Collective Bargaining Units in the Health Care Industry: The NLRB and Rulemaking

I. INTRODUCTION

She worked as a floor nurse for most of her career. She had no voice with which to get more money for her work. She had no voice to ask for, demand or bargain with management for benefits, better conditions, better working hours and possibly, career advancement. Unionization in the hospital was something she believed she would never see. Striking for personal gain was something she never thought she would do. If she did, as many other nurses who have organized across the country had already done, who would take care of the patients? What would happen to them?

Many believe that unionizing in the health care industry has helped to alleviate some of the problems that have existed within the system, including low wages for employees and the lack of an adequate "voice" for employees to air their grievances to management. The National Labor Relations Act (hereinafter NLRA) allows employees to organize into groups and, through such organized groups, to deal collectively with management with respect to employment issues. These organized groups, or bargaining units, generally represent a portion of the workers, to the extent that those workers have similar training, skills, responsibilities, and pay.

Because of the costs involved in negotiating with individual units and the difficulties in determining which bargaining units should be recognized, hospital management has been unresponsive to the intro-

1. Douglas L. Leslie, Labor Bargaining Units, 70 Va. L. Rev. 353, 354-55 (1984). Unions supply their members with many 'goods': wages, seniority rosters, safety in the workplace, arbitration for grievances, and certain conveniences. These 'goods' are collective in nature, which means all individuals of a union benefit from the unions' actions. Id.
2. ROBERT A. GORMAN, BASIC TEXT ON LABOR LAW, UNIONIZATION, AND COLLECTIVE BARGAINING 1 (1976).
duction of labor unions and bargaining units. Consequently, the problem of defining appropriate collective bargaining units in the health care industry has led to protracted and frequent litigation before the National Labor Relations Board (hereinafter NLRB or board). In 1987, the NLRB announced its intention to engage in rulemaking to determine the appropriate number of bargaining units in the health care industry. Approximately two years after that announcement, the NLRB issued a final rule, which it promulgated to clarify the ambiguities and inconsistencies in defining bargaining units.

Prior to promulgating this rule, the NLRB generally relied on a case by case approach in determining bargaining units. The resultant unprecedented litigation over which hospital employees should bargain together, however, awakened the NLRB's dormant rulemaking powers. This was an effort by the NLRB to create a substantive standard to determine appropriate units.

This comment explores the validity of the NLRB's determination of eight presumptive units and ultimately supports the determination.

4. See Leslie, supra note 1, at 381. The NLRB determines which units are appropriate. If management voluntarily recognizes a union, the NLRB will not play a direct role. It is when there is a refusal on the part of the employer to recognize a particular unit that often creates the need for the NLRB to determine the appropriateness of the unit. Id. at 381.

5. See generally American Hosp. Assn. v. NLRB, 899 F.2d 651 (7th Cir. 1990), aff'd, ___ U.S. ___, 111 S. Ct. 1539 (1991); NLRB v. Walker County Med. Ctr., 722 F.2d 1535 (11th Cir. 1984); NLRB v. Res-Care, 705 F.2d 1461 (7th Cir. 1983); Allegheny Gen. Hosp. v. NLRB, 608 F.2d 965 (3rd Cir. 1979). These cases are examples of the disagreements that have existed between labor and management and the methods of determining which bargaining units are appropriate within hospital settings.

6. The NLRB consists of a five member board which is appointed by the President and is responsible for administrating the process by which employees seek to form unions and collectively bargain and administrating unfair labor provisions. GERALD BERENDT, COLLECTIVE BARGAINING 16-18 (1984).


9. Labor Management Relations (Taft-Hartley) Act, 29 U.S.C. sec. 156 (1982). ("[T]he Board shall have authority from time to time to make, amend and rescind . . . such rules and regulations as may be necessary to carry out the provisions of this subchapter [29 U.S.C. sec. 151-58, 159-68].")

In order to develop the background for the subject controversy, part II reviews the legislative history surrounding the NLRA and its amendments. Part III examines the judicial interpretations of the NLRA which attempted to determine appropriate units prior to the promulgation of the new rules. Part IV discusses the newly promulgated rules and standards for defining bargaining units and analyzes the Seventh Circuit's response to a recent challenge to the rules. Part V discusses and analyzes the bargaining units contained in the new rules, and explores the appropriateness of these units. Part VI concludes that there is a sound analytical foundation for the continuation of the units, as they will work to stabilize the health care industry while providing consistency for employees to unionize and bargain collectively.

II. THE LEGISLATIVE HISTORY SURROUNDING THE BARGAINING UNIT DETERMINATION

The NLRA is the primary law that controls labor relations in private industry. This Act developed in three stages. The first stage commenced with the passage of the Wagner Act\(^\text{11}\) in 1935. The Wagner Act was intended to promote employees' rights to unionize for the purposes of collective bargaining.\(^\text{12}\) Some considered the Wagner Act to be protectionist and biased in favor of employees, since it not only gave employees rights to organize, bargain and strike, but facilitated the exercise of these rights.\(^\text{13}\) This Act also established the NLRB and gave the Board the power to remedy unfair labor practices and determine issues of representation.\(^\text{14}\) Furthermore, it empowered the NLRB to order employers to remedy unfair labor practices.\(^\text{15}\)

The second stage in shaping the NLRA began in 1947, when Congress amended the NLRA to create a more balanced approach to regulating employer/employee relations.\(^\text{16}\) The amended act was known

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\(^{14}\) Curran, supra note 10, at 115 n.5.

\(^{15}\) GORMAN, supra note 2, at 5.

\(^{16}\) Labor Management Relations (Taft-Hartley) Act, chap. 120, 61 Stat. 136 (1947) (codified as amended at 29 U.S.C. sec. 141-88 (1982)); see also NLRB v. ResCare, Inc., 705 F.2d 1461, 1465 (7th Cir. 1983) ("Taft-Hartley applied some brakes, so that the balance of power between companies and unions would not shift wholly to the union side.").
as the Taft-Hartley Act and it addressed the perceived abuse of power by the unions. The Taft-Hartley Act also proscribed a range of unfair labor practices so that employees would not be coerced into union activity. 17

The Taft-Hartley Act attempted to establish a balance of powers between labor and management. 18 Whereas the Wagner Act appeared to favor employees and unions, the Taft-Hartley Act sought to limit union power, and to prevent the NLRB from becoming overzealous in regulating employers. 19 The result of these two acts balanced the needs of employees, employers, and unions. 20 The Taft-Hartley Act also contained express language excluding not-for-profit hospitals from its coverage. 21

In 1974, Congress again amended the NLRA, adding what are known as the health care amendments. These amendments accomplished several objectives, including removal of the exemption for not-for-profit hospitals, and addressed the issue of bargaining units in the health care industry. 22 Congress amended the NLRA to address hospitals in an effort to protect employee rights and stabilize the health care delivery system. 23 The amendments applied equally to all hospitals, because, as one commentator noted, over half of all hospital workers were employed by not-for-profit hospitals, yet were not protected by the NLRA. 24 This lack of protection often resulted in

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18. Gorman, supra note 2, at 5. The original Wagner Act, in favoring unions, did not afford any protective measures to employers, but protected employees. This created an excess of bargaining power on the side of unions. The Taft-Hartley Act was designed to give employers and unions equal bargaining power. Id.

19. See Gorman, supra note 2, at 5.

20. Id.

21. 29 U.S.C. sec. 152 excluded "any corporation or association operating a hospital, if no part of the net earnings inures to the benefit of any private shareholder or individual." See 29 U.S.C. sec. 152 (1982).


24. Mary E. Sciarra, Comment, The Nonproliferation Mandate and the Ap-
lower wages and poorer working conditions in these institutions.25 During the 1974 Congressional amendment discussions, Senator Alan Cranston26 stated that the exclusion of not-for-profit hospitals from the NLRB resulted in lower wages, low employee morale and poor working conditions.27

When amending the NLRA in 1974, Congress was faced with the problem of addressing the unique nature of the health care industry. Unlike many other occupations, health care services are absolutely essential. In regulating health care unions, the need for employee protection and advancement must be weighed against the potential disruption in patient care that could result when strikes occur.28 The House and Senate committees recognized that a disruption in the health care delivery system is more serious by comparison than a break in production at an industrial plant, because the health and welfare of patients could be compromised by a strike.29 In order to prevent the potential for serious interruptions in the delivery of health care, and eliminate the not-for-profit exemption so as to improve working conditions for employees of these facilities, some committee members made various proposals.

The most noteworthy proposal was submitted by Senator Taft. Senator Taft introduced a bill that would have prevented more than four bargaining units in health care facilities.30 The rationale for this proposal was a desire to protect the health care industry from fragmentation due to strikes, but still allow employees to organize and collectively bargain under the mandate of the NLRA. However, the Taft bill was not adopted by Congress, and there were no subsequent

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propriate Legal Standard in Health Care Bargaining Unit Determinations, 11 FOR-

25. Id. at 672 n.43 (citing 120 CONG. REC. 12,937 (1974) (statement of Senator Williams), reprinted in LEGISLATIVE HISTORY OF THE COVERAGE OF NONPROFIT HOSPITALS UNDER THE NATIONAL LABOR RELATIONS ACT 93).

26. Democrat from California.

27. 120 CONG. REC. 937 (1974). This change was expected to remedy these problems by extending the benefits of the Act to all hospital employees, not just for-profit hospital employees. Id.

28. See Sciarra, supra note 24, at 673 ("Disruptions caused by organizational drives and recognition strikes in the health care setting ... were thought by Congress to threaten the quality and delivery of life-sustaining services.").

29. St. Vincents Hosp. v. NLRB, 567 F.2d 588 (3d Cir. 1977) (The committee members recognized that inventorying health-care is impracticable.); see also Curran, supra note 10, at 124.

30. S. Comm. 2292, 93d Cong., 1st sess. 5 (1973) (Proposed units were professional, technical, clerical and service, and maintenance).
Although Congress chose not to modify or set a number of bargaining units for the health care industry, it did express fears of the possibility of undue proliferation of bargaining units (which is the creation of too many units). This fear of proliferation was justified in part by the special nature of the health care industry and the seriousness of disruptions in patient care. It was also justified by the large number and diversity of job classifications within a hospital, which makes the creation of too many units a potential problem. Congress' fear of proliferation was not directly addressed by the NLRA. Instead, Congress addressed this issue in the committee notes with an admonition to prevent undue proliferation of bargaining units in the health care industry (herinafter congressional admonition). This admonition provided:

Due consideration should be given by the Board to prevent undue 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 LLRM 1093 (1974), and Woodland Park Hospital, 205 NLRB No. 144, 84 LRRM 1075 (1978), as well as a trend towards broader units enunciated in Extendicare of West Virginia, 203 NLRB No. 170, 83 LRRM 1242 (1973).

Congress acknowledged that a wide diversity of specialized groups creates a potential for labor unrest. Such diversity exists in the health care industry. In the event of labor unrest, fragmentation of the

31. 29 U.S.C. sec. 159 (1982). This section is not directive in the actual number of units to be approved, but provides language which gives the Board the right to decide "in each case," the number of units that will be approved for purposes of bargaining. Id.


34. A maintenance unit in a nursing home was found not to be a distinct group that had separate interests from those of other housekeeping and maintenance units.

35. A unit of x-ray technicians was not found to have a separate community of interest from the employees of other technical employees (such as laboratory technicians and respiratory technicians) in a hospital.

36. S. REP. No. 766, 93d Cong., 2d sess. 5 (1974). Congress did note that it did not adopt all of the views enunciated in Extendicare of West Virginia. The units in Extendicare were very broad and left open much ambiguity that most likely Congress did not want to completely approve of very broad units as a general rule.
health care delivery system could follow.37 The Seventh Circuit has noted that if a key unit in the health care delivery system called for a strike, the entire system could easily be crippled.38 Despite this potential, Congress did not amend the NLRA to limit the number of bargaining units, and provided no guidance for alleviating the potential problem other than the admonition in the committee reports. Neither the NLRB nor the courts have been consistent in applying the NLRA or the admonition.39

III. THE ADMINISTRATIVE AND JUDICIAL RESPONSE TO THE NLRA AND ITS AMENDMENTS IN TERMS OF THE HEALTH CARE INDUSTRY

The overriding issue in many of the post-1974-amendment cases was whether the courts have taken the congressional admonition into consideration when determining the appropriateness of a particular bargaining unit. Some courts have chosen to interpret the admonition as controlling, and have refused to enforce an NLRB decision because the Board did not explicitly take the congressional admonition into account.40 The basis for these decisions is that the Board must consider the congressional admonition, and directly discuss and justify how the action by the NLRB was consistent with that directive.41 The NLRB and courts have made bargaining unit determinations in the

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37. See NLRB v. Res-Care, Inc., 705 F.2d 1461, 1469 (7th Cir. 1983). The court here noted that "[e]mployers prefer fewer, rather than more, collective bargaining units . . . ." Id. This is so because if the units are larger and fewer, there are more employees needed to call a strike than if there were more units. It takes a certain percentage of the membership total to call a strike, so the larger and fewer the units, the lessened possibility for rampant striking. Id.

38. Id. at 1470.

39. Compare IBEW Local 474 v. NLRB, 814 F.2d 697 (D.C. Cir. 1987) (refusing to interpret the admonition as part of the statute or as controlling) with Allegheny Gen. Hosp. v. NLRB, 608 F.2d 965 (3d Cir. 1979) (reading the admonition as controlling, to be considered to its fullest extent).

40. Allegheny Gen. Hosp. v. NLRB, 608 F.2d 965, 968 (3d Cir. 1979) ("Courts of appeal have declared in no uncertain terms that the Board must take heed of the congressional admonition . . . when deciding upon appropriate units in health-care institutions.") (quoting Allegheny Gen. Hosp., 239 N.L.R.B. 872, 887 (1978) (Penello, Member, dissenting)); see also Memorial Hosp. v. NLRB, 545 F.2d 351 (3d Cir. 1976) (Board failed to comply with the admonition, so enforcement was denied). But see IBEW Local 474 v. NLRB, 814 F.2d 697, 714-15 (D.C. Cir. 1987) (recognizing that while committee reports discuss proliferation, the language of the NLRA itself was not changed, and extra-statutory materials can never serve as independent sources of law).

41. Mary Thompson Hosp. v. NLRB, 621 F.2d 858, 861 (7th Cir. 1980) (Board must expressly give consideration to the admonition.).
health care industry with an eye to the delicate nature of health care and the potential for patient care disruption in the event of labor disputes.42

A. THE COMMUNITY OF INTERESTS STANDARD

In bargaining unit determinations43 for other industries, the NLRB has applied what is commonly known as the "community of interests" test.44 This is a method of grouping employees whose "similarity of functions and skills create a community of interest such as would warrant separate representation."45 In applying this test, the NLRB examines the similarity of wages and hours, whether and to what extent common supervision is present, whether there is any type of integration with other employees, geographical proximity, and similarity in the training and skills of the employees.46 After considering these criteria, the NLRB decides if there are sufficiently common or similar factors to warrant separate representation.

In examining bargaining units in the health care industry under the community of interest standard, the NLRB must balance the congressional admonition with the needs of the parties involved.47 The NLRB has found the community of interest standard the most appropriate in other areas of labor relations,48 and has justified the use of this standard in the health care industry. The board has justified the

42. John M. Husband, Determining Appropriate Bargaining Units in Health Care Institutions - The Gap Widens, 40 LAB. L.J. 780, 781 (1981) ("[T]he vital nature of medical care to the public and fact that hospital care is not storable . . . accounts for the sensitivity the NLRB should display to the health care industry.").

43. Unit determinations are a result of a dispute between employer and employees over which employee groupings shall be units that the employer will bargain with. See Thomas J. Wiencek, Comment, Bargaining Unit Determinations in the Health Care Industry - The Gospel According to St. Francis II, 1985 DET. C.L. REV. 67, 68-69 (1985) (citing K. McGuinness, How to Take a Case Before the National Labor Relations Board 105-27 (4th ed. 1976)).

44. See, e.g., NLRB v. Pinkerton's, Inc., 428 F.2d 479 (10th Cir. 1981) (The traditional test developed to assist the Board in making appropriate unit determinations.).

45. IBEW Local 474, 814 F.2d at 703 (quoting American Cyanamide Co., 131 N.L.R.B. 909, 910 (1961)).

46. See Allegheny Gen. Hosp. v. NLRB, 608 F.2d 965, 973 (3d Cir. 1979); see also Gorman, supra note 2, at 69 ("[C]ommunity of interest is a vague standard which does not readily lend itself to mechanical application.").

47. Watonwan Mem. Hosp., Inc., v. NLRB, 711 F.2d 848 (8th Cir. 1983) (The Board may utilize community of interest standards, but must give consideration to the admonition to prevent undue proliferation.).

48. See, e.g., Gorman, supra note 2, at 68-69.
use of this test by pointing out the lack of specific language in the NLRA directing the NLRB to adopt a particular standard. Congress had the opportunity to amend the NLRA to require the use of a standard other than the traditional community of interest standard, but declined to take such action. Instead, Congress left the decision to the discretion of the NLRB.

One court, in determining the appropriate test, expressed concern over the NLRB's lack of express consideration of the congressional admonition. These concerns over the Board's mere mention of the admonition, but its lack of application of the admonition to unit determinations, led to the development of alternative standards for bargaining unit determination.

B. THE ST. FRANCIS I STANDARD: A TWO TIERED APPROACH

In St. Francis Hospital, a new approach to bargaining unit determination was made by the NLRB. In this case, the NLRB upheld the designation of a bargaining unit for maintenance personnel. St. Francis I established a two tiered approach for determining units based on a division of the health care environment into seven general categories. These categories were physicians, registered nurses, other professional employees, business office clerical employ-

49. IBEW Local 474, 814 F.2d at 714-15. ("While we recognize that the committee reports discuss proliferation of bargaining units in the health-care industry, we stress that Congress, in the final analysis, never adopted a proposal to modify section 9."); see also Curran, supra note 10, at 140.


51. Mary Thompson Hosp. v. NLRB, 621 F.2d 858, 862-63 (7th Cir. 1980). This court examined congressional intent closer than the actual Act to determine that the congressional admonition was necessary to determining units. Giving just lip service mention of the admonition was not enough. Id.


54. Id. The NLRB here upheld a bargaining unit determination for a group of maintenance workers. After the unit elected the International Brotherhood of Electrical Workers to represent them, the hospital refused to bargain with the union. The hospital claimed this maintenance unit was inappropriate because under the 1974 amendments to the NLRA, the NLRB could not apply community of interest standards. Id.

55. Id. at 1029.
ees, service, maintenance employees and skilled maintenance employees. In the first tier, the Board requires that a proposed bargaining unit be placed in one of the seven general categories. The employees in the unit must have a broad enough job description to fit into one of these groups. Once the appropriate category is established, the NLRB then applies the traditional community of interest standard to determine whether the proposed unit has the same interests as other units within the seven groups. If there are a significant number of interests which are not the same as any of the seven general groups, separate bargaining status may be obtained.

This analysis balanced the "long established community of interest criteria . . . against the legislative concern about over-proliferation of health care bargaining units." Applying the facts to the two-tiered approach, the NLRB recognized the unit of maintenance workers as a separate bargaining unit. However, The NLRB soon abandoned this approach for a different standard known as the disparity of interests test.

C. THE ST. FRANCIS II STANDARD: THE DISPARITY OF INTERESTS TEST

The NLRB reconsidered its action in St. Francis I and abandoned the two tiered approach in St. Francis Hospital (St. Francis II). In this case, the NLRB adopted a new standard known as the "disparity of interests" standard. This new standard required "sharper than usual differences (or 'disparities') between wages, hours, and

56. Id. These seven groups were chosen because the NLRB determined that most employees would fall within these designations because of the nature of the training and classification of health care employees.

57. Id.

58. Id. at 1029.

59. Id. at 1026.

60. Id.; see also IBEW Local 474 v. NLRB, 814 F.2d 697, 706 (D.C. Cir. 1989) (Discussed St. Francis I and determined that the maintenance workers were separately supervised, shared no duties with other labor employees at the hospital and there was not an intermingling with other services.).


62. St Francis Hosp., 271 N.L.R.B. at 949. (Case again brought back to the Board after the hospital refused to bargain with the union of maintenance workers, the unit deemed appropriate by the Board in the first case.).

63. See John G. Kilgour, The Health-Care Bargaining Unit Controversy: Community of Interest versus Disparity of Interest, 40 LAB. L.J. 81 (1989). This standard, working from a base of just two groups, professional and non-professional, looks at whether the proposed unit is sufficiently different from one of the two groups in order to create a separate bargaining unit. Id. at 88.
conditions, etc. of the requested employees and those in an overall professional or non-professional unit. . . . This standard effectively allowed only two bargaining units — professional and non-professional employees. The disparity of interest standard is more consonant with the congressional admonition because it limits the number of presumptive units to two. In pronouncing this new standard, the NLRB disallowed the maintenance unit it had previously upheld in St. Francis I.

The labor union which represented the maintenance workers in St. Francis II appealed the NLRB decision in *International Brotherhood of Electrical Workers Local Union 474 v. NLRB*. The appellate court rejected the disparity of interests test put forth by the NLRB in St. Francis II and determined that the NLRB had not justified its standard as a reasonable interpretation of the Act. The court also stated that although legislative history may give meaning to ambiguous statutory provisions, courts should not enforce principles that do not have a statutory reference point.

The NLRB and the courts have applied either a community of interest standard or a disparity of interest standard. This resulted

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64. St. Francis Hosp., 271 N.L.R.B. at 953 (parenthetical in the original). The Board noted that the maintenance workers shared the same conditions as service employees, who were a larger group. Maintenance workers were also lesser skilled individuals who worked with service employees. *Id.* at 954.

65. *IBEW Local 474*, 814 F.2d at 709 (discussing St. Francis II).

66. *Id.* (The court in St. Francis II implied that this test was mandated by the 1974 amendments "either without regard to the standards enunciated in section 9 [of the NLRA] or as a supervening standard for employees in the health-care industry.").


68. 814 F.2d 697 (D.C. Cir. 1987).

69. *Id.* at 709.

70. *Id* at 712-13. The NLRB’s suggested formula in St. Francis II relied solely on legislative history without regard to the language in section 9 of the NLRA which gives the NLRB the discretion to determine appropriate units. The admonition against proliferation was contained only in the committee reports, Congress never changed the wording of the Act itself. Although the 1974 amendments did not modify sec. 9 of the NLRA, the NLRB’s decision suggests that unit standards were changed with the amendments. *Id.*

71. See generally Watowan Memorial Hosp. v. NLRB, 711 F.2d 848 (8th Cir. 1983) (using community of interest standards balanced with the congressional admonition); NLRB v. Res-Care, Inc., 705 F.2d 1461 (7th Cir. 1983) (using community of interest standards); Woodland Park Hosp. 205 N.L.R.B. 888 (1973) (using community of interest standards to invalidate a unit of x-ray workers).

72. See generally Mary Thompson Hosp. v. NLRB, 621 F.2d 858 (7th Cir. 1980); Allegheny Gen. Hosp. v. NLRB, 608 F.2d 965 (3d Cir. 1979) (applying disparity of interests test).
in many inconsistent decisions because the two standards vary in their interpretation and the weight the NLRB or the court gives to the congressional admonition. Effectively, because the case by case approach which had been used was inconsistent and subject to individual determinations, the NLRB decided to use its rulemaking power to determine appropriate bargaining units.

IV. THE NLRB'S DECISION TO ENGAGE IN RULEMAKING AND THE SEVENTH CIRCUIT CHALLENGE

By specific provision of the NLRA, the Board has the authority to make rules to carry out its functions. This rulemaking authority is given to federal agencies to assist them in carrying out the provisions of various acts, and agencies can utilize this authority either by making decisions through case by case determination, or by rulemaking.

A. THE RATIONALE AND RESULT OF THE NLRB'S DECISION

In Continental Web Press, Inc. v. NLRB, the Seventh Circuit suggested that the Board engage in rulemaking to promote consistency and to prevent the "surprises" resulting from its case by case method. The rules adopted by the NLRB are different from generalized standards such as the community of interest or disparity of interest tests, in that they firmly establish a set number of bargaining units and prevent individual subjectivity and court interpretation.

There are advantages to formal rulemaking which make it justifiable. It often is more efficient than adjudication because it tends to increase uniformity and stability and decrease costly litigation. It is also a fairer process than adjudication because it supplies all interested persons notice of policy changes that may affect them and allows an opportunity to comment on that policy change. Additionally, the comment aspect of formal rulemaking assists in developing policies.

73. 29 U.S.C. sec. 156 (1982). This section provides that the "Board shall have authority from time to time to make, amend, and rescind ... such rules and regulations as may be necessary to carry out the provisions of this subchapter." Id.
75. 742 F.2d 1087 (7th Cir. 1984).
76. Id. at 1093-94 ("The Board could have prevented surprise by using its dormant rule-making powers.").
78. See Morris, supra note 50, at 34; Curran, supra note 10, at 145.
79. See Morris, supra note 50, at 37-38; Curran, supra note 10, at 146.
knowledgeably and effectively.\textsuperscript{80} Rulemaking frees the NLRB from case law determinations which focus on facts and interests of specific parties and away from "the broad needs and concerns of the entire labor community."\textsuperscript{81} Finally, rulemaking brings some order to the chaos which has surrounded litigation involving unit determinations in the health care industry.\textsuperscript{82}

Regardless of the advantages of rulemaking, an examination of the "in each case" language of 9(b) of the NLRA\textsuperscript{83} suggests that the NLRB must make unit determinations on a case by case basis, and not resort to rulemaking. In fact, one Board member dissented from the approval of rulemaking and declared that rulemaking was foreclosed by the language of section 9(b) of the Act.\textsuperscript{84} He argued that employees' freedom to exercise their rights guaranteed by the NLRA could be compromised by failure to determine bargaining units on a case by case basis.\textsuperscript{85} He also argued that by the 1974 amendments, Congress did not intend to have the NLRB abandon its forty-year-old approach to bargaining unit determination to adopt a new approach.\textsuperscript{86}

One court has argued that rulemaking will pre-determine units and that this will violate the "in each case" language in the NLRA.\textsuperscript{87} The NLRB noted, in its proposal to engage in rulemaking, that the words "in each case" do not preclude the use of rules to make bargaining unit determinations. The rules would merely classify the appropriate unit but the actual unit would be decided in each case.\textsuperscript{88} Congress could have prohibited the use of the NLRB's rulemaking powers if it determined that it was necessary to do so.\textsuperscript{89}

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\item \textsuperscript{80} Morris, \textit{supra} note 50, at 29-30; Curran, \textit{supra} note 10, at 146.
\item \textsuperscript{81} Curran, \textit{supra} note 10, at 146; see also Morris, \textit{supra} note 50, at 30.
\item \textsuperscript{82} See, \textit{e.g.}, American Hosp. Ass'n v. NLRB, 899 F.2d 651, 660 (7th Cir. 1990), \textit{aff'd}, ___U.S. ___ , 111 S. Ct. 1539 (1991).
\item \textsuperscript{83} 29 U.S.C. sec. 159(b) (1982).
\item \textsuperscript{84} Final Rule, 54 Fed. Reg. 16,336, 16,347 (1989).
\item \textsuperscript{85} \textit{Id.} (The dissenter noted that if Congress had intended the Board to embark on a radically different approach to determining units than what was traditional in the industry, it would have said so explicitly.).
\item \textsuperscript{86} \textit{Id.} Congress has usually expressed intentions to change. The plain language of the NLRA must be examined to determine congressional intent. \textit{Id}.
\item \textsuperscript{87} American Hosp. Ass'n v. NLRB, 718 F. Supp. 704, 711-12 (N.D. Ill. 1989), \textit{rev'd}, 899 F.2d 651 (7th Cir. 1990).
\item \textsuperscript{88} Notice of Proposed Rulemaking, 52 Fed. Reg. 25,142, 25,144 (1987); see, \textit{e.g.}, American Hosp. Ass'n v. NLRB, 899 F.2d 651, 656 (7th Cir. 1990), \textit{aff'd}, ___U.S. ___ , 111 S. Ct. 1539 (1991).
\item \textsuperscript{89} See American Hosp. Ass'n v. NLRB, 899 F.2d at 656.
\end{itemize}
The NLRB’s decision to engage in rulemaking was originally intended to alleviate what the NLRB perceived as a fragmentation in the decision making process. The NLRB stated that rulemaking was a better device for avoiding proliferation than the old standards because it gave a clear criterion for determining which units were appropriate. The NLRB defined appropriate bargaining units on the basis of interests that are shared within the group, but disparate from the interests of other groups. Against this background, the NLRB balanced the congressional admonition against undue proliferation.

Through this process, the Board initially established a set of six units: registered nurses, physicians, other professional employees, technical employees, service and maintenance with clerical employees, and guards. The six units were deemed appropriate for larger acute-care hospitals. Smaller acute-care hospitals and nursing homes were allowed the same units, except that due to the probability of less division and specialization within the smaller hospitals, registered nurses and doctors were included in an all-professional unit.

In the final rule, the Board decided on eight bargaining units that would be appropriate for the health care industry. These are: 1. registered nurses, 2. physicians, 3. all professionals except for regis-

90. See, e.g., Notice to Engage in Rulemaking, 52 Fed. Reg. 25,142, 25,142-43 (1987). The Board gave its first notice of intent to engage in rulemaking in 1987. This was followed by a period of comment and discussion. The Board then gave its second proposal to engage in rulemaking. During these time periods, many special interest groups gave opinions and arguments for and against the rulemaking. It is not surprising that the Final Rule noted that the number of opinions and arguments from the hospital industry itself was large compared to other responses. This is probably because of the large numbers of hospitals and their interests.


92. Id.; see, e.g., Masonic Hall v. NLRB, 699 F.2d 626, 631-32 (2d Cir. 1983).


94. Id. The NLRB stated the reasons that these six units were approved was because most of the requests for bargaining units, aside from the statutorily mandated unit of guards, generally fell into one of these six units, so these were felt to be the most appropriate. Id.

95. A small hospital is defined as having 100 beds or less for patient care by the proposed rules. Id.

96. Id. This distinction was in response to concerns from smaller hospitals that they would be financially incapable of bargaining with many units as opposed to larger hospitals. It also recognized the fact that smaller hospitals are unlikely to have the number of members to create a unit. Id.

tered nurses and physicians, 4. technical employees, 5. skilled maintenance employees, 6. business office clerical employees, 7. guards, and 8. nonprofessional employees except for any named above. While the Board did provide for the creation of additional bargaining units "where extraordinary circumstances exist," such determinations are to be made by the Board in an adjudicatory setting and are to be viewed strictly, with only extraordinary circumstances warranting the addition of another bargaining unit.

The final rule did not provide for a different structure for smaller hospitals. The NLRB based this decision on the lack of justification by commentators to the proposed rule, and the NLRB's experience in determining units for smaller hospitals. It was further justified by the creation of the "extraordinary circumstance" exception, which would serve as a deterrent to undue proliferation of units.

In the final rule, the NLRB addressed the congressional admonition by stating that Congress was nondirective on the issue of the number of appropriate units within the statute. Therefore, principles of statutory construction would indicate that this was to be within the provinces of the NLRB. Some commentators argued that the Board ignored the legislative history by giving no effect whatsoever to the admonition, aside from mere acknowledgement of its existence. The NLRB's response to this contention was that the statutory language of the Act was not changed in the 1974 health care amendments. Further, the NLRB responded that although some concern was expressed about numbers of bargaining units, no amendment was

100. Id.
102. Final Rule, 54 Fed. Reg. 16,336, 16,341-42 (1989) (codified at 29 C.F.R. sec. 103). However, the Board addressed small hospital concerns by excluding any unit of five or fewer employees from strict application of the rule. Id.
103. Id. at 16,340-341.
104. Id. at 16,344-45.
105. Id. at 16,345-46.
106. Id. at 16,345 (Commentators addressing the NLRB during the rule discussions argued that congressional silence is no justification for the assigning of an arbitrary number of units that are the largest ever approved in any industry.).
made to determine these units. Consequently, Congress intended to leave that determination within the discretion of the NLRB.\(^{108}\)

The NLRB stated that the units most likely to organize were RNs, technical units, skilled maintenance units, service and unskilled maintenance units, and business office clerical units.\(^{109}\) The Board also noted that most physicians were independent and were not likely to organize. The Board further stated that although guard units are statutorily mandated,\(^{110}\) there have not been many guard cases, because of hospitals generally contracting out for guard services.\(^{111}\) Congress, in setting forth examples of undue proliferation in the NLRA, approved the decisions in *Four Seasons*,\(^{112}\) *Woodland Park*,\(^{113}\) and *Extendicare*.\(^{114}\) These cases were examples of decisions consistent with the congressional intent.\(^{115}\) The Board, acknowledging the congressional admonition containing these decisions when promulgating its rule, stated that it was fulfilling the purposes that Congress intended when making unit determinations.\(^{116}\) The newly promulgated rule was challenged for appropriateness in the Seventh Circuit.

B. THE SEVENTH CIRCUIT CHALLENGE TO THE RULE MAKING

The new rulemaking analysis was first tested in the Seventh Circuit decision of American Hospital Association v. NLRB.\(^{117}\) In this

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108. Final Rule, 54 Fed. Reg. 16,336, 16,345-46 (1989) (codified at 29 C.F.R. sec. 103.30) (The NLRB stated that the comments by the legislators within the committee reports of the 1974 amendments, although helpful, are not controlling or directive.).

109. Id. at 16,346.


111. Final Rule, 54 Fed. Reg. at 16,346. The NLRB felt that most hospitals would not have the full number of units allowed by the rule, using the history of litigation and the types of units which have in the past sought to bargain collectively. Id.

112. 208 N.L.R.B. 403 (1974) (found inappropriate a three employee unskilled maintenance unit in a nursing home).

113. 205 N.L.R.B. 888 (1973) (Board found inappropriate a separate unit of x-ray technicians).

114. Extendicare of West Virginia, 203 N.L.R.B. 1232 (1973) (Board found inappropriate a separate unit of licensed practical nurses).

115. S. REP. No. 700, 93d Cong., 2d Sess. 5 (1974). The rules would prevent such small and indistinguishable groups from being approved, which is the result that Congress intended by approving these decisions, while not directing the NLRB on any certain standard. Id.


117. 899 F.2d 651 (7th Cir. 1990).
case, the American Hospital Association (the AHA) challenged the NLRB’s newly promulgated rule. The district court had invalidated the new rule after examining the history of the NLRA and its amendments. The court held that a case by case procedure in determining units was more appropriate than rulemaking in light of the congressional admonition to prevent undue proliferation and the “in each case” language contained in the NLRA. The court held that the NLRB is not foreclosed from rulemaking in general. However, this rule did not conform to the congressional admonition to prevent undue proliferation. Therefore, the court granted a permanent injunction banning application of the rule.

On review, the United States Court of Appeals for the Seventh Circuit reversed the district court’s decision and upheld the NLRB’s authority to determine collective bargaining units through rulemaking. The court read the Act as favoring employees and their rights to organize, although the NLRA is non-directive on the issue of the number of appropriate bargaining units. Hence the court understood the NLRA to favor many, rather than few bargaining units.
The Seventh Circuit also examined the legislative history of the "in each case" language and found that the legislative committee intended unit determinations to be made by the Board, and not by Congress or the labor/management field.\textsuperscript{125} Congress enacted rulemaking powers in the NLRA at the same time as the section containing the "in each case" language. Therefore, the court reasoned that Congress would have specifically exempted rulemaking for bargaining units had that been its intent.\textsuperscript{126}

The court, in interpreting the undue proliferation language in the congressional comment, stated that it should be treated not as a statute, but as an advisory concern which should not be given statutory weight.\textsuperscript{127} The court justified its holding on the grounds that Congress "does not legislate by issuing committee reports."\textsuperscript{128} The court noted that Congress had before it an example of New York State's counterpart to the NLRB, which had recognized more than twenty-one units in New York hospitals.\textsuperscript{129} The court concluded that the congressional admonition was directed more to this type of undue proliferation, or to units in which the number of employees were too small.\textsuperscript{130}

The United States Supreme Court upheld the Seventh Circuit's ruling,\textsuperscript{131} holding that the NLRB's rulemaking powers are broad under

Web Press v. NLRB, 742 F.2d 1087, 1099 (7th Cir. 1984); NLRB v. Res-Care, Inc., 705 F.2d 1461, 1469 (7th Cir. 1983).

125. American Hosp. Ass'n v. NLRB, 899 F.2d at 713; see also H.R. REP. No. 972, 74th Cong., 1st Sess. 22 (1935); H.R. REP. No. 1147, 74th Cong., 1st sess. 22 (1935). The House Reports say that "section 9(b) provides that the Board shall determine . . . [the appropriate unit]. This matter is obviously one for determination in each individual case, and the only possible workable arrangement is to authorize . . . the Board to make that determination." Id.; H.R. REP. No. 972, 74th Cong., 1st Sess. 22 (1935).

126. American Hosp. Ass'n v. NLRB, 899 F.2d at 656 ("It is probable, no stronger statement is possible, that Congress would have made an explicit exception for unit determination if it had wanted to place that determination outside the scope of the Board's rule-making power.").

127. Id. at 658; accord IBEW Local 474 v. NLRB, 814 F.2d 697, 712 (D.C. Cir. 1987); NLRB v. Res-Care, Inc., 705 F.2d 1461, 1470 (7th Cir. 1983). But see Mary Thompson Hosp. v. NLRB, 621 F.2d 858, 862-64 (7th Cir. 1980) (giving the congressional admonition statutory weight).


129. Id. at 658 (citing Hearings on H.R. 11357 Before the Subcomm. on Labor of the S. Comm. on Labor and Public Welfare, 92d Cong., 2d Sess. 300-01 (1972)).

130. Id. at 659 ("[N]either the cases cited in the admonition nor the admonition itself reads on the propriety of eight units.").

the NLRA, and that the "in each case" language is not a limitation upon the NLRB's powers. The Court determined that the "in each case" language simply indicated that the NLRB should resolve disputes whenever there is a disagreement over the appropriateness of a unit. The Court also held that the congressional admonition should be read merely as a warning to the NLRB, since there is statutory directive limiting the number of units, and there is every indication that Congress intended the NLRB to make unit determinations.

While the propriety of the NLRB's rulemaking has withstood challenge in the United States Supreme Court, the propriety of the presumptive eight units remains in doubt.

V. THE PROPRIETY OF THE EIGHT UNIT PRESUMPTION

Other industries have determined appropriate labor bargaining units by applying the community of interest standard. In the 1970's and early 1980's, numerous decisions in the health care industry applied this community of interest standard to determine the appropriateness of a particular unit. The NLRB's final rule defined the eight groups, or units, as presumptively appropriate for collective bargaining. These units are: 1.) doctors, 2.) registered nurses, 3.) other professionals, 4.) technical employees, 5.) skilled maintenance employees, 6.) business office clericals, 7.) guards, 8.) all other nonprofessional employees. A group of more than five employees fitting into any of these groups creates a presumptive bargaining unit with which the employer must bargain.

Evaluating the merits of the eight unit presumption requires an examination of the work environment of the industry. Health care workers must often deal with low wages, long hours, inadequate benefits, and lack of autonomy. These less desirable aspects of employment exist in an industry that provides continuous care to the nation's population in need of medical attention. A disruption in the provision of medical services can be chaotic, if not life threatening.

132. Id. at 1542-44.
133. Id. at 1543.
134. Id. at 1545.
135. See Berendt, supra note 6, at 68-69 (community of interest often primary consideration).
136. See Kilgour, supra note 63, at 84-85 (outlining the early trend to rely on traditional community of interest standards to make bargaining unit determinations).
138. Id.
for the patients who rely on health care workers for treatment.

The most compelling justification for the congressional admonition is the goal of decreasing the potential for disruptions in patient care. In no other industry could the effects of a strike be more devastating. Unfortunately, these fears have resulted in bargaining restrictions on health care workers, effectively backing them into a corner and decreasing their bargaining power.\textsuperscript{140} The answer to the fear of proliferation, which increases the potential for disruption in patient care, is not the prevention of adequate units with which to bargain. A more logical approach, this author argues, is to examine the units and determine whether or not they will meet the needs of employees, without placing an undue hardship upon the employer.

In determining whether a particular unit may bargain collectively, the NLRB takes into consideration a wide variety of factors: pay, hours of work, benefits enjoyed, education, skills, integration with other classes of employees, and functions of employment.\textsuperscript{141} A large unit, which is favored by the employer because it is more cost effective to bargain with, will also be more difficult to organize, due to the competing interests of the workers involved and the diversity of skills among these workers.\textsuperscript{142} Employees and the unions favor smaller, more cohesive units, which are more effective for addressing individual employee concerns. Smaller units may increase employer costs to a certain degree, simply because of the time it takes to negotiate with each individual unit and the disruption caused by varying bargaining cycles.\textsuperscript{143}

The eight unit presumption promulgated by the NLRB has not been favorably received by some.\textsuperscript{144} There had never been, prior to the new rule, more than eight units certified in one hospital at any given time.\textsuperscript{145} But the health care industry is diverse and has the

\begin{thebibliography}{99}
\bibitem{140} See, e.g., \textit{id.} at 389-90.
\bibitem{141} See \textit{Getman} \& \textit{Pogrebin}, \textit{supra} note 3, at 25.
\bibitem{142} See \textit{Gorman}, \textit{supra} note 2, at 67-68.
\bibitem{143} \textit{Id.}
\bibitem{144} See \textit{American Hosp. Ass'n v. NLRB}, 718 F. Supp. 704 (N.D. Ill. 1989), rev'd, 899 F.2d 651 (7th Cir. 1990) (finding the eight unit presumption improper, but reversed on appeal); see also John C. Kilgour, \textit{The Healthcare Bargaining Unit Controversy: Community of Interest verses Disparity of Interest}, 40 \textit{Lab. L.J.} 81, 90 (1989) (pointing out "that the proposed [eight] units were somewhat different from what the Board ha[d] approved in the past," abandoning the two unit approach of the disparity of interest test).
\bibitem{145} Kilgour, \textit{supra} note 144, at 90. (The Board returned to a standard allowing as large a number of units as there has ever been in hospitals.)
\end{thebibliography}
potential for creating far more than eight units. The eight unit presumption is a reflection of the units that the NLRB had certified in the past through case by case determination.

The fear of proliferation by presuming these units is unfounded, when effect is given to the wide possibilities for other potential units within the system. This author proposes that a hospital has the potential of at least 20 different organizational groups. These may include physicians, R.N.s, L.P.N.s, laboratory technicians, radiology technicians, phlebotomists, respiratory technicians, nurses aides, orderlies, dieticians, dietary aides, pharmacists, pharmacy technicians, housekeepers, maintenance workers, clerical workers, medical records technicians, administrative assistants, admitting personnel, security guards, mental health technicians, counseling staff, and data processing workers. Each of these groups may be found in a relatively small hospital. Although many of these groups share some similarities and common interests, each group is unique in that it fills a special niche within the hospital structure. Even within these groups, there are degrees of specialization and training that may affect the monetary compensation and status of the employee. The above example illustrates what true proliferation could do, and demonstrates that eight units within a hospital is an appropriate number. The presumption ensures that all employees are given the opportunity to bargain

146. See, e.g., NLRB v. Res-Care, Inc., 705 F.2d 1461 (7th Cir. 1983); Woodland Park Hosp., 205 N.L.R.B. 888 (1973); Extendicare of West Virginia, 203 N.L.R.B. 1232 (1973). Many professional and non-professional units have attempted to be certified as a bargaining units. These cases suggest that often it is more than undue proliferation which creates or does not create a specialized unit. A balancing approach between employers and employees is often the determining factor.

147. See, e.g., Kilgour, supra note 144, at 90-91 (It is difficult to organize large units, especially when they conflict with groups that employees identify with.).

148. See NLRB v. Walker County Med. Ctr., 722 F.2d 1535 (11th Cir. 1984) (certifying a group comprised entirely of registered nurses); Watowan Memorial Hosp. v. NLRB, 711 F.2d 848 (8th Cir. 1983) (approving group made up of all technical employees); Montefiore Hosp. & Medical Ctr., 261 N.L.R.B. 569 (1982) (certified group of physicians); Faulkner Hosp., 242 N.L.R.B. 47 (1979) (maintenance unit appropriate); Sutter Community Hosp., 227 N.L.R.B. 181 (1976) (unit of business office clericals approved).

149. An example of this would be the nursing group. Within this profession, nurses can be certified with specialties and thereby make themselves more marketable and increase job status. The interests of these nurses may be very different than floor nurses who have not specialized or pursued additional training. This author bases this information on her experience as a registered nurse in the hospital setting.
effectively, but that the number of units does not become too excessive.

A two unit determination, professional and non-professional, has been proposed as being the most appropriate for the hospital industry.\(^\text{150}\) This author believes that this is an inadequate way to organize the hospital system and secure collective bargaining. The adoption of just two large units could render bargaining wholly ineffective.\(^\text{151}\)

One commentator suggests that a unit comprised of all professionals would be impossible and gives, as an example, the difficulties that would arise from the standpoint of the largest professional group, registered nurses.\(^\text{152}\) These difficulties are in organizing and effectively bargaining for large groups of diverse professionals. This would have the effect of deterring many union organizers from attempting to organize such a unit.\(^\text{153}\) Nurses, who would be included in a group of all professionals, would probably feel that their needs and skills are sufficiently different from other professionals to require separate representation.\(^\text{154}\) A non-professional unit would be equally difficult to organize because of the large numbers of employees it would encompass and the extreme disparities among them.\(^\text{155}\) Two units cannot give employees effective access to bargaining and do not account for the individual nature of the various worker in the health care industry. An examination of each of the eight units as set forth in the promulgated rule illustrates their appropriateness and justifies their use as a presumptive unit.

Each of the eight units set forth in the new rule\(^\text{156}\) has been found appropriate by the Board in bargaining unit decisions. This author believes that the eight units are the only presumptively appropriate units, and approval of other units, absent extraordinary circumstances, would only create fragmentation and proliferation within a given hospital. The units themselves can be justified on the basis of


\(^{151}\) E.g., Kilgour, supra note 144, at 91.

\(^{152}\) Id. at 91 (suggesting that traditional nursing unions, who are affiliates of the American Nurses Association, would probably not be able to organize such a bargaining unit).

\(^{153}\) Id. at 91.

\(^{154}\) Id. at 91 (Nurses probably would not be receptive to representation by non-nursing unions.).

\(^{155}\) Id. at 91.

\(^{156}\) See infra notes 157-76 and accompanying text for a discussion on the units approved by the Board.
case law, NLRB decisions, and examination of the job requirements, interests and interrelationships of the various job classifications within the hospital.

One of the presumptive units under the rule is physicians. Units of physicians have been approved by the NLRB in pre-rule decisions. A unit of physicians is appropriate because of the similar interests shared between physicians that are separate from other professionals. These interests include liability issues, job responsibilities, educational backgrounds and patient care expectations. These interests differentiate physicians from nurses and other hospital professionals. Physicians have a distinct role in the health care setting, and are a presumptively appropriate unit for the industry. Other health care professionals also occupy a special role in the health care delivery system.

Another professional unit approved under the rule is registered nurses. R.N.s are a large, important group of hospital workers. R.N.s are responsible for the direct, primary care of the patients in the hospital. They occupy a special place in the workplace and have issues that are unique to their group, such as career advancement, shift and staffing concerns, wages, and patient care issues. The NLRB also stated, when promulgating the rules, that non-nursing professionals would lose their voice if included with a group of R.N.s. R.N.s generally do not have common supervision, background or licensing requirements compared to other hospital employees. Therefore, R.N.s need to have separate representation due to their unique role, and are a presumptively appropriate unit. There are other professional employees within the hospital setting, but these individual groups may not warrant separate representation.

Other professional employees, such as physical therapists, psychologists, counselors, pharmacists and speech therapists generally

159. See, e.g., Cynthia Sharo, Appropriate Bargaining Units in the Health Care Industry, 5 LAB. LAW. 787, 816 (1988) (Doctors earn more money, have different interests and different input into patient care decisions.).
161. See, e.g., Sharo, supra note 159, at 816 (nurses unique role exists because of continuous patient contact and autonomy on the floor when necessary) (citing 179 DAILY LAB. REP. A-2 (Sept. 17, 1987)).
162. 53 Fed. Reg. 33,900, 33,914 (1988); see also Sharo, supra note 159, at 816.
163. See NLRB v. Walker County Medical Ctr., 722 F.2d 1535 (11th Cir. 1984) (approving R.N.s as a separate bargaining unit).
constitute much smaller, if not singular, groups within the hospital. Because of this, the congressional admonition against undue proliferation would seem to apply and would suggest that these professionals be grouped into one unit for bargaining purposes.164 Creating separate units for each professional group, this author argues, could result in many small units, which would be in direct conflict with the congressional mandate. A group of all remaining professional employees prevents an excess of small units, gives consistency to the hospital environment, and avoids excessive fragmentation. Other employees, such as technical employees, have bargaining needs that are different from the professional hospital employee.

Technical employees generally are comprised of such groups as laboratory technicians, x-ray technicians, phlebotomists, respiratory technicians and licensed practical nurses. Units of all technical employees consist of individuals who have similar salary scales, training and job requirements.165 Usually these technical employees have jobs that involve some degree of patient contact, but are not in charge of patient care.166 A separate unit of any one of the various groups of technical employees would not be appropriate since their wages, shifts, educational backgrounds, and duties are similar.167 Also, the potential of creating many small units exists if all or some of the many types of technical groups are allowed to bargain separately. The increase in the numbers of units to bargain with leads to fragmentation and undue proliferation.168 A group of all technical employees satisfies the need for adequate representation among employees of common backgrounds, while further complying with the congressional admonition.

The next unit approved by the rule is skilled maintenance employees.169 Skilled maintenance employees include such groups as boiler operators, engineers, painters, plumbers, powerhouse employees and mechanics. If all of these employees were grouped according to their individual skills, "[W]e could be faced with requests to find appropriate dozens of separate units of employees performing diverse

165. Watonwan Memorial Hosp. v. NLRB, 711 F.2d 848 (8th Cir. 1983) (affirming group of technical employees).
166. Id. at 851.
168. See supra notes 33-39 and accompanying text for a discussion of the congressional admonition against undue proliferation.
functions [and] such an approach can only lead to an undue fragmentation of bargaining units . . . ."\textsuperscript{170} Thus, the special skills of various maintenance employees, possibly warranting separate representation, must be balanced with the public interest in preventing proliferation in the health care industry.\textsuperscript{171}

A balancing of these two interests suggests that all skilled maintenance employees be represented as one unit for bargaining. These employees share commonalities such as wages, hours, and supervision, and have similar needs to be addressed because of the nature of their work. Also, the NLRB has rejected attempts to create units from smaller groups within the maintenance umbrella.\textsuperscript{172} Therefore, maintenance employees should be a presumptive unit to secure the bargaining needs of maintenance groups. This will prevent fragmentation, which would result if small units within the maintenance group were allowed. The final three presumptive groups, business office clericals, guards, and all other non-professionals, were the last groups that the NLRB determined were appropriate in the health care setting.\textsuperscript{173}

Business office clericals perform duties which are obviously different from professional, technical and maintenance employees. Business office workers generally handle the financial and organizational aspects of the hospital environment. Business office clericals are supervised separately from other hospital workers and have different educational requirements.\textsuperscript{174} These workers also function fairly autonomously from other groups within the hospital setting, and have more traditional working hours. For these reasons, a separate unit representing the needs of these workers is appropriate. Other non-professional employees are grouped together in what appears to be a "catch all" unit to encompass remaining personnel. This unit appears to be designed to prevent any fragmentation and creation of very small units within a given hospital. A unit encompassing the remaining non-professional personnel resolves any potential conflicts early between employees and employers by giving these employees a separate unit

\textsuperscript{170} Shriners Hosps. for Crippled Children, 217 N.L.R.B. 806, 808 (1975).
\textsuperscript{171} See St. Vincent's Hosp. v. NLRB, 567 F.2d 588, 592 (3d Cir. 1977) (stating that the Board should weigh traditional criteria with congressional mandate against proliferation).
\textsuperscript{172} See id. (rejecting unit of four boiler operators); St. Joseph Hosp., 224 N.L.R.B. 270 (1976) (rejecting "maintenance and engineering department" in favor of broader service and maintenance unit); Shriners Hosps. for Crippled Children, 217 N.L.R.B. 806 (1975) (rejecting stationary engineer unit).
\textsuperscript{174} See Sharo, supra note 159, at 817-18 (citing 53 Fed. Reg. 33,900, 33,924-25 (1988)).
with which to identify, but limiting any potential for many units to form.\textsuperscript{175} The unit of guards is a statutorily mandated unit which the NLRB was obligated to recognize.\textsuperscript{176} The Supreme Court has allowed the rules to stand, finding this method of rulemaking preferable to the case by case method, which had not brought the NLRB any closer to defining appropriate units.\textsuperscript{177} The eight units themselves, perhaps the basis for future challenges, are the most efficient, appropriate and cost effective way to secure bargaining for employees in the health care industry.

\textbf{VI. CONCLUSION}

While the decision to engage in rulemaking has not been applauded by many, it is the first time that the Board has sought to bring organization and consistency to labor management in the health care industry. The Supreme Court's approval of the new rules has left one question unanswered: are the eight units themselves appropriate? In light of the structure of the health care industry, it was necessary to create eight units to cope with the wide diversity which exists within a hospital. The eight unit presumption will lead to more stability within the system, while addressing the needs of individual employees. Refusing to recognize any of the eight units will be counterproductive for employers and will lead to dissention and dissatisfaction among employees. Each of the eight units has in the past been certified by the NLRB as appropriate through a case by case determination. By recognizing these eight units, wide scale proliferation of specialized bargaining groups within the hospital will be prevented and the hospital industry can finally escape from its bargaining woes.

\textbf{RHONDA FERRERO-PAT TEN}

\textsuperscript{175} See, \textit{e.g.}, John Robert Shelton, \textit{Note, NLRB Guidelines for Determining Health Care Industry Bargaining Units: Judicial Acceptance or Back to the Drawing Board}, 78 Ky. L.J. 143, 154 n.74 (1990) ("Based on our analysis of the evidence adduced, we have found appropriate separate units of technicals, business office clericals, and skilled maintenance employees. All remaining service and non-professional employees [except guards] shall, therefore, constitute a separate appropriate unit, where requested.") (quoting 53 Fed. Reg. 33,900, 33,927(1988)).

\textsuperscript{176} 29 U.S.C. sec. 159(b) (1982) (providing that guards are to be maintained in a separate bargaining unit).

\textsuperscript{177} See \textit{supra} notes 131-34 and accompanying text. See generally Ursula M. McDonnell, \textit{Comment, Deference to NLRB Adjudicatory Decision Making: Has Judicial Review Become Meaningless?}, 58 U. Cin. L. Rev. 653 (1989) (discussing the NLRB's reluctance to use rule making to give consistency to the field of labor relations).