The Law and Economics of Collective Bargaining for Hospitals: An Empirical Public Policy Analysis of Bargaining Unit Determinations

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The National Labor Relations Board recently promulgated a rule that pre-designated eight hospital bargaining unit classifications. The rule was an unusual deviation from adjudicatory procedures, intended to facilitate administrative approval without increasing strike activity or causing other undesirable collective bargaining outcomes. This article reports empirical data from a national survey of 574 hospitals. The survey was designed to test the economic conclusions that the Board reached in its Final Rule. The article concludes that the data support the Board’s determination that designating the eight classifications is unlikely to cause undesirable collective bargaining consequences.

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Introduction

Hospital employees have had unusual difficulty organizing to bargain collectively with their employers. The historical failure of hospital unionization can be analyzed by examining the legal evolution of bargaining units for hospital employees. Like most other workers, hospital employees were permitted to organize under the Wagner Act in 1935. However, the 1947 Taft-Hartley Act amended the Wagner Act to exempt most hospital employees from collective bargaining. Congress removed this exemption in 1974 and enacted

1. See St. Francis Hosp. and St. Francis Fed'n of Nurses & Health Professionals, 263 N.L.R.B. 834, 836 (1982) (describing one hospital's retaliatory and unfair labor practice following filing of union's election petition). Hospitals have used several tactics to forestall unionization. Many hospitals have religious affiliations, yet administer general health care on a non-denominational basis. Several of these hospitals have raised First Amendment claims to be free from the National Labor Relations Board's jurisdiction after representation elections have been conducted. See St. Elizabeth Hosp. v. NLRB, 715 F.2d 1193 (7th Cir. 1983); St. Elizabeth Community Hosp. v. NLRB, 708 F.2d 1436 (9th Cir. 1983). Other hospitals have used security personnel to surveil employee contact with union organizers. See NLRB v. St. Vincent's Hosp., 729 F.2d 730, 734 (11th Cir. 1984) (concluding that "requiring surveillance of union activities by a supervisor violates [the National Labor Relations Act] if it interferes with the organizational rights of employees").

2. The Wagner Act did not restrict the definition of employer under § 2(2) to exclude any hospitals. See Central Dispensary and Emergency Hosp., 44 N.L.R.B. 533, 540-41 (1942), where in ordering an election for employees petitioning for a representation election the Board noted:

The Hospital contends that it is a charitable institution, but neither charitable institutions nor their employees are exempted from operation of the Act by its terms, although certain other employers and employees are exempted. If Congress did not intend to except charities from the scope of the Act, an exact determination of the Hospital's status in this respect becomes immaterial . . .

Employees of hospitals, like employees of automobile factories, must live upon their wages. The hospital appealed the Board's ruling in NLRB v. Cent. Dispensary & Emergency Hosp., 145 F.2d 852 (D.C. Cir. 1944), cert. denied, 324 U.S. 847 (1945). The court enforced the Board's order, noting:

Respondent [hospital] argues that the spirit or policy of the Act is such that we should read it into an exemption of charitable hospitals . . . We are unable to follow the reasoning . . . We cannot understand what considerations of public policy deprive hospital employees of the privilege granted to the employees of other institutions.

145 F.2d at 853.

3. The Taft-Hartley Act amended the § 2(2) definition of "employer" to exclude "any corporation or association operating a hospital, if no part of the net earnings inure to the benefit of any private shareholder or individual." Labor Management Relations Act, ch. 120, § 101, 2(2), 61 Stat. 136, 137 (1947).

4. Congress amended § 2(2) to make the Act applicable to "health care institution[s]." Act of July 26, 1974, Pub. L. No. 93-360 § 1(a), 2(2), 88 Stat. 395 (1974). Ironically, one rationale for extending coverage of the Act to nonprofit hospital employees was to abate the recognition strikes that had occurred at these institutions, as noted by the 1974 House Committee on Labor and Public Welfare:

The Committee was also impressed with the fact . . . that the exemption of nonprofit hospitals from the Act had resulted in numerous instances of recognition strikes and picketing. Coverage under the Act should completely eliminate the need for any such activity, since the procedures of the Act will be available to resolve organizational and recognition disputes.

in its place limitations on the organizing and collective bargaining rights of these employees. In particular, this legislation contained an admonition to avoid the proliferation of bargaining units in the health care industry (including hospitals). The admonition was designed to protect both hospitals and the public they serve from adverse collective bargaining impacts, such as strikes and jurisdictional disputes. The National Labor Relations Board [hereinafter the Board], the federal agency that administers the Act, recognized hospital bargaining units so as to avoid unit proliferation. However, the process by which bargaining units were determined frustrated the efforts of hospital employees to bargain collectively by producing large units that were unduly difficult to organize and contained multiple and conflicting "communities of interests."

Special factors also adversely affected hospital employees' efforts to organize. Unions consider public support for strikes important, but the care-providing, life-sustaining, and life-saving work of hospital employees make striking seem a grossly insensitive act of self-interest. The decentralized workforce structure in hospitals also has hampered employee efforts to organize.

5. The amendments required that parties in the health care industry provide 90-day notice of termination of a collective bargaining agreement (Act of July 26, 1974, Pub. L. No. 93-360, § 1(d)(1)(A), 88 Stat. 395, 396); provide the Federal Mediation and Conciliation Service (hereinafter FMCS) 60-day notice of contract termination (See id. at § 1(d)(1)(A), 88 Stat. at 396); participate in mediation at the direction of FMCS (See id. at § 1(d)(1)(c), 88 Stat. at 396); and that labor organizations provide a 10-day notice to employers and FMCS before engaging in any work stoppage (See id. at § 1(d)(1)(e), 88 Stat. at 396 (adding current § 8(g) to Act)). The amendments also authorized the establishment of an Impartial Board of Inquiry to resolve particular health industry labor disputes (See id. at § 2 (adding § 213 to Act)).

6. Unions often prepare strike manuals to improve the effectiveness of a local's strike activities. In its strike manual, the United Electrical, Radio and Machine Workers of America stressed the importance of winning public support in making a strike successful:

Winning over public opinion to the side of strikers can be an enormous plus. ... [P]ublic attitudes towards unions and strikes are confused and many people understand very little about either. Some people are anti-union; the best efforts of a Publicity Committee will not change their minds. Others in the general public are pro-union and will be sympathetic. The real audience to reach is the people in between. People who haven't made up their minds because they don't understand why workers need unions or why workers sometimes have to strike.


A Teamsters strike manual advises: "[F]ollow carefully reports of the strike in the media. ... Wage a public opinion campaign. Write letters to the local newspapers. ... If the employer is important to a neighborhood, you might consider soliciting a striker or his spouse to write a letter to a neighborhood newspaper." TEAMSTERS LOCAL NO. 115, INTERNATIONAL BROTHERHOOD OF TEAMSTERS, HOW TO WIN STRIKES 26 (1979). The manual also counsels how to ascertain the attitudes of the local community: "Have the police in the area tended to side with labor or management in disputes? ... Are there certain judges who are more likely to be assigned labor cases than others? ... Do politicians tend to get involved in labor disputes? ... Has the media generally reported labor disputes in your area?" Id. at 9.

7. A decentralized workforce may hinder employee efforts to organize because such an arrangement limits face-to-face interaction and communication. In essence, a highly decentralized workforce impersonalizes relations among employees. See, e.g., St. Francis Hosp. and Inf'tl Bhd. of Elec. Workers, Local 474, 265 N.L.R.B. 1025 (1982) (where employer spread its 1300 employees among 90 separate departments).
The bargaining unit determination process often is a key factor in whether or not a union representation election succeeds. Some hospitals have effectively impeded employee efforts to organize by litigating bargaining unit determinations. Unit determinations are critical to employees' success in organizing and employers' success in defeating unionization. The battle over the composition of the unit is roughly analogous to the home field advantage in sporting competitions; while it does not itself determine the outcome of the competition, it often is an influential factor. In general, small units aid employee efforts to organize because they can better group people with common interests; large units aid employer efforts to defeat unionization because they tend to combine people with conflicting interests.

Election delays decrease the likelihood that a union will win a representation election. By creating bargaining unit disputes, hospitals have delayed elections, thereby harming employee efforts to organize. From the perspective of employees, the National Labor Relations Board's adjudication of these disputes (rather than resolution through administrative rulemaking) has routinized the problem of delay.

8. See infra note 75.

9. These delays have been imposed at all stages, ranging from the initial stages, overseen by regional directors, to the appellate review stage. The case of Hospital Employees Labor Program of Metropolitan Chicago [hereinafter HELP!] provides an example: HELP! filed a representation petition for a business office clerical unit in October 1975. After a series of hearings before the Regional Director, an election was directed and held in April 1976. A post-election hearing was necessary to resolve challenged ballots and objections to conduct allegedly affecting the results of the election. The hearing officer's report on objections recommending certification of the union was issued in September 1976. Briefs by both parties were submitted to the Labor Board in October 1976, and a board decision issued on April 27, 1977, certifying HELP! as a bargaining agent for business office clerical employees. The fifteen months which elapsed from filing of the certification petition to the Board's certification was obviously too long and unfair to the interest of the employees.

10. An employer may consent to a representation election without contesting the composition of the bargaining unit. However, "[t]he scope and composition of the bargaining unit is often a subject of dispute between union and employer ... since this decision can determine whether the union is entitled to representative status. ... In the absence of an agreement by the parties, the Board may be called upon to determine whether a petitioned-for unit of employees is an 'appropriate unit' for collective bargaining. ..." THE DEVELOPING LABOR LAW 413 (Charles J. Morris, et al. eds., 1983). The Board then is called upon
Some hospitals have confounded employee efforts to organize by appealing adverse Board decisions and by refusing to bargain with certified representatives. These strategies have postponed the day when collective bargaining would occur, and have created a tangled mass of confusing precedents to feed the litigation cycle. When litigious hospitals consumed years in appealing Board rulings, ordinary employee turnover often eroded initial organizing gains. In some instances, union supporters were harassed or fired, becoming lessons, perhaps, for the remaining workers.

11. See, e.g., St. Elizabeth Community Hosp., 708 F.2d at 1436. The union won a representation election for service and maintenance employees in June 1977. However, the hospital appealed, challenging some votes, and raising for the first time a First Amendment claim against coverage under the Act. The Ninth Circuit, in a 1980 ruling, held that the hospital had raised a timely First Amendment claim, and remanded the case to the Board. The Board concluded that its jurisdiction would not infringe the hospital’s free exercise beliefs, and would only slightly risk entangling the religious institution with government. The hospital appealed this decision, and on June 23, 1983 -- six years after the election -- the Ninth Circuit upheld the Board’s assertion of jurisdiction. The employees voting for union representation were denied their right to bargain a contract for the entire period. See also St. Francis Fed’n of Nurses v. NLRB, 729 F.2d 844, 857 (D.C. Cir. 1984), where the court, in enforcing a bargaining order against an employer who committed pervasive unfair labor practices, stated: “Saint Francis Hospital is not entitled to use the processes of this court to seek further delay or benefit from the consequences of the unfair labor practices which it committed during the election campaign four years ago.” In testimony given before the Board during its rulemaking hearings, many unions complained that protracted litigation over unit-determination “produced lengthy delays and great difficulties in organizing.” Collective-Bargaining Units in the Health Care Industry, 53 Fed. Reg. 33,900, 33,902 (1988) (to be codified at 29 C.F.R. pt. 103) (proposed Sept. 1, 1988) (citations omitted).

12. During the rulemaking process, the Board commented: “Thirteen years and many hundreds of cases later, the Board finds that despite its numerous, well-intentioned efforts to carry out congressional intent through formulation of a general conceptual test, it is now no closer to successfully defining appropriate bargaining units in the health care industry than it was in 1974.” Collective-Bargaining Units in the Health Care Industry, 52 Fed. Reg. 25,142, 25,143 (1987) (to be codified at 29 C.F.R. pt. 103) (proposed July 2, 1987).

Although the Board is specially empowered to make bargaining unit determinations, its unit determinations in the hospital industry have frequently been reversed. See cases cited infra note 150. Writing for the appeals court in Int’l Bhd. of Elec. Workers Local 464 v. NLRB, 814 F.2d 697 (D.C. Cir. 1987), Judge Harry Edwards observed:

The circuit courts have disagreed, however, on what constitutes adequate consideration of the congressional admonition against undue proliferation. The majority of circuit courts have viewed the legislative history of the 1974 Amendments as mandating the Board to balance traditional community-of-interest criteria against the public interest in undue proliferation. While these courts have not elaborated on how the Board should strike this balance, they have required the Board clearly to explain the manner in which its unit determination implements the congressional policy of non-proliferation.

814 F.2d at 704 (citations omitted).

13. See, e.g., St. Luke’s Memorial Hosp. v. NLRB, 623 F.2d 1173 (7th Cir. 1980) (affirming the Board’s ruling that the hospital committed unfair labor practices by discharging two union stewards); Community Hosp. v. NLRB, 538 F.2d 607 (4th Cir. 1976) (affirming the Board’s finding that the hospital committed an unfair labor practice when it disciplined a nurse for appearing on television for an interview);
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Against this backdrop and after fifty-two years of making unit determinations on a case-by-case basis under the National Labor Relations Act, the Board promulgated its first administrative rule relating to bargaining units.\(^4\) To replace the regime of repetitive bargaining unit contests, the rule established eight pre-designated bargaining units appropriate for hospital employees.\(^5\) In 1991, the U.S. Supreme Court upheld the Board's unit determination rule in American Hosp. Ass'n v. NLRB.\(^6\) This rule is widely viewed as one that will facilitate employee choice in matters of union representation.\(^7\) This study analyzes the public policy implications of American Hosp. Ass'n in light of extensive economic data collected from private hospitals to project whether the Board's rule will result in new types of hospital bargaining units and more workplace disputes, strikes, and wage spillovers.\(^8\) We base our analysis on economic data collected in 1988 and 1989 from 574 private hospitals.\(^9\)

Part I summarizes background information about hospitals and collective bargaining. Part II surveys the economic and personnel management characteristics of hospitals. Part III then focuses more specifically on union organization and collective bargaining in hospitals. In Part IV, we explore the concept of bargaining units, and examine the structure of bargaining units peculiar to hospitals. Part V discusses how the Board made its bargaining unit rule for hospitals. Part VI examines how courts responded to hospital industry chal-

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Misericordia Hosp. Med. Ctr. v. NLRB, 623 F.2d 808 (2d Cir. 1980) (affirming the Board's finding that the hospital committed an unfair labor practice when it fired a nurse who was critical of hospital practices during an accreditation review).


15. See infra notes 226-32 and accompanying text.


17. The newspaper for America's labor federation, the AFL-CIO, reported shortly after the Supreme Court's decision that "[a]fter years of fighting past roadblocks set up by hospital administrators, unions have the green light to organize hospital . . . workers." Candice Johnson, Court Helps Hospital Workers Say Union Yes, AFL-CIO NEWS, May 27, 1991, at 7. Referring to the 9-0 Supreme Court vote sustaining the Board's rulemaking, the AFL-CIO continued: "[T]he Service Employees are distributing leaflets reminding hospital workers that the nine Supreme Court justices want hospital workers to have a fair chance in union organizing campaigns." Id.


19. See infra notes 309-313 and accompanying text.
Challenges to the rule. Part VII presents our empirical public policy analysis of the rule. Specifically, we explain our survey and sample of hospitals, our research questions, and data we collected and analyzed pertaining to the rule's impact on collective bargaining in hospitals. Ultimately, the Article concludes that the new bargaining unit rule will remove an impediment to organizing hospital employees, and thereby make hospital unionization more like other private-sector unionization. We also note, however, that a variety of legal, economic and social forces have depressed general private sector unionization, and we believe these broader influences will also constrain hospital unionization.

I. Background: Hospitals and Collective Bargaining

In this Part, we present data showing the growth in public expenditures for hospital care. We also document the extent to which hospital employment has grown to meet rising demand for hospital services. Part I concludes with a review of the literature that assesses human resource management in hospitals.

A. An Economic Overview of Hospitals

Consumers and government spend huge sums of money on health care, and total spending in this area has sky-rocketed since 1970. Health care spending soared for all age groups, particularly for people of working age. In particular, spending on hospital care has risen sharply since 1970. While increases in wages for hospital employees have accounted for some of this increase, research has shown that wage gains for unionized hospital employees have had a relatively small impact on overall hospital costs.


21. See Daniel R. Waldo et al., Health Expenditures by Age Group, 1977 and 1987, 10 HEALTH CARE FIN. REV. 111 (1989), reporting that health care spending was $51.9 billion for people 19 years and younger (rising 11.6 percent between 1977 and 1987); $231.1 billion for people 19-64 years-old (rising 52.2 percent); and $162.0 billion for people 65 years-old and older (rising 36.2 percent in the period). Total health care spending in 1987 was estimated to be $447 billion, approximately $1,776 per capita of the U.S. population.

22. In 1970, $28 billion was spent on hospital care; by 1987, $194.7 billion was spent. See id.

23. See Myron D. Fotler, The Union Impact on Hospital Wages, 30 INDUS. & LAB. REL. REV. 342, 354 (concluding that "since the wages of nonprofessional personnel account for about 23 percent of total hospital costs, the union impact on hospital costs appears to be in the range of 1-2 percent.") Fotler also found that "maintenance of real wages appears to be a more significant wage determinant than does unionization." Id.
B. Employment in Hospitals

In 1989, 4529 general medical and surgical hospitals reported wage and employment data to the U.S. government. Most hospitals were large employers: 19% employed 500-999 people; 40% employed 1000-2499, and 25% employed 2500 or more people. Moreover, hospital employment is large and growing. For example, hospitals employed an additional 117,000 people in 1989 from the previous year, totaling 3.1 million in their workforce. Wages for hospital employees totaled $68.85 billion in 1989, an increase of $6.30 billion over 1988.

Technological advances in health care were once viewed as a threat to hospital job security; however, the ratio of hospital employees to hospital patients actually increased steadily throughout the 1970s and 1980s. In spite of this growth, job-tenure for employees other than doctors, and for nurses in particular, remains low relative to other occupations, exhibiting a high turnover rate.

The existing hospital employment literature is generally critical of hospital employment practices. A brief review of portions of that literature and some of its findings follows. The empirical analysis provided in this paper does not support or refute this critical perspective. At particular places, however, alternative explanations are provided for some of the literature’s reported conclusions. This literature is included because its treatment of employer-employee relationships in hospitals provides some context to our discussion.

Between 1945 and 1970, employment in hospitals increased sharply, and by 1970 hospitals employed 2.3 million people--a figure that exceeded the combined employment for all labor-intensive industries such as steel and railroads in 1970. In the 1940s and 1950s, hospitals sought to substitute less

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24. This number includes public, as well as private hospitals, and any non-members of the American Hospital Association [hereinafter the Association]. BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, BULLETIN 2364, INDUSTRY WAGE SURVEY: HOSPITALS (MARCH 1989) 6 (table 1) (1989).

25. Nine percent of all hospitals had 250-499 employees, and six percent had fewer than 250 employees. See id.


27. See id.

28. See CHARLES CRAYPO & MARY LEHMAN, HEALTH CARE FOR PROFIT 41 (1986). For example, in 1971 nonprofit hospitals employed an average of 270 employees per 100 patients; in 1980 the ratio was 350 to 100. The ratio similarly increased for investor-owned and government-owned hospitals.

29. Average tenure for nurses, orderlies and attendants was only 5.6 years, compared to 24.8 years for barbers, 15.0 years for telephone line installers, 13.3 years for tailors, and 10.1 years for drivers of heavy trucks. Closer comparisons exist for receptionists, whose tenure averaged 3.3 years; waiters and waitresses, whose tenure averaged 4.4 years; and janitors and cleaners, whose tenure averaged 4.2 years. See U.S. BUREAU OF THE CENSUS, supra note 20, at 393 (table 647).

skilled for more skilled employees (for example, by hiring licensed practical nurses to do the work of registered nurses). However, in the 1960s and 1970s technological and capital improvements squeezed less skilled employment by eliminating old jobs and creating new ones that required greater training.

Further, there is literature to support the claim that hospitals have created distinctive hierarchies, which involved “the separation of estates within hospitals . . . reinforced by measures such as designated uniforms or patches and distinct dining and recreational facilities . . . .” Hospitals, particularly those in urban areas, have become “a window on the changing demography of the working poor.”

Another part of the critical literature views hospitals as opportunistic and self-centered institutions that used their nonprofit status to gain special advantages. Hospitals have long enjoyed a special status in both their communities and the nation. Even though they were frequently among the largest enterprises in a given community, most paid no taxes and were exempted from tort liability, Social Security coverage, and collective bargaining. Nevertheless, many hospitals, particularly the nonprofits, were increasingly successful in limiting their clientele to insureds, while shifting care for indigents to city and federal government hospitals. Nonprofit hospitals have acted as “charities which provided almost no charity, receiving extravagant charitable and commercial support from others . . . earning huge sums . . . [while] ignoring the most important if less dramatic tasks of health care.” The largely nonunion workforce of nonprofit hospitals helped extend the resources of nonprofit hospitals by being low-wage workers, or “involuntary philanthropists.” These conclusions contain kernels of truth. However, this literature overstates the exploitative charges against hospitals and fails to give nonprofit hospitals due credit for charitable service in their communities.

31. Id. at 3.
32. See id.
33. Id.
34. Id. at 6.
36. See id.
38. See UPHEAVAL IN THE QUIET ZONE, supra note 30, at 1.
C. Human Resource Management in Hospitals

Compared to other industries, the professional management of hospitals was slow in developing.\textsuperscript{39} This was especially true for the human resource, or personnel, function.\textsuperscript{40} As late as the 1970s, hospital management was told "more effort is needed in the hospital service to draw attention to the fact that manpower is not used in the best way possible."\textsuperscript{41} Recognizing the need for improved human resource management in hospitals, the American Hospital Association published training and consulting monographs.\textsuperscript{42} Some of the more recent hospital administration publications include policy recommendations that correspond to typical union demands made in collective bargaining.\textsuperscript{43}

In the 1980s and 1990s, the hospital industry came under pressure to change its cost structure.\textsuperscript{44} As hospitals attempted to control costs, their image suffered. Recently, the image of hospitals as charitable, healing institutions has been supplanted by images of hospitals as "medical-industrial complex[es]" and

\textsuperscript{39} See id.
\textsuperscript{40} Id. at 10, observing:

Compared to other workplaces, the voluntary hospital in the postwar period offered an uncharacteristically personalistic work regime. At its best this created a sense of belonging, of individuals pulling together, each held accountable for his or her own efforts on behalf of the hospital and patients. Indeed, some union stalwarts as well as hospital supervisors looked back with regret on the passing of the old regime. While proud of her role in building the union at Beth Israel, Mae Harrison fondly remembered that in the early fifties "it was like one big family.... People were much kinder then, you know, you all worked together."

\textsuperscript{41} GREGORY MILLARD, PERSONNEL MANAGEMENT IN HOSPITALS 1 (1972).
\textsuperscript{42} See, e.g., ADDISON C. BENNETT, PRODUCTIVITY AND THE QUALITY OF WORK LIFE IN HOSPITALS (1983).
\textsuperscript{43} See, e.g., JAMES L. PRICE & CHARLES W. MUELLER, ABSENTEEISM AND TURNOVER OF HOSPITAL EMPLOYEES (1986). These authors make some specific recommendations based on their research of employees and managements at five hospitals. One recommendation is ["h]ospitals should increase the pay of their employees." Id. at 214. Another recommendation is that ["h]ospitals should make sure that pay and seniority are highly correlated" to reduce employee turnover. Id. at 215. It is hard to imagine a union taking issue with these recommendations. See also MARTIN D. HANLON ET AL., ATTEMPTING WORK REFORM: THE CASE OF "PARKSIDE" HOSPITAL 226 (1985) (noting that union-management cooperation would have been better at the hospital if there had been job security for union workers).

On the other hand, current hospital management literature also contains such cynical advice as ["s]weep the office for surveillance devices . . . [u]se a paper shredder to dispose of important papers that are discarded" and ["n]ever say that the hospital cannot grant the union’s demands on wages because of its ‘inability’ to pay . . . [o]therwise the union may examine the hospital’s books . . . [i]nstead, the way to avoid the union’s looking at your books is for the hospital to refuse to grant the union’s demands on wages by stating that to do so would make the hospital noncompetitive." ARTHUR D. RUTKOWSKI & BARBARA LANG RUTKOWSKI, LABOR RELATIONS IN HOSPITALS 79-80 (1984). The book is intended as an aid for hospital labor-relations administrators who bargain with unions.

\textsuperscript{44} The federal government has forced such change upon hospitals by implementing policies with predetermined reimbursements tied to specific diagnostic and treatment categories.
"technical money-making" systems. Also, hospitals have come under increasing scrutiny for anti-competitive practices.

Cost pressures have forced hard choices on hospital administrators involving provision of services and employment matters. The need to change marketing focus and the need to restructure costs affected both their image and their business practices. In the 1980s acute-care hospitals diversified their services and expanded their markets. In response to spiraling costs, hospitals changed and enlarged the human resource, or personnel, function. Human resource management was called upon to restructure jobs and develop other cost-saving practices. These practices have included broadening employee classifications (for example, by creating the new job of “caregivers,” with multiple functions), and increasing part-time employment to cope with increased fluctuation in patient populations. Some hospitals identified traditional functions that could be performed by non-professionals and created new job classifications to provide care more inexpensively. Some hospitals have emphasized the “team concept” organization of their workforces to facilitate employee cross-training and cross-utilization.

II. Union Organizing and Collective Bargaining for Hospital Employees

In this Part, we consider the extent of hospital unionization and the potential for increased unionization. We show that hospital unionization levels have remained relatively low, paralleling unionization in the broader private sector. We also compare compensation for some hospital occupational groups with similar non-hospital occupational groups to suggest that hospital compensation


47. See Collective-Bargaining Units in the Health Care Industry, 53 Fed. Reg. 33,900, 33,902 (1988) (to be codified at 29 C.F.R. pt. 103) (proposed Sept. 1, 1988). For example, some hospitals have recently opened specialty branches such as arthritis units, neo-natal units, intensive-medical and surgical units, trach units, dialysis units, and others. See id. at 33,901.

48. In testimony to the Board, Association members commented that “[i]nflationary pressures have increased while revenues, particularly for in-patient stays, have either decreased or been governed by ceilings.” Id.

49. This change was reported by a large group of proprietary hospitals, National Medical Enterprises. See id. at 33,902.

50. See id.

51. See id.

52. The Association cited this development in human resource management at hospitals as a reason why predesignated bargaining units would be inappropriate because a particular unit determination might create a jurisdictional boundary that would preclude team functioning. The Board dismissed this argument by noting that the “team concept” is not new for hospitals and can conform to pre-designated units. Also, the Board relied upon a study involving sixty randomly selected hospitals and found that less than half use any form of “team concept” management. See id. at 33,907.
may be somewhat low. We conclude that some potential for increased unionization exists. Next, we present an overview of the employment characteristics of the eight occupational groups corresponding to the Board’s bargaining unit rule. This discussion shows the distinctive work and labor market conditions affecting the eight occupational groups and sheds light on the Board’s rationale for identifying these particular groups.

A. Unionization of Hospital Employees: Potential and Reality

One potential benefit to employees of unionization is the improvement of wages and benefits. Thus, to assess the future prospects for unionization of hospital employees, it is useful to examine present levels of employee compensation. Whether compensation for various occupational groups of hospital employees is sufficient to blunt unionization is a matter beyond the scope of this article. We note, however, that compensation for some occupational groups of hospital employees may be low relative to other occupational groups possessing similar skills and qualifications.

For all general medical and surgical hospital employees (from orderlies and janitors to doctors) the average weekly wage in 1989 was $4275 and the annual wage per employee was $22,219. This compensation is low relative to other occupations involving similar employee skills and qualifications. We compared compensation for hospital employees with compensation for employees in grocery stores, dental offices, data processing, and food preparation industries. These occupations tend to employ large numbers of low to moderately skilled workers, as is often the case for non-professional employment in hospital jobs. Employees working in grocery stores in 1989 earned an average weekly wage of $4801 and annual wage of $26,097; in the data processing and preparation industry, employees had an average weekly wage of $5425 and annual wage of $28,183; in the food preparation industry, employees had an average weekly wage of $4565 and annual wage of $23,709; and in the dental industry, employees received an average weekly wage of $4036 and annual wage of $20,971. In sum, the earnings of hospital employees were lower than the earnings of employees in three of the four occupational

53. BUREAU OF LABOR STATISTICS, U.S. DEP’T OF LABOR, supra note 26, at 24 (table 2).
54. See id. at 489 (table 5).
55. See id. at 18 (table 2).
56. See id. at 372 (table 5).
57. See id. at 23 (table 2).
58. See id. at 458 (table 5).
59. See id. at 6 (table 2).
60. See id. at 79 (table 5).
61. See id. at 24 (table 2).
62. See id. at 63 (table 5).
comparison categories. We offer these comparisons only to suggest that there is potential for successful unionization of some occupational groups in hospitals on the basis of compensation.63

In spite of the potential for unionization of hospital employees, unionization of hospital employees is only slightly greater than unionization of the entire private sector of the workforce, which, like most hospital unionization, is predominantly covered by the National Labor Relations Act.64

Unionization has grown gradually in hospitals: in 1961, 3.1% of hospitals had collective bargaining agreements, compared to 6.8% in 1967 and 18.0% in 1973.65 Shortly after the 1974 amendments to the Act were passed, conferring collective bargaining rights upon private, nonprofit hospital employees, the conventional wisdom was that union organizing of hospital workers would grow quickly.66 However, the extent of unionization in hospitals actually declined throughout the 1980s. In 1984, only 17.5% of hospital employees were union members, while 21.4% were covered by a collective bargaining agreement; by 1988, the percentage of hospital employees who were union members dropped sharply to 14.7%, while the percentage of hospital employees covered by a collective bargaining agreement dropped to 17.3%.67 The percentage of union members is lower than the percentage of employees covered because Section 7 of the National Labor Relations Act, as amended in 1947 by the Taft-Hartley Act, recognizes an employee's right not to join a union.68 As the percentages indicate, a fairly large number of hospital employees are either dues-paying non-members or free-riders.69 The percentage of unionized hospital employees

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63. Even where hospital workers are organized, their pay is relatively low. For example, Local 1199J of the National Union of Hospital and Health Care Employees ratified an agreement on June 30, 1990 that raised pay 5% for 1991. According to the district president, the average 1990 wage for the bargaining unit (which had both technical and service workers) was $18,200, an insubstantial sum for people living in the New York City metropolitan area. See BUREAU OF NATIONAL AFFAIRS, DAILY LAB. REP., July 3, 1990, at A13. Ironically, hospital management sought to curb employee health benefits (by demanding that employees make co-payments for health care). The union resisted this demand by threatening to strike over it. See id.

64. The most recent estimate of workforce unionization is 16.6%, and the rate is “4-5 percentage points lower” in the private sector. Michael A. Curme et al., Union Membership and Contract Coverage in the United States, 1983-1988, 44 INDUS. & LAB. REL. REV. 5, 8 (1990).


67. See Curme, supra note 64, at 13 (table 2).

68. With respect to employee rights to organize a union and engage in collective bargaining and other concerted activity, § 7 of the Act provides that employees “shall also have the right to refrain from any or all such activities except to the extent that such right may be affected by an agreement requiring membership in a labor organization as a condition of employment . . . .” 29 U.S.C. § 157.

69. Although § 7 provides that an employee’s right to refrain from union activity may be affected by an agreement requiring union membership, § 14(b) negates a union’s ability to negotiate a union-security clause in certain instances. Section 14(b) states: “Nothing in this Act . . . shall be construed as authorizing the execution or application of labor agreements requiring membership in a labor organization as a condition
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was actually less in 1988 (17.3%) than in 1973 (18.0%), the year before the 1974 amendments to the Act subjected private sector hospitals to federal collective bargaining.

The most recent statistics show that unionization of hospital employees remains at a low level: in 1989, a collective bargaining agreement covered 18% of all registered nurses, 18% of service employees, and 13% of all other employees. Notably, in the wake of the Supreme Court's recent decision upholding the Board's unit determination rule, several unions have started vigorous organizing efforts.

A few unions have done most of the organizing. The American Nurses Association is the largest union with a primary focus in the health care industry, with 1989 membership totaling 196,000. Other unions devoted primarily to health care bargaining include the Federation of Nurses and Health Professionals (30,000 members), Union of American Physicians and Dentists (20,000 members), and National Federation of Licensed Practical Nurses (10,000 members). A few other unions with general memberships have organized large numbers of health care employees. The United Food and Commercial Workers has 70,000 health care members, the American Federation of State, County, and Municipal Employees has 45,000 health care members, the American Federation of Teachers has 40,000 health care members, and the International Brotherhood of Teamsters has 35,000 health care members.

To date, most hospital-sector bargaining involved occupationally homogeneous bargaining units. Evidence shows that units consisting of homogeneous occupations are more likely to be organized and win elections than are units of employment in any State or Territory in which such execution or application is prohibited by State or Territorial law." Thus, while § 7 provides that an employee has a right to refrain from union membership, it effectively means that she may be compelled to pay union dues, where the union has negotiated a dues-payment provision in the collective bargaining agreement (on the theory that the employee should pay for services and benefits derived from union representation, and such a provision is often called a fair-share provision); however, under § 14(b), states are empowered to negate this arrangement, and the practical effect of this power is to make an employee's payment of union dues completely voluntary. In such a situation, it is common that a certain number of employees do not pay dues, but still derive the benefits of union representation—hence the term "free-rider."

70. See BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, supra note 24, at 8.

71. See Bureau of National Affairs, Hospital Organizing Accelerates, 45 UNION LAB. REP. 137 (May 9, 1991).

72. BUREAU OF NATIONAL AFFAIRS, DIRECTORY OF U.S. LABOR ORGANIZATIONS 47 (1990). We use the more general term "health care industry" here because an unspecified portion of this union's membership works outside hospitals (e.g., in nursing homes), and because we were unable to locate data concerning the precise number of union members working in hospitals.

73. See id. at 47-50.

74. See Bureau of National Affairs, supra note 71, at 137. These membership totals do not separate hospital employees from health care employees. The National Union of Hospital and Health Care Employees had 58,000 members in 1986, but this union was formally merged with the Service Employees International Union and American Federation of State, County, and Municipal Employees on June 1, 1989. See id.
consisting of heterogeneous occupations. As of 1988, there were 1024 local unions affiliated with the AFL-CIO that represented non-professional acute-care hospital workers in the United States. Of these, 920 were homogeneous groupings, and 104 were heterogeneous groupings. Consistent with these data, 363 out of 367 American Nurses Association local unions were all-RN units (the other four were so-called all-professional units). In unionized hospitals, the general experience is that unions strike infrequently, much less than in other industries. The California affiliate of the American Nurses Association, for example, has a policy of forsaking strikes in favor of binding arbitration and rarely has failed to reach a contract settlement with employers. Unlike unions in other industries, health care unions have rarely engaged in sympathy strikes. Contrary to the hospital industry’s argument that multiple, small bargaining units increase strike frequency, strikes have been more frequent in larger rather than smaller units. There is evidence that collective bargaining in hospitals has raised hospital costs without raising worker productivity. However, hospital unionization has contributed relatively little to the overall increase in hospital expenditures.


77. See id.

78. The Board reported evidence it adduced pertaining to the frequency of strikes in the health care industry. Data initially compiled by the Federal Mediation and Conciliation Service (FMCS) shows that strikes occurred in only 3.3% of all contract negotiations, including negotiations for nurses. The National Union of Hospital and Health Care Employees (NUHHCE) reported that since 1975 it had negotiated over 1000 contracts with hospitals, and only 43 involved strikes. The Board also reported data showing that the Service and Employees International Union (SEIU) has negotiated over 2700 contracts for hospital employees since 1938, and since that time has had a strike incidence rate of 1.4% per contracts negotiated. The International Union of Operating Engineers (IUOE) represents almost 300 hospital bargaining units, and has had only 25 strikes. Collective-Bargaining Units in the Health Care Industry, 53 Fed. Reg. 33,900, 33,908-9 (1988) (to be codified at 29 C.F.R. pt. 103) (proposed Sept. 1, 1988). For a study on the characteristics of hospital employees who strike, see Robert B. McKersie & Montagne Brown, Nonprofessional Health Workers and a Union Organizing Drive, 77 Q. J. Econ. 372 (1963).


80. See id.

81. See id. at 33,909.

82. See infra note 328.

83. Data from 1984-1987 show that only 16.4% of hospital contracts affected large units (300 or more employees), and yet these contracts were involved in 45.5% of all strikes in the period. The majority of all contracts (51.5%) affected small units (100 or fewer employees), yet these contracts were involved in only 17.7% of all strikes. See Collective-Bargaining Units in the Health Care Industry, 53 Fed. Reg. 33,900, 33,908 (1988) (to be codified at 29 C.F.R. pt. 103) (proposed Sept. 1, 1988).

B. Employment Characteristics of Pre-Designated Bargaining Units

The Board's rules specify eight groups of hospital employees. This section provides a brief overview of the labor markets and employment characteristics of these groups.

1. Nurses

Today the nursing profession is large but suffers from a severe labor shortage. In 1989 there were 371,358 staff nurses in the U.S., 1626 nurse practitioners, 3461 nurse anesthetists, 4925 clinical specialists, 32,777 head nurses, and 11,758 nurse supervisors. The average 1989 weekly salary was $555 for staff nurses, $715 for nurse practitioners, $922 for nurse anesthetists, $708 for clinical nurses, $688 for head nurses, and $715 for nurse supervisors. The average hourly wage for staff nurses in 1989 was $14.50.

Nursing requires specialized training and certification. Nurses perform remarkably uniform functions and services throughout the country. Interaction among nurses in the workplace is high, while interactions between nurses and other hospital employees, including physicians, is relatively low. While some nurses work in multidisciplinary teams containing several classes of professionals and nonprofessionals, this appears to be an industry exception.
and "[b]ecause of licensure limitations, cross-training does not take place between RNs and other employees."93

Nurses have been organized as a separate profession since 1897. In the context of collective bargaining, they have for many years sought separate representation.94 From time to time, however, they have had to accept representation in a broader group to avoid having no representation or paying exorbitant legal expenses to achieve independent representation.95 Where nurses have been included in multi-occupation or multi-professional units, they have not been well-accepted in these groups.96

The collective bargaining interests of nurses, then, are different from the collective bargaining interests of other health care professionals. Nurses have raised collective bargaining issues concerning floating shifts, understaffed shifts, mandatory overtime, and double-shifts.97 A 1990 survey of 1304 nurses reveals the scheduling problem that confronts them: 26% of the respondents reported that on average they work overtime more than once a week, and 86% reported that patient care suffers when nurses work overtime.98 The survey reported that nurses are dissatisfied in general with their employment: only 7% responded that they are treated with the professional respect they deserve, and only 29% were mostly or very satisfied with their work.99

In response, academic studies have proposed or reported scheduling innovations for nurses.100 Some hospitals have formulated special compensation

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93. Id.
94. See id.
95. See id. Testimony at rulemaking hearings revealed that even where nurses were part of a broader unit (i.e., multi-professional or multi-occupational), "the [organizing] campaigns were led by nurses, issues prompting organization were nurses’ issues, and the bargaining was performed by nurses, often with no participation by other hospital professionals." Id.
96. The Board observed, based on much testimony: "OTher professionals often do not participate in the organizing campaigns and are hostile to being included in bargaining units with RNs." Id. at 33,914. The Board further observed: "The main concern of the non-nursing professionals is of being overwhelmed by the large number of nurses and not having their concerns given priority. RNs are the largest professional group in any hospital. . . . They constitute approximately 23% of the hospital workforce." Id.
97. See id. at 33,915.
98. Bureau of National Affairs, DAILY LAB. REP., May 18, 1990, at A6 (reporting a national survey conducted by the Federation of Nurses and Health Professionals).
99. See id. See also Community Hosp., supra note 13, at 608, where a newspaper had published the following, written by a nurse:

I resent your labeling the local nursing salary situation a pay gripe. It is a hard fact in every local nurse’s life . . . I find dedication will not feed my family; enthusiasm will not pay the house note. Concern will not build a bank account for old age nor help with my children’s college education. Love will not provide me with a car, or gas to run it. Former patients will not provide my family’s clothing.

100. See JAMES L. PRICE & CHARLES W. MUELLER, PROFESSIONAL TURNOVER: THE CASE OF NURSES (1981); Charlotte Anzalone, Planned Supplemental Staffing is a Practical Alternative, 55 HOSPITALS 70 (1981); Norma Chaska et al., A Joint Effort to Mediate the ‘Outside Source’ Staffing Dilemma, 10 J. NURSING ADMIN. 13 (1980); Teddy Langford & Patricia A. Prescott, Hospitals and Supplemental Nursing
plans and other policies to attract nurses for evening and midnight shifts. Many collective bargaining agreements address these issues in ways that could not be replicated for other health care professionals. In responding to a severe nationwide nursing shortage, some employers who negotiate with nurses' organizations proposed mid-term contract reopenings only for nurses to raise general wages or to set new weekend pay-rates. An American Nurses Association survey shows that 57% of its contracts contain "alternative scheduling" provisions, and 98% contain shift bonuses for evening and night shifts.

In general, nurses and other health care employees have reached agreements with their employers without striking. In fact, for eighteen years, the American Nurses Association had a policy against striking, and even now its California chapter offers binding interest arbitration as a substitute for striking. Relatively few strikes were lengthy or involved large numbers of nurses.

Evidence shows that because their labor market is distinct from other labor markets, unionized nurses have not benefitted from wage-leapfrogging. This term refers to contract settlements in which compensation increases are based implicitly or explicitly on comparisons with settlements reached by other bargaining units that bargained earlier with their employers. However, there is some contrary evidence that suggests in the absence of unions, hospitals have entered into informal agreements among themselves to limit employee wage gains. As to the specific impact of collective bargaining on nurses' wages

102. See id.
103. See id. at 33,916 (noting that "hospitals are trying innovative proposals for nurses: opening contracts for them alone; raising wages; setting weekend differentials").
104. Id. at 33,915. Bureau of Labor Statistics [hereinafter BLS] data show that 98% of all hospitals pay shift differentials. For example, 71.3% of these hospitals computed the differential rate for third-shift nurses in flat dollars and cents per hour, while 21.5% pay the differential as a percentage of an individual's hourly rate (2.8% had another method for paying the differential). 20.5% of straight-rate paying hospitals paid $2.00 or more per hour premium pay to third shift nurses; 19.6% of percentage-rate paying hospitals paid a premium of 10% or more of an individual's base pay. See id.
105. See id. The Board cited FMCS data showing that among all health care employees, including nurses, the average incidence of strikes was 3.3% of negotiated contracts, and between 1984 and 1987, the rate averaged 1.5%. See id.
106. See id.
107. See id. For example, a nurses' strike in Ashtabula, Ohio lasted 572 days. One strike in Minneapolis-St. Paul, Minnesota involved 6,000 nurses in a multi-employer unit. See id.
108. Id. at 33,912 ("The record evidence based on actual experience shows that wage-leapfrogging has not occurred in the hospital industry.") The Board also found that special limitations in Medicare and Medicaid reimbursement policies which prevent passing-through spiraling wages have diminished the possibility of wage-leapfrogging. See id.
and benefits, there is anecdotal evidence that union representation has helped nurses earn better wages.\textsuperscript{110}

2. Physicians

For many years, the physician supply relative to demand was low, resulting in high physician incomes. One observer attributed this to the American Medical Association's cartelization of physicians through extremely restrictive medical school accreditation standards and state licensing procedures.\textsuperscript{111} Regardless of the explanation for the scarcity of physicians, the result has been high rates of return on physicians' educational investments.\textsuperscript{112}

Starting in 1970, the physician to population ratio in the U.S. began to increase sharply,\textsuperscript{113} and more recently, there has been conflicting evidence as to whether physician incomes are rising or falling. The increase in the supply of physicians was due to an increase in the number of accredited medical schools and in the number of medical graduates.\textsuperscript{114} As a result, some evidence shows that the high returns on medical education previously enjoyed by physicians have eroded. One recent estimate pegs the decline in real physician income between 19\% and 45\%.\textsuperscript{115} A sufficient drop in physician income would suggest some potential for an increase in physician unionization. However, two recent studies suggest that even though the supply of physicians is continuing to rise in the 1990s, physicians' net income is also rising.\textsuperscript{116}

\textsuperscript{110} For example, the New York Nurses Association reached agreement in April 1990 with five hospitals in Queens and Brooklyn that increased the top annual base pay for nurses with 25 years of experience to $53,625. Starting annual salaries, which under the expired contract ranged from $30,000 to $31,000, improved sharply to between $35,000 and $37,000 under the new agreement. See Bureau of National Affairs, DAILY LAB. REP., April 6, 1990, at A11.


\textsuperscript{112} See MILTON FRIEDMAN & SIMON KUZNETS, INCOME FROM INDEPENDENT PROFESSIONAL PRACTICE (1945); H.G. LEWIS, UNIONISM AND RELATIVE WAGE RATES IN THE UNITED STATES 290 (1963); Frank A. Sloan, Lifetime Earnings and Physicians Choice of Specialty, 24 INDUS. & LAB. REL. REV. 47, 49 (1976).

\textsuperscript{113} See Monica Noether, The Growing Supply of Physicians: Has the Market Grown More Competitive? 4 J. LAB. ECON. 503, 506 (1986). In 1960 there were 1.4 physicians per 1000 U.S. residents; in 1970 there were approximately 1.45 physicians per 1000 population; and in 1980, there were over 1.80 physicians per 1000 population. See id.

\textsuperscript{114} See id. at 505. Noether reported that the number of medical schools rose from 87 in 1963 to 126 in 1980, and the number of graduates rose from 7264 to 15,135. See id.

\textsuperscript{115} See id. at 529. Noether estimates that since 1965, the number of practicing physicians has increased between 25,000 and 101,000, and that physician income, measured in 1972 adjusted dollars, has fallen between $3500 and $30,400. See id.

\textsuperscript{116} Recent research shows that in Quebec, Canada, where there are stringent price controls on physician service prices, physician costs rose nonetheless because the supply of physicians increased. Extrapolating from these data, researchers Kevin Grumbach and Philip R. Lee concluded: "The rapid expansion of physician supply in this decade will intensify the conflict between payers attempting to hold down the ceiling on expenditures . . . and physicians attempting to maintain their incomes." Ron Winslow,
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Apart from whether physician incomes are rising or falling, two legal factors inhibit physician unionization. Some states, such as Texas, prohibit by statute any employment arrangement making a physician an employee. In addition, many physicians work as independent contractors for hospitals, and therefore are not eligible for collective bargaining under the Wagner Act.

In adjudicated unit determination cases involving physicians, the Board consistently found that physicians comprise a separate unit. In rulemaking, the Board found that physicians should constitute a separate unit because they have few, if any, employment interests in common with nurses or other professional employees. Physicians have their own community of interests: they have advanced training, high earnings, and are self-supervising.

In some cases physicians have been placed in all-professional bargaining units in the past, but these arrangements have proven to be unworkable. The Board found little or no evidence that a separate unit for physicians would lead to repetitive bargaining, frequent strikes, or jurisdictional disputes. Also, the Board downplayed the possibility that most hospitals would have physician units by noting that many physicians work as independent contractors for hospitals.

In its interim rulemaking the Board devoted more attention to nurses and physicians than to other occupational groups, perhaps because the Board

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Rising Supply of Doctors May Be Bad Medicine for Health Costs, WALL ST. J., May 8, 1991, at B1. Another study reported by the Wall Street Journal, conducted by John Hughes, provides data showing that classic supply and demand relationships may not apply to the supply of physicians and costs for their services. One reason may be that as physicians see their patient loads diminish, they perform more services and order more tests per patient. Hughes cited data showing that physician costs rose 69% in Canada between 1975 and 1987, after adjusting for inflation, and physician use of medical services increased 46% in the same period. See id.


119. The lead case on this issue is Ohio Valley Hosp. Ass'n, 230 N.L.R.B. 604 (1977). However, in Cedars-Sinai Medical Ctr., 223 N.L.R.B. 251 (1976), the Board ruled that interns and residents are not employees for purposes of the Act.


121. See id. Physicians have baccalaureate degrees, a medical degree that reflects four years of classroom training, and two to six year post-graduate internships under the direction of experienced physicians. See id.

122. See id.

123. See id.

124. See id. The Board recounted the experience of all-professional bargaining units including doctors, nurses, pharmacists, and others, in Florida. For example, employers wanted to raise doctor salaries to attract more doctors, but found that the local union insisted on pay raises for all other professional employees as well. See id.

125. See id.

received more data and information pertaining to these two groups. Still, the Board analyzed the employment characteristics of the other pre-designated bargaining groups. The shorter treatment of these groups in this Article generally reflects the Board’s shorter treatment.

3. Other Professionals

A group of professional employees other than nurses and physicians work in hospitals. In its rulemaking, the Board counted social workers, lab technologists, and pharmacists among this group. The Board recognized that if these professionals were grouped with either physicians or nurses, their interests would be “overwhelmed.” Consequently, the Board created a separate unit for these employees, but decided against further subdividing this group to avoid the unit proliferation problem envisioned by Congress.

In 1989, hospitals employed 5326 occupational therapists (whose average weekly pay was $549); 17,677 pharmacists (whose average weekly pay was $743); 1997 speech pathologists (whose average weekly pay was $556); 10,338 medical social workers (whose average weekly pay was $523). Also, hospitals employed 5673 dieticians.

4. Technical Employees

Hospitals employ a large cadre of specially trained technical employees including lab assistants, respiratory therapists, X-ray technicians, emergency medicine personnel, and medical records transcribers. In its rulemaking, the Board also included LPNs (licensed practical nurses) in this category. The Board reasoned that these employees “perform jobs involving the use of

127. See Collective-Bargaining Units in the Health Care Industry, supra note 117, at 33,918.
128. Id.
129. See id. “Despite the desire expressed by some other professionals for their own separate units it seems clear to us that to provide for such additional units might create the proliferation which Congress meant to avoid.” Id.
130. BUREAU OF LABOR STATISTICS, U.S. DEP’T OF LABOR, supra note 24, at 10.
131. See id. at 9.
independent judgment and specialized training, as opposed to service and maintenance employees who generally perform unskilled tasks and need only a high school education.” The Board further distinguished this group from service and maintenance employees by noting that these employees provide direct patient care. Frequently, these employees require specialized training and certification. The Board also noted that technical employees have greater earnings than service and maintenance employees. Furthermore, the Board noted that these employees are usually under separate supervision and are rarely cross-trained to perform other functions.

The Board observed that there was nothing novel about its decision to create a separate unit for technical employees. Among the 588 hospitals with at least one AFL-CIO-affiliated union, 311 hospitals had a separate unit for technical employees, while only 52 had combined technical and other non-professional employees. Technical employees have distinct employment interests including training, schedule rotation, and certification requirements.

In 1989 hospitals employed 39,724 medical machine operators (whose average weekly pay was $431); 3971 diagnostic medical sonographers (whose average weekly pay was $501); and 2001 EEG technicians (whose average weekly pay was $387). Also, hospitals employed 24,882 X-ray technicians.

5. Skilled Maintenance

Initially, the Board considered a general maintenance classification consisting of service, maintenance, and clerical employees but decided to carve

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136. These employees provide routine clinical tests, respiratory therapy, x-rays, ultrasounds, and CAT scans, for example. See id.
137. See id.
138. The Board found that technical employees average over $2,000 more in yearly wages than service and maintenance employees. See id.
139. See id. at 33,919 ("There is no temporary interchange, and little permanent interchange between technical employees and other non-professionals . . . . ")
142. See id. at 33,920.
143. BUREAU OF LABOR STATISTICS, U.S. DEP’T OF LABOR, supra note 24, at 9.
144. See id. at 10.
out a unit for skilled maintenance employees because "[e]vidence from the rule-
making hearings shows that skilled maintenance employees perform functions
apart from those of unskilled . . . employees." In particular, the Board
noted work performed by skilled maintenance employees such as maintenance
and repair of a hospital's power plant and of its heating, air conditioning,
refrigeration, electrical and plumbing systems. The Board further noted that
skilled maintenance employees frequently require specialized vocational training
and, in some instances, certification. The Board cited 1985 Department of
Labor data indicating a wide wage differential between skilled and unskilled
hospital maintenance employees. The Board noted that this group of employ-
ees had a competitive external labor market for its services, raising the possibil-
ity of "highly mobile cross-industrial career paths as the operation and mainte-
nance of physical plant systems are the same no matter in which industry they
are performed." Finally, the Board found that a separate unit for skilled
maintenance employees would not result in unit proliferation because of the
distinct character of this group, and that this unit determination would not
increase the likelihood of strikes or wage-leapfrogging. The hospital industry
opposed a skilled maintenance unit on the grounds that "skilled maintenance
frequently constitutes less than 2 percent of the workforce."

skilled and unskilled maintenance employees together because it believed maintenance skill levels applied
to a narrow range of jobs, that skilled and unskilled employees frequently interact on the job, and that this
broader grouping would avoid unit proliferation.

147. See id.
148. See id. at 33,921.
149. Id.
150. See id. at 33,922-23. The Board's data showed that strikes among this group were infrequent. For
example, among the 237 skilled maintenance units represented by the IUOE, there have been only 25 strikes
ever. Also, the Board found that sympathy strikes among this group were virtually non-existent. The Board
also noted that since wage rates for this group were generally based on the wages of skilled maintenance
workers in other industries, rather than on the wages of other health care industry employees, the group
posed little threat of wage-leapfrogging to employers. See id.

Prior to the rulemaking, the Board on numerous occasions recognized separate units for maintenance
employees, and in all these cases, appellate courts denied enforcement of the Board's order. See Mary
Thompson Hosp., 241 N.L.R.B. 766 (1979) (certifying unit of licensed stationary engineers), enforcement
denied, 621 F.2d 858 (7th Cir. 1980); Allegheny Gen. Hosp., 239 N.L.R.B. 872 (1978) (certifying unit of
maintenance employees), enforcement denied, 608 F.2d 965 (3d Cir. 1980); Mercy Hosp. Ass'n, 238
N.L.R.B. 1018 (1978) (certifying unit of maintenance and engineering employees); enforcement denied, 606
F.2d 22 (2d Cir. 1979), cert. denied, 445 U.S. 971 (1980); Long Island College Hosp., 228 N.L.R.B. 83
(1977) (certifying unit of maintenance and engineering employees), enforcement denied, 566 F.2d 833 (2d
Cir. 1977), cert. denied, 435 U.S. 996 (1978); West Suburban Hosp., 224 N.L.R.B. 1349 (1976) (certifying
unit of maintenance employees), enforcement denied, 570 F.2d 213 (7th Cir. 1978); Memorial Hosp., 220
N.L.R.B. 402 (1975) (certifying unit of maintenance employees), enforcement denied, 545 F.2d 351 (3d
Cir. 1976).

be codified at 29 C.F.R. § 103). The Board dismissed this argument by observing that "[w]here the entire
workforce is very small, we believe that even smaller sub-groups will seldom want separate units; nor will
unions be likely to organize such small units." Id.
6. **Business Office Clericals**

In its rulemaking, the Board found that the job duties of hospital clerical employees differ substantially from the duties of other employees. Typically, business office clerical employees “are primarily responsible for a hospital’s financial and billing practices . . . and deal with Medicare, DRGs, varying price schedules, multiplicity of insurance types, and new reimbursement systems.” Also, the Board found that “[i]ncreasing computerization of financial management has led to specialization and has reduced the clerical duties of other hospital employees.” The educational requirements of business office clerical employees are higher than those for service and maintenance workers, and business office clericals are increasingly exposed to more specialized training such as “programming, coding, abstracting, and billing . . .” According to a 1985 wage survey cited by the Board, business office clericals earned an average of $2,000 more than service workers, underscoring the distinctive nature of their work.

The Board found that business office functions are often centralized and limited to a business office under the control of the hospital’s general management. The Board determined that it is common for business office clericals to be isolated physically from other work groups. Consistent with the general data concerning the lack of occupational mobility for business office clericals, the Board observed that “[b]usiness office clericals have few avenues of advancement within health care facilities; rather, they have a separate and increasingly well-defined external labor market.”

Clerical employees comprise a sizeable segment of a hospital’s workforce. In 1989, there were 54,063 unit secretaries (with average weekly pay of $303); 21,150 admitting clerks (with average weekly pay of $298); 13,689 medical transcriptionists (with average weekly pay of $342); 2944 payroll clerks

153. Id.
154. Id.
155. See id. Business office clericals typically are required to have a high school diploma and some demonstrated office skills. A majority of these workers are overqualified relative to typical entrance requirements and possess some college education. Service workers, in contrast, are not required to have advanced education and prior work experience. See id.
156. Id.
157. See id. at 33,925.
158. See id.
159. See id.
160. Id.
(with average weekly pay of $343); and 10,816 switchboard operators (with average weekly pay of $294).162

Special employment issues have arisen in the external labor market for clerical jobs. For example, environments for clerical employees (hospital workers and others) pose unique health and safety risks: eye strain from concentrated work on screen-based technology, muscular strain from long periods of sedentary work, potential pregnancy risks, and general stress.163 Additional work-related issues include compensation and employee evaluation, reductions in force, retraining,164 and job satisfaction in highly routinized work.165 We briefly survey these issues because they may be amenable to resolution through the collective bargaining process.

The Board focused some of its attention on the disproportionate percentages of women employed in certain jobs, including business office clerical positions. While this phenomenon is not confined to hospitals, it is especially evident there. This phenomenon raises the concern that firms tend to create implicit male and female employment tracks.166 Commentators have observed that “[i]n the particular case of female non-manual employment, it is difficult to avoid the conclusion that ‘rewardable’ (or ‘promotable’) characteristics are constructed in a manner that systemically exclude women.”167 While collective bargaining is not a panacea for the problems entailed in sex-stratified employment, it may provide a vehicle for addressing some of these problems.

7. Other Non-Professional Employees

In 1989, hospitals employed 42,574 food service helpers (with average weekly pay of $259), 89,094 janitors and cleaners (with average weekly pay of $266), and 11,220 laundry workers (with average weekly pay of $274).168

162. See id. at 11. A large group not counted in the BLS survey is billing clerical workers, who are distinguishable from the payroll clerks included in the survey.
164. See id. at 91-92.
165. See HARRY BRAVERMAN, LABOR AND MONOPOLY CAPITAL (1974). Braverman argues that the work of office clericals are tasks stripped of creativity, involve ever less skill as a result of technology gains, and reflect the application of “Taylorism” to office functions. He concludes that the skilled “all-around clerical worker” is being reduced to a “subdivided detail worker.” Id. at 315.
166. See ROSEMARY CROMPTON & GARETH JONES, WHITE-COLLAR PROLETARIAT: DESKILLING AND GENDER IN CLERICAL WORK 137 (1984) (empirical study of bank employment finding that 82% of the working women surveyed were employed in clerical grades, while only 30% of the men surveyed were employed in the same grades).
167. Id. at 145. The pervasive nature of this phenomenon is reflected in a 1980 Department of Labor survey of occupations that found that women comprised 90.1% of all billing clerks; 86.6% of all file clerks; 74.9% of all office machine operators, 97.2% of all receptionists, and 100% of all medical secretaries. Julianne M. Malveaux, Moving Forward, Standing Still: Women in White Collar Jobs, in WOMEN IN THE WORKPLACE 109 (Phyllis Wallace ed., 1982).
168. BUREAU OF LABOR STATISTICS, U.S. DEP’T OF LABOR, supra note 24, at 11.
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Collective bargaining for service employees can greatly enhance their compensation and working conditions.\textsuperscript{169} The Board devoted little discussion or analysis to this group, noting simply: "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 . . . shall, therefore, constitute a separate appropriate unit, where requested."\textsuperscript{170}

8. **Guards**

The Taft-Hartley Act made the collective bargaining representation of guards completely independent from the representation of all other employees.\textsuperscript{171} Congress isolated guards "to insure to an employer that during strikes or labor unrest among his other employees, he would have a core of plant-protection employees who could enforce the employer's rules for the protection of his property and persons thereon without being confronted with a division of loyalty between the employer and dissatisfied fellow union members."\textsuperscript{172} Consequently, the Board had no choice but to create a separate unit for hospital guards, despite the Congressional directive to limit the number of units.\textsuperscript{173} The Board has also applied the separate guard unit provision to security employees who perform non-security functions, such as maintenance.\textsuperscript{174}

\textsuperscript{169} After threatening to strike, approximately 1000 service employees working in 16 nursing homes won a 40% pay raise over a three year period in a collective bargaining agreement ratified on January 25, 1990. Even with the large wage gain, the average annual wage for a service worker was projected to be only $14,500 by the end of the contract, when wage rates would peak. The union contended that notwithstanding the impressive wage gains won, their members would still be "forced to live on incomes far below the poverty level" of $18,000 for a family of four. For the first time, these workers won the right to have every other weekend off. Bureau of National Affairs, \textit{DAILY LAB. REP.}, Jan. 29, 1990, at A5-6.


\textsuperscript{171} Section 9(b)(3) prevents the mixing of guards and non-guards in the same bargaining unit. It does so by preventing guards from being included in units consisting of other employees (the Board shall not include in any unit "any individual employed as a guard to enforce against employees and other persons rules to protect property of the employer or to protect the safety of persons on the employer's premises." Labor Management Relations (Taft-Hartley) Act, § 9 (b)(3), 29 U.S.C. § 159 (b)(3) (1988)). Section 9(b)(3) also limits the membership of any labor organization that represents guards to only guards (the Board is prevented from certifying any labor organization as the representative of a guard unit "if such organization admits to membership, or is affiliated directly or indirectly with an organization which admits to membership employees other than guards."). \textit{Id.}


\textsuperscript{174} See A.W. Schlesinger Geriatric Ctr., Inc., 267 N.L.R.B. 1363 (1983) (finding that employees who split time between maintenance and security duties were guards under the Act).
III. Bargaining Unit Determinations

In this Part we consider what the size and number of bargaining units imply for employees voting for union representation and for effective collective bargaining. We then examine how Congress legislated particular restrictions in 1974 on health care bargaining units, including hospitals.

A. Theories of Bargaining Unit Size

Union and management differ as to how the Board should determine bargaining units. Generally, unions favor smaller, more homogeneous units to maximize the similarity of employee interests within the unit. In the abstract, unions might prefer large units because they add members and resources, and can inflict more harm to an employer during a strike than a small unit. In reality, however, the size and structure of a unit affects election outcomes, and recent literature suggests that unions win a higher proportion of representation elections involving smaller units. In addition, a large unit may only be a successful striking unit if there is a union shop contract (compelling union membership as a condition for employment, and thereby making everyone in the unit a union member). In addition, large units may be particularly susceptible to employer tactics such as granting employment preferences to a group of strikers who abandon their strike and return to work (for example, low seniority strikers who may be granted highly-prized domiciles or shifts left vacant by more senior strikers).

In contrast, management prefers larger units. Management seeks administrative efficiency and prefers to conduct business with one entity rather than many. Management also wants to increase the diversity of interests among

175. A classic illustration of this point is presented in St. Francis Hosp. and Electrical Workers, IBEW, Local 474, 265 N.L.R.B. 1025 (St. Francis I). The union sought to represent 39 highly skilled maintenance employees, but the hospital argued that the appropriate bargaining unit should be a combined maintenance and service unit. The hospital employed approximately 400 service employees whose jobs generally required low-level skills. In contrast, the maintenance unit included boiler operators (whose job required a minimum of four years of boiler experience); painter/vinyl hangers (whose job required five years of experience); carpenters and cabinetmakers (whose job required four years of experience); and plumbers and electricians (whose jobs required two to three years of experience). By enlarging the unit, the hospital hoped to create such diversity of interests that no union would win election. See also Note, The National Labor Relations Board's Proposed Rules on Health Care Bargaining Units, 76 Va. L. Rev. 115, 117-18, 121-28 (1990).

176. See American Hosp. Ass'n v. NLRB, 899 F.2d 651, 654 (7th Cir. 1990), noting: "[T]he larger and more heterogeneous the unit is, the harder it will be for the members to agree on a common course of action. The diversity of . . . the interests of the members of a large and heterogeneous unit will make collective action more difficult, so it will be hard for a union to gain majority support . . . or to use it to bargain effectively (for example, by making a credible threat to strike)."

177. See Delaney & Sockell, supra note 75, at 271; Delaney, supra note 75, at 159.

employees, to build potential cleavages in the unit, and to increase a union’s cost of organizing the unit.

Bargaining unit determinations are especially difficult in the hospital industry “because the work force of a hospital (or nursing home or rehabilitation center) tends to be at once small and heterogeneous.”

A hospital’s workforce may include “physicians, registered nurses . . . nurses’ aides, lab technicians, orderlies, physical therapists, dieticians, cooks, guards, clerical workers, maintenance workers, and others—but often only a few of each.” Thus it is conceivable that “even a hospital of average size might have ten or twenty or even more units,” if units were drawn to be strictly homogeneous. Unit proliferation in the health care industry raises many concerns, including an increase in work stoppages, thus imperiling patient care; whipsaw between units, leading to wage-leapfrogging and inflation; and an unacceptably high increase in employer administration expenses.

Section 9(b) of the Act gives the Board the authority to determine appropriate bargaining units. In addition, it specifies that professional employees and guards must be granted separate bargaining units. The Act gives the Board flexibility in making other unit determinations, stating that the primary consideration should be to facilitate employee organization. However, the Board also takes other interests into account in making bargaining unit determinations, such as the employer’s ability to administer efficiently one or more collective bargaining agreements. The Board’s judgment in making unit

180. Id.
181. Id.
183. See infra note 324 and accompanying text.
186. 29 U.S.C. § 159(b).
187. See id. at § 159(b)(1).
188. The statute states: “The Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by [the Act], the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof . . . .” Id. at § 159(b).
189. In its proposed rulemaking, the Board noted: “Some unions question the relevance of costs in determining hospital bargaining units. In view of Congressional concern in the health care amendments with the ability of health care institutions to deliver uninterrupted health services, it is relevant to consider whether multiple units increase costs to health care institutions . . . .” Collective-Bargaining Units in the
determinations has been widely litigated, regardless of industry and union, and the Supreme Court has consistently upheld the Board’s discretionary authority to make unit determinations.

B. Bargaining Units in the Health Care Industry

Public policy concerning collective bargaining rights of hospital employees is best understood in a historical context. The Wagner Act was passed in 1935 to facilitate worker organization. Unionization increased sharply between 1935 and 1947. In 1947, the Wagner Act was amended by the Taft-Hartley Act, which was designed to counter-balance the power and growth unions enjoyed under the Wagner Act. The Wagner Act made no specific provision for the health care industry; the Taft-Hartley Act, however, exempted nonprofit hospitals from its coverage. In 1974, Congress amended the Act to include all private health care institutions, both proprietary and nonprofit.

Health Care Industry, 53 Fed. Reg. 33,900, 33,909 (1988) (to be codified at 29 C.F.R. pt. 103) (proposed Sept. 1, 1988). Although the Board was prepared to consider employer administrative expenses arising out of collective bargaining, the Board concluded: “There was no empirical or specific evidence showing comparative labor costs in hospitals with different numbers of units.” Id. The Board also observed: “The industry contends that small hospitals are particularly vulnerable to increased costs and cannot afford the money and staff resources needed for dealing with multiple units. However, we were not provided with empirical data for comparison. We note also that few health care facilities have more than two or three units.” Id. at 33,910.

190. See, e.g., Continental Web Press, Inc. v. NLRB, 742 F.2d 1087, 1090 (7th Cir. 1984); NLRB v. Res-Care, Inc., 705 F.2d 1146, 1468-1471 (7th Cir. 1983).


192. See ARCHIBALD COX ET AL., LABOR LAW 85 (1991), observing that “the Wagner Act of 1935 established on a permanent foundation the legally protected right of employees to organize and bargain collectively through representatives of their own choosing.”

193. Id. at 84, noting: “In 1933 less than 3,000,000 workers were members of trade unions. Early in the 1940’s 12,000,000 workers were organized.”

194. “By 1947 the labor movement had achieved great power. . . . The public was worried about the power of unions. . . . In 1947 there were many who saw the danger of nationwide [work] stoppages as a threat to the social system.” Id. at 93. “In analyzing the background of the Taft-Hartley Act one must also give a prominent place to anti-unionism.” Id. at 94.

195. All private hospitals were originally subject to the Wagner Act. Section 2(3) of the Act excluded from the definition of employer “the United States or any wholly owned Government corporation . . . or any State or political subdivision . . . .” COX ET AL., noted that “the most significant group of excluded employers are public employers—federal, state, county, and municipal governments. Their exclusion results in the lack of protection under the Labor Act for some 17% of the nonagricultural workforce.” Id. at 100. It should be noted, however, that many public employees not covered by the Act may be covered by special public sector collective bargaining laws, both at the federal and state or local government levels.

196. The Taft-Hartley Act amended the Wagner Act by exempting private nonprofit hospitals. For a brief time in the 1960s, the Board specifically excluded private proprietary hospitals from its jurisdiction. See Flatbush Gen. Hosp., 126 N.L.R.B. 144 (1960) (finding that such hospitals generated insufficient interstate commerce to be included in the Board’s jurisdiction). The Board reversed this position in Butte Medical Properties, 168 N.L.R.B. 266 (1967) (exercising jurisdiction over private proprietary hospitals with gross annual revenues of at least $250,000).

In so doing, Congress recognized that the health care industry differed from ordinary industry since work stoppages would affect people in need of immediate and perhaps life-saving care.\textsuperscript{198} As a result, Congress provided the public additional protection against the potentially health-threatening consequences of health care strikes and work interruptions. It passed a statutory amendment that provided for mandatory federal mediation and required a longer period of strike notice than for other industries.\textsuperscript{199} A second protection was expressed in a committee report, admonishing the Board to give consideration to preventing proliferation of bargaining units in the health care industry.\textsuperscript{200} Although this second protection does not have the force of statutory law, the Board has always considered its bargaining unit determinations for the health care industry to be subject to this admonition (including its unit determination rulemaking).

Congress was concerned with bargaining unit proliferation in the health care industry because multiple units could wage-whipsaw employers (that is, the units could try to leapfrog each other's gains) and embroil employers in jurisdictional work disputes.\textsuperscript{201} Congress considered but did not accept a statutory proposal by Senator Robert Taft to limit the number of bargaining units in a nonprofit health care institution to five units.\textsuperscript{202} This might suggest that Congress intended the Board to make bargaining unit determinations for the health care industry through its ordinary unit determination procedures, with additional criteria to avoid unit proliferation.

Section 9 of the Act sets forth the manner in which bargaining unit determinations are made. "Unit determinations must assure to employees the fullest freedom in exercising the rights guaranteed by . . . [the Act]."\textsuperscript{203} The result of the Board's interpretation of this language is that unit determinations can

\textsuperscript{198} See also St. Vincent’s Hosp. v. N.L.R.B., 567 F.2d 588, 590 (3rd Cir. 1977) (noting Congressional committees' view of health care strikes as more serious than industrial strikes).


\textsuperscript{200} The legislative history of the 1974 amendments to the Act contains the following language, distinguishing the Board’s treatment of bargaining units for hospitals from other industries:

Due consideration should be given by the Board to preventing proliferation of bargaining units in the health care industry. In this connection, the committee notes with approval the recent Board decisions in Four Seasons Nursing Center, 208 N.L.R.B. No. 50, 85 L.R.R.M. 1093 (1974) and Woodland Park Hospital, 205 N.L.R.B. No. 144, 84 L.R.R.M. 1075 (1973), as well as the trend toward broader units enunciated in Extendicare of West Virginia, 203 N.L.R.B. No. 170, 83 L.R.R.M. 1242 (1973).


\textsuperscript{202} S. 2292, 93d Cong., 1st Sess. (1973), \textit{reprinted in LEGIS. HIST., supra note 200, at 457-58}.

\textsuperscript{203} 29 U.S.C. § 159(b) (1973).
enhance or frustrate the prospects for electing union representation and, in the long run, influence whether a unit will be cohesive or fractious. The Board cannot use "the extent to which employees have organized" as the controlling criterion for certifying election petitions.

Section 9 also dictates that "[t]he Board shall decide in each case whether . . . the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof." Hospital employers viewed the "in each case" language as requiring individually adjudicated unit determinations in cases where an employer and a union cannot agree on an appropriate bargaining unit, as opposed to units pre-determined by a rule. The Board thus has the power to choose between employer, craft, or plant units, reflecting the very different patterns of organizing a workforce by competing labor federations, namely the American Federation of Labor and the Congress of Industrial Organizations, in the 1930s. As to the "in each case" proviso, the legislative history is bare, leaving little guidance to reviewing courts.

Although the Act provides the Board with some guidance, the Board had to develop its own appropriate bargaining unit standards. The Board has consistently used employee "community of interest," which includes similarity of wages and hours, extent of common supervision, extent of workplace contact between employees, and industry or area patterns of bargaining as its stan-

204. Small units are more conducive to effective organization than large units since small groups of people are theoretically more likely than large groups to have common interests and, consequently, are more likely to bargain effectively.
207. In oral argument before the Supreme Court, the Hospital Association's attorney, James D. Holzhauer, claimed that "the Board ignored the requirement of Section 9(b) of the Act that the 'Board shall decide [the appropriate bargaining unit] in each case.'" Bureau of National Affairs, DAILY LAB. REP., Feb. 26, 1991, at A5.
208. Judge Richard Posner observed:

At the time the Wagner Act was passed, there was an enormous diversity of bargaining units, in major part reflecting the different characters of the two major labor federations, the AFL and the CIO-the former a federation of craft unions, the latter of plant unions. If the Board had ruled that all bargaining units should be craft units or that all should be plant units, it would have altered the balance of power between the federations dramatically.

American Hosp. Ass'n. v. NLRB, 899 F.2d at 656 (7th Cir. 1990).
209. The House Reports provide what little guidance exists: 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 impartial governmental agency, the Board, to make that determination." H.R. REP. No. 972, 74th Cong., 1st Sess. 20 (1935); H.R. REP. No. 1147, 74th Cong., 1st Sess. 22 (1935).
210. Judge Posner found this history unrevealing: "[A]ll this appears to mean is that unit determination is a task meant for the Board rather than for either the Congress or the employees themselves." American Hosp. Ass'n. 899 F.2d at 656.
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dard. Using the "community of interest" test, the Board has found five general types of units before its rulemaking: registered nurses, other professionals, technical employees, service and maintenance employees, and business office clericals.

IV. The Board's First Rulemaking

In this Part, we examine how the Board undertook the first formal rulemaking in its history. We then explore how it modified its proposed and interim rules. Finally, we discuss the Board's rule in its final form. In particular, we consider how the Board supported a rule that creates a fairly large number of pre-designated bargaining units and applies to only a segment, albeit an important one, of the health care industry.

A. The Rulemaking Process and Eight Pre-Designated Hospital Bargaining Units

In its fifty-two year history, the Board rarely engaged in rulemaking. Unlike other federal agencies, it established virtually all of its doctrines through adjudication. In general, the Board, like other administrative agencies, has discretion to regulate by means of rulemaking or adjudication. Many of the factors considered relevant in an adjudication may also be considered relevant in a rulemaking. Since its establishment in 1935, the Board has had rulemaking authority under Section 6 of the Act. However, the Board's nonuse

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211. See Morris, supra note 10, at 416-17.
213. The Board established by formal rulemaking that a private, non-profit college or university would be subject to its jurisdiction if the institution's gross annual revenue exceeded $1 million. See Morris, supra note 10, at 1631, citing NLRB RULES AND REGULATIONS AND STATEMENTS OF PROCEDURE, SERIES 8 (as last amended, Jan. 8, 1976), § 103.1 (1976). The Board also asserted jurisdiction through formal rulemaking over certain symphony orchestras, see id. at § 103.2, but refused to extend jurisdiction over the horse-racing and dog-racing industries. See id. at § 103.3.
214. See Morris, supra note 10, at 1628.
216. In this instance the Board observed: "Although under rulemaking we shall attempt to avoid the doctrinal formulation utilized under adjudication, many of the factors we consider will be similar." Collective-Bargaining Units in the Health Care Industry, 53 Fed. Reg. 33,900, 33,905 (1988) (to be codified at 29 C.F.R. pt. 103) (proposed Sept. 1, 1988). These factors included uniqueness of function, training, education, licensing, wages, hours and working conditions, supervision, employee interaction, and, where relevant, bargaining history.
217. Section 6 states: "The Board shall have authority from time to time to make, amend, and rescind, in the manner prescribed by the Administrative Procedure Act, such rules and regulations as may be necessary to carry out the provisions of [the National Labor Relations Act]." 29 U.S.C. § 156 (1988).
of its rulemaking authority prompted some commentators to question whether that authority had atrophied.\textsuperscript{218}

The Board published its first Notice of Proposed Rulemaking on July 2, 1987, stating that it sought empirical evidence to make an informed judgment as to what types of units should be found to be appropriate in the health care industry.\textsuperscript{219} It first proposed that in acute care units with more than 100 beds, six units would be appropriate.\textsuperscript{220} Initially it proposed that four units would be appropriate for nursing homes and smaller hospitals.\textsuperscript{221} The Board then held hearings in Washington, D.C., Chicago, and San Francisco, in order to collect rulemaking evidence.\textsuperscript{222}

The Board issued its Second Notice of Proposed Rulemaking on September 1, 1988.\textsuperscript{223} The revised proposed rule dropped the distinction between large and small hospitals and exempted nursing homes and psychiatric institutions from the rule's coverage.\textsuperscript{224} The Board divided the single proposed unit consisting of service, maintenance, and clerical employees into separate units comprised of skilled maintenance, business office clericals, and service and other non-professional employees.\textsuperscript{225}

The Board published its Final Rule on April 21, 1989.\textsuperscript{226} The rule designated eight potential bargaining units for acute care hospitals: (1) all registered nurses, (2) all physicians, (3) all professionals except registered nurses and physicians, (4) all technical employees, (5) all skilled maintenance employees, (6) all business office clerical employees, (7) all guards, and (8) all other non-professional employees.\textsuperscript{227} The rule provided an exception from the predesignated units in "extraordinary circumstances," which would include a unit


\textsuperscript{220} See id. at 25,149. The proposed units were registered nurses; physicians; technical employees; service, maintenance, and clerical employees, except guards; and guards.

\textsuperscript{221} These units were professional employees; technical employees; all service, maintenance and clerical employees except guards; and guards.


\textsuperscript{223} See id.

\textsuperscript{224} See id. at 33,927-30.

\textsuperscript{225} See id. at 33,920-27.

\textsuperscript{226} 29 C.F.R. § 103.30 (1991)

\textsuperscript{227} See id. at § 103.30(a).
of five or fewer employees. In the case of petitions for additional units in hospitals with "non-conforming units," the rule required the Board to find appropriate units for the petitioning employees "which comport, insofar as practicable, with the appropriate units set forth in paragraph (a) of this section." The Board defined "hospital" in the same manner in which the Medicare Act defines that term. In addition, it made the rule applicable to acute care hospitals only. The rule exempted nursing homes, psychiatric hospitals, and rehabilitation hospitals. In explaining why it had engaged in rulemaking for the first time in its history, the Board noted that "one important advantage of rulemaking is the certainty it offers." The Board observed that "facilities and employee functions in hospitals and other health care institutions of approximately the same size and type are virtually identical," and concluded that the new rule would "go along way" towards eliminating redundant litigation. It left some room for single-case consideration of a special unit in the event of an "extraordinary circumstance." In providing this exception, it stated its intent to construe "extraordinary circumstances" narrowly so as "not to provide an excuse, opportunity, or loophole for redundant or unnecessary litigation." To bolster this intention, the Board also enumerated certain grounds that would not be considered as a basis for applying the exception.
A party seeking an exceptional unit is provided a hearing for that special purpose. 239

B. The Board Justifies Its New Rule

While engaged in its rulemaking, the Board received thousands of comments, 1500 of which came in the last comment period alone. 240 Most of those comments were from hospitals, but the majority of the hospitals' comments were written as form letters and contained little useful information. 241 Hospital industry comments raised numerous objections to the proposed rule. 242

The Board claimed that its rulemaking would end the waste and futility of making hospital bargaining unit determinations by adjudication. It reasoned that in scores of contested unit determination cases, it had reached almost perfectly consistent results; thus, the outcome of adjudicated cases had become a foregone conclusion: "[F]rom 1975 to 1984, despite lengthy adjudicatory proceedings the Board found RN units appropriate in 24 out of 25 published cases; technical units appropriate in 18 out of 18 cases; business office clerical units appropriate in 8 out of 8 cases." 243 In addition, the Board supported its rulemaking on cost-saving grounds: "[T]he increased predictability which institution's workforce over several buildings. See id.

239. Collective-Bargaining Units in the Health Care Industry, 54 Fed. Reg. 16,336 (1989) (to be codified at 29 C.F.R. § 103). A party is entitled to a hearing before an administrative officer or one of the Board's regional directors. The Board may also be petitioned to rule on a petition for an exceptional unit. In addition, the rule provides for judicial review where the petition for an exceptional unit is denied. While this procedure provides due process, it also seems to open a way for employers to forestall unionization. See id.

240. See id.

241. In the final comment round, the Board received only 30 comments supporting its rule and 1465 comments opposing it. However, the Board put little weight on the volume of comments received. Units of large hospital chains sent in one form letter per unit. Although most of the comments came from the hospital industry, the Board found that the canned nature of these comments "contain[ed] brief arguments without supporting detail." Id.

242. In brief, the industry argued that the rule: (1) unfairly singled out the health care industry; (2) violated the Act's § 9(b) requirement of case-by-case unit determination (i.e., no pre-designated units); (3) violated Board precedent; (4) proliferated units, against congressional admonition; (5) should have established only professional and non-professional units; (6) would enhance union organizing; (7) increased the likelihood of strikes, jurisdictional disputes, and other disruptions to health care; (8) would raise health care costs by allowing unions to wage-whipsaw hospitals; (9) would limit hospitals in flexibly managing their workforces; (10) ignored changes in the industry; (11) inappropriately established units for RNs and skilled maintenance employees; (12) would increase litigation; (13) unfairly failed to distinguish between small rural hospitals and large urban hospitals; (14) failed to account for evidence adduced during the rulemaking; (15) should be replaced by a special Board panel that would make unit determinations; (16) unfairly limited an employer's response time during a union organizing campaign; (17) did not sufficiently provide for exceptional cases. See Collective-Bargaining Units in the Health Care Industry, 54 Fed. Reg. 16,336, 16,336-37 (1989) (to be codified at 29 C.F.R. § 103).

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rulemaking will bring to the process of determining bargaining units will . . . result in cost savings not only for the Board but also for health care institutions as well as for employee organizations.”

In response to hospital claims that multiple units would increase their costs, the Board found that “[t]here was no empirical or specific evidence showing comparative labor costs in hospitals with differing numbers of units.” Also, responding to the hospital industry’s concern that the rule would result in unions coordinating their bargaining to the disadvantage of hospitals, the Board concluded that there was little evidence of such coordinated bargaining among existing units.

The Board reached the important conclusion that “the record fails to demonstrate that finding a limited number of occupationally-homogeneous units to be appropriate would inhibit functional integration on the job, increase strikes, jurisdictional disputes, or wage whipsawing, or substantially increase costs to industry or to workers.” It concluded: “[w]e believe that finding only two broad units appropriate would unduly hamper organizing and effective bargaining, and would not carry out Congress’ intent in the health care industry.”

The Board reasoned that its rulemaking would curtail unit-determination litigation while still permitting employers complete flexibility to restructure jobs and occupations. By the Board’s reasoning, its rule did not constitute unit proliferation.

244. Id.
245. Id. at 33,909. The industry also argued that small hospitals would be especially affected by large negotiation and contract administration costs, but the Board concluded that “we were not provided with empirical data for comparison.” Id. at 33,910.
246. See id. at 33,911. In fact, the Board found that in New York City, a large health care employee local union had moved away from city-wide bargaining to address issues specially concerning each hospital. See id.
247. Id. In issuing its final rule, the Board reported that several hospitals submitted comments discussing their experiences with strike costs. For example, O’Bleness Memorial Hospital reportedly spent over $40,000 on strike security and legal fees, Pottsville Hospital spent $20,000 in legal fees and Wadley Hospital reported that a strike in 1978 cost up to $1 million. Collective-Bargaining Units in the Health Care Industry, 54 Fed. Reg. 16,336, 16,339 (1989) (to be codified at 29 C.F.R. § 103). The Board concluded that “the costs of the small number of strikes mentioned do not seem disproportionate to what we believe Congress must have anticipated when it authorized collective bargaining in the health industry by placing it under the Board’s jurisdiction in 1974.” Id.
249. “[T]he Board anticipates that rulemaking will ultimately result in less, rather than more, litigation about the boundaries of appropriate units.” Id. at 33,904.
250. See id. Employers had argued that the pre-designated units would actually tie their hands in redefining jobs and occupations. The Board responded: “Health care providers remain as free as they ever were to respond to external events except . . . as limited by the constraints of any collective-bargaining obligations that may result from unionization . . . .” Id.
251. The Board noted: “[T]he evidence taken during the rulemaking proceeding has convinced the Board, contrary to its earlier belief, that eight possible units . . . should be found appropriate in acute care hospitals. In reaching this conclusion, the Board has carefully considered the Congressional admonition against proliferation. . . . The Board has examined the units found appropriate to ensure they are not so numerous as to create a never-ending round of bargaining sessions, and that each unit represents truly distinctive interests and concerns . . . .” Id. at 33,933.
The Board tried to minimize the novelty of its first formal rulemaking by noting that it “has long made use of ‘rules’ of general applicability to determine appropriate units. . . .”252 At the same time, it noted that the Supreme Court long ago endorsed the principle that “the Board may articulate the basis of its order by reference to other decisions or its general policies laid down in its rules . . . reflecting its ‘cumulative experience’ . . . .”253 The Board rejected the industry’s argument that section 9(b) of the Act requires case-by-case unit determination through adjudication. In doing so, it cited Heckler v. Campbell,254 in which the Court upheld the Department of Health and Human Services’ rulemaking that replaced adjudicated, case-by-case disposition of disability claims with a formula for making initial disability determinations.255

V. Judicial Review of the Board’s Rulemaking

We begin this Part by briefly examining the appellate process for the Board’s bargaining unit determinations. We note that the process is sufficiently time-consuming to encourage some hospitals to contest unit determinations for the sole purpose of frustrating organizing efforts. We also note that even though appellate courts purport to apply a deferential standard of review in unit determination appeals, their review has in reality seemed less than deferential. We show that over a period of years, appellate courts have divided sharply in their treatment of particular unit determinations. We then explain why a federal district court enjoined the Board’s rule before it became effective. Finally, we analyze the Seventh Circuit’s and Supreme Court’s reasoning in upholding the rule.

252. Collective-Bargaining Units in the Health Care Industry, 54 Fed. Reg. 16,336, 16,338 (1989) (to be codified at 29 C.F.R. § 103). The Board then cited four unit determination rules it had made through its case-by-case methodology: “(1) single facility units are presumptively appropriate (citation omitted); (2) . . . residual units are not separately appropriate when sought by an incumbent (citation omitted); (3) . . . plant clericals and office clericals do not constitute an appropriate unit absent an agreement of the parties (citation omitted); (4) . . . the appropriate unit in decertification elections is the certified or recognized unit.” Id.

253. Id. (quoting NLRB v. Metro. Life Ins. Co., 380 U.S. 438, 444 n.6 (1965)).


255. The Heckler Court concluded:

It is true that the statutory scheme contemplates that disability hearings will be individualized determinations based on evidence adduced at a hearing. . . . But this does not bar the Secretary from relying on rulemaking to resolve certain classes of issues. The Court has recognized that even where an agency’s enabling statute expressly requires it to hold a hearing, the agency may rely on its rulemaking authority to determine issues that do not require case-by-case consideration.

Heckler, 461 U.S. at 467.
A. The Appellate Process: Thwarting Unionization by Delay?

Delay in holding representation elections benefits employers. The problem of delay has been compounded by judicial review of Board orders. Most of the Board’s rulings and actions are reviewable first in the circuit courts of appeal and subsequently in the U.S. Supreme Court. Delay in holding representation elections benefits employers. The problem of delay has been compounded by judicial review of Board orders. Most of the Board’s rulings and actions are reviewable first in the circuit courts of appeal and subsequently in the U.S. Supreme Court. Evidence suggests that the overload resulted from more aggressive and hostile management practices directed at unions, which unions challenged by filing unfair labor practice charges. In a separate but related vein, one commentator who studied employer incentives for complying with the Act concluded: “The Board’s remedial awards appear to have little influence on behavior, and the analysis confirms the meager incentives for employer compliance in the absence of stronger remedies.”

The combination of weak remedial Board orders, case backlog at the Board, and lengthy judicial review of Board orders may have encouraged some hospitals to resist unionization by simply exhausting all available Board and court appeals.

Federal courts of appeal have purported to apply a deferential standard in reviewing Board unit determinations. Nevertheless, they have overturned a large number of these determinations. The Board responded to numerous

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256. Section 10(e) of the Act provides: “The Board shall have power to petition any court of appeals of the United States... for the enforcement of [its] order...” The Board has no inherent authority to execute its orders, and a party subject to a Board order may fail to comply with such an order without incurring any additional penalty. See Morris, supra note 10, at 1695.

257. For example, in February 1984, a record 1674 cases were pending before the Board. By July 1, 1986, the number of cases dropped below 1000, and by July 1988 the backlog dropped to 707 cases. The Board considers 400-600 cases an appropriate backlog. See Bureau of National Affairs, DAILY LAB. REP., July 28, 1989, at A4.

258. See PAUL C. WEILER, GOVERNING THE WORKPLACE 40 (1990). Weiler notes that employers benefit under the Act by breaking the law:

[When the employer uses the crudest tactic of all, firing union supporters in the midst of a representation campaign, the legal response is picayune. If the employer chooses to contest the case up until the first legally enforceable order is issued, that order will not be forthcoming for about a thousand days. . . . At the same time, the monetary penalty faced by the employer for depriving any union supporters of their job is an award of no more than the net back pay lost by the fired employee. . . . Small wonder, then, that the incidence of such illegal firings has spiraled from under 1,000 a year in the late fifties to over 10,000 in the mid-eighties.]


260. See NLRB v. Res-Care, Inc., 705 F.2d 1461 (7th Cir. 1983).

court reversals of hospital unit determinations in *St. Francis Hospital* [hereinafter *St. Francis I]*\(^\text{262}\) by establishing a two-tier unit determination test.\(^\text{263}\) Without resorting to rulemaking, the Board identified seven potentially appropriate units.\(^\text{264}\) It then determined whether a community of interest existed within each unit.\(^\text{265}\) A unit that did not fit into a pre-designated group would be considered only in extraordinary circumstances.\(^\text{266}\)

The hospital in *St. Francis I* refused to bargain with the unit that the Board certified. Consequently, the Board in *St. Francis Hosp.* [hereinafter *St. Francis II]*\(^\text{267}\) adopted a "disparity of interest" test, which was intended to take into account the congressional admonition to avoid undue unit proliferation.\(^\text{268}\) The new test would lead to approval of a unit when there existed "sharper than usual differences (or 'disparities') between the wages, hours, and working conditions, etc., of the requested employees and those in an overall professional or nonprofessional unit."\(^\text{269}\) The Board viewed this new approach as a more flexible means of responding to the "diverse nature of today's health care industry"\(^\text{270}\) and as a truer reflection of "Congress' intent that the Board be free to exercise flexibility in dealing with unit determinations on a case-by-case basis."\(^\text{271}\) The D.C. Circuit refused to enforce the Board's *St. Francis II* unit determination and remanded the case to the Board for further consideration.\(^\text{272}\) The Board, perhaps tired of the endless second-guessing of its standards and unit determinations, went forward with its first rulemaking exercise.\(^\text{273}\)

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\(^{262}\) St. Vincent's Hosp. v. NLRB, 567 F.2d 588 (3d Cir. 1977).

\(^{263}\) 265 N.L.R.B. 1025 (1982).

\(^{264}\) See id. at 1029.

\(^{265}\) See id. at 1029.

\(^{266}\) See id. at 1029.

\(^{267}\) The units consisted of physicians, registered nurses, other professional employees, business office clerical employees, technical employees, service and maintenance employees, and skilled maintenance employees.

\(^{268}\) See id. at 953.

\(^{269}\) Id.


\(^{271}\) See id. at 953 n.39.

\(^{272}\) Id. at 951 n.17.

B. Judicial Review of the Rule

In *American Hospital Association v. NLRB,* the American Hospital Association sought to enjoin the Board’s Final Rule the day the rule was published. The Board responded by challenging the district court’s jurisdiction to hear the Association’s complaint. The court denied the Board’s motion to dismiss and permanently enjoined the Board from using the rule. While recognizing that Congress granted the Board broad discretion to make unit determinations under section 9 of the Act, the court stated, “[w]e will not, however, sustain a use of this discretion if it is based on the Board’s erroneous understanding of the statute.” The Association argued that section 9(b) requires case-by-case, or adjudicated, unit determination: “The Board shall decide in each case whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this subchapter the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision . . . .” Thus, any rule that pre-designates bargaining units contravenes section 9(b).

In response the Board argued that “because the text of the statute offers no determinative guidance, [the court is] obligated to give deference to an agency interpretation which is based on a permissible construction of the statute.” The court “refuse[d] the Board’s invitation to defer to their interpretation of 9(b).” In doing so, it supported its review by stating that “the words of the statute do not lend a definitive answer with respect to the scope of the NLRB’s rule-making authority under 9(b).” It also found that the Board’s rulemaking constituted a change in policy which amounted to “vacillation.”

The court accepted the Association’s view that the Board’s rulemaking for the hospital industry was inconsistent with congressional intent. It noted that

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276. In balancing the potential for injury to hospitals, the court cited “the destruction of peace and the creation of turmoil in management/employee relationships” if the rule were not enjoined. 131 L.R.R.M. at 2754. As to the harm caused unions and employees seeking organization, the court stated “[t]he only harm . . . is the loss of 60 or 90 or 120 days of organizing time . . . . That is a harm that should not be made light. . . . But it is not in my view particularly significant. . . .” Id.
278. Id. at 710.
279. Id. (emphasis added).
280. See id.
281. Id. at 711.
282. Id.
283. Id.
284. “Prior to the Rule, for over fifty years, the Board’s policy was to make bargaining unit determinations through administrative review of each petition. . . . When, as here, an administrative agency vacillates in its interpretation of an authorizing statute, its interpretation is entitled to little deference.” Id. at n.12.
“the explanation in the House Report, a persuasive indicia of Congressional intent, provides compelling support that Congress contemplated that unit determinations would require fact specific inquiries,” and concluded that the Board’s argument failed to take any account of the “in each case” language of section 9(b). The court limited its holding to overturning this rulemaking for unit determination in the hospital industry and accepted the Association’s argument that the rule would violate the congressional admonition against unit proliferation. It ultimately concluded that “the appropriate remedy is to permanently enjoin the NLRB’s Final Rule . . .”

The Board appealed in American Hospital Association v. NLRB, and the Court of Appeals vacated the District Court’s injunction in a decision written by Judge Richard Posner. Unlike the District Court, the Court of Appeals was unpersuaded that the “in each case” language of section 9(b) deprived the Board of authority to make bargaining unit determinations by rulemaking. Finding the legislative history of section 9(b) “scanty,” it reasoned:

Since three sections earlier in the [Act], in a provision . . . enacted at the same time as section 9(b), Congress had granted the Board explicit rulemaking power, it is probable . . . 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 rulemaking power.

It continued:

Since there is no reason why Congress might have wanted to carve out unit determinations from the grant of rulemaking power in section 6 and no indication beyond the ambiguous semantics of the word “case” that it did not want to do this, we conclude that unit determination is not excepted from the Board’s power under that section.

285. Id. at 712.
286. “If we were to accept the Board’s construction, the words ‘in each case’ become superfluous in the context of § 9(b).” Id.
287. The court observed “this case presents a far narrower issue: the extent of the Board’s rulemaking under 9(b) in the context of the health care industry.” Id. at 713.
288. See id. at 716.
289. Id.
290. 899 F.2d 651 (7th Cir. 1990).
291. Id. at 656.
292. Id.
293. Id.
In addition, the Court of Appeals rejected the Association's argument that the rule violated the congressional admonition against unit proliferation, and it noted that the Association essentially lost its legislative battle sixteen years earlier.\(^2\) The Health Care Amendments Act of 1974 was passed without including the Association's proposal to limit health care bargaining units by statute to a small number which, if successful, would have discouraged the formation of potentially large units with conflicting interests. Judge Posner dismissed the significance of language in the congressional committee report on the Amendments which expressed the view that the number of health care bargaining units should be small:

Congress legislates by passing bills and sending them to the President for his signature. It does not legislate by issuing committee reports. . . . [T]he fact that the hospital industry would have dearly loved to amend the unit-determination provision and yet failed to do so must give us pause in treating the 'admonition' as if it were a statute, which anyway it plainly is not. To treat it as one would give the hospital industry something it tried and failed to win from Congress.\(^2\)\(^9\)\(^5\)

Thus, Judge Posner blocked the Association's attempt to rescue the legislative battle it lost in 1974. Considering what Congress meant to prohibit in the way of unit proliferation, Judge Posner recounted that, "[T]he cases cited in the admonition were ones in which the Board had rejected minuscule or arbitrary units of specialized nonprofessional employees."\(^2\)\(^9\)\(^6\)

Judge Posner disposed of the Association's third and final argument that the Rule is arbitrary and capricious by castigating the Association for failing to articulate a more rational alternative\(^2\)\(^9\)\(^7\) and for its grudging and unresponsive participation in the rulemaking process. He concluded, "it is not for us to fine-tune the regulatory process by telling the Labor Board that its rule should make slightly more distinctions than it does, or slightly fewer."\(^2\)\(^9\)\(^8\)

The Association appealed, and in American Hospital Association v. \(NLRB,\)\(^2\)\(^9\)\(^9\) the U.S. Supreme Court affirmed the decision of the Court of

\(^{294}\) See id. at 656-57.
\(^{295}\) Id. at 657-58 (citations omitted).
\(^{296}\) Id. at 658.
\(^{297}\) "[I]t would impress us more if the industry had proposed an alternative that recognized the diversity of the industry but preserved the virtues of the rule; the only alternative it proposed is a rule that would state a rebuttable presumption that the three statutorily separate units are appropriate. Such a rule is no rule." Id. at 659. Judge Posner's conclusion is insightful; in effect, all that the industry proposed were units for guards and professional employees--who were already required by the Act to be in separate units--and a completely inclusive unit for everyone else.
\(^{298}\) Id. at 660.
Appeals. It held that Section 9(b) does not limit the Board’s rulemaking authority under Section 6 of the Act. It also found that the rule does not violate the congressional admonition against unit proliferation and is neither arbitrary nor capricious.

Responding to the Association’s view that the “in each case” language of Section 9(b) required unit determination by adjudication, the Court found that, “[t]he more natural reading of these three words is simply to indicate that whenever there is a disagreement about the appropriateness of a unit, the Board shall resolve the dispute.”\(^3\) The Court did not conclude that Section 9(b) limited such dispute resolution to case-by-case adjudication: “The requirement that the Board exercise its discretion in every disputed case cannot fairly or logically be read to command the Board to exercise standardless discretion in each case.”\(^3\)

The Court also found that the legislative history of Section 9(b) is too limited to support the Association’s view that the “in each case” language requires unit determination by adjudication:

The sparse legislative history of the provision affords [the Association] no assistance. . . . If this amendment had been intended to place the important limitation on the scope of the Board’s rulemaking powers that [the Association] suggests, we would expect to find some expression of that intent in the legislative history . . . .\(^3\)

The Court next considered the Association’s view that the rule is invalid because it would lead to unit proliferation. It concluded that when Congress admonished the Board to avoid unit proliferation in the health care industry, Congress imposed no requirement against a fixed number of pre-determined units, but rather commanded the Board to give “due consideration” to the problem of unit proliferation in fashioning its unit determinations.\(^3\) It then concluded that based on its examination of the record, the Board “gave extensive consideration to this very issue.”\(^3\)

\(^3\)Id. at 1542.
\(^3\)Id. at 1543. The Court approvingly cited KENNETH CULP DAVIS, ADMINISTRATIVE LAW TEXT 145 (3d ed. 1972):

[The mandate to decide 'in each case' does not prevent the Board from supplanting the original discretionary chaos with some degree of order, and the principle instruments for regularizing the system of deciding 'in each case' are classifications, rules, principles, and precedents. Sensible men could not refuse to use such instruments and a sensible Congress would not expect them to.]

\(^3\)Id. at 1544.
\(^3\)Id. at 1545.
\(^3\)Id.
The Court finally dismissed the Association’s argument that the rule is arbitrary and capricious, ignoring, “critical differences among the 4,000 acute-care hospitals in the United States, including differences in size, location, operations, and workforce organization.” It found that the rule was sufficiently grounded in the Board’s extensive rulemaking record and its previous experience of determining health care units by adjudication:

Given the extensive notice and comment rulemaking conducted by the Board, its careful analysis of the comments that it received, and its well-reasoned justification for the new rule, we would not be troubled even if there were inconsistencies between the current rule and prior NLRB pronouncements.306

The Court stated that “[t]he Board’s conclusion that, absent extraordinary circumstances, ‘acute care hospitals do not differ in substantial, significant ways relating to the appropriateness of units,’ was based on a ‘reasoned analysis’ of an extensive record.”

The Supreme Court ended its decision by remarking, “[i]n this opinion, we have deliberately avoided any extended comment on the wisdom of the rule, [and] the propriety of the specific unit determinations . . . .”308 This statement leaves open for analysis broader policy issues such as the effects of bargaining unit determinations on the outcomes of industrial relations, including strikes, wage settlements, and wage spillover or leapfrogging. We designed our survey to analyze empirically the actual impact of the Board’s rulemaking.

VI. Survey Sample, Public Policy Questions, Results and Conclusions

In this Part we explain the characteristics of our sample and how the sample was derived. We then pose several research questions to guide our public policy analysis. In particular, we ask whether the rule creates new types of units that did not occur through bargaining unit adjudication and whether multiple units are associated with leapfrogging effects, jurisdictional disputes, and strikes. Based on our data, we conclude that the rule generally does not create units that were not also created by unit-adjudication; that the order in which a unit bargains is not associated with higher wage settlements; that hospitals with multiple bargaining units have somewhat higher wage rates and more jurisdictional disputes but fewer jurisdictional work stoppages, compared to hospitals

305. Id. at 1546.
306. Id.
307. Id.
308. Id. at 1547.
with fewer units; and that hospitals with multiple units experience an average of one strike every nine years.

A. Sample and Data Characteristics

In 1988 we mailed surveys to 1184 hospitals randomly selected from the 3982 general medical-surgical hospitals under the Board's jurisdiction. The survey was completed and returned by 491 (41.5%) of these hospitals. We surveyed an additional 182 hospitals not in the original random sample. Hospitals were chosen for the non-random sample based on Board election reports, union records, and other sources in order to get information from hospitals with more than one bargaining unit. The survey was completed and returned by 83 (45.6%) of these hospitals. The two samples include 574 hospitals out of 1366 hospitals surveyed for a total response rate of 42.0%.

We tested our sample for response bias which might arise from the possibility that the characteristics of hospitals responding to our survey differed from the general population of hospitals. We found that the geographic distribution, number of beds, managerial structure and union status of surveyed hospitals resembled the population. While it is possible that the responding hospitals differed from the population in other unmeasured characteristics, we are reasonably confident that this sample is free of response bias.

We chose the non-random sample because, prior to our survey, there were no comprehensive data on the prevalence of multiple unit hospitals. Although we expected some multiple unit hospitals to respond to our randomly distributed survey, we added the non-random sample of hospitals to ensure that we collected data for multiple unit hospitals. Ultimately, we combined the random and non-random samples because our analyses did not require that they be separated for meaningful results.

We collected wage data for employees in six typical hospital occupations: registered nurses, licensed practical nurses, pharmacists, food service helpers, X-ray technicians, and stationary engineers. Questions also pertained to the number of jurisdictional or work assignment disputes during the preceding year and the number of work stoppages at the hospital since 1980. We asked hospitals with unions about the number of bargaining units, the composition of those units, the name of the union or unions representing hospital employees, the number of contracts signed since 1980, and data on current contracts.

309. The population is defined by the American Hospital Association’s annual survey of affiliated hospitals, which comprised 98.7% of the 4036 general medical-surgical hospitals in the nation.
310. We asked for the straight-time maximum hourly wage rates for these employees.
311. The questionnaire defined such disputes as “employees objecting to assigned tasks” on the basis that it is outside the scope of their job or responsibility.
We supplemented the survey with additional information about each hospital, including data about each hospital's product and labor markets, and the number of hospital beds, managerial structure, patient mix, occupancy rate, and service mix for each responding hospital.

B. Public Policy Research Questions

This Part frames five questions regarding the possible consequences of the rule which we sought to address through survey data. Discussion of the results follows in the subsequent section.

(1) Will the bargaining unit rule create new types of units that did not exist under prior unit determinations? Table I and the accompanying discussion help to answer this question.

(2) Assuming that hospitals may have to bargain with up to eight separate units under the Board's unit rules, is there evidence that wage-settlements for units that bargain first during a cycle of contract negotiations have spillover effects on wage-settlements negotiated later in the bargaining cycle?

We ask question (2) because the hospital industry argued that as the number of units increases, hospitals would fall victim to wage-leapfrogging or an inflationary spillover effect. They argued that unions who bargain later rather than sooner use earlier settlements as a floor for their minimum settlement. Thus, a hospital negotiating with eight separate units might have an inflationary progression of contracts, with the first contract settled providing a 4.00% raise, the second contract settled providing a 4.25% raise, the third contract settled providing a 4.50% raise, and so forth. Worse, the cycle would repeat as the next round of negotiations opened, with the first union looking back to the eighth union's settlement of 6.00% as a floor for its demands.

In its rulemaking, the Board did not consider the research literature on wage-leapfrogging or spillover effects in market economies. Because this part of our public policy analysis relates to this literature, we briefly review important studies in this literature.

313. See AMERICAN HOSPITAL ASS'N, ANNUAL SURVEY OF HOSPITALS (1985).
Early studies suggested that spillovers ran from union to nonunion firms; in other words, wage settlements in unionized firms spilled over in the form of large raises in nonunion firms. However, later studies showed that spillovers can run "backwards," from nonunion to union firms. Other studies suggest that uncertainty over present and future inflation rates and retrospective experience with rising inflation raise expectations of wage increases. A recent study based on a wage survey of 300 U.S. hospitals found that "if a hospital paid relatively high wages to one occupation, it was likely to pay high wages to workers in other occupations as well." One commentator observed:

It is well known that there is a high degree of intercorrelation across groups . . . in wage change. However, since this intercorrelation could stem from many factors, including classical market forces, the observation that wage changes in Unit 2 tend to be associated with wage changes in Unit 1 does not confirm wage spillovers, imitation, interdependence, or pattern bargaining.

This commentator argues that so-called evidence of spillover effects are spurious because a statistical technique for isolating true spillover effects has not been applied.


317. See Flanagan, supra note 315; Johnson, supra note 315.


319. One school of thought holds that inflationary expectations are "backward looking." See Daniel J.B. Mitchell, How to Find Wage Spillovers (Where None Exist), 21 INDUS. & LAB. REL. REV. 134 (1990). This conclusion should not be confused with wage-leapfrogging, where a wage settlement for Unit 1 causes an incremental increase in wages for Unit 2. For example, the conclusions of Groshen and Krueger could be explained by a high cost of living in the area where the hospital employs people: all wages would be relatively high to account for the cost-of-living factor.

320. See id.
The public policy relevance of this more general economic literature is evident in the 1974 amendments to the Act. Senator Taft explained that "unwarranted unit fragmentation" would lead to wage-leapfrogging, which would cause patient care disruptions and higher health care costs. The hospital industry built on this policy concern by arguing that as the number of units increased, the wage-leapfrogging would result in inflationary spillover effects. Table 2 and its accompanying discussion help to explain whether a bargaining unit's position in the bargaining queue is related to a pattern of higher wage rate settlements.

(3) As the number of bargaining units increases, will hospitals' labor costs rise as well? Table 3 and its accompanying discussion address the hospital industry's argument that labor costs would increase proportionately.

(4) Does the number of work assignment disputes increase as bargaining units increase? The hospital industry argued that increases in the number of bargaining units in a given hospital would tend to increase the frequency of work assignment disputes, which in turn would degrade the quality of health care.

One episode best captured management's perspective of the work-assignment dispute argument. Nurses, nurses aides, and housekeeping employees all refused to clean feces of incontinent patients, as each group claimed that this was a job for one of the other employee groups. Table 4 and its accompanying discussion shed light on the effect of unit proliferation on the frequency of work assignment disputes and strikes.

(5) Will unit proliferation increase the frequency of strikes occurring with the negotiation of collective bargaining agreements?

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323. See LEGIS. HIST., supra note 200, at 113-14.
324. Wage-leapfrogging occurs when a union successfully uses a previously negotiated wage increase in another unit as a floor, not an acceptable goal, from which to bargain. Theoretically, wage-leapfrogging can create upward spiraling wages for multiple unit employers. In contrast, a pattern-setting strategy is characterized by each successively negotiating unit trying to match prior wage settlements.
325. See supra note 185.
326. See Collective-Bargaining Units in the Health Care Industry, 53 Fed. Reg. 33,900, 33,922 (1988) (to be codified at 29 C.F.R. pt. 103) (proposed Sept. 1, 1988). The Board rejected a main thrust of the industry's work jurisdiction argument: "In general, industry witnesses were unable to support the allegation that allowing separate skilled maintenance units would increase the number of jurisdictional disputes in the industry." Id.
327. MARTIN D. HANLON ET AL., ATTEMPTING WORK REFORM: THE CASE OF PARKSIDE HOSPITAL 35-36 (1985). The dispute was resolved by an arbitration decision which reestablished locational standards for this particular work assignment: if the feces were in the bed, the nurses did the work; if within six inches of the bed, the nurse's aides did the work; and the housekeepers cleaned anything beyond six inches. Imagine enforcing the standard in questionable instances! See id.
328. The Board recounted testimony by hospital industry witnesses: "Some witnesses' statements that multiple units lead to strikes... were, for the most part, general and speculative, and not supported by examples." Collective-Bargaining Units in the Health Care Industry, 53 Fed. Reg. 33,900, 33,908 (1988) (to be codified at 29 C.F.R. pt. 103) (proposed Sept. 1, 1988).
We relate this research question to a large volume of economic literature on strikes, part of which has focused on macro-level phenomena such as unemployment, inflation, and the business cycle,\textsuperscript{329} and part of which has focused on cross-sectional data involving industries, particular unions, regions or countries.\textsuperscript{330} Additionally, some recent studies have used aspects of the bargaining unit or collective bargaining agreement to analyze the incidence, severity, and length of strikes,\textsuperscript{331} while others have examined the public policy aspects of strikes.\textsuperscript{332} Table 5 and its accompanying discussion provide a basis for evaluating whether the number of bargaining units is related to strike activity.

C. Results and Conclusions

Table 1 presents the distribution of bargaining units reported in the survey. Hospitals reported thirteen types of units, not counting a small number of miscellaneous units categorized in Table 1 as “others.” Seven of the reported types of units corresponded precisely to the predesignated units under the Board’s rule: registered nurses, skilled maintenance, technicals, other professionals, service workers, business office clericals, and guards. Together, these units comprised 70.7% of all the units reported in the survey. When licensed practical nurses are included as technical employees, as the rule provides,\textsuperscript{333}


\textsuperscript{333} "Technical units generally encompass a wide range of classifications, including LPNs . . . ." Collective-Bargaining Units in the Health Care Industry, 53 \textit{Fed. Reg.} 33,900, 33,920 (1988) (to be codified
these seven units accounted for 79.1% of the units which existed before the rulemaking.

In a narrow sense, the new rule created some new types of units that did not already exist. For example, our data in Table 1 show that 5.2% of reported units were combined service and maintenance units. Under the new rule, those combination units would be divided into distinct service and maintenance units. In addition, 1.3% of reported units were mixed service and technical units. Under the new rule, these combination units would be separated into technical and nonprofessional units. Also, 3.4% of the units before implementation of the rule were combined professional and nonprofessional units. The rule would disaggregate the professionals component into physician and other professionals units. Finally, before implementation of the rule, 1.6% of units were “all professionals,” a designation that combined the physician and other professionals units designated by the rule. The rule would simply disaggregate these professional groups. Summing the foregoing percentages, 11.5% of the units determined before implementation of the rule were merely aggregated versions of discrete designations under the rule; these units are still embraced by the rule, but are simply disaggregated. We conclude, therefore, that the seven units created by rulemaking, excluding guards, which are required by statute to be a separate unit, will not vary much from the types of units that the Board determined through adjudications.

It should also be observed that our sample included no all-physician units. All-professional units, including combinations of physicians, psychologists, pharmacists, and others, accounted for only 1.6% of the reported units. The new rule would divide all-professional units. Physicians would have their own unit. Pharmacists, psychologists, and other professionals would have a small all-professional unit, now called “other professionals.” If our data in Table 1 reflect the experience of hospital professionals, newly created physician units and other professional units will not be a large proportion of all hospital units.

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Table 1

Relative Frequencies of Different Types of Hospital Bargaining Units

<table>
<thead>
<tr>
<th>Bargaining Unit</th>
<th>Frequency</th>
<th>% (Cumulative)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adjudicated Units</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>119</td>
<td>21.3% (21.3%)</td>
</tr>
<tr>
<td>Skilled Maintenance</td>
<td>85</td>
<td>15.2% (36.5%)</td>
</tr>
<tr>
<td>Technicals</td>
<td>74</td>
<td>13.3% (49.8%)</td>
</tr>
<tr>
<td>Other Professionals</td>
<td>56</td>
<td>10.0% (59.8%)</td>
</tr>
<tr>
<td>Service</td>
<td>36</td>
<td>6.4% (66.2%)</td>
</tr>
<tr>
<td><strong>Business Office Clericals</strong></td>
<td>13</td>
<td>2.3% (68.5%)</td>
</tr>
<tr>
<td>Guards</td>
<td>12</td>
<td>2.2% (70.7%)</td>
</tr>
</tbody>
</table>
The data in Table 2 provide a basis for testing the relationship between the number of bargaining units and wage-leapfrogging. The data strongly suggest that wage-leapfrogging does not occur as the number of bargaining units increases. The mean wage increase for any unit that was the first unit in its hospital to negotiate a contract in the most recent round of negotiations was 3.93%. There were 153 cases in which a second unit existed and negotiated a contract following another unit. The mean wage increase for the unit negotiating second in sequence was 4.01%, an increase amounting to less than one-tenth of one percentage point more than the first unit's wage increase. There were seventy-five contracts for units that were third in the sequence of bargaining. These units actually had a lower mean wage increase than either the first or
the second unit that negotiated. The mean wage increase dropped more than three-tenths of a percentage point between the second and third units in the bargaining sequence and by more than half a percentage point between the third and fourth units in the sequence.

The data on units queued second through fourth show no evidence of wage-leapfrogging. In fact, these data could support a hypothesis of reverse whipsawing (that is, employers may use a previously settled agreement to argue that the next group's wages should be lower than the preceding group's). The anomaly in this pattern occurred for the small number of fifth-in-line units. Only thirty-eight of these units were reported. These units enjoyed a 4.25% annual wage increase, a figure well above any of the earlier settled contracts. The upward movement in the size of the wage increase disappeared, however, for sixth-in-line and seventh-in-line units, which had mean wage increases of 3.47% and 3.00% respectively.

Using control variables (see explanatory note following Table 2), we obtained similar findings. The second-in-sequence unit had a higher mean wage increase than the first unit, but the third and fourth units had smaller increases than the first unit's. The fifth-in-line unit had a higher rate of increase than any of the previous units, but the sixth unit's average wage increase was less than the fifth unit's.

The important conclusion from Table 2 is that our data do not show any significant leapfrogging effect for multiple units with respect to their order of bargaining. This conclusion contradicts industry arguments concerning wage-leapfrogging and is consistent with the Board's findings that "[s]ome witnesses' statements that multiple units lead to . . . wage whipsawing were, for the most part, general and speculative, and not supported by examples"334 and that "[w]age whipsawing or leapfrogging virtually never occurs with skilled maintenance units inasmuch as the wages of skilled maintenance employees are generally based on the wages of skilled maintenance employees in other industries, rather than on the wages of other health care industry employees . . . ."335

335. Id. at 33,922-23. The Board also stated: "The fact that RNs are in a different labor market militates against leapfrogging . . . ." Id. at 33,912.
### Table 2

Percentage Annual Wage Increase in Current Contract, By Order of Negotiation

<table>
<thead>
<tr>
<th>Order of Negotiation</th>
<th>Mean Increase in Annual Wage (Uncontrolled) (Current Contract)*</th>
<th>Percentage Increase in Annual Wage (Controlled) (Current Contract)**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>3.93%</td>
<td>1.84%</td>
</tr>
<tr>
<td>2nd</td>
<td>4.01%</td>
<td>2.24%</td>
</tr>
<tr>
<td>3rd</td>
<td>3.69%</td>
<td>1.73%</td>
</tr>
<tr>
<td>4th</td>
<td>3.11%</td>
<td>1.17%</td>
</tr>
<tr>
<td>5th</td>
<td>4.25%</td>
<td>2.26%</td>
</tr>
<tr>
<td>6th</td>
<td>3.47%</td>
<td>2.11%</td>
</tr>
<tr>
<td>7th</td>
<td>3.00%</td>
<td>N.A.</td>
</tr>
</tbody>
</table>

* Mean wage increase, uncontrolled for other factors.

** Mean wage increase, controlling for the effects of: date the contract went into effect, presence of cost-of-living adjustment in contract, hospital affiliation with holding company, Medicare and Medicaid patient loads, region, non-profit status, inflation rate during contract negotiations, types of employees covered by contract, county per capita income and population density, alternative wage rate, hospital’s share of total county hospital beds, hospital size, occupancy rate, and local cost-of-living. The mean wage increase reported in this column is the predicted value of the wage increase derived from a regression of the (uncontrolled) wage increase on all of the aforementioned explanatory variables and evaluated at the sample means of those explanatory variables.
The data in Table 3 test the proposition that hourly wages increase with the number of bargaining units. Some factors can influence both wage rates and number of bargaining units, apart from collective bargaining dynamics. To control for the effects of these factors, we included the following as control variables in a multiple regression equation: county per capita income, costs of living, population density, hospital's county-wide market share, number of beds, occupancy rate, non-profit status, Medicare and Medicaid patient load, and membership in Kaiser Permanente. In order to derive the data in Table 3, we then used the regression equation to evaluate the predicted value of the hourly wage at the sample mean values of all of the control variables.

Table 3 shows the controlled maximum hourly wage rate for RNs, X-ray technicians, pharmacists, stationary engineers, and food service helpers. The evidence appears to support the industry's argument that as the number of bargaining units increases, hourly wage rates rise in these occupations, even after controlling for enumerated factors.

Table 3 presents enough data to make hundreds of wage comparisons. For example, we can compare increases or decreases in wage rates as the number of units increases from one to three to six.

In hospitals reporting only one unit, RNs earned an hourly wage rate of $13.76. The rate for 3 units was $14.23, a $0.47 or 3.4% increase over the rate for single-unit hospitals. The hourly rate for RNs in hospitals with six units was $14.58, $0.82 or 6.0% more than in one unit.

In hospitals with one unit, X-ray technicians earned $11.27. However, where there were three units in the hospital, X-ray technicians earned $0.24 more per hour (a 2.1% increase), and where there were six units, they earned $0.76 more per hour (a 6.7% increase).

For a general discussion of multiple regression, see NORMAN H. NIE ET AL., STATISTICAL PACKAGE FOR THE SOCIAL SCIENCES 320-60 (2d ed. 1975).

We included a unit's Kaiser Permanente membership status because we found earlier evidence that Kaiser, unlike the rest of the industry, did not oppose multiple units in its hospitals and, on balance, was much more accommodating in its collective bargaining experience than the rest of the industry. In sum, we wanted to control for any relationship between generous wage agreements and Kaiser's style or philosophy of collective bargaining.

As we developed our survey, we contemplated three measurements to represent wage data: entry-level wage rates, mean or median wage rates, and maximum wage rates for each occupational group. We realized, however, that for some occupational groups hospitals prefer or are able to hire experienced employees and, therefore, hire relatively few people at the entry-level. Consequently, it is not uncommon for unions to negotiate somewhat depressed entry-level wage rates, since there is not a sizeable entry-level constituency in the union. Thus, entry-level wages can be misleading for some occupational groups. Ideally, we would prefer median wage rates. However, we considered the risk of respondent error in reporting median wage data too great to opt for these otherwise preferred data. We therefore chose to have respondents report their maximum wage rates because these data would be readily available, and because, given the compressed or short wage-scale ladders for most hospitals, a large number of employees are earning maximum rates.
Pharmacists working in a hospital with one bargaining unit earned $18.04 per hour. They averaged $0.34 more per hour (a 1.9% increase) where there were three units, and averaged $1.01 per hour more (a 5.6% increase) where there were six units.

Food service helpers working in a hospital with one bargaining unit earned $6.74 per hour, earned $0.85 more per hour (a 12.6% increase) where there were three units, but earned $0.68 more per hour (10.1% more) where there were six units.

Stationary engineers working in a hospital with one bargaining unit earned $12.10 per hour, earned $0.44 more per hour (a 3.6% increase) where there were three units, and earned $1.68 per hour more (13.9% more) where there were six units.

These data suggest that as the number of bargaining units increases, hourly wage rates for six basic occupations in hospitals also increase. Reading the data in Table 3 in conjunction with the data in Table 2 yields the following important conclusions. Contrary to hospital industry arguments, wage-whipsawing resulting from a sequence of bargaining with multiple units does not occur. However, wage rates rise as the number of bargaining units increases. We offer two theories to explain this particular pattern of wage increases.

One theory is that as there are more units at a hospital, relatively weak units may be able to negotiate contracts they otherwise would not get because the employer develops a unified bargaining strategy, and because the employer and unions see the equity of consistent treatment with respect to wage increases across all units. Certainly, it would be difficult for a skilled maintenance unit to argue that it contributed more to a hospital’s bottom-line than a registered nurse’s unit, or vice versa. The performance of a hospital is truly the product of an integrated effort, and this may create a leveling effect in compensation that benefits otherwise weak units. The data presented do not provide direct support, however, for this theory.
### Table 3

Maximum Wage Levels For Selected Occupations,  
By Number Of Bargaining Units, 1988, with Control Variables*

<table>
<thead>
<tr>
<th>Bargaining Units</th>
<th>Nurses (RNs)</th>
<th>X-Ray Technicians</th>
<th>Pharmacists</th>
<th>Stationary Engineers</th>
<th>Food Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>$13.46</td>
<td>$10.91</td>
<td>$17.85</td>
<td>$11.95</td>
<td>$6.51</td>
</tr>
<tr>
<td>1</td>
<td>$13.76</td>
<td>$11.27</td>
<td>$18.04</td>
<td>$12.10</td>
<td>$6.74</td>
</tr>
<tr>
<td>2</td>
<td>$13.90</td>
<td>$11.07</td>
<td>$17.59</td>
<td>$11.75</td>
<td>$7.06</td>
</tr>
<tr>
<td>3</td>
<td>$14.23</td>
<td>$11.51</td>
<td>$18.38</td>
<td>$12.54</td>
<td>$7.59</td>
</tr>
<tr>
<td>4</td>
<td>$13.74</td>
<td>$11.71</td>
<td>$18.08</td>
<td>$12.14</td>
<td>$7.08</td>
</tr>
<tr>
<td>5</td>
<td>$14.74</td>
<td>$11.98</td>
<td>$19.36</td>
<td>$14.00</td>
<td>$7.60</td>
</tr>
<tr>
<td>6</td>
<td>$14.58</td>
<td>$12.03</td>
<td>$19.05</td>
<td>$13.78</td>
<td>$7.42</td>
</tr>
<tr>
<td>7</td>
<td>$14.72</td>
<td>$11.42</td>
<td>$18.20</td>
<td>$13.76</td>
<td>$7.35</td>
</tr>
<tr>
<td>8</td>
<td>$13.56</td>
<td>$12.59</td>
<td>$19.20</td>
<td>$13.41</td>
<td>$6.99</td>
</tr>
</tbody>
</table>

* See explanatory note following Table 2 for control variables. For the method by which the data in table 3 was derived, see text accompanying notes 338 and 339.

A second theory is that increasingly discrete units are more likely to be unified in their demands, and more capable of mounting a credible strike threat in support of wage demands. At some point the bargaining unit may become sufficiently discrete and narrow to be incrementally more effective at the bargaining table, holding other factors constant. Such unit discreteness may
yield a "bargaining unit premium"--some additional increment of compensation that reflects a unit's improved bargaining power. Thus, "bargaining unit premiums" may reflect greater labor market competition for particular units, and/or greater probabilities that particular units may strike.\footnote{339} However, the data presented do not provide direct support for this theory.

Table 4 presents data that test the proposition that the frequencies of work assignment disputes and work assignment strikes increase as the number of bargaining units increases.\footnote{340} We find strong, suggestive evidence in support of this proposition.\footnote{341} In cases of nonunionization and therefore no bargaining, the baseline for work assignment disputes in 1987 was 4.00 disputes (n=378 reporting hospitals). Hospitals with one unit (n=50) reported 2.80 work assignment disputes. For each hospital with two to five units, the average number of work assignment disputes was above the baseline average: 4.23 disputes for hospitals with two units (n=39), 8.25 for hospitals with three units (n=24), 8.69 for hospitals with four units (n=16), and 6.88 for hospitals with five units (n=8). Hospitals with two to five units comprise the bulk of multi-unit hospitals (87 reporting hospitals), and these hospitals clearly experienced a higher incidence of work assignment disputes compared to hospitals with one or no units. Thus, we conclude that there is an empirical basis for the hospital industry's concern that work assignment disputes tend to increase as the number of bargaining units increases, with the noteworthy exception of hospitals with only one bargaining unit.

\footnotetext{339}{It is difficult to imagine a workforce organized as a "wall-to-wall unit" (in other words, one that encompasses nurses, skilled maintenance employees, food service helpers and others), that would stand united in their collective bargaining demands, in light of huge differences in their interests, occupational outlooks, and underlying composition by social class, race, and gender. A wall-to-wall unit is structurally incapable of presenting a solid front threatening to strike. However, as the workforce breaks down into its economic and sociological parts, the threat to strike may be more credible. This element of pressure, once introduced into bargaining, may yield a unit-premium. In offering this explanation, we note the critical difference between actually striking and credibly threatening to strike. A credible threat to strike may require little more than an obvious display of unity and purpose as negotiations begin. Perhaps the greatest single factor contributing to the threat to strike is not overt statements of strike-intentions; it is the very discreteness or homogeneity of the unit.}

\footnotetext{340}{A "work assignment dispute" is considered to arise at any active displeasure with a work assignment, even including simple, informal complaints. Our survey prefaced the work assignment dispute question with this explanation: "The next question asks about work assignment disputes (either formal or informal). A work assignment dispute is a dispute whereby an employee objects to an assigned task. The underlying contention is embodied in the beliefs that 'they shouldn't do that--that's our job' or 'that's not my responsibility.'" Thus, we worded the work assignment dispute question to capture as much dispute activity as possible, even including informal objections to work assignments. Our survey question asked hospital personnel officers: "During 1987 how many work assignment disputes occurred that you knew about? (If you are not sure, please give your best estimate.)"}

\footnotetext{341}{This study does not include tests of statistical significance for these data. For a more sophisticated statistical treatment, see Schwarz & Koziara, supra note 182.}
Table 4

Work Assignment Disputes and Work Assignment Strikes or Work Stoppages by Number of Bargaining Units, 1987

<table>
<thead>
<tr>
<th>Number of Bargaining Units</th>
<th>Mean Work Assignment Disputes (Number of Reporting Hospitals)</th>
<th>Mean Work Assignment Strikes (Number of Reporting Hospitals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>4.00 (378)</td>
<td>.06 (393)</td>
</tr>
<tr>
<td>1</td>
<td>2.80 (50)</td>
<td>.20 (51)</td>
</tr>
<tr>
<td>2</td>
<td>4.23 (39)</td>
<td>0 (41)</td>
</tr>
<tr>
<td>3</td>
<td>8.25 (24)</td>
<td>1.00 (25)</td>
</tr>
<tr>
<td>4</td>
<td>8.69 (16)</td>
<td>.19 (16)</td>
</tr>
<tr>
<td>5</td>
<td>6.88 (8)</td>
<td>0 (8)</td>
</tr>
<tr>
<td>6</td>
<td>4.36 (11)</td>
<td>0 (11)</td>
</tr>
<tr>
<td>7</td>
<td>3.33 (12)</td>
<td>0 (10)</td>
</tr>
<tr>
<td>8</td>
<td>10.57 (7)</td>
<td>.29 (7)</td>
</tr>
</tbody>
</table>
How frequently do such disputes mushroom into strikes or work stoppages? In general, the answer is that they rarely do and that the number of bargaining units has little or no apparent relationship to strike frequency. For hospitals with zero units (393 reporting hospitals), work assignment strikes occurred in 6 of 100 disputes. This frequency rose sharply to 20 of 100 instances for the 51 reporting hospitals with one bargaining unit. Unlike the pattern observed for work assignment disputes, the strike/work stoppage rate was actually less in hospitals with two, five, six and seven units than in hospitals with zero or one unit. These multi-unit hospitals had no incidence of work stoppages or work assignment strikes (a total of 70 out of 118 multi-unit hospitals). Since these hospitals comprise most of the multi-unit hospitals, we conclude that larger numbers of bargaining units are not associated with increases in work assignment stoppages or strikes. However, hospitals with 3 units experienced a relatively high rate of work stoppage and strike activity: 1.00 incident per hospital, with 25 hospitals reporting. Our study does not account for this increased activity, but we view this occurrence as a possible anomaly since strike and work stoppage activity dropped to zero in hospitals with more units.

The data in Table 4 indicate that increasing numbers of bargaining units lead to more work assignment disputes, and this increase may be due to workers' and unions' increased sensitivity to work jurisdictional issues. As collective bargaining units become more homogeneous, they are more likely to focus on jurisdictional issues. However, collective bargaining appears to minimize the impact of many of these disputes. We suggest that they may have been disposed of through the grievance system that typifies collective bargaining agreements.

The proposition that larger numbers of bargaining units are associated with increased strike activity (excluding work assignment work stoppages or strikes) is examined in Table 5. In general, the data supported the industry's contention that strike activity increased as the number of bargaining units rose. The baseline of strike activity (that is, the rate for the 392 hospitals reporting zero units) was 1 strike per 100 hospitals between 1980-1988. Hospitals with one and two units reported almost identical rates: 16 and 17 strikes per 100 hosp-

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342. We separated work assignment disputes from other kinds of disputes because they often are specific to a single individual or a small group of people and have different effects than larger conflicts, such as wage-rate disputes. In the case of work assignment disputes, work stoppages are likely to be different than full-scale strikes. They may take the form "I'm not doing this work assignment," or "I'm not doing any work until we get this problem worked out." This type of work stoppage is quite different from other strikes in terms of the number of people participating or affected, the duration, and the spontaneity of action.

343. These strikes would include economic strikes (strikes over terms of a new contract) or strikes over an unfair labor practice. Our survey question reads: "Since 1-1-80, how many work stoppages has your hospital had due to all other causes?"
tals over the eight year period, respectively. This rate rose sharply for multi-unit hospitals. Among the 71 hospitals with 3 to 8 units in the survey, there were 66.92 strikes other than work assignment work stoppages during the eight year period. Thus, hospitals with three or more units reported slightly less than one strike (.94254) each during the nine years covered by the survey. These statistics support the hospital industry's contention that the Board's new rule will lead to more strike activity, since an increase in multi-unit hospitals is likely under the rule. Nonetheless, though strikes may be much more frequent overall, the data suggest that each multi-unit hospital would experience only one strike every nine years.

**Table 5**

Strikes (Excluding Work Assignment Strikes)
by Number of Bargaining Units, 1980-1988

<table>
<thead>
<tr>
<th>Number of Bargaining Units</th>
<th>Strikes Per Hospital, 1980-1988 (Number of Reporting Hospitals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>.01 (392)</td>
</tr>
<tr>
<td>1</td>
<td>.16 (51)</td>
</tr>
<tr>
<td>2</td>
<td>.17 (41)</td>
</tr>
<tr>
<td>3</td>
<td>.52 (25)</td>
</tr>
<tr>
<td>4</td>
<td>.81 (16)</td>
</tr>
<tr>
<td>5</td>
<td>.50 (8)</td>
</tr>
<tr>
<td>6</td>
<td>1.54 (11)</td>
</tr>
<tr>
<td>7</td>
<td>.80 (5)</td>
</tr>
<tr>
<td>8</td>
<td>2.67 (6)</td>
</tr>
</tbody>
</table>
VII. Implications for the Future of Collective Bargaining in Hospitals

The preceding Part presented evidence that tested important arguments raised by the hospital industry during the Board's rulemaking. Contrary to the industry's arguments, the evidence suggests that predesignated units did not vary much from pre-existing units and that wage-leapfrogging was not associated with bargaining sequence. However, the evidence seems to support the hospital industry's contention that work assignment disputes are higher in multi-unit hospitals, and that multi-unit hospitals experience a higher rate of strike activity than those with few or no units. Although strikes were more numerous for multi-unit hospitals, each hospital on average suffered only one strike in nine years. The evidence also shows that as the number of bargaining units increases, so do wage rates for various hospital occupations, as the hospital industry has argued.

The predictions about the future of collective bargaining for hospitals in the post-rule period seem to be overly optimistic for unions and overly pessimistic for the industry. Proponents of collective bargaining recognize that small, discrete unit determinations enhance the prospects for unionization. However, these proponents may overlook the fact that the primary effect of the rule is to limit employer efforts to challenge bargaining unit determinations, which in effect limits the ability of a hospital to use delay as a union-resistance tactic. The tactic of procedural delay to forestall a representation election or an obligation to bargain should not be confused with the issue of whether employees want union representation in the first place. Our point is that the rule does not in itself increase employees' desire for union representation. In most non-hospital industries, union organizing has been weak. Thus, we see no...
reason, for example, why food service helpers in hospitals should be easier to
organize than food service helpers in non-hospital restaurants and cafeterias.

Those who predict a boom in hospital unionization seem to overlook the
complex of factors weighing against unionization in general. A mix of good
management and coercive management practices contribute to low unionization
rates in American workplaces. Some employers succeed in intimidating their
employees during organizing drives. In some of the litigated cases reviewed
in this paper, there was evidence of such employer conduct. On the other
hand, such efforts may be unnecessary if the employers realize that their
workforce is basically content, and therefore not a good target for unioniza-
tion.

The doomsday predictions concerning the fate of hospitals affected by
the rule also appear to be overstated. In the past, the hospital industry has tried to
frighten the public into believing that strikes will cripple health care deliv-
ery. Such public appeals are similar to earlier arguments that steel and auto
strikes would cripple the U.S. economy and possibly impair national defense.

but in the early 1980s, won only about 45% of such elections. Moreover, the average number of workers
organized in a single NLRB election in 1950 was 157, while in 1980 that average fell sharply to 54. In sum,
unions have been winning far fewer new members, and when they have won elections, their gains have been
much smaller than before. Richard B. Freeman, Why Are Unions Faring Poorly in NLRB Representation

348. See, e.g., William N. Cooke, The Rising Toll of Discrimination Against Union Activists, 24 INDUS.
REL. 421 (1985); Paul Weller, Promises to Keep: Securing Workers’ Rights to Self-Organization Under the
NLRA, 96 HARV. L. REV. 1769 (1983). See also JOHN LAWLER, UNIONIZATION AND DEUNIONIZATION
(1990). Lawler observes that employers have been much more assertive in the 1980s in resisting unions
than in earlier decades, not only in opposing organizing drives, but in using “deunionizing” tactics, where
the workplace is organized. These tactics have included petitioning for decertification, use of striker replace-
ments, lockouts, “hard” bargaining, employee attitude surveys, surveillance and interrogation of employees,
disinvestment in unionized plants while opening or expanding facilities that are non-union, double-breasted
operations, subcontracting unionized work, avoidance of labor contracts through bankruptcy, and alter-ego
transactions. Id. at 174-75.

349. See supra notes 1, 7, 11, 13.

at A18 (“It isn’t clear why nonunion workers have become more anti-union. Nonunion workers are no better
doctor financially now than a decade ago, but their satisfaction level for some reason has increased.”). See
also Jack Fiorito, Political Instrumentality Perceptions and Desires for Union Representation, 8 J. LAB.
REL. 271 (1987); Herbert G. Heneman, III & Marcus H. Sandver, Predicting the Outcome of Union
Certification Elections: A Review of the Literature, 36 INDUS. & LAB. REL. REV. 537 (1983); Stuart A.
Youngblood et al., The Impact of Work Environment, Instrumentality Beliefs, Perceived Labor Union Image,

351. On behalf of the industry, Representatives Quie, Steiger, Eshelman, and Erlenbom added these
views in the legislative history of the 1974 amendments:

[W]e believe that the bill should contain further amendments to the ... Act which would not only
recognize the rights of patients and the public, but which would protect these wholly unrepresented
individuals, whose interests should be paramount in our considerations, from labor disputes which
interfere with the delivery of health care services . . . .

LEGIS. HIST., supra note 200, at 280.
Certainly, strikes inflict harm, and sometimes great harm, but the damage tends to be localized and more easily ameliorated than some union critics suggest.

In our view, hospital managements that choose to confront unionization aggressively will find that they can exercise potent legal tactics. One such tactic is to replace striking employees permanently. According to government and private estimates, a significant number of employers already hire permanent replacements during strikes. Even when a hospital may be reluctant to replace its striking workforce, it may nevertheless find its bargaining power enhanced by the Supreme Court’s dicta in *Mackay Radio*. Evidence suggests that the judicial policy of permitting the hiring of permanent replacement workers helped to hold wage settlements in collective bargaining agreements under the yearly rate of inflation throughout the 1980s. Management’s actual or threatened resort to self-help may thus be a powerful tool in restraining union wage demands. Why wouldn’t some hospitals facing a threatened strike by food service helpers counter-threaten to continue operations by hiring permanent replacements? Why wouldn’t some hospitals facing a threatened strike by nurses counter with a “TWA ploy” to work through the strike, and offer strikers special inducements (such as day shift and afternoon shift preferences) to break the strike? The special skills of many hospital employees may be inadequate protection against permanent replacements, since such trained groups as air traffic controllers, prison guards, teachers, airline pilots,

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352. Statement of Franklin Frazier, Trends in the Number of Strikes and Use of Permanent Strike Replacements in the 1980s (June 6, 1990) (on permanent file with the University of Illinois Law Review).
353. “Although [the Act] provides, ‘Nothing in this Act shall be construed so as to interfere with or impede or diminish in any way the right to strike,’ it does not follow that an employer, guilty of no act denounced by the [Act], has lost the right to protect and continue his business by supplying places left vacant by strikers.” NLRB v. Mackay Radio & Telegraph Co., 304 U.S. 333, 345 (1938). Thus, the employer who hired permanent replacements employees “was not bound to displace men hired to take the strikers’ places in order to provide positions for them.” Id. at 347.
354. See Trans World Airlines, Inc. v. Indep. Fed’n of Flight Attendants, 489 U.S. 426 (1989). After going two years without a contract, the union staged a strike against the airline. The airline countered by hiring 2350 replacement employees and inducing striking flight attendants to abandon their strike. TWA used an especially effective method for breaking the strike: it offered returning strikers their choice of domicile or base of operation (a major contract feature) temporarily vacated by a striker, but stated that the returning employee could permanently keep the position. As a consequence, strikers with unappealing domiciles (usually employees with low seniority) were induced to cross at the expense of stalwart strikers. The strategy was aimed at (1) inducing low-seniority strikers to abandon the strike to gain a domicile that might otherwise take years to gain, and (2) inducing high-seniority strikers to abandon the strike to preserve their domicile. The Court held that this strategy did not discriminate illegally against striking employees whose domiciles were lost. The case arose under the Railway Labor Act; however, the anti-discrimination language under the Railway Labor Act corresponds closely to § 8(a)(3) of the National Labor Relations Act.
357. For example, a strike by teachers in Homer, Illinois in 1987 lasted over six months, and during that time, the school district hired replacement teachers.
and NFL football players,\textsuperscript{359} have been readily replaced during their strikes.\textsuperscript{360}

As for the argument that unionized labor will raise labor costs and thereby harm the industry, the Board concluded that unionization induces a "minimal cost impact" on hospitals of three to five percent.\textsuperscript{361} While the Board's numerical estimation of the increased cost of unionization may be correct, a three to five percent increase in total costs may be significant. Many hospitals already have serious cost pressures. Nevertheless, the Act does not permit employers to inhibit union organization based on cost considerations.

However, there are numerous lawful practices common to collective bargaining that alleviate the cost pressures an employer faces. For example, a hospital with a unionized janitorial staff or food service group could negotiate to subcontract its work to a less costly provider.\textsuperscript{362} Hospitals could bargain for productivity gains tied to increased compensation, as has been done in other industries.

We conclude that the recent National Labor Relations Board rule should make hospital labor relations more like those of other private industries. In today's climate, this means relatively low unionization levels,\textsuperscript{363} low wage gains,\textsuperscript{364} and low strike rates.\textsuperscript{365} If unions regain their economic strength, perhaps different dynamics will prevail, but this day is too distant to foresee.

\begin{itemize}
\item \textsuperscript{358} See Bureau of National Affairs, \textit{DAILY LAB. REP.}, Aug. 5, 1985, at A6 (reporting that a U.S. district court enjoined United Airlines from continuing to hire replacement pilots while United's pilots were on strike); Bureau of National Affairs, \textit{DAILY LAB. REP.}, Aug. 28, 1985, at A7 (reporting that Continental Airlines withdrew recognition from its pilots' union during the union's two-year strike).
\item \textsuperscript{359} See Cynthia L. Gramm & John F. Schnell, Crossing the Picket Line: An Analysis of Player Choice During the 1987 National Football League Strike (October 1989) (unpublished manuscript, on file at University of Illinois' Institute of Labor and Industrial Relations, Room 237).
\item \textsuperscript{360} A general discussion of the employer's tendency to work through strikes can be found in \textit{CHARLES R. PERRY ET AL., OPERATING DURING STRIKES} (1984).
\item \textsuperscript{362} Under First Nat'l Maintenance Corp. v. NLRB, 452 U.S. 666, 679-680 (1981), an employer is free to sub-contract bargaining work provided that its motivation is related to changing the nature or scope of the business, even if sub-contracting adversely affects a bargaining unit.
\item \textsuperscript{363} In the period 1980-1989, unionization rates in private industry (i.e., non-government employment) have plummeted in the U.S. In 1980, 20.1% of wage and salary earners were members of unions. See Larry T. Adams, \textit{Changing Employment Patterns of Organized Workers}, 108 MONTHLY LAB. REV. 25 (1985). The 1989 rate was only a little more than half that rate--12.4%. See \textit{BUREAU OF LABOR STATISTICS, U.S. DEPT OF LABOR, VOL. 37, EMPLOYMENT AND EARNINGS} 232 (Jan. 1990). The only gains in unionization rates have occurred in the government sector--ironically, a diminishing sector for hospital employment as increasing numbers of county and city hospitals close.
\item \textsuperscript{364} First year wage agreements provided average raises of 2.4% in 1988, 3.4% in 1989, and 3.9% in the first half of 1990. Bureau of National Affairs, \textit{DAILY LAB. REP.}, July 12, 1990, at B1. Even though wage agreements have been improving from labor's perspective, these improvements should be read in light of prevailing inflation rates. Between April 1990 and April 1991, for example, consumer prices for all items rose 4.9%, a figure that significantly exceeds the average 1990 wage gain. See \textit{BUREAU OF LABOR STATISTICS, U.S. DEPT. OF LABOR, supra} note 184, at 7. In sum, wage increases in collective bargaining agreements are not keeping up with inflation.
\item \textsuperscript{365} See Bureau of National Affairs, \textit{supra} note 364, at B1 (giving strike data).
\end{itemize}
In the meantime, hospital employees will now have a fairer chance to organize if they wish, and the Board's limited resources will not be expended on the tactical dispute of hospital unit determinations.
Appendix: Survey

Directions

This survey is for acute care hospitals. If your hospital has other facilities, such as a nursing home, please do not include them in your answers. Please note: Non-union hospitals should answer Questions 1-6; unionized hospitals should answer Questions 1-12.

1. Approximately how many people does your hospital currently employ?
   
   Regular Full-Time __
   Regular Part-Time (less than 35 hours per week) __

2. What was the maximum straight time hourly wage for each of the following positions as of 12-30-1985 and 1-1-1988. (Do not include benefits, bonuses, or shift or other differentials).

<table>
<thead>
<tr>
<th>OCCUPATIONAL GROUP</th>
<th>12-30-1985</th>
<th>1-1-1988</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Duty RN</td>
<td></td>
<td></td>
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<tr>
<td>X-Ray Technician</td>
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<tr>
<td>Pharmacist</td>
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<td>Stationary Engineer</td>
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<tr>
<td>Food Service Helper</td>
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<tr>
<td>LPN</td>
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</tbody>
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The next question asks about work assignment (or work out of classification) disputes (either formal or informal). Think of a work dispute as employees objecting to assigned tasks. Examples include the belief that “they shouldn’t do that—it’s our job” or “that’s not my responsibility.”

3. During 1987 how many work assignment disputes occurred that you knew about? (If you are not sure, please give your best estimate.)

   _____
4. Since 1-1-1980, how many work stoppages has your hospital had due to work assignment disputes?

How many had a negative effect on patient care?

5. Since 1-1-80, how many work stoppages has your hospital had due to all other causes?

How many had a negative effect on patient care?

6. Do unions currently represent any of your hospital’s employees? (check one.)

Yes  
No  
Don’t know

7. How many bargaining units does your hospital currently have?
Please answer Questions 8-12 on the grids below providing information on each organized bargaining unit:

<table>
<thead>
<tr>
<th>BARGAINING UNIT DESCRIPTION</th>
<th>QUESTION 8: SINCE 1-1-1980 HOW MANY CONTRACTS HAVE BEEN NEGOTIATED IN EACH UNIT?</th>
<th>QUESTION 9: WHAT IS THE STARTING DATE FOR THE CURRENT CONTRACT IN EACH UNIT?</th>
<th>QUESTION 10: WHAT IS THE AVERAGE ANNUAL PERCENT WAGE INCREASE FOR EACH UNIT'S CURRENT CONTRACT (EXCLUDING COLAS)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Professionals</td>
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<td>RNs</td>
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<td>Other Professionals</td>
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<td>Technicals</td>
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<td>LPNs</td>
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<td>Service and Maintenance</td>
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<tr>
<td>All Non-Professionals</td>
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<tr>
<td>Business Office Clericals</td>
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</tr>
<tr>
<td>Guards</td>
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<tr>
<td>Others (Specify)</td>
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<tr>
<td>Bargaining Unit Description</td>
<td>Question 11: Does the current contract for each unit contain a cost of living adjustment (COLA)?</td>
<td>Questions 12: What is the name of the union which represents employees in each unit?</td>
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