go through the credentialing process. Registered nurses who are licensed to practice in the expanded role, e.g., master-level nurses, are also eligible to be credentialed as allied health professionals, and practice psychotherapy independently. Nine nurses at McLean have done so; only two of them, however, one nurse educator and one clinical specialist, are nonsupervisory nurses who would be bargaining unit employees. None of McLean's staff nurses are authorized to practice independently and most would have to undertake years of additional schooling to do so.

Nurses at McLean are paid according to a separate salary schedule for nurses,²³ under which annual salaries for nurses fall generally within the same range as that of other profes-

sionals, with the exception of physicians, whose base salary is substantially higher. Examples of annual minimum and maximum salaries for various registered nurse and other professional positions are set forth below.²⁴

<i>Nursing Positions</i>	<i>Minimum</i>	<i>Maximum</i>
Staff nurse, community residential nurse, utilization review coordinator	\$30,208	\$48,695
Medical clinic nurse practitioner, research nurse, triage nurse, quality assurance manager	32,406	52,241
Clinical nurse specialist I, infection control nurse, nurse clinician, nurse practitioner, occupational health coordinator	34,674	55,892
Clinical nurse specialist II, instructor nursing education	37,049	59,721
<i>Other Professionals</i>	<i>Minimum</i>	<i>Maximum</i>
Rehabilitation coordinator, clinical social worker I, clinical dietician	26,890	40,552
Teacher secondary school	25,388	54,683
Occupational therapist	28,172	42,482
Resident	29,500	40,400
Clinical social worker II	29,521	44,518
Assistant psychologist	30,000	45,635
Associate child psychologist	35,252	57,007
Psychiatrist in charge	44,000	68,270
Assistant biochemist, assistant in chemistry, associate neurobiologist, assistant research child psychologist, research associate, research fellow, and numerous other research titles	26,891	83,477
Associate child psychiatrist	54,348	79,585
Child psychiatrist, psychiatrist	80,000	101,311
Physician	85,000	104,002

In addition to the above-described base salaries, psychiatrists and psychologists are eligible, in their capacity as credentialed psychotherapists, to supplement their income by performing work as a therapist beyond their regular work re-

²² As medical school appointees, physicians are given an academic as well as a functional title, but the medical school appointment carries with it no added duties or compensation.

²³ Under the salary schedule for nurses, staff nurses, community residence nurses, and utilization review coordinators are classified as weekly paid employees. Medical clinic nurse practitioners, research nurses, triage nurses, and the quality assurance manager are listed in a pay category which appears on both the weekly and monthly paid nursing schedules, and it is unclear in which category they fall. The remaining positions are monthly paid. Weekly paid employees are eligible for overtime.

²⁴ For purposes of comparison I have relied on Emp. Ex. 35 in Case 1-RC-19750, which conveniently sets forth the annualized minimum and maximum salaries for positions in the Employer's proposed professional unit by title. A 3-percent salary increase, which went into effect March 1992, is not reflected in Emp. Ex. 35. However, that increase would not have altered the relative standing of the various positions. I note that Exh. 35 also does not reflect a 5-percent market adjustment for staff nurses, a 5-percent increase in the minimum for all nursing positions, a 5-percent increase in the maximum for some nursing positions, and a 4-percent increase for the clinical social worker I position which was implemented in October 1992.

quirements. For example, about one-third to one-half of the PICs perform about 9 to 20 units (hours) of clinical service per week, for which they are compensated at the rate of \$50 per hour, thus supplementing their base salary by \$450 to \$1000 per week. Many further supplement their income by doing weekend rounds over and above the 9 to 20 units, which is billed at anywhere between 4 to 15 clinical units of service.²⁵ About 1 in 10 nonsupervisory psychologists also supplement their base salary by doing 3 to 5 hours per week of therapy under the unit system, at the rate of \$35 to \$40 per hour. Credentialed social workers are eligible to participate in the unit system of compensation at the rate of \$30 per hour. Most social workers do not perform work under the unit system, but those who do pick up about 1 to 6 hours of extra work per week.

In addition to being compensated by McLean through salary or billable units, most psychiatrists, psychologists, and credentialed social workers engage in private practice at McLean, for which they get paid directly by their patients and/or their insurers, generally at the rate of \$90 to \$100 per hour. They may see private patients in their McLean offices during the regular workweek so long as it does not interfere with their duties as employees. These professionals are allowed to use their McLean secretaries to perform billing and receptionist services in connection with their private practices, so long as they pay them extra for such services, generally about \$100 per month. Psychologists generally spend about 10 to 15 hours per week in private practice; social workers who are eligible to engage in independent psychotherapy generally devote about 2 to 16 hours to their private practices. There is no record evidence as to the average number of hours psychiatrists engage in private practice, but joint appointees are subject to a Harvard Medical School guideline under which they may not earn in private practice more than twice the maximum salary for their academic rank. Some nurses supplement their income by doing part-time work elsewhere, on their own time, such as temporary work for agencies that provide home care, at the rate of \$22 to \$23 per hour.

McLean periodically surveys compensation rates for comparable positions at other hospitals in the area and, from time to time, has increased salaries for particular positions based on market conditions. In October 1992, McLean implemented a 5-percent market-based increase to all staff nurses, and also increased the minimum salary for all nurses, as well as the maximum for all staff nurses. Nurses have been singled out for one or two other such increases in recent years. However, in the past few years McLean has also awarded salary increases based on market forces to other professionals: psychiatrists in 1985, clinical educators in 1989, accountants in 1990, occupational therapists in 1989 and 1991, pharmacists in 1990 and 1992, and research employees. The

²⁵ About 10 to 12 psychiatrists and psychologists, described as "status seven" employees, work only under the unit system and are not paid a salary. These doctors agree with McLean on a target number of units they will bill annually, and are paid 12 regular monthly paychecks based on that target. Their productivity is reviewed every 3 months, and their target or compensation is adjusted accordingly. If they work at least .40 fte, they are eligible for benefits such as pension and health insurance, but are not eligible for vacation or holiday pay. The parties have stipulated that they are employees within the meaning of the Act.

entry level salary for clinical social workers I was increased in October 1992, at the same time the adjustment for nurses was implemented.²⁶

While the minimum salary for any given position reflects the lowest salary that any employee in that grade receives, some employees may, depending on their experience, be hired at a salary up to 25-percent higher than the minimum. Nurses are the only category of employees at McLean for whom the hiring ceiling has been set at 35-percent higher than minimum. Entry-level salaries for all employees, except doctors (psychiatrists and PhD psychologists), are established by the human resources department. The entry-level salary for doctors is established by their hiring department.

Staff nurses who serve as charge nurse or shift coordinator are paid a 50-cent-per-hour charge differential and are the only professionals who receive such a benefit.²⁷ Staff nurses are paid a shift differential of \$1 per hour for evening shifts, \$2 per hour for night shifts, and an additional \$1 per hour for weekend shifts. The only other professionals who work off-shifts and are entitled to a shift differential are pharmacists, admissions coordinators, and discharge coordinators,²⁸ who are paid at the rate of 60 cents per hour for evening and weekend shifts and \$1.20 per hour for night shifts. McLean offers a degree differential of 3 percent for obtaining a bachelors degree and 3 percent for obtaining a master's degree which historically has been applied only to registered nurses.²⁹ As weekly paid employees, staff nurses receive overtime pay and holiday premium pay at the rate of time and a half. Other professionals who are weekly paid, such as pharmacists, admissions coordinators, and some research employees, are also eligible for overtime pay. Monthly paid employees—including psychiatrists, psychologists, social workers, rehabilitation staff,³⁰ and nurses in such positions as nurse clinician, clinical educator in nursing, nurse practitioner, clinical nurse specialist—are not eligible for overtime pay.

Staff nurses, who are entitled to 3 weeks of vacation to start, are the only employees at McLean who are entitled to

²⁶ The October 1992 salary adjustment for nurses and social workers was announced in September 1992 after the hearing in this matter had been closed. The Petitioner moved to reopen the record for the limited purpose of introducing evidence relative to that issue. The motion was granted, and the hearing was reopened for one day on December 1, 1992, for that purpose.

²⁷ The Employer notes in its posthearing brief that community residence counselors also receive charge pay; as stipulated nonprofessionals, however, their working conditions are not relevant to the determination of unit scope among professional employees.

²⁸ Although Director of Human Resources Gary Kalajian testified that rehab counselors who work off-shift receive a shift differential, Director of Rehabilitation Services Frances Palmer testified that they are monthly paid employees and do not receive either an evening or weekend differential for working at those times.

²⁹ McLean points out that a degree differential has also been recently awarded to a pharmacy supervisor and a community residence counselor; neither of those categories, however, would belong in any unit found appropriate here, as pharmacy supervisors are stipulated supervisors, and community residence counselors are stipulated nonprofessionals.

³⁰ Although Kalajian testified that "recreation counselors" are eligible for overtime pay, Palmer testified that the title "recreation therapist" is obsolete, that the correct title is now rehabilitation program coordinator, which is a monthly paid position and not eligible for overtime pay.

4 weeks' vacation after 1 year of employment. Other professionals, with the exception of joint appointees, start out with 2 or 3 weeks of vacation, depending on their grade, and are not entitled to 4 weeks of vacation until their fourth or fifth year of employment, depending on the position. Joint appointees are entitled to 1 month's vacation to start.

In the event of discharge or other disciplinary action, professional employees who are credentialed—physicians, psychologists, and some social workers—have access to a special appeals procedure pursuant to the bylaws for professional staff or allied health professionals. This process includes procedural protections such as the right to a fair hearing with sworn testimony, the right to counsel, the right to a transcript, the right to submit a report, and ultimate review by McLean's executive committee and, for doctors and psychologists, McLean's trustees. Nurses who are disciplined are entitled to appeal pursuant to the standard grievance procedure available to all other McLean employees, which does not include the due-process protections afforded to credentialed professionals and which ends at a lower level of review.

With the above-described exceptions, the personnel policies and remaining fringe benefits offered by McLean are applied uniformly to all professional employees. All professionals receive the same holidays, time off with pay, bereavement leave, jury duty leave, leaves of absence, medical insurance, dental insurance, life insurance, business travel insurance, long-term disability coverage, pension plan, tax saving plans, health clinic, tuition reimbursement, and employee assistance plan.³¹ All employees use a common entrance and have equal access to parking areas. A child care center, credit union, cafeteria, and recreation building are open to all McLean employees.

The record reflects certain distinctions between the operation of a psychiatric hospital versus a general acute care hospital that the Employer alleges have an impact on the role of the registered nurses and other professional employees in a psychiatric setting. First, in addition to the use of psychotropic medications and intensive psychotherapy to treat patients, an important component of the treatment of patients in a psychiatric hospital is the "therapeutic milieu." A therapeutic milieu essentially connotes an environment in which patients feel safe and understood. This includes ensuring the physical safety of patients who may be suicidal or violent. It also connotes a setting in which patients are surrounded by staff who relate to them in a supportive, therapeutic manner and in which patients feel that they are part of a community.

An important aspect of treatment at McLean is its use of multidisciplinary teams composed of psychiatrists, nurses, social workers, psychologists, and rehabilitation professionals. Given the complexity of the psychiatric disorders treated at McLean, treatment is not a job for one person, but requires a team of professionals, all of whom play a role in developing a relationship with patients and in providing the interventions necessary to recovery. Effective patient care requires flexibility on the part of professionals on the team, so that if a patient finds a relationship with a team member of

a particular discipline to be the most therapeutic, the treatment team can "flex" in that direction.

According to Dr. Lloyd Sederer, McLean's associate director for clinical services, there needs to be a sense of true partnership in the clinical enterprise among the different disciplines in order for the therapeutic milieu to work, and nurses must be identified as wholly a part of the treatment team and not segregated. He testified that a significant conflict among the staff on a team can have an adverse effect on the therapeutic milieu and that, in his clinical judgment, a separate bargaining unit for nurses would be inconsistent with the therapeutic milieu.

Dr. Mirin, general director and psychiatrist in chief, testified that professionals in a mental health setting need to work together in a tight-knit fashion, that a different set of employment terms for one professional group versus another could have a profoundly negative effect on McLean's ability to deliver patient care, and that separate bargaining units for one group of employees would strain the relationship between those employees who are in and out of the unit. He expressed his opinion that if nurses had different vacation or holiday benefits from other members of the team, it might be difficult to schedule meetings for the treatment teams. Finally, he testified that having to transfer employees from one part of the hospital to another in accordance with a seniority clause in a union contract, as opposed to in accordance with what makes common sense, would be disruptive, and that a third party intervening in the relationship between the hospital and its professional staff would undermine the sense of community and family that McLean tries to foster among its employees.

McLean also attempted to demonstrate that multiple bargaining units would have a harmful effect on the therapeutic milieu through the testimony of Roy Ettlinger, who has served as an administrator in several public and private psychiatric institutions. Because Ettlinger has managed psychiatric facilities with multiple unions, one union, and no unions, McLean contends that he is in the unique position of being able to compare the effect on patient care of these various bargaining unit configurations. Ettlinger worked for several years in a managerial capacity at Marlboro Psychiatric Hospital in New Jersey, a public psychiatric hospital which had four bargaining units: a technical and maintenance unit, a unit of other nonprofessionals, a professional unit, and a unit of police. He testified that psychiatric patients are very sensitive to conflicts between staff and may wonder if they are the cause. As an example of the potential danger posed by multiple bargaining units, Ettlinger cited an instance at Marlboro Psychiatric Hospital in which the union representing mental health workers and dietary employees struck as a result of an impasse in contract negotiations, and the other unions crossed the picket lines to work. This, according to Ettlinger, caused angry feelings between employees in the different bargaining units which spilled over into the therapeutic milieu, disrupting patient treatment and leading to an increase in acting-out behavior and assaults by patients on other patients and staff. Ettlinger also testified, however, that some members of the very same bargaining unit who struck also chose to work during the strike.

Ettlinger has also worked at the Human Resources Institute Hospital (HRI) in Brookline, Massachusetts, a private psychiatric hospital in which registered nurses are rep-

³¹ The tuition reimbursement program and employee assistance plan are not available to joint appointees, and the life insurance and long-term disability plan for joint appointees is different.

resented in a bargaining unit along with LPNs, milieu therapists, mental health workers, clericals, dietary workers, and occupational therapy aides. The remaining professional employees at HRI—social workers, occupational therapists, recreational therapists, psychologists, pharmacist, and clinical coordinators—are unrepresented. There have been no jurisdictional strikes. While there have been some jurisdictional disputes between nurses and nonrepresented professional staff, they have been disputes over professional roles unrelated to any right asserted pursuant to the nurses' collective-bargaining agreement. There has been no adverse impact on the therapeutic milieu at HRI due to differences in terms of employment between represented and unrepresented employees. Similar disagreements over professional roles have also arisen between social workers and registered nurses at the Arbour Hospital, a nonunionized private psychiatric hospital in Jamaica Plain, Massachusetts, where Ettlinger has also worked.

Ettlinger also testified that at Marlboro Psychiatric Hospital, scheduling problems arose due to the fact that the professional and paraprofessional members of the treatment teams had different processes for requesting vacation and had contractual seniority rights affecting scheduling of vacation. However, the hospital also had difficulty scheduling vacation for social workers, psychologists, nurses, and rehab personnel, notwithstanding the fact that they were all in the same bargaining unit. At HRI, the fact that represented and unrepresented employees had disparate holidays off also created operational problems; at Marlboro Psychiatric Hospital, all employees in the four bargaining units there had the same holiday schedules.

In rebuttal to Ettlinger's testimony concerning the adverse impact of separate representation for nurses, the Petitioner offered the testimony of Elaine Mauger, Julie Pinkham, and Shelley Reeve. The Petitioner represents various all-RN bargaining units at several area hospitals.³² Reeve, Mauger, and Pinkham are the MNA staff representatives assigned to represent bargaining units of registered nurses at Saint Elizabeth's Hospital, Cambridge Hospital, Carney Hospital, Faulkner Hospital, Newton-Wellesley Hospital, Waltham-Weston Hospital, New England Medical Center, Marlboro Hospital, and Quincy Hospital. As MNA representatives, they are responsible for negotiating collective-bargaining agreements and processing grievances on behalf of bargaining unit members. Each of these hospitals is an acute care general hospital that also has one or more psychiatric units. Registered nurses employed on the psychiatric units are included in the all-RN bargaining units.

The psychiatric units in the hospitals represented by the Petitioner also use multidisciplinary teams composed of nurses, physicians, social workers, psychologists, and rehabilitation workers who collaborate in the assessment and treatment of patients. They also treat patients using a combination of individual, family, group, and milieu therapy.³³

³² The Petitioner represents all-professional units at two area hospitals, Malden Hospital and Morton Hospital and Medical Center. The Petitioner also represents a bargaining unit of state hospital employees which includes nurses, psychologists, physicians, and pharmacists.

³³ In the cases of Waltham-Weston Hospital and Carney Hospital, the testimony of the MNA reps as to how the psychiatric units at these hospitals operate was supplemented by policy and procedure

As at McLean, registered nurses are the only professionals who work three 8-hour shifts around the clock. None of the three representatives has ever received any complaints from management at any of these hospitals that representation of psychiatric nurses separate from the other professionals on the psychiatric units has had any adverse impact on the delivery of patient care. There have been no work jurisdiction disputes at any of these hospitals, nor have any grievances been filed which have involved the other professionals.

In 1989, after extensive hearings, the Board promulgated at 29 CFR Section 103 its rule for determining appropriate bargaining units in the health care industry. Under that rule, there are eight presumptively appropriate bargaining units in health care facilities, including a separate unit of all registered nurses. While the rule was originally intended to cover psychiatric facilities, the Board eventually determined that the rule would apply only to acute care hospitals and that bargaining unit determinations for psychiatric hospitals and other non-acute care facilities should continue to be made on a case-by-case basis.³⁴ The standard by which the

documents published by those hospitals and stipulated by the parties to be authentic and currently in use. Pet. Exhs. 37 and 38, published by those hospitals and stipulated by the parties to be authentic and currently in use.

³⁴ The Employer contends in a motion to dismiss (Emp. Exhs. 1a and 1b), which has not been expressly withdrawn, although it was not renewed in its brief, that because the Board's rules governing bargaining units in health care facilities specifically exempted psychiatric facilities from coverage, unit determinations in psychiatric facilities continue to be governed by the disparity of interest test set forth in *St. Francis Hospital*, 271 NLRB 948 (1984) (*St. Francis II*), under which separate RN units were routinely rejected by the Board. Alternatively, the Employer moves to dismiss on the ground that even under the old community of interests test, the Board found in *Mount Airy Psychiatric Center*, 253 NLRB 1003 (1981), that professionals in psychiatric hospitals should not be divided into separate units. Since *Mount Airy* "commands" dismissal of the petition under any possible standard, the Employer argues, a hearing is unnecessary. The motion is denied. The proper standard for determining appropriate bargaining units in nonacute care health facilities was announced by the Board in the *Park Manor Care Center* decision, described below. Because *Park Manor* was issued by the Board the day after the Employer submitted its motion to dismiss, the Employer did not have the benefit of that decision at the time the motion was submitted. That *Park Manor* governs the principles applicable to unit determinations for all health care facilities exempt from rulemaking, including psychiatric hospitals, was recently confirmed by the Board in its order denying review of the companion case in this matter, *McLean Hospital Corp.*, 309 NLRB 564 (1992). As for the contention that the holding in *Mount Airy* "commands" dismissal of the petition without a hearing, the Board never suggested in *Mount Airy* that its finding in that case would apply uniformly to all psychiatric hospitals; in fact, the Board specifically stated in *Mount Airy* that it reached its decision with *Newton Wellesly Hospital* in mind, under which the Board has a responsibility to decide "in each case," after a thorough examination of the particular facts, whether the requested unit is appropriate.

I also reject the Employer's contention at 93 of its posthearing brief that

[By] exempting psychiatric hospitals from the regulations calling for a separate nurses unit, the Board *already* has determined that a separate nurses unit is not appropriate for a psychiatric hospital such as McLean. [Emphasis in original.]

The Board stated clearly in rulemaking that it had decided to proceed as to psychiatric hospitals "on a case-by-case basis" and gave no indication whatsoever that any particular unit configuration would

Board will determine appropriate bargaining units in non-acute care facilities was established in *Park Manor Care Center*, 305 NLRB 872 (1991). Under the “pragmatic or empirical community of interests approach,” set forth in *Park Manor*, the Board will consider background information gathered during rulemaking and prior precedent involving either the type of unit sought or the particular type of health facility in dispute, as well as traditional community of interest factors. The Board suggested that it would be helpful to compare and contrast the work force in the unit sought with the work force in acute care hospitals. Finally, the Board noted in *Park Manor* that certain general principles set forth in the rulemaking procedure are equally applicable to unit determinations in non-acute care facilities:

[I]n exercising its discretion to determine appropriate units, the Board must steer a careful course between two undesirable extremes; If the unit is too large, it may be difficult to organize, and, when organized, will contain too diversified a constituency which may generate conflicts of interest and dissatisfaction among constituent groups, making it difficult for the union to represent; on the other hand, if the unit is too small, it may be costly for the employer to deal with because of repetitious bargaining, and/or frequent strikes, jurisdictional disputes and wage whipsawing, and may even be deleterious for the union by too severely limiting its constituency and hence its bargaining strength. [Footnote omitted.] The Board’s goal is to find a middle-ground position, to allocate power between labor and management by “striking the balance” in the appropriate place, with units that are neither too large nor too small. [Footnote omitted; 53 Fed.Reg. 33904, 284 NLRB at 1534.]

Id. at 5.

The Petitioner contends that the petitioned-for bargaining unit of all registered nurses is appropriate. The Employer maintains that, due to its status as a psychiatric hospital, an all-professional unit is the smallest appropriate unit at McLean. Applying the principles of *Park Manor* to the facts of this case, I find, for the reasons set forth below, that a unit of registered nurses is appropriate.

Looking first to the Board’s experience during rulemaking, the Board’s examination of registered nurses at acute care hospitals resulted in a finding that these employees constitute a discrete group whose distinctive interests warrant separate representation. The evidence showed that RNs are the only professionals who are required, as a group, to be on duty 24 hours a day, 7 days a week and are the only professionals regularly required to work overtime. While there are isolated examples of other professionals working evenings or weekends, most work primarily day shifts during the weekdays. Thus nurses have a unique collective-bargaining interest in such matters as scheduling, shift differentials, and floating. Nurses are also unique in that they use the nursing process to assess patients and in that their profession demands con-

tinuous contact with patients, while the patient contact by other professionals is more intermittent. RNs alone continually monitor patients to make sure that physicians’ orders are carried out and that treatment procedures are not proving harmful. All acute care facilities have a department of nursing managed by RNs, and nurses overwhelmingly report to nurses. While some nurses work in other departments, the vast majority are ultimately responsible to the director of nursing. Some hospitals use “product line management,” a system of organization by type of service under which nurses may be responsible in some way to the manager of a project, but they still report to nursing supervisors. 53 Fed.Reg. 33911–33912, 284 NLRB at 1544.

The Board also noted that nurses are in a distinct labor market, which hospitals sometimes recognize by having nurse recruiters, a position which does not exist for other professionals. Because nurses are overwhelmingly female, and because RN wage scales are tied to RN wages at other hospitals, there is no pressure to increase wages from outside the industry, resulting in low nursing salaries relative to those of other professionals. While all professions require specialized education and training, nurses must pass licensing exams which are uniform throughout the country, and must follow state nurse practice acts under which no other health care workers may function as a nurse. RNs must report errors made by other professionals, e.g., errors in medication dosages by pharmacists, which may result in antagonism between RNs and other professionals. Cross-training and interchange is limited because of licensing requirements for RNs and the other professionals; RNs cannot be replaced by other professionals. While other professionals may occasionally perform RN functions, e.g., watching a heart monitor while nurses are on break, such examples are minimal. 53 Fed.Reg. 33912–33913, 284 NLRB at 1544–1547.

RNs in acute care hospitals do not have regular or recurring contact with nonnurse professionals, in part because licensing regulations preclude health care professionals from doing each others’ work, because RNs have different working hours, and because many nonnurse professionals are located away from the patient units where RNs work. While some hospitals use multidisciplinary teams which interact daily and have weekly formal meetings, the Board was not persuaded that the team concept detracted from the appropriateness of an all-RN unit. The Board noted that team members interact only with the few other members of their team, that other duties may prevent RNs from participating fully in teams, and that participation in teams does not alter each professional’s scope of practice or separate identity. The Board also found that the hospital industry had offered only unsubstantiated speculation that separate RN unit would adversely affect team care. 53 Fed.Reg. 33912–33913, 284 NLRB at 1545–1547.

The Board found that nurses have historically sought separate representation and that other professionals often do not react favorably to their inclusion with RNs. This is due in part to the fact that RNs in acute care hospitals may outnumber other professionals by a ratio of 4 to 1 or more, and the nonnurse professionals are concerned that their interests will not be given priority in an all-professional unit due to their smaller numbers. The Board found no evidence of wage whipsawing or jurisdictional disputes between unions of professional employees in the hospital industry. With regard to

be automatically precluded. 53 Fed.Reg. 33930, 284 NLRB at 1570 (1988). I also note that this argument, also made and rejected in the companion case to this proceeding, has already been implicitly rejected by the Board in its denial of the Employer’s request for review of my decision in that case.

strikes, the Board found that the strike percentage (number of strikes per contract negotiations) was relatively low in the health care industry and that hospitals continued operations during them. It further found that even in an all-professional unit, RNs, because of their numbers, could obtain a strike vote over the objections of the other professionals, and that a strike by an all-professional unit would be even more disruptive to a hospital than a strike by an all-RN unit. Finally, the Board found that due to a nursing shortage and a trend toward higher patient acuity, fewer nurses are required to care for more seriously ill patients, leading to more stress among the remaining RNs. It noted that nurses view separate collective bargaining as a vehicle for improving their working conditions and that hospitals are trying innovative proposals targeted at RNs in an effort to attract and keep them. 53 Fed.Reg. 33912-33916, 284 NLRB at 1545-1551.

With regard to psychiatric facilities, the Board found that, unlike acute care hospitals, psychiatric hospitals do not treat physical illness, that RNs are not the primary facilitators of care, and that RNs' work is closely integrated with that of psychologists, social workers, doctors, and other counselors. The Board further observed that there are more professionals other than nurses and doctors in psychiatric facilities, with the ratio of nurses to other professionals about 1:1; therefore nonnurse professionals would not have the same concern about being outnumbered as they would in an all-professional unit in an acute care hospital. For these reasons the Board decided to exclude psychiatric hospitals from application of its rule for acute care hospitals and to proceed as to them on a case-by-case basis. 53 Fed.Reg. 33929-33930, 284 NLRB at 1568-1570.

While there are some important differences between the roles of nurses in psychiatric and acute care hospitals, I find that the factors which supported the Board's decision to permit separate nurses units in acute care hospitals are present at McLean and justify a similar result. Although all professional employees have certain working conditions, personnel policies, and benefits in common, the registered nurses share other unique working conditions, interests, and benefits which distinguish them sufficiently from the remaining professionals to warrant separate collective bargaining. Like the nurses in acute care hospitals, nurses at McLean are the only professionals who are responsible for providing patient care 24 hours a day, 365 days a year. While there is evidence that some other professionals work occasional evenings and weekends, and that doctors may be on call for emergencies at night, no other professional group at McLean covers the patient units three shifts a day. This work schedule gives the nurses unique bargaining interests in shift and weekend differentials, shift rotation schedules, overtime, charge pay, and special incentives targeted exclusively at nurses, such as the 24-hour weekend package.

The evidence does show that there is somewhat more overlap between the functions of nurses and other team members at McLean than there is between the nurses and other professionals at acute care hospitals. In this regard, because McLean's patients are admitted due to mental rather than physical illness, the primary focus of care is on psychiatric rather than medical treatments, and all team members engage in individual counseling, group therapy, and treatment planning in rounds and team meetings. While nurses at McLean may spend relatively less time engaged in medical

tasks as compared to their counterparts at acute care hospitals, I find, however, that traditional nursing tasks still constitute a significant aspect of their role which differentiates them from the remaining professionals. In addition to treating patients by means of individual, group, and milieu therapy, McLean treats patients with medical treatments such as drug and electroconvulsive therapy. Nurses at McLean are the only professionals, aside from physicians, who may administer medications. While the vast majority of the medications administered are psychotropic drugs, they have physical effects which must be monitored by medical professionals. While other professionals observe patients and may report whether or not they feel a drug has been effective for a given patient, only doctors and nurses are trained and responsible by law for the safe and effective administration of drugs, and nurses are uniquely responsible for teaching patients about their medications. Only nurses may act in a charge capacity and give and receive report at the change of shifts. Only nurses transcribe physicians' orders, check vital signs, and perform periodic safety checks. Nurses are the only professionals other than doctors who, by law, may authorize physical seclusion and restraint. While McLean is not designed to treat patients with serious or life-threatening medical conditions, some patients do require treatment for routine, concurrent medical conditions, a function performed only by nurses. Because many of the foregoing functions may be performed, by law, only by a licensed registered nurse, no other professional may substitute for a nurse who is absent from work. The uniqueness of their role is also underscored by the fact that, while 21 nurses at McLean have transferred from one nursing position to another, no other professional has ever transferred into an RN position and no nurses have transferred into non-RN positions. Because of their unique role, nurses attend a 3-week orientation at the outset of employment and annual mandatory training which is attended by no other professional groups at McLean.

In finding an all-RN unit appropriate I also rely on the fact that the vast majority of the registered nurses, like the nurses in acute care hospitals, are administratively segregated within a department of nursing and are separately supervised by other registered nurses. Although professionals at McLean are affiliated with their "program" as well as their professional department, this is not unlike the "product line management" system of organization by type of service that acute care hospitals also use. Notwithstanding that affiliation with a program, for purposes of hiring, evaluation, termination, and other disciplinary matters, nurses report to a hierarchy of other registered nurses to whom no other professionals report.

The appropriateness of a separate nurses unit is also supported by sharp differences in the level and methods of compensation for nurses versus the other professionals. While the base salary levels for nurses are generally within the same range as those for most other professional groups, physicians may earn twice as much as nurses, counting base salary alone. Physicians' higher base salaries, coupled with their ability to earn even more based on the unit system of reimbursement and in private practice, their prestigious academic appointment, and their separate system for hiring, setting salaries, and grieving discipline combine to make the bargaining interests of McLean's physicians so divergent from those of the nurses, that I find it would be inappropriate to include

them in a unit with nurses. To the degree that psychologists and social workers are credentialed pursuant to the professional or allied health professional bylaws, their ability to supplement their income through the unit system and private practice and their access to a separate grievance procedure also gives them different bargaining interests from the nurses, who with rare exceptions, have no such opportunity. While the Employer argues that nurses may also supplement their income with outside employment, nurses' ability to earn \$23 per hour on their own time is simply not comparable to the opportunity afforded other professionals to see private patients in their McLean offices during the regular workweek at the rate of \$90 to \$100 per hour.

In approving an all-RN unit, I am aware that because they co-lead group therapy sessions with other professionals and attend multidisciplinary team meetings and rounds, nurses at McLean generally have more interaction with other professionals than do nurses in acute care hospitals.³⁵ I also concur with the Employer that most staff nurses probably have more interaction with the professionals on their own units than they do with nurses who work on other inpatient units. I find nonetheless that nurses have sufficient contact with one another and, more important, sufficient common interests, to justify separate representation as a group. The Board has never required that all members of a bargaining unit have contact with one another. If that were the case, the unit of professionals proposed by the Employer would be equally inappropriate, as psychiatrists, psychologists, social workers, and rehabilitation personnel are also permanently assigned to one unit at McLean and presumably have just as little contact with the professionals on other inpatient units as nurses do. Following that argument to its logical conclusion, the only appropriate units would be separate bargaining units for each inpatient unit, a solution which would surely violate the Congressional mandate against undue proliferation of bargaining units.

An examination of prior precedent involving the appropriateness of separate bargaining units for registered nurses also supports this result. In the 10-year period following passage of the 1974 Health Care Amendments which extended the protections of the Act to employees in nonprofit hospitals, the Board, applying traditional community-of-interests analysis, consistently approved all-RN units. The Board's reasoning, first set forth in *Mercy Hospitals of Sacramento*, 217 NLRB 765 (1975), was that nurses are the only professionals required to be on duty 24 hours a day, that their duties, by law, may not be delegated to other professionals, and that the vast majority of nurses are administratively separated in a nursing department as required by state law, under which they are subject to common supervision by head nurses and higher level managers who have authority to hire, fire, and regulate working conditions. Based on these factors, the Board found that RNs possess "interests evidencing a greater degree of separateness than those possessed by most other professionals in the health care industry." *Id.* at 767. Responding to judicial criticism that it had not given due deference to the Congressional admonition against proliferation of bargaining units in the health care industry, the Board

modified its approach during this period, but continued to approve separate units for nurses.³⁶

In the face of continued criticism by the circuit courts, the Board reversed gears in *St. Francis Hospital*, 271 NLRB 948 (1984) (*St. Francis II*), in which it held that the "disparity of interests" test better met Congressional concern over undue proliferation. Under that analysis, sharper than usual differences between the requested group and an overall professional or nonprofessional unit are required in a health care facility to justify separate representation. Applying the disparity of interests test, the Board found separate RN units inappropriate in *Keokuk Area Hospital*, 278 NLRB 242 (1986), and *North Arundel Hospital Assn.*, 279 NLRB 311 (1986).

Finally, after the *St. Francis II* approach was itself severely criticized by several circuit courts, the Board decided to engage in rulemaking to determine appropriate health care bargaining units, but to process all petitions under the disparity of interests test pending issuance of a final rule. *St. Vincent Hospital*, 285 NLRB 365 (1987). During this interim period, the Board found separate RN units appropriate in a few further cases, including *St. Vincent Hospital*. During rulemaking, however, the Board observed that, having had the opportunity to consider the substantial empirical evidence adduced in rulemaking, it had a far better understanding of the role of nurses in hospital operations, and that, were it to apply that empirical evidence, it might well reach a different result in *St. Vincent*. 53 Fed.Reg. 33916, 284 NLRB 1551 fn. 22.

The only Board decision involving registered nurses in a psychiatric hospital is *Mount Airy Psychiatric Center*, 253 NLRB 1003 (1981), in which the Board rejected the petitioned-for unit of registered nurses in favor of an all-professional unit. Mount Airy was divided into four programs for different types of patients. Two programs were staffed by nurses who performed traditional nursing functions and employed the standard nursing hierarchy in which staff nurses, charge nurses, and head nurses reported to higher level nurses. Two were headed by nonnurse program coordinators who served as administrators of their respective programs. One of these, the adolescent section, employed "charge persons" rather than charge nurses and team leaders rather than staff nurses. Two of the five charge persons and six of the fifteen team leaders were nonnurses, professionals with a master's in psychology or a related field; the rest were RNs. All team leaders and charge persons, RN and non-RN, performed virtually the same duties. Team leaders were assigned to work the three round-the-clock shifts, and their responsibilities included getting children up, taking vital signs, checking personal hygiene, feeding the children, and engaging in one-to-one counseling. The task of making medical assessments and administering medication in the adoles-

³⁵ As noted above, acute care hospitals also use multidisciplinary teams to some degree, but the Board found that the team concept did not detract from the appropriateness of RN units.

³⁶ In *Newton-Wellesley Hospital*, 250 NLRB 409 (1980), the Board declared that it disavowed any intention to create an irrebutable presumption in favor of an all-RN unit and that it would consider the particular circumstances of each case. In that case and a series of cases thereafter, however, it continued to approve all-RN units. In *St. Francis Hospital*, 265 NLRB 1025 (1982) (*St. Francis I*) the Board announced that it would consider a maximum of seven potentially appropriate units in health care cases, including a registered nurses unit, that they would be neither presumptively appropriate nor invariably granted, and that it would continue to apply community-of-interest criteria.

cent section was delegated to an RN “associate charge nurse”; RN charge persons and RN team leaders did not get involved with medical treatments, except for infrequent emergencies when the associate charge nurse was unavailable. An RN team leader who called in sick could be replaced by a non-RN team leader. All team leaders, RN and non-RN, were answerable to a head nurse, or in her absence, to the charge person on duty. Observing that all team leaders performed virtually the same daily tasks, substituted for each other, received the same benefits, and were subject to the same supervision, and that the responsibility for preparing and administering medication had been generally removed from the RN team leaders,³⁷ the Board concluded that all the team leaders stood in an identical position and that, under the circumstances, the exclusion of nonnurse team leaders from the unit would be improper. Finally, having found that the unit must include nonnurse team leaders and charge persons, the Board concluded that nine remaining professionals—pharmacists, occupational therapists, social workers, and an educator—must also be included in the unit, because the only alternative would be to create a small residual unit of nonnurse professionals who exhibited little community of interest among themselves. *Id.* at 1006–1007.

I find that the factors which justified the inclusion of the team leaders and charge persons with the registered nurses in *Mount Airy* are absent at McLean. Unlike the nonnurse team leaders and charge persons in *Mount Airy*, no nonnurse professionals at McLean share the same title as staff nurses, work side by side with them on three around-the-clock shifts, or perform virtually identical tasks. In this regard, non-RN team members at McLean do not perform such nursing tasks as getting patients up in the morning, feeding them, and taking their vital signs. Staff nurses at McLean, unlike RN team leaders at *Mount Airy*, are responsible for administering medications and other medical treatments. While psychiatric nurses may focus less on medical treatments than nurses at acute care hospitals, the administration of medications is one of their necessary functions and one which may be performed by no other professionals with the exception of doctors. Unlike the team leaders at *Mount Airy*, no other professionals at McLean can replace a staff nurse who calls in sick, and no other professionals report to nurses.

The only other Board decision involving registered nurses in a psychiatric setting is *Newton-Wellesley Hospital*, 250 NLRB 409 (1980).³⁸ The *Newton-Wellesley* case involved an acute care hospital which also had a psychiatric unit. Having found an all-RN unit to be appropriate, the Board noted that

³⁷ The Board acknowledged that the registered nurse team leaders, unlike the non-RN team leaders, were licensed to administer medical treatments, and that this difference in professional training might be a crucial factor in finding a separate RN unit appropriate in other circumstances. This factor was not dispositive in *Mount Airy*, the Board held, because the RN team leaders were not generally required to administer medications.

³⁸ The Petitioner also relies on a decision by this Region involving registered nurses in a psychiatric setting. In *Faulkner Hospital*, Case 1–RC–17481, an acute care hospital with a psychiatric unit, the Acting Regional Director found a separate RN unit appropriate based on differences in the education, duties and responsibilities, licensure, and supervision of the RNs, notwithstanding the psychiatric unit’s emphasis on teams composed of RNs and social workers which met daily, and the fact that positions on the unit were defined by role rather than discipline.

in reaching its conclusion it had paid special attention to the close working relationship between the nurses and other professionals in the psychiatric unit. The psychiatric nurses at *Newton-Wellesley* co-lead therapy groups with social workers. Both RNs and mental health counselors, who in that case were professionals, served as “key persons” who coordinated patient care, met with other professionals involved in a given patient’s care, and shared other duties, such as admissions screening. Both RNs and mental health counselors rotated on a three-shift basis and shared clinical supervision. Only RNs, however, could give medications, change dressings, transcribe orders, serve in “charge” positions, or give “reports” to the incoming shift of nurses. Based on these differences in duties the Board declined to place the mental health counselors in the registered nurses unit, noting additionally that mental health counselors did not transfer to other areas of the hospital as RNs did, were not licensed, and were administratively responsible to a different chain of command. Although not controlling, the Board also noted that the Petitioner did not seek to represent the mental health counselors.

The Employer also points to two prior decisions I issued concerning another psychiatric hospital, *Brattleboro Retreat*, in support of its position that only an all-professional unit is appropriate in psychiatric hospitals. The Employer argues that in my decision in *Brattleboro Retreat*, Case 1–RC–19451 (Oct. 5, 1990), a prerulemaking case, I found that an all-professional unit was “presumptively appropriate.” While the quotation is correct, it is taken out of context. The Petitioner in *Brattleboro Retreat* sought to represent a unit consisting of all of the Employer’s professional employees. The Employer proposed a unit consisting of all employees, both professional and nonprofessional, who were involved in direct patient care, but did not seek an election pursuant to *Sonotone Corp.*, 90 NLRB 1236 (1950). Therefore, the Employer sought a unit which, on its face, was prohibited by the Act, and which I consequently rejected with the above remark. While a unit of all professionals has always been presumptively appropriate, both before and after rulemaking, the issue presented here, whether a smaller petitioned-for unit might be appropriate, was not litigated in *Brattleboro Retreat*. With regard to my conclusion in *Brattleboro Retreat* that school teachers should be included in the professional unit, the Employer argues that it has made an even stronger case for inclusion of McLean’s professionals on the treatment team than was made for the teachers in *Brattleboro Retreat*. Whether or not one position should be included in a professional unit, however, sheds no light on the issue in this case, the propriety of an all-professional unit in the first instance.

The Employer also argues that my decision in a subsequent case involving *Brattleboro Retreat*, Case 1–RC–19742 (dismissal letter from Regional Director to counsel for Petitioner, March 26, 1992) (*Brattleboro II*),³⁹ “again reflects an unwillingness to allow separate bargaining units and the resulting fragmentation of employees in psychiatric hospitals.”⁴⁰ Employer’s posthearing brief at 135. In

³⁹ A request for review in Case 1–RC–19742 is presently pending before the Board.

⁴⁰ The Employer argues in its brief that *Brattleboro II* deserves significant weight as the only opinion applying the *Park Manor*

Brattleboro II I did reject the petitioned-for unit of technical employees in favor of an all nonprofessional unit. I did not conclude, however, as the Employer suggests, "that multiple bargaining units are inappropriate for nonprofessionals in psychiatric hospitals." *Id.* at 135. Rather I found that carving out a separate unit of technical employees at that particular facility, which consisted of *both* a psychiatric hospital and a nursing home,⁴¹ would be inappropriate on the facts of that case, which differ from the facts of this case in many significant respects. In *Brattleboro II*, I found that many of the employees in the petitioned-for unit, which consisted largely of mental health workers, like many of the nontechnical, nonprofessional employees, needed only a high school education and did not acquire their skills through technical schools or colleges. Thus the qualifications, skill level, and training of the two groups were similar, as were the wage groupings. I found that the technical employees had important and frequent work-related contact with nontechnical, nonprofessional employees and shared common duties and supervision with some of them. Unlike acute care hospital technical employees, the technicals at Brattleboro were directly involved in patient care. The facility, while large, was relatively smaller than McLean, and I found that the specialized staffing and lack of contact often seen in large institutions was not present. By contrast, McLean is a large, world-renowned, elite institution, recently ranked as the top psychiatric hospital in the country. With its highly sophisticated and specialized staff, McLean bears as close a resemblance as a psychiatric facility can to the model of an acute care hospital described by the Board.

The Employer contends that psychiatric hospitals must be treated differently from acute care hospitals due to the nature of their severely disturbed patient population and the importance of the therapeutic milieu. Specifically, the Employer argues that having separate bargaining units and different terms of employment for one professional group versus another would strain the relationship between team members and that this, in turn, could adversely affect the therapeutic milieu. I find, as did the Board in rulemaking, that "[t]he industry offered only unsubstantiated speculation that team care would be adversely affected" by separate RN units. 53 Fed.Reg. 33913, 284 NLRB at 1546. In fact, the evidence

analysis to psychiatric hospitals. After the briefs in this case were filed, however, I issued my decision in the companion case involving this Employer, *McLean Hospital Corp.*, Case 1-RC-19749 (Oct. 19, 1992), order denying review 309 NLRB 564 (1992). In that case I approved the petitioned-for unit of skilled maintenance employees over the Employer's objection that an all nonprofessional unit was the smallest appropriate unit in a psychiatric hospital. Thus, the Employer's contention that I am invariably unwilling to allow bargaining units smaller than all-professional or all nonprofessional in psychiatric facilities has now been put to rest.

⁴¹The Employer's posthearing brief refers to Brattleboro Retreat only as a psychiatric hospital, omitting mention of the fact that the facility had two components, a psychiatric hospital and a nursing home. In the decision I discussed the Board's observations in rulemaking that there is generally less diversity among technical and service employees, greater overlap of functions, and greater contact among nonprofessional employees in nursing homes as opposed to acute care hospitals, and I found those observations to be true at Brattleboro Retreat. Thus, Brattleboro Retreat is, in part, a completely different kind of facility from McLean, and the Employer's reliance on the decision in that case is, to that degree, misplaced.

shows that the various professional groups on McLean's multidisciplinary teams *already* work under substantially different terms of employment and that, nonetheless, the teams function smoothly. For example, for the most part, only doctors, psychologists and social workers are eligible to practice independently and participate in the unit system of reimbursement and McLean-supported private practice. Nurses are the only professionals on the teams who receive shift differentials, weekend differentials, overtime, charge pay, degree differentials, and the weekend package. Nurses are eligible for 4 weeks' vacation after 1 year, whereas other team members, with the exception of joint appointees who have an even more liberal vacation plan, must wait 4 or 5 years to be entitled to 4 weeks. There is no reason to suggest that differences in terms and conditions of employment achieved through separate collective bargaining for nurses will cause any more conflict than the numerous differences already instituted unilaterally by this Employer. To the contrary, given the fact that nonnurse professionals at McLean would still be outnumbered by the nurses by 1.5 to 1, the potential for conflict between team members may be higher if they are all in the same bargaining unit and nonnurse professionals feel that their concerns aren't given priority.

With respect to the Employer's concern that having different holidays or vacation policies for different team members will make it difficult to schedule team meetings, the fact that employees take holidays and vacations always causes scheduling problems for employers, whether they are in the same or different bargaining units, represented or unrepresented. Ettlinger testified that Marlboro Psychiatric Hospital had difficulty scheduling vacation for its professionals notwithstanding the fact that they were all in the same bargaining unit. To the degree that is a concern for this Employer, it is free to unilaterally implement the same holiday and vacation policies that it negotiates with the nurses for its unrepresented professionals. With respect to McLean's concern that if a patient finds a relationship with a nurse or a team member of another discipline to be the most therapeutic, the treatment team must be able to "flex" in that direction, there is no apparent reason why a nurse in an RN unit would be less willing or able than a nurse in an all-professional unit to engage in a therapeutic relationship with a given patient; such matters are not normally implicated by collective bargaining, which is limited to terms and conditions of employment. Finally, with respect to Mirin's testimony that it would be disruptive to have to follow a contractual seniority clause with respect to transfers and that a "third party" would undermine the relationship between McLean and its staff, suffice it to say that the Employer's preference not to be unionized is not at issue here.

Nor am I persuaded by Ettlinger's testimony that multiple units pose a danger to the therapeutic milieu because of possible ill feelings created when one unit strikes and another crosses the picket lines. In the incident described by Ettlinger, some members of the very same bargaining unit that struck also crossed the picket line.⁴² Notwithstanding

⁴²I note that in the incident described by Ettlinger involved a conflict between the nonstriking RNs and striking mental health workers, the latter being nonprofessional employees who would never be in the same bargaining unit with the nurses at McLean in any event.

Continued

Ettlinger's testimony that the striking workers at Marlboro Psychiatric Hospital had no angry feelings toward their fellow bargaining unit members who worked during the strike, common sense dictates that in the event of a strike, strikers are likely to be equally if not more angry at members of their own bargaining unit who cross the picket line than at members of other bargaining units who do so. Thus, having fewer and larger bargaining units at a psychiatric hospital will not necessarily reduce the risk of the type of conflict described by Ettlinger.

In any event, there is no evidence that separate representation for nurses will lead to an increase in disputes. I note that none of the hospitals at which the Petitioner represents separate RN units have ever complained to the Petitioner's representatives that representation of psychiatric nurses apart from the other professionals on the psychiatric units has had any adverse impact on their patients, and that there have been no work jurisdiction disputes or grievances between professionals at those facilities. Ettlinger similarly testified that at HRI, where nurses were represented apart from the other professionals, there was no adverse impact on the therapeutic milieu due to differences in terms of employment between represented and unrepresented professionals. The only disputes that arose between nurses and unrepresented professionals at HRI were the same sort of disagreements over professionals roles that arose between nurses and other professionals at a nonunionized facility where Ettlinger worked.

The Employer asserts that the hearing officer committed prejudicial error in excluding Ettlinger's testimony comparing psychiatric hospitals with acute care hospitals, but allowing MNA Representatives Reeve and Pinkham to testify about operations in psychiatric units in acute care hospitals where they represent all-RN bargaining units. The hearing officer permitted Ettlinger to testify about his experience with bargaining units in other psychiatric hospitals, but excluded his testimony about the differences and similarities between acute care and psychiatric hospitals on the ground that Ettlinger was not qualified by virtue of his background to testify as an expert about acute care hospitals. I concur with the hearing officer's ruling that Ettlinger's experience at acute care hospitals was too limited and dated to qualify him to provide probative expert testimony on that subject.⁴³

Ettlinger provided no examples of such conflicts between professional groups.

⁴³In any event, I question the relevance of testimony describing the operations of acute care hospitals. When the Board stated in *Park Manor* that it would be helpful to compare and contrast the work force in the unit sought with the work force in acute care hospitals, it meant to compare evidence about the work force in the disputed facility to its findings in rulemaking about the work force in acute care hospitals. This was not an invitation to reopen the extensive record in rulemaking with regard to acute care hospitals. *Child's Hospital*, Case 3-RC-9734 (Sept. 20, 1991) (not reported in Board volumes). (The Regional Director is cautioned not to permit evidence that is merely duplicative of or cumulative to the evidence already considered by the Board in the rulemaking proceeding and set forth in the supplemental information, but only to permit such evidence unique and special to this employer.) *St. Margaret Memorial Hospital*, 303 NLRB 923 (1981) (Denying review of Regional Director's decision that the hearing officer properly precluded Employer of an acute care hospital from introducing evidence that contradicts the Board's findings in support of its rule regarding skilled maintenance units).

Ettlinger worked for 1 year in 1970 at Mount Sinai Medical Center in New York as an assistant to the president where he worked on special projects such as reducing patient waiting time in the outpatient and radiology departments and reducing redundant paperwork in the laboratory. For 3 years in the early 1980s he was a part-time surveyor of acute care hospitals for the Joint Commission on Accreditation of Hospitals, where he was primarily responsible for surveying dietary, maintenance, and housekeeping departments. In 1986 he worked for 9 months as a consultant to Massachusetts Osteopathic Hospital while setting up a geropsychiatric unit, where he spent some unspecified amount of time working with other hospital departments. For 2-1/2 years in the late 1980s Ettlinger sat on the board of trustees of the Massachusetts Hospital Association, which primarily represents acute care hospitals, and attended Association meetings during which such issues as the reimbursement system for general hospitals, quality assurance, and the relationship of the medical staff to general hospitals was discussed. Ettlinger testified that he has never personally supervised nurses or any other types of employees in an acute care hospital, directly or indirectly. He has never worked in patient care areas in an acute care hospital. His service on the board of trustees did not provide any experience which would provide insight into the role of nurses at an acute care hospital or their community of interest with other professionals. The hearing officer's ruling is affirmed.

With regard to the testimony of the MNA representatives, they testified, essentially, that they represent several all-RN units which include nurses from psychiatric wards, that those psychiatric units employ other professionals and use a team approach, and that they have nonetheless never received complaints from management at those facilities that representation of nurses apart from the other professionals on the psychiatric units has caused any problems. The Employer complains that Reeve and Pinkham, unlike Ettlinger, were allowed to testify over McLean's hearsay objections about the operations of psychiatric units at those hospitals, despite the fact that they had never worked in those hospitals, they had spent little or no time on the units, and their testimony was based on conversations with nurses employed by those hospitals. I affirm the hearing officer's ruling allowing this testimony. The purpose of the testimony was not to provide a detailed comparison of the operation of psychiatric units in acute care hospitals with McLean,⁴⁴ a subject about which I agree they did not have sufficient first-hand knowledge, and, unlike Ettlinger, they were not purporting to offer expert testimony regarding the operations of acute care hospitals. Rather, the thrust of their testimony was to rebut Ettlinger's testimony that separate representation for various employee groups at psychiatric hospitals where he had worked had caused conflict between team members and disrupted the therapeutic milieu. As the collective-bargaining representatives for the bargaining units at those hospitals, the MNA reps were clearly in a position to have first-hand knowledge as to whether or not management at those institutions had

nance units). In view of this admonition, I have disregarded testimony by other witnesses, including Reeve, describing their experience as nurses in acute care hospitals.

⁴⁴If that was indeed the Petitioner's intent in offering the testimony, I have not considered it for that purpose in light of the witnesses' lack of first-hand knowledge.

ever complained that representing psychiatric nurses apart from other psychiatric professionals had caused labor disputes or adversely affected patient care. While they may not have detailed first-hand knowledge concerning the operations of those psychiatric units, Reever and Pinkham are clearly in a position to know through their experience as labor representatives such general information as whether or not those psychiatric units employ other professionals or use multidisciplinary teams, group therapy, and milieu therapy. The testimony of the MNA representatives with respect to this general description was also corroborated by policy and procedure statements from two of the hospitals about which they testified.

The Employer contends that the hearing officer also erred in striking from the record Ettlenger's testimony concerning the frequency of disputes between the unions at Marlboro Psychiatric Hospital. After describing four such disputes, Ettlenger testified that they were "common occurrences," but he was unable to recall any further examples. In light of Ettlenger's inability to recollect any further specifics, I affirm

the hearing officer's ruling that this characterization be stricken.

. . . .

Accordingly, based on the foregoing and the stipulations of the parties, I find that the following employees of the Employer constitute a unit appropriate for collective bargaining within the meaning of Section 9(b) of the Act:⁴⁷

All full-time and part-time registered nurses employed by the Employer at its Belmont, Massachusetts location, including per diems nurses who work on average 4 or more hours per week, but excluding all other employees, managerial employees, guards, and supervisors as defined in the Act. [Footnote omitted.]

⁴⁷ In view of my decision that a unit of registered nurses is appropriate, I find it unnecessary to decide whether the professionals at the Arlington School and Adolescent Day Service have a community of interest with the other professionals at McLean or to decide the various issues relating to the supervisory, professional, and employee status of certain employees in the larger unit proposed by the Employer.