LABOR LAW—THE ST. FRANCIS II DISPARITY OF INTERESTS TEST—IS IT NECESSARY?

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INTRODUCTION

Health care is a unique commodity. There exists a strong public interest in the uninterrupted provision of quality care. The role of the government in the area of labor relations in the health care industry is to protect the interests of health care consumers while safeguarding the right of employees to engage in concerted activity for their mutual aid and protection.¹

The National Labor Relations Board (NLRB) is the agency charged with overseeing the establishment and conduct of the collective bargaining process in the private sector.² One task assigned to the Board by the National Labor Relations Act (NLRA) is the determination of appropriate bargaining units within a given industry and enterprise.³ Ever since the enactment of the 1974 health care amendments to the National Labor Relations Act,⁴ the Board has applied the community of interest standard to determine appropriate bargaining units in the health care industry. In 1984, in St. Francis Hospital & IBEW⁵ [hereinafter St. Francis II], the Board reconsidered its earlier decision

³. "The Board shall decide in each case whether, in order to assure employees the fullest freedom in exercising the rights guaranteed by this Act, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof. . . ." 29 U.S.C. § 159(b) (1982). This determination of an appropriate unit is important for several reasons. The size and occupational make-up of the bargaining unit will greatly affect the outcome of the representation election. See Chaison, Another View of Union Organizing and the Small Employer, 19 Marq. Bus. Rev. 143 (1975); Rose, What Factors Influence Union Representation Elections?, cited in Chaison, Unit Size and Union Success in Representation Elections, Monthly Lab. Rev., Feb. 1973, at 51-52 (1973). Also, the unit chosen by the Board will circumscribe the bargaining goals (and bargaining strength) of the parties. See R. Gorman, Basic Text on Labor Law 67 (2d ed. 1982). In determining an appropriate bargaining unit, the Board tries to promote industrial peace through a stable collective bargaining relationship while at the same time affording employees freedom of choice. Kalamazoo Paper Box Corp., 136 N.L.R.B. 134, 49 L.R.R.M. 1715 (1962).
in *St. Francis Hospital & IBEW*[^6], [hereinafter *St. Francis I*] and adopted a new standard for determining appropriate units in the health care industry.[^7] To be certified as a separate unit, petitioning employees must, under *St. Francis II*, demonstrate that a disparity of interests exists between themselves and other non-management employees, rather than showing that the employees in the requested unit share a community of interest.[^8]

This note argues that applying the disparity of interests test will not result in an appropriate balance between the right of professional health care employees[^9] to organize under the Act and the public’s need for uninterrupted quality health care. The result of the new test may be a subjugation of the professional employee’s right to organize rather than a balance. This result is at odds with the Act’s goal of encouraging collective bargaining.[^10]

Part One briefly examines the controversy between some courts of appeals and the Board over the correct interpretation of the Congressional admonition against undue proliferation of bargaining units in the health care industry.[^11] This conflict led to the NLRB’s adoption of the disparity of interests test. Part Two points out that this test ignores empirical research which indicates that an expansion of unit size among professional health care employees will hamper substantially their ability to organize and, more importantly, will eliminate much of the incentive for professional health care employees to engage in collective bargaining. It further contends that the predictable results of the test will so discourage organizing among professional em-


[^8]: Id.

[^9]: This note discusses only the rights of professionals employed in hospitals and health care institutions.

[^10]: Experience has proved that protection by law of the right of employees to organize and bargain collectively safeguards commerce from injury, impairment, or interruption, and promotes the flow of commerce by removing certain recognized sources of industrial strife and unrest, by encouraging practices fundamental to the friendly adjustment of industrial disputes arising out of differences as to wages, hours, or other working conditions, and by restoring equality of bargaining power between employers and employees. . . . It is declared to be the policy of the United States to eliminate the causes of certain substantial obstructions to the free flow of commerce and to mitigate and eliminate these obstructions when they have occurred by encouraging the practice and procedure of collective bargaining and by protecting the exercise by workers of full freedom of association, self-organization, and designation of representatives of their own choosing, for the purpose of negotiating the terms and conditions of their employment or other mutual aid or protection.


[^11]: See infra notes 39-44 and accompanying text.
ployees as to effectively deny them the right of self-organization and collective bargaining.

Finally, Part Three notes that in light of the safeguards already present in the law, the Board's extension of the additional "protection" of requiring larger professional employee units in the health care industry is unwarranted and contrary to the "twin goals" of the 1974 amendments.12

I BACKGROUND

A. The 1974 Health Care Amendments

The enactment of the National Labor Relations (Wagner) Act gave all health care employees the right to engage in collective bargaining with their employers.13 In 1947, the Labor-Management Relations (Taft-Hartley) Act excluded non-profit hospital employees from the coverage of the NLRA.14 The 1974 health care amendments


In explaining the need for the amendments, the Senate committee report stated: "The Committee was also impressed with the fact, emphasized by many witnesses, that the exemption of non-profit hospitals from the Act has resulted in numerous instances of recognition strikes and picketing." S. REP. No. 766, 93d Cong., 2d Sess. 3, reprinted in 1974 U.S. CODE CONG. & ADMIN. NEWS 3946, 3948. See also Delaney, Union Success in Hospital Election, 20 INDUS. REL. 149, 150 (1981).
to the NLRA removed the exclusionary language of the Taft-Hartley Act. 15 Lawmakers determined that it no longer made sense to leave workers employed in this expanding sector of the economy outside the protection of the Act. 16 These amendments advanced two basic purposes which have become known as the “twin goals” of the amendments: (1) to extend the right to organize and the right to bargain collectively to non-profit sector health care employees; and (2) to assure a continued supply of quality health care to patients and communities. 17

Congress recognized that there is a strong public interest in the provision of health care services uninterrupted by labor disputes. While strikes and work stoppages in most private sector industries have an adverse effect on commerce, this effect is seldom immediate or life-threatening. Disruptions in the flow of health care services could have immediate and serious consequences to individual patients as well as to entire communities.

Congress took steps to safeguard public access to uninterrupted, quality health care. It admonished the National Labor Relations Board to refrain from promoting the proliferation of bargaining units in the health care industry. 18 Along with extending to health care employees the right to organize and bargain collectively, Congress modified various sections of the National Labor Relations Act to restrict the exercise of these rights. 19 As a result, health care employees exercise their collective bargaining rights and their rights to negotiate, picket, and collectively withhold their labor in a very different statutory environment from other unionized private sector employees. 20

At the same time, however, Congress referred to the extension of

16. In discussing the purpose of the amendments, the Senate committee stated:
   "The Committee could find no acceptable reason why 1,427,012 employees in these non-profit, non-public hospitals representing 56% of all hospital employees, should continue to be excluded from the coverage and protections of the Act. In the Committee's deliberations on this measure, it was recognized that the needs of patients in health care institutions required special consideration in the Act . . . ."
17. HISTORY OF THE COVERAGE OF NONPROFIT HOSPITALS, supra note 12, at 256-57; see also 120 CONG. REC. 13,560 (1974).
18. See infra note 34 and accompanying text.
19. See infra notes 108-21 and accompanying text.
20. Major differences include: 29 U.S.C. § 158(d)(A) (1982) (lengthening the required notice of contract expiration or termination period from 60 days to 90 days for health care employees, including a lengthening of notice to the FMCS from 30 days to 60 days); 29 U.S.C. § 158(d)(B) (1982) (30 day notice to FMCS of a dispute on initial con-
collective bargaining rights to non-profit sector health care employees as a "twin goal" of the 1974 amendments. Congress intended that these employees should have the right to choose whether they will use the vehicle of collective bargaining to resolve their problems on the job. Certainly, it is in the public interest that the government should actively discourage health care employees from using "self-help" methods such as recognition strikes.

Thus, the 1974 amendments set for the NLRB the delicate task of balancing two co-equal social goals: fostering collective bargaining in the non-profit health care industry while protecting public access to uninterrupted, quality health care. The application of the 1974 amendments, and the congressional admonition, are at the heart of the controversy over appropriate bargaining units in the health care industry.

B. The Congressional Admonition Against Proliferation of Bargaining Units in the Health Care Industry

The large number of professions, crafts, and job classifications present in the organization of the modern hospital creates the potential for many separate bargaining units. Despite the congressional admonition against it, bargaining unit proliferation may not, in itself, be inherently wrong. Rather, allowing the various professions, crafts, and job classifications within a hospital each to obtain separate

tracts unique to health care); 29 U.S.C. § 158(g) (1982) (10 day notice requirement to institutions by health care employees before engaging in any picketing).


22. "Coverage under the Act should completely eliminate the need for any such activity, since the procedures of the Act will be available to resolve organizational and recognitional disputes." S. REP. NO. 766, 93d Cong., 2d Sess. 1, reprinted in 1974 U.S. CODE CONG. & ADMIN. NEWS 3946, 3948.

23. See supra note 17.

24. What follows is a brief overview of the legislative history of the congressional admonition against proliferation of bargaining units in the health care industry and the controversy between the Board and the courts of appeals regarding its interpretation. For further analysis of the legislative history and the controversy itself, see Bumpass, Appropriate Bargaining Units in Health Care Institutions: An Analysis of Congressional Intent and its Implementation by The National Labor Relations Board, 20 B.C.L. REV. 867 (1979); Feheley, Amendments to the National Labor Relations Act; Health Care Institutions, 36 OHIO ST. L.J. 235 (1975); Vernon, Labor Relations in the Health Care Field Under the 1974 Amendments to the National Labor Relations Act: An Overview and Analysis, 70 NW. U.L. REV. 202 (1975).

25. However, multiple units invariably will increase administrative costs. Personnel departments will be called upon to negotiate with a number of bargaining agents and administer different contracts. Also, a multiple unit structure may give rise to "whipsawing" and "leapfrogging" tactics by the competing unions and thus raise labor costs.
representation may assure employees "the fullest freedom in exercising the rights guaranteed by this [Act]."\textsuperscript{26} The Board would simply apply the community of interests test to determine the appropriateness of the unit petitioned for and decide the issue as it does in any other industry.\textsuperscript{27}

There are strong indications that this approach would result in a multitude of separate bargaining units in an average modern hospital.\textsuperscript{28} Modern American hospitals are highly developed bureaucracies.\textsuperscript{29} The Board would apply its traditional "craft" criteria to an industry where specialization and departmentalization are the rule. Various medical support personnel, such as laboratory technologists, physical therapists and psychiatric social workers, are likely to have

\begin{itemize}
  \item \textsuperscript{26} 29 U.S.C. § 159(b) (Supp. I 1983). See supra note 3.
  \item \textsuperscript{27} In evaluating a petition to determine the appropriateness of the unit requested, the Board looks at such factors as: (1) similarity in the scale and manner of determining earnings; (2) similarity in employment benefits, hours of work and other terms and conditions of employment; (3) similarity in the kind of work performed; (4) similarity in training, qualifications, and skill of the employees; (5) frequency of contact or interchange among employees; (6) geographic proximity; (7) continuity or integration of production process; (8) common supervision and determination of labor-relations policy; (9) relationship to the administrative organization of the employer; (10) history of collective bargaining; (11) desires of affected employees; (12) extent of union organization. See A. Cox, D. Bok & R. Gorman, Cases & Materials on Labor Law 300 (8th ed. 1977); R. Gorman, supra note 3. The Board enunciated the community of interest test in Continental Baking Co., 41 N.L.R.B. 998 (1942).
  \item \textsuperscript{28} Consent elections do not produce opinions by regional boards regarding the appropriateness of the unit, but directed elections do. The hospital industry has tended to oppose unionization vigorously. Cain, Becker, McLaughlin & Schwenk, The Effect of Unions on Wages in Hospitals, 4 Res. Lab. Econ. 191, 194 (1984). Thus, consent elections are rare. Voluntary recognition is "nonexistent" in the hospital industry; Becker & Miller, supra note 13, at 313. Thus, a fair number of written decisions on bargaining unit determinations in health care institutions exist.
  \item \textsuperscript{29} S. Goldsmith, Modern Hospital Management 141-42 (1984).
\end{itemize}
different degrees and educational backgrounds; to be licensed or certified by different bodies; and have separate professional organizations. Craftspeople can range from carpenters, electricians, and plumbers to audio-visual technicians and CAT scanner repairers. Even apart from direct patient care departments, there are medical records departments, food service, laundry, and grounds crews; any one of these departments might be eligible for separate representation.

This type of fragmentation of the workforce into multiple separate bargaining units was of major concern to the legislators considering the 1974 amendments. Reference was made to the construction industry during the debate on the amendments. In that industry, various groups of tradespeople such as carpenters, masons, and electricians routinely are found to constitute separate bargaining units entitled to separate representation. A contractor might have agreements with a dozen different unions, each having different wage rates, work rules, and grievance procedures. A strike, for whatever reason, by one of these unions might idle many other tradespeople and perhaps halt construction completely. While the costs and delays resulting from such strikes may be inconvenient but perhaps tolerable in the construction industry, similar interruptions of the flow of medical services

30. It is possible that many of these groups could qualify for separate representation under the Mallinckrodt standard. Mallinckrodt Chemical Works, 162 N.L.R.B. 387, 64 L.R.R.M. 1011 (1966). Under the Mallinckrodt standard craft units are established where there can be found a “distinct and homogeneous group of skilled journeymen craftsmen performing the functions of their craft on a nonrepetitive basis.”

31. Id. The Board’s recent decision in North Arundel Hosp. & Md. Nurses Ass’n, 279 NLRB Dec. (CCH) ¶ 17,804 (Apr. 16, 1986), illustrates the diversity and departmentalization of the ranks of professional employees in modern hospitals. There the Regional Director granted a separate bargaining unit to registered nurses, citing as support for his decision the distinct job responsibilities of RNs and their organization into a separate department. The Board noted that: “Carried to its logical extreme, the Regional Director’s rationale could result in separate bargaining units for professionals in the pharmacy, physical therapy, radiology/CT/nuclear medicine, laboratory/pathology, patient services, respiratory/pulmonary, and social work departments . . . .”

32. The issue of proliferation of bargaining units in health care institutions has also greatly concerned me during consideration of legislation in this area. Hospitals and other types of health care institutions are particularly vulnerable to a multiplicity of bargaining units due to the diversified nature of the medical services provided patients. If each professional interest and job classification is permitted to form a separate bargaining unit, numerous administrative and labor relations problems become involved in the delivery of health care.


33. On the issue of unit proliferation, Senator Taft remarked: “The administrative problems from a practical operation viewpoint and labor relations viewpoint must be considered by the Board on this issue. Health-care institutions must not be permitted to go the route of other industries, particularly the construction trades, in this regard.” Id. at 12,945 (statement of Sen. Taft).
could endanger individual patients as well as the health of entire communities that rely on a strike-bound hospital.

The Senate committee directed the Board to avoid unit proliferation in the health care industry, using the words:

Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in Four Seasons Nursing Center, 208 NLRB No. 50, 85 LRRM 1093 (1974), and Woodland Park Hospital, 205 NLRB No. 144, 84 LRRM 1075 (1973), as well as the trend toward broader units enunciated in Extendicare of West Virginia, 204 NLRB No. 170, 83 LRRM 1242 (1973).3

3. By our reference to Extendicare, we do not necessarily approve all of the holdings of that decision.34

However, Congress rejected amendments which would have mandated by statute a prescribed number of units.35 Congress did not intend to preclude the Board from relying on its own expertise in determining appropriate units in the health care industry.36 The 1974 amendments do not contain any specific reference to bargaining unit structure; nor do the amendments direct the Board to adopt a particular method of approach in determining an appropriate unit in the health care industry.

35. S.2292, introduced by Senator Taft, would have placed a four unit cap on the number of appropriate units in the health care industry. This language was deleted from the final bill. 120 Cong. Rec. 13,561 (1974).
36. Of the language quoted supra at note 33, Senator Taft said: “I believe this is a sound approach and a constructive compromise, as the Board should be permitted some flexibility in unit determination cases.” 120 Cong. Rec. 12,944 (1974) (statement of Sen. Taft).

Senator Williams stated:

The National Labor Relations Board has shown good judgment in establishing appropriate units for the purposes of collective bargaining, particularly in wrestling with units in newly covered industries. While the Board has, as a rule, tended to avoid unnecessary proliferation of collective bargaining units among nonsupervisory employees, particularly when there is such a history in the area or a notable disparity of interests between employees in different job classifications.

While the committee clearly intends that the Board give due consideration to its admonition to avoid an undue proliferation of units in the health care industry, it did not within this framework intend to preclude the Board acting in the public interest from exercising its specialized experience and expert knowledge in determining appropriate bargaining units.

Unit determinations based on substantial evidence are "rarely to be disturbed." However, several courts of appeals have been willing to overturn unit determinations in the health care industry. The reason commonly cited for this lack of deference to the agency's expertise is that the Board has not followed properly the Congressional admonition and instead has allowed proliferation of units within hospitals and other health care institutions.

The Ninth Circuit Court of Appeals found in the legislative history of the 1974 amendments a mandate for the adoption of a disparity of interests test. The Tenth Circuit Court of Appeals distinguished this test from the Board's community of interest approach, which the court characterized as starting with a narrow unit and adding employees with shared interests. An approach which comports with the congressional admonition, the court contended, would begin with the broadest unit possible and would narrow it by excluding employees with interests disparate from this group. In Allegheny General Hospital v. NLRB the Third Circuit Court of Appeals expressed its im-

38. "Overt urn" is perhaps imprecise here. The reviewing court actually denies enforcement of a Board bargaining order based on what it considers to be an inappropriate unit determination, in effect overturning the Board's decision. See, e.g., NLRB v. Fredrick Memorial Hosp., 691 F.2d 191 (4th Cir. 1982); Presbyterian/St. Luke's Medical Center v. NLRB, 653 F.2d 450 (10th Cir. 1981); Allegheny Gen. Hosp. v. NLRB, 608 F.2d 965 (3d Cir. 1979); NLRB v. Mercy Hosp. Ass'n., 606 F.2d 22 (2d Cir. 1979); NLRB v. St. Francis Hosp. of Lynwood, 601 F.2d 404 (9th Cir. 1979); NLRB v. West Suburban Hosp., 570 F.2d 213 (7th Cir. 1978).
39. See, e.g., Mary Thompson Hosp., 621 F.2d at 861; Mercy Hosp. Ass'n., 606 F.2d at 28; West Suburban Hosp., 570 F.2d at 216.
40. St. Francis Hosp. of Lynwood, 601 F.2d at 419. The court found that the legislative history of the 1974 amendments:
[R]equir[ed] the Board to determine not the similarities among employees in the same job classification (indeed the fact that they share the same classification would inevitably lead to the discovery of many similarities), but instead the "disparity of interests" among employee classifications which prevent a combination of groups of employees into a single broader unit thereby minimizing unit proliferation.

Id.
42. Id. The St. Francis II majority specifically declined to adopt the Tenth Circuit Court of Appeals' "rigid" disparity of interests test, and agreed with the Eighth Circuit Court of Appeals' analysis in Watonwan Memorial Hosp. v. N.L.R.B., 711 F.2d 848, 850 (1983), that such a test would "always require the Board to select the largest appropriate bargaining unit." St. Francis II, 271 N.L.R.B. at 950, 116 L.R.R.M. at 1470. The majority rejected this "per se" approach for a more "flexible" disparity of interests test along the lines advocated by the Ninth Circuit.
43. 608 F.2d 965 (3rd Cir. 1979).
patience with the Board's adherence to the community of interest standard:

This petition for review of an order of the [Board] requires us to review the actions of an agency that declines to follow our precedent while conceding applicability of that precedent. We hold that the NLRB must respect the applicable decisions of this court, and therefore we grant the [Hospital's] petition for review and deny the Board's cross-petition for enforcement.44

Not all the circuit courts of appeals have agreed with the Ninth Circuit's reading of the legislative history of the 1974 amendments. The Court of Appeals for the Eleventh Circuit found no legislative history to support a disparity of interests test45 and the Second Circuit disregarded the test proposed by other courts of appeals, stating that it was balancing the "employees' rights to exercise section 7 rights with the congressional admonition against unit proliferation."46 The D.C. Circuit has recently held that: "The 1974 Amendments in no way require the Board to apply a disparity-of-interest standard when determining appropriate bargaining units in nonprofit health-care institutions."47 Both views of the legislative history enjoy support from commentators.48 Attorney Michael Stapp has argued that the dispute

45. NLRB v. Walker County Medical Center, 722 F.2d 1535 (11th Cir. 1984).
46. Trustees of Masonic Hall & Asylum Fund v. NLRB, 669 F.2d 626, 633 (2d Cir. 1983).
47. IBEW v. NLRB, No. 85-1642 (D.C. Cir. Mar. 20, 1987) [hereinafter St. Francis III]. On August 28, 1984, shortly after suffering reversal in St. Francis II, the IBEW requested the Board to withdraw its remand of the case and enter a final order disposing of the unfair labor practice charge. On June 26, 1985 the Board dismissed the complaint in the unfair labor practice proceedings and cleared the way for an appeal. In St. Francis III, Judge Edwards stated that the Board in St. Francis II had considered the disparity of interest test mandated by the 1974 Amendments. The D.C. Circuit unanimously disagreed, however, finding that "in adopting the disparity-of-interests standard, the Board ignored fundamental principles of statutory interpretation." Id. at 27. Because the Board's decision was based on an erroneous view of the law, the court, mindful of SEC v. Chenery, remanded without expressing an opinion on the proper outcome of the case. Id. at 4-5. The court did not rule on whether or not the Board could adopt the disparity of interest standard as a matter of policy under the discretionary power granted it by section 9 of the Act.
between the Board and some of the appeals courts was a result of "philosophical differences regarding the relative status of the community of interest test and the unit proliferation issue." The Board had felt it necessary to strike a balance between the employees' right to a bargaining unit based on this test and the congressional admonition. Attorney Michael Curley has contended that the disparity of interests test will result in fewer units in health care institutions and thus comports with the congressional intent that a more restrictive approach be taken toward health care unit determinations. Accordingly, Curley has characterized the Board's approach prior to St. Francis II as "flawed."

The Board ultimately adopted a disparity of interests test in St. Francis II. The next section examines this test more closely and discusses its suitability for resolving conflict in the health care industry.

C. The Board Adopts the Disparity of Interests Test

1. St. Francis I

On September 28, 1979, the International Brotherhood of Electrical Workers (IBEW) Local 474 filed a petition with the NLRB to hold a representation election for a group of skilled maintenance employees at St. Francis Hospital in Memphis, Tennessee. On November 19, 1979, the employer requested review of the Regional Director's unit determination decision. On December 4, 1979, the National Labor Relations Board granted the employer's request for review. The Board rendered its decision upholding the Regional Director's decision on December 16, 1982 (St. Francis I).


49. Stapp, supra note 48, at 76.
50. Id.
51. Curley, supra note 44, at 121.
52. Id. at 122.
53. Id. at 121.
55. On November 5, 1979, the Regional Director (Region 26) found an appropriate unit of maintenance employees including more job classifications than the unit requested by the union, but far fewer than the employer's request for a unit of all service and maintenance employees at the hospital. The employer filed a request for review of the Regional Director's decision and the National Labor Relations Board granted that request on December 4, 1979. At the close of balloting of the subsequent directed election (December 7, 1979), the Board impounded the ballot box.

Two years later, on December 16, 1982, the NLRB issued its decision (St. Francis I) on the employer's request for review of the Regional Director's unit determination deci-
St. Francis I 56 explicated the "two-step" analysis used to resolve unit determinations in health care institutions. First, the Board establishes seven "potentially" (but not presumptively) appropriate units. 57 If the unit requested by the petitioning employees does not match the definition of one of these units, it is "presumptively" inappropriate and the petition is dismissed. This caps the number of appropriate units for health care institutions. 58 If the unit petitioned for survives this step, the Board's second step is to consider arguments based on the specific characteristics of the particular institution to determine whether the petitioning employees share a sufficient community of interest to be granted a separate bargaining unit. 59 The Board does not impose automatically the seven unit scheme on a particular health care institution. If the organizational make-up of a particular enterprise is such that splitting the employees into one or more of these units would be artificial or inappropriate, a separate unit would not be granted. Thus, an enterprise should have no more than seven appropriate units and, de-

sion and direction of election. The Board agreed with the Regional Director's decision finding the unit in which the election was held to be appropriate for bargaining. The Board opened the impounded ballot box on January 5, 1983, and certified IBEW Local 474 as the exclusive collective bargaining agent for the employees in the unit.

On January 17, 1983, in response to a request by the union to open negotiations, the employer, in writing, refused to recognize or bargain with the union. On January 21, the union filed 8(a)(1) and 8(a)(5) (failure to bargain) charges against the employer. The employer defended the ensuing summary judgment motion by maintaining that the unit as found by the Regional Director and approved on review by the full Board was inappropriate. Although parties are not allowed to raise as a defense and re-litigate issues which were litigated in a prior representation hearing, the Board, sua sponte, decided to reconsider its decision in St. Francis I.

57. Id. at 1031, 112 L.R.R.M. at 1160.

We begin with a maximum of seven potentially appropriate units, derived through our 8 years' experience with the industry: physicians, registered nurses, other professionals, technical employees, business office clerical employees, service and maintenance employees, and maintenance employees. These units are neither presumptively appropriate nor will they invariably be granted. They are, rather, commonly found employee groups which may warrant their own bargaining units.

Id. (emphasis in original).

58. One commentator contends that the majority's "cap" is ineffective. Yet, under the following circumstances, this figure could be inflated beyond seven units: (1) a separate guard unit pursuant to statutory requirement; (2) where a prior bargaining relationship existed with an employee group which does not conform to one of the seven basic units; (3) a stipulation of the parties; (4) unit approval due to comity; or (5) some other "extraordinary circumstance."

Note, supra note 47, at 681-82 (footnotes omitted). The St. Francis I majority claimed, however, that "additional unit" cases would be rare, St. Francis I, 265 N.L.R.B. at 1032, 112 L.R.R.M. at 1160.

pending on local factors, might have fewer. In this way, the Board applies the congressional admonition by factoring it into the first step of the analysis.

The majority said that *St. Francis I* explained the approach the Board had used implicitly since 1974 in determining appropriate bargaining units in the health care industry. The courts of appeals may have misunderstood the Board's processes if they have assumed the Board has applied only the community of interests test, without more, to the health care industry. The Board has not merely genuflected to the congressional admonition against undue proliferation of bargaining units. The majority believed that its approach implemented the congressional admonition and struck the appropriate balance between proliferation of units and the employees' right to organize.

2. *St. Francis II*

But if *St. Francis I* was in some way the "culmination" of this line of analysis, it was also its demise. Indeed, the Board never utilized *St. Francis I*. Despite a sizable backlog of cases the Board did not issue a decision in a unit determination case in the health care industry for a year and a half. Instead, the Board, on its own initiative, reconsidered *St. Francis I*, overruling it in August of 1984.

The majority in *St. Francis II* acknowledged that the Board's interpretation of the Congressional admonition against proliferation of bargaining units in health care institutions was at odds with the decisions of several of the courts of appeals. The Board turned from the traditional community of interests standard and adopted a unique dis-

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60. *Id.*
61. *Id.* at 1031, 112 L.R.R.M. at 1160.
62. *Id.* at 1029-30, 112 L.R.R.M. at 1158-60.
63. "My colleagues in the majority have successfully prevented that case and any case relying on it from seeing the light of day. As of today, the *St. Francis I* standard has never received a full review in any court of appeals." *St. Francis Hosp. & IBEW*, 271 N.L.R.B. 948, 955, 116 L.R.R.M. 1465, 1472 (1984) (Member Zimmerman dissenting) (footnote omitted).
64. Member Zimmerman noted in January of 1981, almost two years prior to the decision in *St. Francis I*, that the Board was "fully aware of the large number of cases awaiting decision on this issue" (health care unit determinations), and promised that the Board would "endeavor to reach it with something greater than all deliberate speed." Zimmerman, *Trends in NLRB Health Care Industry Decisions*, 32 LAB. L.J. 3, 7 (1981).
65. By the time *St. Francis II* issued, the Board had a backlog of some 80 cases; the largest single category of backlogged cases. *St. Francis II*, 271 N.L.R.B. at 955 n.3, 116 L.R.R.M. at 1472 n.3 (Member Zimmerman dissenting).
66. See supra note 55.
parity of interests standard for health care unit determinations.\footnote{68} Under the disparity of interests test, the Board subjected the unit petitioned for by the employees to heightened scrutiny,\footnote{69} requiring a finding of sharper than usual differences between the petitioning employees and the non-petitioning employees in order for the unit to be appropriate.\footnote{70} This is a different and more rigorous standard than the Board uses in any other industry.\footnote{71}

II. POTENTIAL EFFECTS OF THE DISPARITY OF INTERESTS TEST

In \textit{St. Francis II}, the majority clearly stated the logical and statutory underpinnings of its position. First, "Congress concluded that the object of minimizing work stoppages resulting from initial organizational activities, jurisdictional disputes, and sympathy strikes could best be achieved, and thus the likelihood of disruptions to health care reduced, by minimizing the number of units appropriate in the health care industry."\footnote{72} Second, the Board declared that applying the disparity of interests test to unit determinations in the health care industry "must necessarily result in fewer units and will thus reflect meaningful application of the congressional injunction against unit fragmentation."\footnote{73}

The important social goal of providing health care services uninterrupted by labor disputes must be balanced against another important goal; protecting the employees' rights to organize and bargain collectively. These rights are embodied in Section 1 of the Wagner Act\footnote{74} and reiterated in the legislative history of the 1974 health care amendments.\footnote{75} The failure to provide a mechanism for the exercise of these rights may bring about results which are antithetical to the accompanying goal of assuring uninterrupted health care services.\footnote{76}

\begin{itemize}
\item \footnote{68} Id. at 954, 116 L.R.R.M. at 1471.
\item \footnote{69} Id. at 953, 116 L.R.R.M. at 1470.
\item \footnote{70} Id.
\item \footnote{71} Id. (footnote omitted).
\item \footnote{72} Id. at 951, 116 L.R.R.M. at 1470.
\item \footnote{73} Id. at 950-51, 116 L.R.R.M. at 1468.
\item \footnote{74} Id. at 953, 116 L.R.R.M. at 1470.
\item \footnote{75} See infra note 13.
\item \footnote{76} "The Board seems to be ignoring the fact that if employees in the hospital indus-
Many American labor leaders have predicted that health care employees may resort to such extra-legal tactics if they are systematically frustrated by the Board's policy.\textsuperscript{77}

But the disparity of interests test may result in units of such size and heterogeneity that employees would not, in the overwhelming majority of cases, be able to organize successfully. Even if the employees were able to win a representation election, the heterogeneity of the unit could prove an obstacle to achievement of their collective bargaining goals. Such results would be antithetical to the twin goals of the 1974 amendments.

Non-proliferation of units is a tool for minimizing work stoppages and the resultant disruption in the flow of health care services. Used in conjunction with the other special provisions of the Act which apply to health care employees,\textsuperscript{78} this tool should bring about a proper balance of the "twin goals." However, the Board should not use non-proliferation to prevent health care employees from organizing themselves into unions on the pretext of preventing work stoppages and disruptions to the delivery of health care services. In adopting the disparity of interests test, the Board should not achieve the proper, desired goal of minimizing work stoppages by the use of an improper, undesirable means; specifically, preventing health care employees from organizing.

A. Effect of Unit Size on the Outcome of Representation Elections

The NLRB does not employ economists, industrial sociologists, or other like professionals to engage in empirical research and inform its decisionmaking process.\textsuperscript{79} It has no yardstick against which to
measure the results of the policies it adopts in the course of individual adjudications. It cannot present its statutory and precedential arguments to the courts of appeals buttressed with data which would predict what results will flow from the adoption or rejection of particular policies. Neither has the Board engaged in any type of rulemaking, informal or formal, in its over fifty year history. When courts defer to Board decisions, they are merely yielding to the collective experience of the Board members in the area of labor relations and their familiarity with the NLRA and Board precedent.

The Board's adoption in *St. Francis II* of the "disparity of interests" test is a fundamental break in the way it has interpreted the health care amendments since their enactment in 1974. Prior to *St. Francis II*, the Board relied on the community of interest test used in other industries, modified by the congressional admonition against proliferation of bargaining units in health care institutions. The logic of this approach, or at least the articulation of the premises, appeared to culminate in the "two-tiered" scheme espoused by the majority in *St. Francis I*. Several courts of appeals recommended the disparity of interests test as the correct way to implement the congressional admonition against proliferation of bargaining units in the health care industry. However, neither the courts nor the Board thoroughly considered the effect of the disparity of interests test on industry employees and their rights to organize.

One truth on which both academics and practitioners of labor...
relations certainly agree is that the Board's unit determination decision has a profound effect on employer-employee relations in a given enterprise. As a Brookings Institute study noted over fifteen years ago:

Unit determination plays a large role in both the private and public sectors in influencing which, if any, union will be chosen as a bargaining representative, the power structure of bargaining, the ability of various groups of employees to affect directly the terms and conditions of their employment, and the peacefulness and effectiveness of the bargaining relationship. 84

The average acute care hospital has a large number of employees who potentially are eligible for a "professional" unit under either St. Francis I or St. Francis II. Typically, the largest single group is registered nurses. 85 If a single group of these employees, such as registered nurses, is not able to demonstrate a disparity of interests from the other professional employees 86 under St. Francis II they likely will be lumped together in a single election unit. 87 In Keokuk Area Hospital

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84. H. Wellington & R. Winter, The Unions and the Cities (1971). See also Rose, supra note 3; Another View of Union Organizing, supra note 3.
85. This note uses registered nurses as an example of a contiguous, recognizable group of health care professionals.
86. Former Chairman Van De Water considered the disparity of interests test to entail two appropriate units for health care institutions, all professionals and all non-professionals. The burden would be on the petitioning employees (e.g. registered nurses) who would be granted a more limited unit "but only where it is clearly established that the employees in the proposed unit have a notable disparity of interest from employees in the larger unit which would prohibit or inhibit fair representation for them if they were denied separate representation." St. Francis Hosp. & IBEW, 265 N.L.R.B. 1023, 1040, 112 L.R.R.M. 1153, 1167 (1984) (Chairman Van De Water dissenting).
87. This note does not attempt to give an exhaustive account of regional directors' decisions on appropriate bargaining units after St. Francis II. It is too early to predict what factors must be present and in what quantities to constitute a "disparity." However, a sampling of initial interpretations of St. Francis II by regional directors sheds some light. In January 1986, the Regional Director vacated an April 2, 1980, election held in a unit of engineering employees at the Community Hospital of Glen Cove, N.Y. The Director found that the hospital's 1,100 employees could be grouped into three units: finance, medical, and service and maintenance. Community Hosp. at Glen Cove, NLRB 29-RC-4833 (Jan. 17, 1986). In Doctors Hosp. of Montclair & Local 1428 of the United Food & Commercial Workers, NLRB 31-RC-4837 (Jan. 24, 1985), Regional Director Roger Goubeaux re-opened the case of a union that had been certified in 1981 to represent medical technicians, pharmacists, and registered dieticians. Goubeaux revoked certification and ruled that the
and Iowa Nurses Association, 88 the Regional Director certified an all RN unit in 1980. The employer refused to bargain and on August 27, 1984, the National Labor Relations Board remanded the case for further consideration consistent with St. Francis II. On January 11, 1985, the Regional Director revoked certification of the union and directed an election in an all professional unit. The National Board unanimously approved this unit determination on January 27, 1986. 89 In the recent case of North Arundel Hospital and Maryland Nurses Association, 90 the Regional Director approved the all-RN unit requested by the petitioner. He did so even after reconsideration based on the disparity of interests test set forth in St. Francis II. The National Board unanimously reversed, finding that “the smallest appropriate unit for bargaining must be an overall professional unit.” 91 On December 29, 1986, in Middletown Hospital Association and Ohio Nurses Association, 92 the Board unanimously affirmed an administrative law judge’s decision, made on the basis of St. Francis II, that an RN only unit at Middletown Hospital was not appropriate. The Board expressed approval that the ALJ’s decision was “premised largely on factors other than the degree of functional integration between the two groups, such as similarity of pay and benefits and centralized labor relations and personnel policies.” 93

It is manifestly difficult to organize such an overall professional unit. The difficulties stem from the divergent characteristics of the sub-groups comprising the overall professional unit. For example, many employees do not know each other or even see each other at their place of employment. Further, some sub-groups are physically isolated from each other, and some employees are involved in direct patient care while others never see a patient. It is difficult for a bargaining agent to meld an effective organizing committee from such a disparate group. The fact that these employees have widely varied professional and employment goals discourages consensus on the

unit was inappropriate because it did not include registered nurses. Director Robert Fuchs found a unit of all RNs at Calais, Maine, Regional Hospital appropriate in May of 1983; but on December 7, 1984 he issued a supplemental decision finding that, after St. Francis II, only an all professional unit was appropriate. Calais Regional Hosp. & Me. State Nurses Ass’n, NLRB 1-RC-17,830 (Dec. 7, 1984).

88. 278 N.L.R.B. No. 33 (Jan. 27, 1986).
89. Id.
90. NLRB Dec. (CCH) ¶ 17,804 (Apr. 16, 1986).
91. Id.
92. 282 N.L.R.B. No. 79 (Dec. 29, 1986). The Ohio Nurses Association has filed an appeal with the Court of Appeals for the District of Columbia Circuit. No decision has been handed down as of the time of this writing.
93. Id.
changes to be made in their work-life through collective bargaining, the ultimate end of the organizing effort.

Professor Gorman has stated that union organizers prefer smaller, more homogeneous units while management usually prefers a larger, more heterogeneous unit for election purposes.\textsuperscript{94} This observation, albeit correct, may mask a more significant variable in the labor relations equation. A recent study conducted by Professor John Thomas Delaney, \textit{Union Success in Hospital Representation Elections},\textsuperscript{95} examines what factors affected the outcome of representation elections in hospitals. After considering political, social, and economic variables which might affect elections, Professor Delaney found that the factor which correlates most strongly with the success or failure of union organizing efforts is \textit{unit size}.

These data suggest that NLRB administrative decisions significantly affect the results of representation elections in hospitals. For instance, if the Board recognizes small, specialized hospital units, unions seem to benefit. Conversely, if the Board favors large or broad units, hospitals seem to benefit. \textit{In general, the nature of the bargaining unit and elections process may be more important determinants of union success in elections than environmental or hospital factors.}\textsuperscript{96}

Thus, when the Board adopts a test which it knows will result in larger bargaining units, the Board should realize that, at the same time, it is making it more difficult for employees to organize and win certification elections. To this extent, the Board may be frustrating the goal of fostering collective bargaining in an effort to prevent undue proliferation.

B. \textit{Effect of Occupational Heterogeneity on Collective Bargaining and Election Outcomes}

Research indicates that "traditional" economic issues (e.g. wages and pensions) are not the prime motivating factors behind the organizing efforts of health care professionals.\textsuperscript{97} Not surprisingly, the

\begin{itemize}
\item \textsuperscript{94} R. GORMAN, \textit{supra} note 3, at 68; Curley, \textit{supra} note 44.
\item \textsuperscript{95} Delaney, \textit{supra} note 14. \textit{See also} Becker & Miller, \textit{supra} note 13.
\item \textsuperscript{96} Delaney, \textit{supra} note 14, at 159 (emphasis added).
\item \textsuperscript{97} A recent report issued by the American Hospital Association indicates that U.S. health professionals share these goals. The report says that the list of professional concerns and organizing issues shared by professional and white collar health care employees include quality of care, quality of work, stress, job restructuring, and adequate staffing. \textit{Organizing in Health Care Industry Expected to Increase in Coming Years}, Daily Lab. Rep. (BNA) No. 15 (Jan. 23, 1987).
\end{itemize}
bargaining goals of RNs also do not center on economic issues.98 "Professional issues" such as staffing (nurse/patient ratio), availability of future professional educational opportunities, in-service instruction, and better equipment rank high on the list of negotiating priorities.99 Although there is little comprehensive research available in the United States, Professor Allen M. Ponak conducted a revealing study on the collective bargaining goals of Canadian RNs.100 The study tested two hypotheses: that RNs distinguished professional goals from "traditional" bargaining goals; and that they attached priority to those professional goals in negotiations. The results of the study "indicated not merely that professional bargaining goals were important but that they were more important, than traditional bargaining goals . . . ."101 Other studies indicate that when employees with different professional goals are required to engage in a common collective bargaining process, the professional goals of both groups are submerged in favor of economic objectives, which are the only types of issues that allow a consensus to emerge.102 Lacking consensus, the employees also lack the bargaining strength to enforce their demands on management.

Two inferences regarding the future behavior of RNs can be made from the above research. First, RNs will be less likely to exercise their right to organize (and risk possible repercussions from management) if they are included in units with professional employees that do not share their employment goals. The RNs will realize at the outset of the organizing process that it is unlikely that their professional concerns will muster strong support from other medical professionals such as laboratory technologists or pharmacists, much less non-medi-

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98. A 1981 study of unionism in the health care industry noted that "RNs dominate union activity among professional workers," and that: "Their principal interest and frequent source of conflicts with management has been in the nonwage area, particularly staffing levels and assignments." Cain, Becker, McLaughlin & Schwenk, supra note 27, at 309.

99. See supra note 97.


101. Id. at 406 (emphasis added). See also Bruggink, Finan, Gendel & Todd, Direct and Indirect Effects of Unionization on the Wage Levels of Nurses: A Case Study of New Jersey Hospitals, 6 J. LAB. RES. 381 (1985). "Even though RN's in teaching hospitals have higher work requirements, the coefficient for the teaching hospital dummy is statistically insignificant. Apparently, no additional wage rewards are required for the increased work effort." Id. at 413. An uncontrolled but nonetheless interesting sampling was taken by RN Magazine on the issue of nurses and unionization. On the issue of what bargaining goals nurses would like to see unions address, the results of this survey correlate strongly with the trend suggested by the studies cited above. See Lee, A Wary New Welcome for Unions, RN, Nov. 1982, at 35-40.

102. Perry & Angle, Bargaining Unit Structure and Organizational Outcomes, 20 INDUS. REL. 47 (1981); Cain, Becker, McLaughlin & Schwenk, supra note 27.
cal professionals. In turn, this will make achievement of these goals at the bargaining table less likely. With the end product of the organizing effort—the right to engage in collective bargaining—seen as an inefficient vehicle for the achievement of these professional goals at the heart of their employment concerns, RNs will be far less likely to engage in the time consuming and risky business of union organizing.

Even if professional employees are successful in organizing themselves into these heterogeneous bargaining units, the units' very heterogeneity may force a subjugation of those professional and employment goals of greatest concern to RNs in favor of the "common ground" issues of wages, pensions, health benefits, and the like. 103 This is hardly the goal which the Board sets out to achieve in unit determinations, viz., a unit which assures employees the fullest freedom in exercising the rights guaranteed by the Act. 104

The Board should reconsider whether the disparity of interests test strikes the proper balance. Even if some employees are able to organize, the fruits of collective bargaining may be denied them in contradiction to the purpose of the 1974 amendments.

### III. Is the Adoption of the Disparity of Interests Test Necessary?

Non-proliferation of bargaining units is not an end in itself. It is a means of minimizing work stoppages which interrupt provision of health care services. In the words of the St. Francis II majority, the disruptions said to flow from undue proliferation of bargaining units are "work stoppages resulting from initial organizing activities, jurisdictional disputes, and sympathy strikes." 105 This section of the note examines each in turn.

It is far from clear why work stoppages should result from initial organizing activities within health care institutions more frequently in smaller units than in larger ones. Since the enactment of the 1974 amendments, recognition strikes in the health care industry, never a common occurrence, have been even more rare. 106 Health care employees are, generally, less likely to strike to gain recognition when

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103. See generally Perry & Angle, supra note 100; Cain, Becker, McLaughlin & Schwenk, supra note 27. See also Ponak, supra note 100.
105. See supra note 72 and accompanying text.
106. Testifying before the House Subcommittee on Labor-Management Relations and on Manpower and Housing on October 10, 1984, Executive Vice-President of the National Union of Hospital and Health Care Employees, Bob Muehlenkamp, stated that in the ten years since the enactment of the 1974 amendments, his 100,000+ member union
they are presented with a peaceful, legal alternative.  

Unlike other private sector employees who may begin organizational picketing and strike activity at any time, Section 8(g) of the Act, added by the 1974 amendments, requires labor organizations to give notice to the Federal Mediation and Conciliation Service ten days prior to engaging in picketing, strikes, or other concerted work stoppages at health care facilities. Employees whose labor organizations do not comply with the notice provisions of Section 8(g) lose the protection of the Act. Section 8(b)(7)(C) requires that a union which is picketing for recognition file for an election "within a reasonable period not to exceed thirty days from the commencement of the picketing," and that the Board move expeditiously to determine the appropriate unit and direct an election. Given these statutory constraints and the paucity of recognitional strike activity since enactment has been involved in only four recognition strikes. 56 WHITE COLLAR REP. (BNA) 415 (Oct. 10, 1984).

107. Although there have been hospital strikes in some areas of the country, they are rare. One of the local organizers for the Service Employees International Union indicated to me that the main force working against using the strike weapon is the employees themselves. As he put it, "Getting them to join the union was difficult, but getting them to strike would be impossible—they identify with the patients and their critical place in the hospital organization."

T. BAROCCI, NON-PROFIT HOSPITALS 151 (1981). See also Cain, Becker, McGaughlin & Schwenk, supra note 27, at 193; Lee, supra note 101, at 35-40 (poll shows many RNs opposed to striking).

108. A labor organization before engaging in any strike, picketing, or other concerted refusal to work at any health care institution shall, not less than ten days prior to such action, notify the institution in writing and the Federal Mediation and Conciliation Service of that intention .... The notice shall state the date and time that such action will commence.

29 U.S.c. § 158(g) (1982).

109. "Any employee who engages in a strike within any notice period specified in subsection, or who engages in any strike within the appropriate period specified in subsection (g) of this section, shall lose his status as an employee of the employer engaged in the particular labor dispute, for the purposes of sections 8, 9, and 10 of this Act ...." 29 U.S.C. § 158(d) (1982).

110. 29 U.S.C. § 158(b)(7)(C) (1982). But it was the intent of the Senate to shorten the period in the case of recognitional picketing at a health care institution.

In recognition picketing cases under Section 8(b)(7)(C), the National Labor Relations Board has ruled that a reasonable period of time is thirty days absent unusual circumstances such as violence or intimidation. It is the sense of the Committee that picketing of a health care institution would in itself constitute an unusual circumstance justifying the application of a period of time less than thirty days.


111. [W]hen such a petition has been filed the Board shall forthwith, without regard to the provisions of section 159(c)(1) of this title or the absence of a showing of a substantial interest on the part of the labor organization, direct an election in such unit as the Board finds to be appropriate and shall certify the results thereof ....
of the amendments, increasing the size of bargaining units probably will not reduce the already minimal number of such disruptions. On the contrary, labor leaders warn that the frustration caused by Board policy on unit determinations in the health care industry may lead to such disruptions by encouraging employees to bypass Board procedures. 112

On the issue of jurisdictional disputes, congressional concern is well-meaning, but it appears misplaced. Health care institutions employ a broad spectrum of professionals, technicians, and tradespeople, and generally have a ramified structure of job classifications and responsibilities. This structure contains the potential for disputes over allocation of duties between bargaining units. Congress, mindful of the difficulties which proliferation of bargaining units has caused in the construction industry, accordingly sought to eliminate this potential source of disruption from the health care industry. 113

However, state laws license medical professionals and para-professionals in the health care field. Health care professionals legally cannot delegate most of their duties and responsibilities. 114 Nor is it likely that hospitals would agree to delegation given the increased risk of error and liability. Engaging in a work stoppage to force an employer to transfer work from one bargaining unit to another would violate Section 8(b)(4)(D) of the Act. 115 Moreover, the Board has the


Failure to file a petition within the "reasonable time" specified in 29 U.S.C. § 158(b)(7)(C) leaves the union open to an unfair labor practice charge. 29 U.S.C. § 160(l) (1982) directs the Board to move quickly on such violations: "[T]he preliminary investigation of such charge shall be made forthwith and given priority over all other cases . . . ." 29 U.S.C. § 160(l). The restraining order shall issue if the court finds "substantial and irreparable injury to the charging party will be unavoidable." Id.

112. See supra note 77 and accompanying text.
113. See supra note 33.
114. The Board is aware of this feature of the health care industry. Recently, in the course of reviewing a unit determination, the Board noted:

Moreover, although the Regional Director found little evidence of interchange of duties or functions between registered nurses and other professionals, it is clear that this lack of interchange is inherent to (sic) the health care industry because all of the professional employees—including registered nurses—have received specialized education and training in their own fields so as to make job interchange impossible, or even illegal, where state certification or licensure is required.


115. It shall be an unfair labor practice for a labor organization or its agents . . . to engage in, or to induce or encourage any individual employed by any person engaged in commerce or in an industry affecting commerce to engage in, a strike . . . where . . . an object thereof is: (D) forcing or requiring any employer to assign particular work to employees in a particular labor organization or in a
power to expedite settlement of jurisdictional disputes under Section 10(k), and Section 10(l) of the Act. Lastly, the potential threat of work stoppages caused by jurisdictional disputes simply has not materialized. The adoption of a new test which yields larger and fewer bargaining units is not needed to ameliorate a problem that does not exist.

The issue of sympathy strikes similarly has not emerged as a major problem within the health care industry since the enactment of the 1974 amendments. Here again, analogies to the problem of sympathy strikes in the construction industry, attributed to proliferation of bargaining units, break down. Health care employees do not have the same degree of union consciousness or solidarity that has developed as a result of decades of tradition in the construction industry. Rather, they continue to view their primary mission as service to the patient and the community and tend not to honor the picket lines of striking co-workers.

The notice provisions of the LMRA also apply to non-striking employees who concertedly refuse to cross the picket lines of other employees. The few instances of sympathy strikes which have occurred typically have been cases of professional employees (RNs) refusing to cross the picket lines of striking non-professional employees (service and maintenance personnel) or vice-versa. By its own terms,
the disparity of interests test would not address this problem.\textsuperscript{122}

Recognitional, jurisdictional, and sympathy work stoppages were not major problems for the health care industry during the ten years the Board adhered to its \textit{St. Francis I} view of the congressional admonition against proliferation of bargaining units. Ample means exist within the Act to deal effectively with whatever sporadic outbreaks of such activity that occur. Despite the premises articulated by the \textit{St. Francis II} majority, the adoption of the disparity of interest test was not dictated by necessity.

\textbf{CONCLUSION}

Congressional concern over labor relations in the health care industry is valid. This industry must be, and has been, treated differently than other industries in the private sector. Employees must be constrained in the exercise of the rights guaranteed them by Section 7 of the NLRA because of the impact on helpless patients and the public. They must, however, be able to exercise those rights within the framework of labor legislation. Forcing health care employees to resort to economic coercion in order to gain recognition and the free exercise of collective bargaining would be disastrous.

The \textit{St. Francis II} majority based adoption of the disparity of interests test on its interpretation of the legislative history of the 1974 amendments. In so doing, the majority turned its back on the interpretation the Board has held since the enactment of the amendments,\textsuperscript{123} They did not address the empirical results of the Board’s original interpretation at any point. They did not address the poten-

\textsuperscript{122} See Remarks by Robert Muehlenkamp, Executive Vice-President of the National Union of Hospital and Health Care Employees testifying before the House Subcommittee on Labor-Management Relations on Manpower and Housing, 56 \textsc{White Collar Rep.} (BNA) 415 (Oct. 10, 1984).

\textsuperscript{123} John Fanning, former Board Chairman commented on the Board’s reversal of precedent: “How can we both be following Congressional mandate? . . . To have every decision reversed—we couldn’t have been that wrong.” 56 \textsc{White Collar Rep.} (BNA) 253 (Aug. 22, 1984).

However, this is precisely what one commentator, Attorney Debra Dyleski-Najjar, contends.

From 1974 until 1984, however, the Board applied traditional community-of-interests standards and, contrary to the intent of Congress, certified virtually every petitioned-for group of health care workers as a separate appropriate unit. This failure to heed the congressional admonition contributed to an increase in the number of strikes in the health care industry following the enactment of the 1974 amendments. Thus, it is apparent that the community-of-interests test not only violated congressional intent, but also resulted in the very end which the nonproliferation mandate was designed to avoid. . . .

[T]he Board’s prior unit determination findings and the fragmentation of in-
tial effects of the new disparity of interests test at any point. What remains is a combat of conflicting interpretations of congressional action; what emerges is a new test which gives little guidance to the bench and bar.\textsuperscript{124}

Member Zimmerman stated in his dissent in \textit{St. Francis II} that the issue of unit determinations in the health care industry is ripe for rulemaking.\textsuperscript{125} Member Dennis expressed similar views in her concurring opinion.\textsuperscript{126} The majority declined to exercise the Board's rulemaking authority.\textsuperscript{127}

However, the issue of unit determinations in the health care industry presents itself as a strong candidate for breaking with the

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\end{itemize}
Board's "tradition" of avoiding rulemaking. The health care industry is expanding; more of these issues will arise. During the past twelve years, adjudication produced a tremendous number of cases concerning unit determinations and the disparity of interest test will only continue this trend.\textsuperscript{128} Litigation always means delay. In the sphere of labor relations, delay often translates into the destruction of union majorities, the de facto denial of bargaining rights, and ultimately, the demise of confidence in the efficacy and impartiality of the National Labor Relations Board.\textsuperscript{129}

Rulemaking would require a thorough discussion of the empirical data and societal consequences of unit determination decisions. It would allow full participation by the labor movement in the process. The rulemaking procedure would encourage interested parties (principally unions and employer associations) to fund industrial relations research which would better equip the Board to design a workable system which would safeguard the public interest while ensuring employees of non-profit health care institutions the right to organize and engage in collective bargaining—the goals of the 1974 amendments. Litigation over unit determinations should decrease, because the guidelines for those decisions would have been reached by some rough consensus between management and labor; or at least after full partici-

\textsuperscript{128} "Although both union and management representatives hoped \textit{St. Francis [II]} would mean an end to the decade of debate, experts on both sides agree that litigation on the bargaining unit issue will continue for years." 56 \textsc{White Collar Rep.} (BNA) 250 (Oct. 22, 1984).

\textsuperscript{129} Veteran union organizer Eileen McManus related this experience:

I filed a petition for a unit of Registered Nurses in Maryland in 1979, about a week before \textit{St. Francis of Lynwood} issued out of the [Ninth] circuit. We made what was in retrospect an unfortunate decision to maintain our petition for Registered Nurses, which of course the Employer contested. The election was held in a timely fashion, and we won with better than a two-to-one margin. The employer refused to negotiate, we filed charges, the Board granted summary judgment, and the case went to the Fourth Circuit Court. The Court remanded the case to the Board with instructions to rewrite its decision with more attention to the unit proliferation issue. The case went back to the Board and stayed there until \textit{St. Francis II} issued. It was then remanded to the Region, and we were notified about two months ago that a new election in an all professional unit had been ordered. . . . Given that we still would have won the first election by more than a comfortable margin if all of the people the employer wanted in had voted and had voted no, it's been an interesting exercise. In the six years that intervened between our mandate and the decision to order the second election, nearly all of our organizing committee had been pressured to leave. The unit size, according to the Employer, has doubled. This is not an isolated case, nor is it even our worst case.

Address by Eileen McManus, entitled \textit{A Union Perspective on Health Care Bargaining Units}, Association of Labor Relations Agencies Conference (July 25, 1985).
pation by both in the process. Courts of appeals should be expected to afford deference to future Board unit determinations because the Board will have brought its expertise in labor relations, not statutory interpretation, to the issues.

Other commentators have advanced alternatives short of rulemaking. Attorney Michael Stapp has suggested that the Board adopt a "rulemaking approach" to the adjudication of unit determinations in health care institutions. 130 This approach would balance the likelihood that patient care disruptions will result from granting a separate bargaining unit to the petitioning employees against the degree to which employees' organizational rights would be furthered by granting the requested unit. 131 Stapp argues that only by weighing the actual threat of patient care disruption against the community of interest of the petitioning employees and the free exercise of their right to engage in collective bargaining can the reasoning behind the congressional admonition against unit proliferation be implemented and the "twin goals" of the amendments be realized. 132

Professor of Labor Relations James Gross would have Congress repeal the language of the Labor-Management Relations Act which forbids expenditures by the Board for employment of economists and sociologists. 133 He views this deficiency as an underlying cause of the Board's vacillation on many important labor relations issues as well as the reason for the lack of judicial deference to Board expertise. Empirical investigation of past as well as potential future effects of Board policy would give the Board its own source of information by which to judge the adversaries' arguments in each particular adjudication. An examination of the results of the Board's decisions by the use of empirical data and professional research may aid in gaining enforcement of

130. Stapp, supra note 48, at 71 n.65.

131. This would be a case-by-case empirical approach which would determine the propensity for patient care disruptions in a particular institution.

Factors to be considered in determining the likelihood of patient care disruptions would include the total number of authorization cards signed in the proposed unit; the different facilities in the proposed unit; the likelihood that a strike by one particular bargaining unit would be debilitating to the hospital; the likelihood that other employees would cross picket lines should a strike occur in the proposed unit; the authorization card support of the various job classifications within the bargaining unit; and the past history of labor unrest in the facility (e.g., wildcat strikes).

Id.

132. Id.

133. Reshaping of the National Labor Relations Board, supra note 79, at 264-66.
its orders in courts of appeals, as well as bolster management and labor confidence in the competence and impartiality of the Board.

The ideas advanced here, and in other commentaries, should lead us to question whether the disparity of interests test is adequate to the task of achieving the balance between the public need and employees' rights sought by Congress when it passed the 1974 health care amendments to the Labor-Management Relations Act. But we must strike the proper balance. We cannot allow employees in this vital sector of our economy to lose faith in our system of labor legislation.\textsuperscript{134}

\textit{William F. Donahue}

\textsuperscript{134} On May 4, 1987, the Board heard oral argument in the matter of St. Vincent Hosp. & Health Center & Mont. Nurses' Ass'n, NLRB Case No. 19-RC-11496. That case is an appeal from a Regional Director's decision, based on \textit{St. Francis II}, that disallowed a unit limited to registered nurses requested by the union in favor of an all-professional unit. The union's appeal is based on \textit{St. Francis III}. In addition to adjudication, the Board's alternatives include rulemaking and seeking review by the Supreme Court. At the time of this writing, the Board has not taken any action.