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REGISTERED NURSE BARGAINING UNITS:
UNDUE PROLIFERATION?

NLRB v. St. Francis Hospital

St. Francis Registered Nurses Association, United Nurses Associations of California (the union) filed a petition for a representation election for a unit of registered nurses employed at St. Francis Hospital (the hospital). At the hearing on the bargaining unit determination, the hearing officer for the National Labor Relations Board (the Board) refused to admit evidence offered by the hospital to support a finding of an all-professional unit, instead of the unit consisting solely of registered nurses requested by the petitioner. The regional director subsequently held that the unit comprised exclusively of registered nurses (RNs) was an appropriate bargaining unit and ordered an election. In doing so he rejected the hospital's claim that the hearing officer made prejudicial error in refusing evidence to support the appropriateness of an all-professional unit.

The union won the election, was certified, and sought to bargain. When the hospital refused to bargain, the union filed unfair labor practice charges, and a complaint was issued. Finding that the hospital was trying to relitigate matters considered by the regional director below, the Board granted summary judgment at the hearing on the complaint. The Board ordered the hospital to bargain and upon refusal sought enforcement of its order in the Ninth Circuit Court of Appeals. The court of appeals denied enforcement.

These issues were considered on appeal: (1) whether the hearing officer erred in refusing evidence offered by the hospital which supported an all-professional unit, instead of an RN only unit; and (2) whether the Board's determination of the appropriate bargaining unit was arbitrary, capricious, and unsupported by substantial evidence.

The refusal to admit evidence at the hearing was based on a "per se" rule established in Mercy Hospitals, Inc., which allows units to be com-

1. 601 F.2d 404 (9th Cir. 1979).
2. An offer of proof was allowed, but the hospital maintained that this offer was limited and that it did not waive objection to the hearing officer's ruling by submitting the limited offer. Id. at 407.
4. The third issue in the case, which will not be discussed in this Note, was the supervisory status of assistant head nurses. The court found the assistant head nurses to be properly included in the bargaining unit and deferred to the Board's decision on this finding of fact. The court held that the decision was supported by substantial evidence in the record and that it did not conflict with any congressional directive. 601 F.2d at 422.
prised solely of RNs whenever sought. The hospital offered to show that its organization and its integration of all professional employees made this case distinguishable from *Mercy* and that certain factual conclusions reached in *Mercy* were wrong and therefore inapplicable. Specifically, the hospital offered to show that there was no singular history of collective bargaining by registered nurses in this country, in the Sacramento area where the hospital in *Mercy* was located, or in southern California where the respondent hospital is located.\(^6\) The hospital made this offer because a singular history of separate representation of RNs had been heavily relied upon in *Mercy*. In response the Board made two distinct arguments: where registered nurses have sought to bargain, they have done so in units limited to their own profession; and registered nurses have a community of interest which entitles them to a separate unit.\(^7\)

The court held that the hearing officer had erred by refusing the hospital's evidence supporting an all-professional unit. In addition, the Board's decision that the unit consisting solely of RNs was appropriate was held to be arbitrary and capricious. It found that the "per se" policy that a bargaining unit consisting solely of RNs is presumptively appropriate when sought in a nonprofit hospital is not consistent with the congressional directive that the Board give due consideration to prevent undue proliferation of bargaining units in the health care industry. The court attacked the bases for *Mercy*, namely, a singular history of separate representation among RNs, and a community of interest among RNs. The court said the "singular history" did not exist and that disparity of interest, not community of interest, was necessary to justify a separate bargaining unit.\(^8\) The court did not say that a bargaining unit consisting solely of RNs can never be valid,\(^9\) but here the rule that such a unit is always valid, coupled with the exclusion of evidence to the contrary, constituted reversible error.\(^10\) The court said that presumptions may be employed by the Board so long as interested parties are given the opportunity to present evidence to rebut the presumptions.\(^11\)

The court in *St. Francis* relied heavily on prior law regarding appropriate bargaining units in the health care industry, including the legislative history and decisions of other courts of appeal. A survey of the history and precedent in this area begins with the National Labor Relations Act,\(^12\) passed in 1935, which was intended by Congress to decrease industrial strife and encourage collective bargaining among employees.\(^13\)

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\(^6\) 601 F.2d at 418.
\(^7\) *Id.*
\(^8\) *Id.* at 419.
\(^9\) *Id.* at 416, 419.
\(^10\) *Id.* at 416.
\(^11\) *Id.*
Non-profit hospitals were included, but little collective bargaining was done in the health care industry. In 1947, the Taft-Hartley amendments excluded nonprofit hospitals, like St. Francis, and their employees from coverage and protection of the Act. An increasing amount of labor unrest, low wages, and poor working conditions in nonprofit private hospitals led Congress to extend the protection of the Act to these employees in 1974.

In enacting the 1974 amendments, Congress noted the unique service of the health care industry and its sensitivity to labor disputes, and accordingly built in several protective mechanisms. Congress did not specify any set number of bargaining units in this industry, leaving that determina-

14. The NLRB asserted jurisdiction over a nonprofit hospital in Central Dispensary and Emergency Hosp., 44 N.L.R.B. 533, 541, 42-5 CCH 6048 (1942) ("employees of hospitals, like employees of automobile factories, must live upon their wages"). The Board's decision was upheld in NLRB v. Central Dispensary and Emergency Hosp., 145 F.2d 852, 853 (D.C. Cir. 1944), cert. denied, 324 U.S. 847 (1945) ("We cannot understand what considerations of public policy deprive hospital employees of the privilege granted to the employees of other institutions.").

As early as 1946, registered nurses represented by the California Nurses Association had their first contract with the San Francisco Bay area hospitals. See Miller, Development and Structure of Collective Bargaining Among Registered Nurses, 50 PERSONNEL J. 134 (1971). Nurses associations in Washington, Minnesota, and Oregon were recognized as bargaining agents for their members as well. See, e.g., What State Associations Did in 1945, 46 AM. J. NURSING 67 (1946).


16. The amendment that excluded nonprofit hospitals was offered with the rationale that hospitals were charitable institutions and not in interstate commerce. Senator Tydings of Maryland offered the amendment, and Senator Taylor of Idaho questioned him: "Mr. Taylor. What would be the effect if nurses in a hospital should decide to organize. Would it prevent their organization? Mr. Tydings, I do not think it would." 93 Cong. Rec. 4997 (1947). Nurses were not prevented from organizing under the amendment, but neither were they protected or encouraged to do so; the organization of nurses and other health care workers was retarded.

The American Nurses Association and professional engineering societies argued for separate bargaining units during hearings. As a result, professionals were given the right to a separate bargaining unit. See Scott & Smith, The Taft-Hartley Act and the Nurse, 56 AM. J. NURSING 543 (1956).


18. These include the requirements of early notice of intent to modify or terminate a contract, a 10 day strike or picket notice to the health care institution and the Federal Mediation and Conciliation Service (FMCS) and, if warranted, a discretionary fact-finding board of inquiry by FMCS. 29 U.S.C. §§ 158, 171, 183 (1976). The effectiveness of these mechanisms is discussed in FEDERAL MEDIATION AND CONCILIATION SERVICE, IMPACT OF THE 1974 HEALTH CARE AMENDMENTS TO THE NLRA ON COLLECTIVE BARGAINING IN THE HEALTH CARE INDUSTRY (1979).
tion to the Board, but did direct the Board to give due care to preventing undue proliferation of bargaining units in the health care industry and noted with approval several decisions the Board recently had made.

Two principal dangers of undue proliferation of bargaining units were

19. Senator Robert Taft introduced a bill which would have provided no more than four units in the health care industry: professional employees, technical employees, clerical employees, and service and maintenance employees. The bill, S. 2292, 93d Cong., 1st Sess., 119 Cong. Rec. 26791 (1973) was not enacted. In presenting the conference report on the bill which was adopted, Senator Williams for the Senate conferees 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 an unnecessary proliferation of collective bargaining units, sometimes circumstances require that there be a number of bargaining units among non-supervisory employees, particularly where there is such a history in the area or a notable disparity of interests between employees in different job classifications.

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

120 Cong. Rec. 22575 (1974). The weight to be given these remarks, made after passage by the House and Senate but before adoption of the conferees' report, may be great or light with regard to Congress's intent to have the Board exercise its discretion. The court in St. Francis, while contending that the "history in the area" was not singular nor impressive, gave great weight to the "disparity of interest" statement. 601 F.2d at 418-19.

20. The House and Senate Committee Reports state:

Effect on Existing Law—Bargaining Units

Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection, the Committee notes with approval the recent Board decisions in *Four Seasons Nursing Center*, 408 N.L.R.B. No. 50, 85 L.R.R.M. 1098 (1974), and *Woodland Park Hospital*, 205 N.L.R.B. No. 184, 84 L.R.R.M. 1074 (1973), as well as the trend towards broader units enunciated in *Extendicare of West Virginia*, 203 N.L.R.B. No. 170, 83 L.R.R.M. 1242 (1973).

In footnote 1, the House and Senate reports said, "By our reference to *Extendicare*, we do not necessarily approve (all of the holdings) of that decision."


The cases cited in the Committee Reports indicate no change from the normal pattern in unit determination. In *Four Seasons*, the Board rejected a proposed unit of only two maintenance employees. In *Woodland Park*, the Board rejected a proposed unit of x-ray technicians. In *Extendicare*, the Board found appropriate two units; one of all LPNs and another of all technical employees and service and maintenance employees. The footnote in the Reports referring to that decision may mean that Congress did not necessarily approve of separate LPN units—LPNs are now placed in units with other technical employees. For further discussion of this issue, see note 27 *infra*. Of course, it could also mean that Congress did not approve of separate LPN units, and that it would not approve of separate RN units either.
foreseen: the possibility of numerous strikes, having the potential to shut down the facility as other employees honored picket lines; and numerous bargaining units being utilized in "whipsaw" fashion, each union using the preceding settlement to increase its wage demands, thus disproportionately increasing labor costs in the industry.21

After the 1974 amendments, the NLRB continued its policy of finding separate units for registered nurses appropriate.22 In 1975 the Board, in Mercy, overruled a regional director's finding that three units—professional, service and maintenance, and office clerical—were appropriate.23 It instead found appropriate the following units: registered nurses, when they seek to be represented in exclusive units,24 other professional employees,25 service and maintenance employees, and clerical employees. While the Board in Mercy did not state that its decision was to be established policy, it relied on Mercy in Methodist Hospital, Inc.26 and found that a unit of all professionals excluding RNs was presumptively appropriate. Since that time, Board decisions have made possible a total of seven units in health care institutions, and have consistently permitted units comprised solely of RNs whenever sought.27

   24. The Board's wording is important: "[R]egistered nurses, if they are so sought and they so desire," are entitled to a separate bargaining unit. Id. at 767, 89 L.R.R.M. at 1100. The court in St. Francis said that the Board did not always adhere to its Mercy decision and cited Family Doctor Medical Group, 226 N.L.R.B. 118, 93 L.R.R.M. 1193 (1976). In that case, however, the unit being sought included RNs with lab technicians and dieticians, and not RNs as a separate unit. The Board's inclusion of RNs in a larger unit, then, was not contrary to Mercy.
   25. The Board heard oral argument and received briefs amicus curiae from a number of parties, including the American Nurses Association and other health care professional associations, in this consolidated case to determine health care facility bargaining units. The Board concluded: "[T]hese individual professional groups have failed to demonstrate the kind or degree of separate representation ... so important to our finding that RNs may constitute a separate professional bargaining unit." 217 N.L.R.B. at 769, 89 L.R.R.M. at 1102.
   27. The Mercy decision allowed four separate units, not five as stated in St. Francis. 601 F.2d at 414 n.11. The confusion arises over "supplemental employees." While this is a separate heading in the Mercy decision, closer reading reveals that these are similar to part-time or temporary employees. The Board decided they would be eligible to vote, but they would be part of the other four units (most in the service and maintenance unit) and would not constitute a separate unit by themselves.

Mercy established the four units listed; technical employees were made a fifth separate unit in Barnett Memorial Hosp. Ass'n, 217 N.L.R.B. 775, 89 L.R.R.M. 1083 (1975), and LPNs were placed in the technical unit in St. Catherine's Hosp., 217 N.L.R.B. 787, 89 L.R.R.M. 1070 (1975). Doctors could constitute
St. Francis is the first decision to overturn the Board on an RN unit determination. For example, in Bay Medical Center v. NLRB, 588 F.2d 1174 (6th Cir. 1977), the court upheld, on the basis of a history of separate bargaining, a Board decision finding a unit of practical nurses to be separate. The court stated, "Courts have long recognized that the Board may take bargaining history into account when determining whether a proposed bargaining unit is appropriate." Id. at 1177. See Libbey-Owens Ford Co. v. NLRB, 495 F.2d 1195, 1200 (3d Cir. 1974); NLRB v. Zayre Corp., 424 F.2d 1159, 1165 (5th Cir. 1970). In NLRB v. Sweetwater Hosp. Ass'n, 604 F.2d 454 (6th Cir. 1979), the court found a technical unit decision appropriate and indicated that the Board "has not yet caused such fragmentation as to violate the ... mandate." Id. at 458.

30. See NLRB v. Mercy Hosp., 606 F.2d 22 (2d Cir. 1979); St. Vincent's Hosp. v. NLRB, 567 F.2d 588 (5th Cir. 1977).

31. 601 F.2d at 416, 418. Specifically, the court cited Long Island College Hosp. v. NLRB, 566 F.2d 833 (2d Cir.), cert. denied, 455 U.S. 966 (1977); St. Vincent's Hosp. v. NLRB, 567 F.2d 588 (3d Cir. 1977); Memorial Hosp. v. NLRB, 545 F.2d 351 (5th Cir. 1976); NLRB v. West Suburban Hosp., 570 F.2d 213 (7th Cir. 1978).

32. RNs were bargaining in separate units long before the protection of the Act was extended. See note 14 supra. In 1965, an American Nurses Association (ANA) report to state constituents indicated that 25,300 RNs were represented at their place of employment by state nurses associations, with 9685 of those covered by formal contracts. ANA, Summary of State Nurses Association Economic
If substantial evidence that the exclusively RN unit is appropriate is presented on remand in *St. Francis*, the burden will then be on the employer to show that the unit is clearly not appropriate.\textsuperscript{33} Indeed, a Ninth Circuit case has held that the burden is on the employer to prove that the Board's unit determination is wrong in a registered nurse bargaining unit.\textsuperscript{34}

The second area of disagreement the court in *St. Francis* found with *Mercy* was the use of the community of interest test. Community of interest is a traditional Board test of appropriateness of unit,\textsuperscript{35} but in *St. Francis* the court held that the proper test for determining an appropriate unit in the health care industry should not be community of interest, but dis-

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Twelve states provided legislation prior to the 1974 NLRA amendments which covered some employees of nonprofit hospitals: Connecticut, Hawaii, Massachusetts, Michigan, Minnesota, Montana, New York, Oregon, Pennsylvania, Rhode Island, Washington, and Wisconsin. In Oregon and Montana the statutes provide protection for RNs and LPNs only; in Massachusetts the statute was passed first for nurses, and extended to other employees later. State nurses associations initiated and lobbied in favor of such legislation. See, e.g., Mahoney & Conlon, *Bargaining Rights for Nurses*, 66 Am. J. Nursing 544 (1966).


The consistent selection of the state nurses association affiliates of the ANA, which with few exceptions represent RNs exclusively, also indicates a history of separate bargaining by RNs. Of the 130,000 nurses under contract in the United States, ANA affiliates represent 110,000. Gideon, *American Nurses Association: A Professional Model for Collective Bargaining*, 2 J. Health & Human Resources 14 (1979). The union in *St. Francis* is a spinoff of the California Nurses Association and sought an RN only unit.

Argument can be made that history of bargaining after 1975, when the Board started finding RN only units, should be disregarded as evidence because there was no other choice than RN only bargaining. The Board, however, made it clear in *Mercy* and in subsequent decisions that when a broader unit than RN only is sought by the employees, it can be had. RNs have sought to be represented in units comprised solely of RNs so consistently that this has provided a now massive history of separate unit bargaining.

The employer and the court in *St. Francis* pointed to the minority of nurses in the nation and in the area of the St. Francis hospital who were represented in separate bargaining units, but this is merely a reflection that a minority of RNs in the industry are organized. About 130,000 of the 900,000 RNs working in the United States are now working under collective bargaining agreements. Gideon, *id.* The fact that many nurses are not organized into collective bargaining units is of questionable relevance to the issue of whether those who are organized are in RN only units.

\textsuperscript{33} NLRB v. J.C. Penney Co., 559 F.2d 973 (5th Cir. 1977).

\textsuperscript{34} NLRB v. Doctors' Hosp., 489 F.2d 772 (9th Cir. 1973) (the issue pertained to supervisors in an RN only unit and was decided prior to the 1974 amendments).

\textsuperscript{35} NLRB v. Sunnyland Ref. Co., 474 F.2d 407, 409, 410 (5th Cir. 1973); NLRB v. Belcher Towing Co., 284 F.2d 118, 121 (5th Cir. 1960).
parity of interest. This "disparity of interest" test is gleaned from the legislative history of the 1974 health care amendments; specifically, from one remark of Senator Williams. The court did not define its disparity test, but it may be similar to the theory expressed by Board member Penello in his dissent in *Allegheny General Hospital* in which he suggested that a super community of interest test is necessary. The court did say that the traditional community of interest test would be "subordinated" to the directive against undue proliferation and suggested a balance between the congressional mandate and the employees' right to representation. If Congress's directive to avoid undue proliferation in health care facilities means that a test different from community of interest must be employed in those bargaining unit determinations, a substantial change in unit determinations in the health care industry will be in order. It would also mean far less Board discretion would be permitted in this industry than in others. The Board's authority in unit determinations in other industries involves "of necessity, a large measure of informed discretion and the decision of the Board, if not final, is rarely to be disturbed." 

In a conflicting decision subsequent to St. Francis, the Board in *Garden City Hospital* decided to continue to use the community of interest test in health care bargaining unit determinations. The Board has accepted the remand in St. Francis, but is seeking certiorari in *NLRB v. Mercy Hospital Association*. At least one Board member has indicated that

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36. On review of the Mercy decision on the narrow issue of whether the Board's refusal to accept the parties' stipulation of unit was arbitrary, the Ninth Circuit Court of Appeals said, "[U]se of this doctrine [community of interest] is entirely proper... where the appropriate bargaining unit is disputed." *NLRB v. Mercy Hosps., Inc.*, 589 F.2d 968, 973 (9th Cir. 1978). The court apparently approved the community of interest standard in health care institutions in that case, though it found this standard to be insufficient to override a stipulation by the parties where it had been a Board policy to accept such stipulations. *Mercy Hosps., Inc. v. NLRB*, 589 F.2d 968 (9th Cir. 1978).

37. For the text of the remark, see note 19 supra.


39. 601 F.2d at 419.


42. 606 F.2d 22 (2d Cir. 1979). Telephone conversation with Linda Sher, Associate General Counsel for Supreme Court Litigation, Washington, D.C. (Jan. 3, 1979). In response to the decisions of the various circuits, the Board considered what Congress meant by "proliferation" in *Allegheny Gen. Hosp.*, 239 N.L.R.B. 104, 100 L.R.R.M. 1030 (1978). In deciding to use a community of interest test for maintenance worker units in hospitals, the Board indicated the following factors: similarity of wages and hours, frequency of contact, degree of interchange and functional integration, area practice and patterns of bargaining, and history of bargaining of employees who would be in the unit. As noted earlier, that Board decision was recently overturned. *Allegheny Gen. Hosp. v. NLRB*, 608 F.2d 965 (3d Cir. 1979). In Garden City Hosp., 244 N.L.R.B. 108, 102 L.R.R.M. 1146 (1979), the Board reaffirmed its 1978 *Allegheny* decision and
the Board may continue the policy of allowing RN only units.\textsuperscript{43}

Assuming a base of substantial evidence is obtained on the RN history of separate bargaining and community of interest, will the Ninth Circuit and other courts of appeal uphold an RN only unit, absent indication from the Board that it has specifically considered or "subordinated" those factors to the public interest? RN only units are presently being found appropriate in Board unit determinations. Based on past decisions, those determinations will be upheld in the Sixth Circuit,\textsuperscript{44} might not be upheld in the Ninth,\textsuperscript{46} and how they will fare in other circuits is an open question.

The immediate effect is that hearing officers will let evidence in regarding all-professional units whenever RN units are sought. The likely effect of this is to increase delay and expense to employee groups seeking representation as well as to employers seeking to defeat such representation. Once determinations are made, it is probable that more section 9(d) "end runs"\textsuperscript{46} such as existed in \textit{St. Francis} will be encouraged. Here, the petition was filed in 1976 and the employees are not yet to the bargaining table. The cost to the hospital of pursuing the appeal was undoubtedly substantial; this cost will ultimately be borne by the consumers of health care.

Whether or not the Board's decisions promote "undue proliferation," the congressional intent behind that mandate must be remembered. As noted earlier, the fears of extending the protection of the Act to health care workers with possible proliferation of units were that strikes would result, along with whipsaw wage increases. There is at least some evidence to indicate that these fears are not being realized, even under the Board's present community of interest test.\textsuperscript{47}

\textsuperscript{43} Personal conversation with Howard Jenkins, NLRB member, at Columbia, Missouri (Oct. 25, 1979).

\textsuperscript{44} Bay Medical Center v. NLRB, 588 F.2d 1174 (6th Cir. 1978), cert. denied, 100 S. Ct. 53 (1979).

\textsuperscript{45} NLRB v. St. Francis Hosp., 601 F.2d 404 (9th Cir. 1979).

\textsuperscript{46} Direct review of bargaining unit determination is not available under 29 U.S.C. § 159(d) (1976) unless the Board violates a clear and mandatory provision of the NLRA. Boire v. Greyhound Corp., 376 U.S. 473 (1964); Leedom v. Kyne, 358 U.S. 184 (1958). The route to review is a refusal to bargain after the unit is certified, unfair labor practice charge and complaint, and appeal of the subsequent Board order to bargain.

\textsuperscript{47} The FMCS documents a lower strike rate in the health care industry than in other industries—4% rate in health care versus 15% in other industries—even though many of the contracts are first contracts, a more strike-prone situation. Barrett, \textit{A Discussion}, 28 Lab. L.J. 525 (1977). Whipsaw wage increases are not affecting costs greatly; only a small part of the staggering increases in the cost of hospital care is attributable to wages. Rises in labor costs are actually declining. \textit{Wage-Price Council Says Rising Wages Are Small Factor in Hospital Cost Inflation}, \textit{Daily Lab. Rep.} (BNA) 9-10 (Jan. 20, 1977). The whole issue of proliferation seems overrated. In only 117 of 2585 bargaining situations, approximately 4% of the time, did two or more unions represent workers within one institution. Of