

# HEALTH CARE LAW UNDER THE NLRA

## I. BACKGROUND AND INTRODUCTION TO THE HEALTH CARE AMENDMENTS OF 1974

In 1974, Congress amended the National Labor Relations Act (“NLRA” or “Act”) to establish the new category of employer called “health care institutions”, which was defined to include “any hospital, convalescent hospital, health maintenance organization, health clinic, nursing home, extended care facility, or other institution devoted to the care of sick, and for an aged person(s).”<sup>1</sup> Previously, non-profit hospitals had been excluded by statute from the definition of “employer” under the Act,<sup>2</sup> and the National Labor Relations Board had exercised jurisdiction only over proprietary hospitals and nursing homes.

Additionally, the 1974 amendments to the NLRA affected Sections 8(d) and 8(g) of the Act whereby specific, and more stringent, notice requirements were placed upon the parties as they related to the termination and modification of collective bargaining agreements,<sup>3</sup> and upon unions before they could lawfully strike or picket at a health care institution.<sup>4</sup> Also, Section 8(d) was modified to provide that individuals striking in violation of these new notice requirements would lose any protections as “employees” under the Act.

Following these legislative changes in 1974 the NLRB and the Courts have engaged in the process of developing a significant body of case law in this area. This paper will discuss the Board’s determination of appropriate bargaining units among health care institutions through the use of the general community of interest test, as well as by the promulgation of the “eight unit standard” specifically for the health care industry. Also discussed are the various notice requirements imposed by the 1974 amendments with respect to the termination or modification of labor agreements under Section 8(d) and notification of strike or picketing activity under Section 8(g).

## II. DETERMINATION OF APPROPRIATE BARGAINING UNITS

Before the NLRB will commence the election process, a petition must first be filed with the local regional office of the Board.

A petition may be filed by:

- (1) An employee, individual, or group of employees acting on behalf of employees;<sup>5</sup>
- (2) A labor organization acting on behalf of employees;<sup>6</sup> or
- (3) An employer, but only when one or more individuals or labor organizations have presented to it a claim to be recognized as the employees’ representative.<sup>7</sup>

In the event that a petition is filed, one of the first inquiries to be addressed by the Regional Director is the appropriateness of a bargaining unit. This issue is resolved either by a stipulation between the parties, or if they cannot agree on an appropriate unit, it must be processed by means of a representation hearing.

An underlying purpose of a hearing in regard to bargaining unit determinations is to give the labor organization and employer an opportunity to present witnesses and evidence pertaining to the petitioned for unit or to some other separate and distinct units. Regardless of whether the employer or labor organization is seeking to adjudicate the matter, when faced with the issue of determining “an appropriate bargaining unit”, the standard traditionally used by the Board in making its determination is referred to as the “community of interests standard”.

#### **A. The Community of Interests Standard**

When applying the “community of interests standard” the Board evaluates numerous factors such as the employees’ wages, hours and working conditions; the employees’ qualifications, training and skills; the frequency of contact and degree of interchange with other employees; the frequency of transfer to and from the petitioned for unit; commonality of supervision; degree of integration with the work functions of other employees; area practice; patterns of collective bargaining; and the collective bargaining history.”<sup>8</sup>

By evaluating the above enumerated factors on a case-by-case basis, the Board determines what is or are “appropriate bargaining unit(s)”. Significantly, in making this determination, the NLRB is only required to designate “an appropriate bargaining unit, not the most appropriate bargaining unit.”<sup>9</sup> This flexible, unbridled standard allows the Board to use a great amount of discretion in unit determination cases.

Although the “community of interests standard” was uniformly applied to all industries including the health care industry by the Board since the Act was first promulgated, in response to criticism from the Ninth and Tenth Circuits, the NLRB in 1984 decided to abandon the “community of interests standard” and to adopt a new standard, entitled the “disparity of interests test”, in the health care industry.<sup>10</sup> One reason for changing the standard was the fact that the Ninth and Tenth Circuits consistently held, in overruling the NLRB’s bargaining unit determinations that, “the Board’s adherence to the community of interests standard [was] indicative of its failure to adopt its processes to the special circumstances of the health care field.”<sup>11</sup>

In formulating the new standard, the Board itself noted that a major concern to Congress in amending the NLRA<sup>12</sup> in 1974 was not “merely removing the exclusion of nonprofit hospitals from the definition of employer in Section 2(2) [of the Act]. Congress also was concerned that the needs of patients in health care institutions required special consideration under the Act, and therefore the legislative amendments imposed certain restrictions not applicable to other industries.”<sup>13</sup> The NLRB went on to state:

“The paramount public interest in maintaining uninterrupted accessibility to health care facilities required that further protection and special care would have to be taken to avoid the ultimate disruptions in health care institutions caused by organizing drives and related activities such as strikes and slowdowns. Congress concluded that the object of minimizing work stoppages resulting from initial organizational activities, jurisdictional disputes and sympathetic strikes could best be achieved and thus the likelihood

of disruption to health care reduced, by minimizing the number of units appropriate in the health care industry.”<sup>14</sup>

Additionally, Congress was concerned with the proliferation of bargaining units in the health care industry, and thereby it was requiring a more rigid test for determining appropriate bargaining units in this setting. The adoption of the “disparity of interests test” was the Board’s means of addressing the “special consideration” required within the health care industry and its answer to Congress’ concerns regarding the proliferation of bargaining units. By adopting the “disparity of interests test” the NLRB hoped to silence its critics, as well as to limit the number of bargaining units within a health care facility.

## **B. Disparity of Interests Test**

The Board’s shift to the “disparity of interests test” was first enunciated in the case of *St. Francis Hospital*.<sup>15</sup>

In justifying the abandonment of the “community of interests standard” and the adoption of the “disparity of interests test” the Board, quoting the Ninth Circuit, stated, the Act requires “the Board to determine not the similarities among employees in the same job classification ... but instead the disparity of interests among employee classifications which would prevent a combination of groups of employees into a single broader unit thereby minimizing unit proliferation ... By focusing upon the disparity of interests between employee groups which would prohibit or inhibit fair representation of employee interests, a balance can be made between the congressional directive and the employees’ right to representation.”<sup>16</sup> Additionally, the Ninth Circuit had held in the past that, “Separate bargaining units in the health care field must be justified in terms of a disparity that precludes combination, not an internal consistency within a class that could justify separation.”<sup>17</sup>

The NLRB also noted, as the Tenth Circuit had stated, a “disparity of interests test” was more appropriate since it is “not the similarity of employees’ training, hours, conditions and activities which determine the appropriateness of the unit. It is, rather, the dissimilarity of interests relevant to the collective bargaining process that determines which employees are not to be included in a proposed unit. The proper approach is to begin with a broad proposed unit and then exclude employees with disparate interests.”<sup>18</sup> The Board concluded that “the phrase disparity-of-interests properly emphasizes that more is required to justify a separate unit in a health care institution than in a traditional industry or commercial facility. . . Requiring greater disparities in the usual community-of-interest elements to accord health care employees separate representation must necessarily result in fewer units and will thus reflect meaningful application of the congressional injunction against unit fragmentation.”<sup>19</sup>

However, in adopting the new “disparity of interests test” the Board failed to satisfy the concerns of the Second,<sup>20</sup> Eighth<sup>21</sup> and Eleventh<sup>22</sup> Circuits. Although these circuits agreed with the NLRB that bargaining units in the health care industry required special consideration, they did not agree with the use of the “disparity of interests test”. Due to the vast amount of criticism the NLRB received from the various Circuit Courts in conjunction with the disagreement of the courts with regard to the appropriate test to apply, the Board in 1987 decided to utilize its

rulemaking power conferred to it under Section 6 of the NLRA,<sup>23</sup> and its proposed rules regarding appropriate bargaining units in the health care industry.

The NLRB, in deciding to exercise its rulemaking power, determined that “establishing bargaining units by rulemaking will better effectuate the purposes and policies of the National Labor Relations Act than continuing lengthy and costly litigation over the issue of appropriate bargaining units in each case.”<sup>24</sup> As part of the rulemaking process, the Board held numerous hearings where individuals, labor organizations, associations, etc. were given an opportunity to testify on the issue of appropriate bargaining units in the health care industry. After more than two years of hearings and the receipt of comments from over 315<sup>25</sup> individuals, special interest groups, labor organizations and associations, the Board on April 21, 1989 adopted final Rules and Regulations regarding appropriate bargaining units in the health care industry (“1989 Rules and Regulations”).

These rules are intended to set forth the appropriate bargaining units in an “acute care hospital” to eliminate the need for a representation hearing before the NLRB. By specifically setting forth clear, distinct and rigid bargaining units within an “acute care hospital”, the Board sought to avoid delays in the election process resulting from litigation by employers and labor organizations over the issue of what is an “appropriate bargaining unit”. However, significantly, the final rules only apply to “acute care hospitals” and they do not deal with non acute care facilities.

### **C. Non Acute Care Facilities**

Due to the fact that the Board excluded non acute care facilities, such as nursing homes, from the term “acute care hospital” in the 1989 Rules and Regulations, the Board was left to formulate a new standard for such institutions. Therefore, in the case of *Park Manor Care Center*<sup>26</sup>, the NLRB stated that:

“we do not choose, at this time, to substitute for either the disparity of interests or community of interests test yet another short-handed phrase by which units in all nursing homes and other non acute care facilities will be measured. Instead, we prefer to take a broader approach utilizing not only community of interests factors but also background information gathered during rule making and prior precedent. Thus ... our consideration will include those factors considered relevant by the Board in its rulemaking proceedings, the evidence presented during rulemaking with respect to units in acute care hospitals, as well as prior cases involving either the type of unit sought or the particular type of health care facility in dispute. We hope, however that after various units have been litigated in a number of individual facilities and after records have been developed and a number of cases decided from those records, certain recurring factual patterns will emerge and illustrate which units are typically appropriate.”<sup>27</sup>

Additionally, the Board noted that, “Although nursing homes were excluded from the Board’s rulemaking, the Board nonetheless believes that comparing and contrasting individual nursing home work forces with those in the acute care hospitals would aid in determining appropriate units.”<sup>28</sup>

Rather than formulate another standard to be used in non acute care facilities, or to resurrect the “community of interests standard” or the “disparity of interests test”, the NLRB in *Park Manor Care Center* decided to follow closely the standards set forth in its 1989 Rules and Regulations together with prior case law. Therefore, although the 1989 Rules and Regulations specifically excluded non acute care facilities, the Board, when given an opportunity, immediately applied a similar standard to these facilities. By adopting this mixed standard, it appears that the NLRB has attempted to minimize litigation over the issue of appropriate bargaining units in non acute care facilities as well.

#### **D. Acute Care Hospitals**

Pursuant to its 1989 rulemaking, the Board defined the term “acute care hospital” as:

“either a short term care hospital in which the average length of a patient stay is less than thirty days, or a short term hospital in which over fifty percent of all patients are admitted to units where the average length of a patient’s stay is less than thirty days ... The term acute care hospital shall include those hospitals operating as acute care facilities even if those hospitals provide such services as for example, long term care, outpatient care, psychiatric care or rehabilitative care, but shall exclude facilities that are primarily nursing homes, primarily psychiatric hospitals or primarily rehabilitation hospitals.”<sup>29</sup>

Under the 1989 Rules and Regulations, the NLRB adopted eight specific appropriate bargaining units that are, except in cases of extraordinary circumstances, the only appropriate bargaining units within acute care hospitals. These eight units are:

1. All registered nurses;
2. All physicians;
3. All professionals except for 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 non-professional employees except for technical employees, skilled maintenance employees, business office clerical employees and guards.<sup>30</sup>

However, as noted above, the Board stated that where extraordinary circumstances exist, it would determine the appropriate units by adjudication.<sup>31</sup> Additionally, if the petitioning labor organization seeks to have a combination of the eight units, the Board may, in its discretion, combine such units where appropriate.<sup>32</sup> An example of an “extraordinary circumstance” is a unit of five or fewer employees, which, according to the NLRB, warrants a case-by-case unit determination.<sup>33</sup> The Board’s reason for treating this situation as an extraordinary circumstance is because such a limited unit would, in many cases, be impractically small. “Where so few employees are involved despite the shared unique concerns and background that would otherwise make the separate units appropriate, these concerns may be outweighed by considerations of disproportionate, unjustly cost and undue proliferation of units.”<sup>34</sup> The Board’s rule setting forth appropriate units applies only to initial organizing attempts or, where there are existing nonconforming units, to a petition for a new unit of previously unrepresented employees, which would be an addition to the existing units at the employer’s facility.<sup>35</sup>

In 1991, a number of organizations including the American Hospital Association challenged the validity of the eight units standard. However, a unanimous Supreme Court upheld the NLRB’s use of its rule making power to define appropriate bargaining units for health care workers in acute-care hospitals.<sup>36</sup>

## **E. The Eight Separate and Distinct Appropriate Bargaining Units**

### **1. All Registered Nurses**

According to the Board, a unit limited to registered nurses is appropriate since such professionals are solely responsible for providing patient care 24-hours a day, 365 days a year; no other professional group covers patient units three shifts a day; work schedules give nurses a unique bargaining interest in shift and work differentials, shift rotation schedules, overtime, and special incentives targeted exclusively at nurses.<sup>37</sup> Further, nurses have similar education, training, experience and licensing not shared by other employees.<sup>38</sup>

### **2. All Physicians**

Physicians require a separate bargaining unit since they have considerably more training than other hospital professionals, they earn substantially more than other professionals and supervision of physicians is limited.<sup>39</sup> The Board has been extremely rigid with regard to who is to be included in physician bargaining units. Questions have been arising about the scope of the physicians unit after the Board reversed its 1976 holding<sup>40</sup> that interns and residents are primarily students and thus not employees protected by the Act and brought these doctors within the Act’s scope in 1999.<sup>41</sup>

### **3. All Professionals Except for Registered Nurses and Physicians**

Of paramount importance to the NLRB in developing the “eight unit standard” was to limit the overall number of bargaining units within acute care hospitals. With this in mind, the

Board developed a category to encompass all other professionals except for registered nurses and physicians. Since the Board has not enunciated a concrete definition of the term “professionals”, this unit can best be described as a catch all category that includes any other professional who does not fit within the other seven bargaining units.

#### **4. All Technical Employees**

A bargaining unit limited to technical employees is appropriate since, “technical employees perform jobs involving the use of independent judgment and specialized training.”<sup>42</sup> “These employees are “further distinguished by the support role they play within the hospital, and by the fact that they work in patient care.”<sup>43</sup> The Board in applying this standard has included such positions as: operating room technicians,<sup>44</sup> surgical technicians,<sup>45</sup> cerebrovascular laboratory technicians,<sup>46</sup> audiovisual service specialists.<sup>47</sup> However, the NLRB has excluded positions such as burn and rehabilitation medical technicians,<sup>48</sup> media aids and pathology technicians,<sup>49</sup> radiology technician assistants,<sup>50</sup> clinic testing technicians,<sup>51</sup> pharmacy technicians<sup>52</sup>, medical quality control technicians<sup>53</sup> and physician referral representatives.<sup>54</sup>

#### **5. All Skilled Maintenance Employees**

The Board has stated that “a distinguishing characteristic of skilled maintenance employees is that they work on systems and equipment as opposed to involvement in direct patient care.”<sup>55</sup> Employees included in the skilled maintenance category require some form of formal education or formal training in a vocational or trade school.<sup>56</sup> Positions, such as grounds workers, are not included in a skilled maintenance employee category since they are primarily engaged in landscaping duties and routine maintenance of exterior parts of a hospital.<sup>57</sup> The Board has further determined that job categories including grounds mechanics, project support coordinators, printers, operating room supply specialists, respiratory equipment technicians, mold makers and radiological and diagnostic services department are not appropriate within the category of skilled maintenance employees since such positions are not related to the maintenance of hospitals’ physical plant systems.<sup>58</sup>

#### **6. All Business Office Clerical Employees**

With the 1989 Rules and Regulations the NLRB set forth a unit for business office clerical employees who perform business and office related functions, have minimal contact with other unit employees or patients, work in specific geographically areas of the hospital or perform functions that are separate and apart from service and maintenance employees.<sup>59</sup>

#### **7. All Guards**

Included within the NLRB’s interpretation of the term “guards” are hospital traffic control guards and security officers, where such employees are charged with enforcing the hospital’s rules against both employees and non-employees, and they are responsible for protecting the hospital’s property and safety of persons or property.<sup>60</sup> Further, hospital security dispatchers are guards within the meaning of the Act since they are directly responsible for being alert to any incident or problem which needs responsive actions and/or follow-up reporting to the proper authorities. Additionally, the Board has held that a hospital van driver is a guard under

the NLRA where such an individual is responsible for being alert to security problems, rules or violations and responding to threatening situations when needed.<sup>61</sup>

## **8. All Non-Professional Employees Except for Technical Employees, Skilled Maintenance Employees, Business Office Clerical Employees and Guards**

As a corollary to its category for “all professional employees that are neither physicians nor nurses”, the Board created an umbrella category for all non-professional employees who do not fit into the categories set forth for technical employees, skilled maintenance employees, business office clerical employees and guards. Since the adoption of the 1989 Rules and Regulations the NLRB has determined that such non-professionals include receptionists,<sup>62</sup> hospital billing specialists,<sup>63</sup> pathology information processors,<sup>64</sup> patient financial services employees<sup>65</sup> and medical records employees.<sup>66</sup>

Although the Board, through its rule making power, attempted to eliminate the delays in the election process by setting forth specific, rigid “appropriate bargaining units” within acute care hospitals, the issue of what employees should be placed in each of the eight categories still remained to be resolved and thus has resulted in continued litigation. For example, while it is clear that a physician belongs in a unit of physicians and a nurse in a unit of nurses, as seen above, there are numerous other positions within acute care hospitals which are not so clear and thereby, they require a hearing to determine their appropriate placement.

### **F. Combined Non Acute Care/Acute Care Facilities**

In an interesting twist, the NLRB in the case of *Child’s Hospital*<sup>67</sup> held that where an acute care hospital is combined with a nursing home, or other non acute care hospital, and the two are sufficiently integrated, both physically and operationally, they should be treated as a single facility. Based on this fact, the Board further stated that the combination of an acute care hospital and long term facility would remove the acute care hospital from under the eight bargaining unit rule. Therefore, when confronted with a combined acute care/nursing home type situation, the NLRB will apply the traditional “community of interests test”. However, in *Kirkville College*, the Board held that when a Medical School and acute care hospital were sufficiently integrated physically and operationally, the employees of both should be placed in common units under the hospital rules.<sup>68</sup>

## **III. SUPERVISORY STATUS OF NURSES**

Whether nurses in acute care hospitals, nursing homes and other healthcare setting are supervisors excluded from the protections of the Act is a question that has confounded the Board for over a decade.

Under federal labor law, the definition of a “supervisor” has three elements: a supervisor must have the authority (1) “in the interest of the employer,” (2) to “hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action,” and (3) the exercise of such authority must not be “of a merely routine or clerical nature, but [must] require[] the use of independent judgment.”<sup>69</sup>

The contested status of nurses under this definition can be traced to two sources. The overlap of this definition of excluded supervisors and that of included professional employees<sup>70</sup> is one of the roots of the controversy over nurses' status. The statutory definition of included professionals requires that a professional be engaged in work "involving the consistent exercise of discretion and judgment in its performance."<sup>71</sup> The definition of excluded supervisors also requires the exercise of an apparently similar form on "independent judgment."<sup>72</sup> In addition, most professionals (and many technical and other skilled employees who also exercise independent judgment in their jobs) routinely give assignments to and direct other employees in order to accomplish their professional duties. For example, a doctor asks a nurse for a scalpel and a lawyer asks a clerk to file a document. The combination of these two factors raised the question of whether this common form of assignment and direction means that all or most professionals, who by definition "consistently exercise ... discretion and judgment," fall within the definition of supervisors because they have authority to "assign" or "responsibly to direct" other employees and such authority requires the "use of independent judgment."

The Board's first approaches to these problems, as they are manifest among nurses, involved constructions of the first and third elements of the definition of a supervisor set out above. In each instance, the Board excluded a category of conduct from that conduct that is "in the interest of the employer" or that "requires the use of independent judgment," essentially on the grounds that the conduct was professional rather than supervisory. In each instance, the Board's categorical approach was rejected by the Supreme Court.

Initially, the Board approached this issue by asking whether nurses were acting "in the interest of the employer" in assigning or directing work. The Board held that, when the assignment or direction was in the interest of patient care, and thus within the scope of a nurse's professional responsibilities, it was not "in the interest of the employer" and did not render the nurse a supervisor.<sup>73</sup> In considering the 1974 amendments to the Act that brought the employees of proprietary hospitals within its scope, the relevant Senate committee suggested that Congress accept this approach.<sup>74</sup> Nevertheless, in 1994 the Supreme Court rejected the Board's construction of the phrase "in the interest of the employer" in *NLRB v. Health Care & Retirement Corp. (HCR)*.<sup>75</sup>

Following the *HCR* decision, the Board again addressed this dilemma, this time through a construction of the third element of the "supervisor" definition, requiring that the exercise of authority to assign or responsibility to direct involve "independent judgment." In its first post-*HCR* decision addressing the supervisory status of nurses, the Board held that nurses do not exercise independent judgment within the meaning of the Act when they exercise ordinary professional judgment.<sup>76</sup>

The Board application of the definition of supervisor to nurses was once again rejected by the Supreme Court in *NLRB v. Kentucky River Community Care*.<sup>77</sup> The holding of that case is, however, a narrow one; the Court only rejected the Board's effort to create a categorical exclusion from the scope of what constitutes independent judgment. The Supreme Court addressed only the question of "whether judgment is not "independent judgment" to the extent that it is informed by professional or technical training or experience."<sup>78</sup> And, the Court held only that the Board may not employ a "categorical exclusion of professional judgments from a term, "independent judgment," that naturally includes them."<sup>79</sup>

Thus, several important aspects of the existing jurisprudence on “supervisory status” remain unaffected by the *Kentucky River* decision. First, the decision does not undermine prior Board decisions based on the other indicia of supervisory status, i.e., authority to hire, transfer, suspend, lay off, recall, promote, discharge, reward, discipline or adjust grievances.

Second, the decision does not alter the requirement that the requisite independent judgment be used *in the exercise of the supervisory authority*. Thus, the fact that a nurse uses independent judgment in developing a patient care plan does not establish that the nurse is a supervisor since that task is not among the listed § 2(11) supervisory duties even if the nurse also assigns or directs other employees, so long as the assignment or direction is merely routine or clerical. Similarly, it may take a great deal of independent judgment for a doctor or nurse to decide that a patient needs an X-ray. But, once that judgment has been exercised, directing an orderly to take the patient to the X-ray department is likely a purely routine act. Taking patients to X-ray is a normal and regular job duty for an orderly and the doctor or nurse does not exercise independent judgment in selecting an available orderly to perform this task.

Third, the decision did not deprive the Board of discretion to determine how much independent judgment is enough to render an employee a supervisor. In fact, the Court made clear that exactly where the “threshold” is between independent judgment and judgment that is so constrained as to be merely routine or clerical is a question committed to the discretion of the Board. The Court held that the term “independent judgment” was ambiguous “with respect to the *degree* of discretion required for supervisory status” and, thus, “it falls clearly within the Board’s discretion to determine, within reason, what scope of discretion qualifies.”<sup>80</sup> This echoed the Court’s earlier statement in *HCR* that it is “no *doubt* true” that “the phrases in § 2(11) such as “independent judgment” and ‘responsibly to direct’ are ambiguous, so the Board needs to be given ample room to apply them to different categories of employees.”<sup>81</sup> Thus, the *Kentucky River* Court agreed that “many nominally supervisory functions may be performed without the ‘exercise [of] such a degree of ... judgment or discretion ... as would warrant a finding’ of supervisory status.”<sup>82</sup>

Fourth, the decision does not change the law with respect to assignment or direction that is sufficiently constrained by employer policies, directions or practices and that it falls below the threshold of “independent judgment.” For example, a nurse on the night shift who has authority to “assign” off-duty employees to a shift and post when scheduled employees do not show up for work, does not exercise independent judgment if the employer’s policies *require* that the nurse call in off-duty employees whenever the staff-patient ratio falls below a set level and, as is often the case, *require* that off-duty employees be called in a prescribed order (such as seniority). Indeed, the Supreme Court endorsed this line of Board doctrine in *Kentucky River*. The Court expressly embraced the Board’s understanding that “the degree of judgment that might ordinarily be required to conduct a particular task may be reduced below the statutory threshold by detailed orders and regulations issued by the employer.”<sup>83</sup> The Court cited as an example of the Board’s proper exercise of its discretion, the Board’s conclusion in *Chevron Shipping Co.*<sup>84</sup> that “although the contested licensed officers are imbued with a great deal of responsibility, their use of independent judgment and discretion is circumscribed by the master’s standing orders, and the Operating Regulations, which require the watch officer to contact a superior officer when anything unusual occurs or when problems occur.”<sup>85</sup>

Thus, both before and after *Kentucky River*, the Board has held that when directions are given within a framework of standard operating procedures, the giving of the directions does not require the exercise of independent judgment. In *Dynamic Science*, a decision issued after *Kentucky River*, the Board held that where instructions are “circumscribed by detailed orders and regulations issued by the Employer and other standard operating procedures,” the instructor does not exercise independent judgment sufficient to make him or her a supervisor.<sup>86</sup> Accordingly, putting points three and four together, after *Kentucky River* it remains within the Board’s discretion to determine whether employees’ discretion to assign or direct is circumscribed in such a manner – by employer policies, instructions from higher management, standardized procedures, etc. – as to fall below the threshold of “independent judgment” set by § 2(11). Indeed, the District of Columbia Circuit recently affirmed a post-*Kentucky River* Board holding that LPNs working in a nursing home were not supervisors for precisely this reason.<sup>87</sup>

Finally, the burden of proving supervisory status continues to rest with the party asserting that an employee is a supervisor. The Supreme Court resolved the conflict in the circuits on this issue in a manner favorable to the Board in *Kentucky River*. The Court sustained the Board’s conclusion that the burden of proving every element of supervisory status rests on the party urging exclusion.<sup>88</sup>

The General Counsel has issued guidance on how the status of nurses should be analyzed after *Kentucky River*.<sup>89</sup> In three pending cases,<sup>90</sup> one arising out of a hospital, one out of a nursing home, and one involving leadmen in a factory rather than nurses, the Board itself requested briefs from interested parties on the questions raised by the Supreme Court. However, as of this date the cases remain undecided. The last word from the Board on this subject appears in *Wilshire of Lakewood*, 345 NLRB No. 80 (Sept. 30, 2005), and that case did not address the critical assign and direct issues.

#### **IV. NOTICE PERIODS APPLICABLE IN HEALTH CARE INSTITUTIONS**

To avoid strikes and lockouts, the NLRA requires covered employers and unions to give advance notice of the proposed termination or modification of collective bargaining agreements. The failure to adhere to the notice provisions constitutes an unfair labor practice under Section 8 of the Act. Most industries covered by the Act are subject to the general notice periods set forth in 8(d)(1).<sup>91</sup> Employers and unions within the health care industry, however, are subject to special notice periods found in 8(d)(A)-(C) and 8(g).<sup>92</sup>

##### **A. Notice of Proposed Termination or Modification of Existing Agreements: Section 8(d) of the Act**

The general notice provision for termination or modification of agreements, as set forth in 8(d)(1),<sup>93</sup> requires one party to give notice to the opposing party sixty days prior to the proposed termination.<sup>94</sup> Where a contract has an expiration date, notice must be given within sixty days of the expiration date.<sup>95</sup> Under the special rules applicable to health care institutions under 8(d)(A), a party seeking to modify or terminate an agreement must give the other party at least *ninety days’* notice of the proposed termination or modification.<sup>96</sup> In addition, Section 8 requires the parties to notify the Federal Mediation and Conciliation Service (“FMCS”) and any analogous state agency of the proposed action.<sup>97</sup> The FMCS is required to promptly contact the parties and

use its best efforts to bring about resolution of the dispute.<sup>98</sup> The employer and the union are bound to prompt and full participation in meetings arranged and conducted by the service to facilitate settling the dispute.<sup>99</sup>

Generally, the notification to the FMCS and applicable state counterparts must be made within thirty days of the notice set forth in 8(d)(1).<sup>100</sup> Parties in the health care industry, likewise, must notify FMCS and the applicable state agency within thirty days of their giving notice to one another, or at least sixty days prior to the date of the proposed modification or termination.<sup>101</sup>

## **B. Notice in Anticipation of a Strike: Section 8(g) of the Act**

One further notice requirement applies only to unions in the healthcare industry. A union cannot strike or picket a healthcare institution without providing ten days written notice both to the employer and to the Federal Mediation and Conciliation Service.<sup>102</sup> Then notice must state the date and time the action will commence. The notice need not specify whether the action will be a strike or picketing, however.<sup>103</sup> Once noticed, the strike or picketing cannot start at a later time without a written agreement between the parties. Based on clear legislative history, the Board and General Counsel long held that (1) a strike or picketing could commence a reasonable time after the noticed time (understood to mean up to 12 hours later) and (2) that with an additional 12 hours notice the strike or picketing could commence up to 72 hours after the noticed time.<sup>104</sup> However, the former construction was recently rejected by the Board in a case holding that a strike commencing less than four hours after the noticed time was unprotected. The Board held that only a *de minimis* delay was permitted absent written agreement. In addition, the latter construction was also recently rejected by the D.C. Circuit which held that it was inconsistent with the plain text of the Act.<sup>105</sup>

Sympathy strikes have been the subject of 8(g) litigation. The Courts have construed the Act's notice requirements applicable to a union which failed to give the ten days' notice that its members would honor another union's strike at the same health care institution.<sup>106</sup> Section 8(g) has also been applied to sympathy strikes by outside unions.<sup>107</sup> The notice requirements apply only to labor organizations. Strikes by individual employees or informal groups of employees are not covered.<sup>108</sup>

Courts have held that Section 8(g) does not apply to a trade union which pickets and strikes an outside contractor performing work on the premises of a covered health care institution but the Board has disagreed if the picketing is directed at the health care institution.<sup>109</sup> On the other hand, Section 8(g) was held to apply to the picketing of a health care institution, where the picketing was in response to the management's hiring of replacement employees by the hospital.<sup>110</sup> [intentional omission of two sentences]

## **C. Remedies for and Defenses to Alleged Violations of Section 8(g)**

Cases have dealt with the available remedies to parties aggrieved by the failure of the other side to abide by the notice requirements under Section 8(g). Where a union fails to give appropriate notice, and its members strike, an employer may have the discretion to fire those employees for taking part in the unprotected unfair labor practice.<sup>111</sup> However, the Board has

held that employees who picket when their union has not given adequate notice cannot be fired.<sup>112</sup> The only remedy in that situation is a charge against the union. If, however, an employer does not terminate striking employees and agrees with the union to arbitrate the issue of appropriate discipline for the striking employees, then the employer is bound by the arbitrator's decision.<sup>113</sup> In the context of an unfair labor practice proceeding, a union may be able to defend itself against a complaint alleging an 8(g) violation where the work stoppage is *de minimis*.<sup>114</sup> The NLRB found a violation of Section 8(g), refusing to hold that a union's picketing of a health care institution was *de minimis*, where the picketing lasted forty-five minutes.<sup>115</sup> In addition, a union's failure to comply with the ten day notice requirement may be excused if an employer abuses the notice to undermine the bargaining relationship by bringing in large numbers of replacements or stockpiling materials.<sup>116</sup> Finally, unions accused of violating Section 8(g) may invoke a defense that originated in *Mastro Plastics Corp. v. NLRB*, in the context of the failure to abide by 8(d) notice requirements.<sup>117</sup> The *Mastro Plastics* defense excuses a union's non-compliance with the Act's notice requirements where the employer has also committed unfair labor practices.<sup>118</sup> Cases dealing with the application of the *Mastro Plastics* defense take into account the nature and degree of the employer's violations, as well as the potential for hardship on persons requiring uninterrupted medical care.<sup>119</sup>

## **ENDNOTES**

- 
- 1 29 U.S.C. § 152(14) (1974).
  - 2 29 U.S.C. § 152(2) (1947).
  - 3 29 U.S.C. § 158(d) (1974).
  - 4 29 U.S.C. § 158(g) (1974).
  - 5 29 U.S.C.A. § 159(c)(1)(A).
  - 6 29 U.S.C.A. § 159(c)(1)(A).
  - 7 29 U.S.C.A. § 159(c)(1)(B).
  - 8 *St Francis Hospital*, 271 NLRB 948 ft. 35 (1984).
  - 9 *Omni-Dunfey Hotels, Inc.*, 283 NLRB 475 (1987).
  - 10 *See, St. Francis Hospital*, 271 NLRB 948 (1984).
  - 11 *St. Francis Hospital*, at 950.
  - 12 29 U.S.C.A. § 151 *et. seq.*
  - 13 *St. Francis Hospital*, at 953.
  - 14 *St. Francis Hospital*, at 951.
  - 15 271 NLRB 948 (1984).

---

<sup>16</sup> *St. Francis Hospital*, at 951 citing *NLRB v. St. Francis Hospital*, 601 F.2d. 404 (9th Cir., 1979).

<sup>17</sup> *NLRB v. HMO International*, 678 F.2d. 806 (9th Cir., 1982).

<sup>18</sup> *St. Francis Hospital*, at 951 citing *Presbyterian/St. Luke Medical Center*, 653 F.2d. 450, 457 ft. 6 (10th Cir., 1981).

<sup>19</sup> *St. Francis Hospital*, at 953.

<sup>20</sup> *See, Trustees of the Masonic Hall v. NLRB*, 699 F.2d. 626 (2nd. Cir., 1983).

<sup>21</sup> *See, Watonwan Memorial Hospital v. NLRB*, 711 F.2d. 848 (8th Cir., 1983).

<sup>22</sup> *See, NLRB v. Walker County Medical Center*, 722 F.2d. 1535 (11th Cir., 1984).

<sup>23</sup> 29 U.S.C.A. § 156 which states, in relevant part, “the Board shall have authority ... to make, amend, and resolve ... such rules and regulations as may be necessary to carry out the provisions of the subchapter.”

<sup>24</sup> 29 C.F.R. part 103 (1988).

<sup>25</sup> 29 C.F.R. part 103 (1988).

<sup>26</sup> 305 NLRB 872 (1991).

<sup>27</sup> *Park Manor Care Center*, at 875.

<sup>28</sup> *Park Manor Care Center*, at 875.

<sup>29</sup> 29 C.F.R. part 103 (1989).

<sup>30</sup> 29 C.F.R. part 103 (1989).

<sup>31</sup> 29 C.F.R. part 103 (1989).

<sup>32</sup> 29 C.F.R. part 103 (1989).

<sup>33</sup> 29 C.F.R. part 103 (1989).

<sup>34</sup> 29 C.F.R. part 103 (1989).

<sup>35</sup> *See Crittenton Hospital*, 328 NLRB No. 120 (1999)

<sup>36</sup> *American Hospital Association v. NLRB*, 499 U.S. 606, 111 S.Ct. 1539, 113 L.Ed. 2d. 675 (1991).

<sup>37</sup> *Holliswood Hospital*, 312 NLRB No. 196 (1993).

<sup>38</sup> 29 C.F.R. part 103 (1988).

<sup>39</sup> 29 C.F.R. part 103 (1989).

<sup>40</sup> *Cedars-Sinai Medical Center*, 223 NLRB 251 (1976).

<sup>41</sup> *Boston Medical Center*, 330 NLRB 152 (1999).

<sup>42</sup> 29 C.F.R. part 103 (1989).

<sup>43</sup> 29 C.F.R. part 103 (1988).

---

44 *Meriter Hospital*, 306 NLRB 598 (1992).  
45 *Rhode Island Hospital*, 313 NLRB No. 29, 145 LRRM 1308 (1993).  
46 *Id.* at 1309.  
47 *Id.* at 1310.  
48 *Id.* at 1310.  
49 *Id.* at 1310.  
50 *Id.* at 1310.  
51 *Id.* at 1310.  
52 *Meriter Hospital*, at 601.  
53 *Id.* at 600.  
54 *Rhode Island Hospital*, at 1310.  
55 *The Jewish Hospital of St. Louis*, 305 NLRB 955 (1991).  
56 *Id.* at 956.  
57 *Id.* at 956.  
58 *Ingalls Memorial Hospital*, 309 NLRB No. 57 (1992).  
59 *St. Luke's Episcopal Hospital*, 222 NLRB 674 (1976).  
60 *Rhode Island Hospital*, at 1309.  
61 *Id.* at 1309.  
62 *Charter Hospital of St. Louis, Inc.*, 313 NLRB No. 157 (1994).  
63 *Rhode Island Hospital*, at 1311.  
64 *Rhode Island Hospital*, at 1311.  
65 *Rhode Island Hospital*, at 1311.  
66 *Rhode Island Hospital*, at 1311.  
67 307 NLRB 90 (1992).  
68 *Kirksville College*, 274 NLRB 794 (1985).  
69 29 U.S.C. § 152(12).  
70 *See id.* §§ 152(12), 159(b)(1).  
71 *Id.* § 152(12).  
72 *Id.* § 152(11).  
73 *Northcrest Nursing Home*, 313 N.L.R.B. 491, 492-93 (1993).  
74 S. REP. NO. 93-766, 93<sup>rd</sup> Cong., 2d Sess. At 6 (1974).

---

75 511 U.S. 571, 584 (1994).

76 *Providence Hosp.*, 320 N.L.R.B. 717, 729-30 (1996), *enf'd*, 121 F.3d 548 (9<sup>th</sup> Cir. 1997).

77 532 U.S. 706 (2001).

78 *Id.* at 708.

79 *Id.* at 721.

80 *Id.* at 713.

81 511 U.S. at 579.

82 532 U.S. at 713.

83 *Id.* at 713-14.

84 317 N.L.R.B. 379, 381 (1995).

85 532 U.S. at 714.

86 334 N.L.R.B. No. 57, at \*2 (2001). *See also Greenhorne & O'Mara, Inc.*, 326 N.L.R.B. 514, 517 (1998); *Chevron Shipping*, 317 N.L.R.B. at 381; *Clark Machine Corp.*, 308 N.L.R.B. 555, 555-56; *Aircraft Displays, Inc.*, 262 N.L.R.B. 1233, 1234 (1982); *Am. Radiator & Standard Sanitary Corp.*, 119 N.L.R.B. 1715, 1717-18 (1958); *VIP Health Servs. Inc. v. NLRB*, 164 F.3d 644, 649 (D.C. Cir. 1999).

87 *Beverly Health & Rehabilitation Servs., Inc. v. NLRB*, No. 01-1405, 2003 U.S. App. LEXIS 1750, at \*15 (D.C. Cir. Jan. 31, 2003).

88 532 U.S. at 711-12.

89 G.C. Memo. OM 04-09 (Oct. 31, 2003).

90 *Oakwood Healthcare, Inc.*, &-RC-221412; *Golden Crest Healthcare Center*, 18-RC-16415, 16416; *Croft Metals, Inc.*, 15-RC-8393.

91 The sections of the LMRA discussed in this section are set forth at 29 U.S.C.A. § 158. The provisions are referred to as “8” followed by the subsection. The provisions concerning notice of termination or modification of a collective bargaining agreement are set forth in 8(d)(1).

92 29 U.S.C.A. § 158(d)(A).

93 29 U.S.C.A. § 158(d)(1).

94 29 U.S.C.A. § 158(d)(1).

95 29 U.S.C.A. § 158(d)(1).

96 29 U.S.C.A. § 158(d)(A).

97 29 U.S.C.A. § 158(d)(3).

98 29 U.S.C.A. § 158(d)(C).

99 29 U.S.C.A. § 158(d)(C).

---

<sup>100</sup> 29 U.S.C.A. § 158(d)(3).

<sup>101</sup> See, 29 U.S.C.A. § 158(d)(3). Where a dispute arises during bargaining for an initial collective bargaining agreement among parties in a health care institution, following recognition or certification of a labor organization, section 8(d)(B) applies. Section 8(d)(B) requires the labor organization to give thirty days notice of the existence of the dispute to the state and federal mediation and conciliation services listed in section 8(d)(C). See 29 U.S.C.A. § 158(d)(B)-(C).

The NLRB and the Ninth Circuit have held that the thirty day notice requirement begins to run upon actual notification by the party seeking modification or termination. *Affiliated Hospital of San Francisco v. Scarce*, 415 F.Supp 711, 93 LRRM 2307 (ND Cal, 1976), *aff'd*, 583 F.2d 1097, 99 LRRM 3197 (9th Cir. 1978). The period does not necessarily start to run on the last possible day for notifying the agency, unless actual notice is given on that day. *Id.*

<sup>102</sup> 29 U.S.C. § 158(g).

<sup>103</sup> *Greater New Orleans Artificial Kidney Center*, 240 NLRB 432, 435-36 (1979); G.C. Memo. 74-79 (Aug. 20, 1974).

<sup>104</sup> *Alexandria Clinic*, 339 NLRB No. 162 (2003); *aff'd*, 406 F.3d 1020 (8<sup>th</sup> Cir. 2005).

<sup>105</sup> *Beverly Health & Rehabilitation Servs., Inc. v. NLRB*, 317 F.3d 316 (D.C. Cir. 2003).

<sup>106</sup> *NLRB v. Stationary Engineers Local 39*, 117 LRRM 2956.

<sup>107</sup> See, *Service Employees Local 200 (Eden Park Management)*, 263 NLRB 400, 111 LRRM 1613 (1982).

<sup>108</sup> *Mt. Carmel Hospital*, 355 NLRB 833 (1981); see also *Montefiore Hospital and Medical Center v. NLRB*, 621 F.2d 510, 104 LRRM 2160 (2d Cir. 1980) (holding non-union doctors not a labor organization for purposes of inclusion within Act's scope).

<sup>109</sup> *Painters Local No. 452 (Henry C. Beck Company)*, 246 NLRB 970, 103 LRRM 1002 (1979); *NLRB v. IBEW, Local 388*, 548 F. 2d 704, 94 LRRM 2536 (7th Cir.), cert. denied, 434 U.S. 837, 96 LRRM 2514 (1977).

<sup>110</sup> *Bricklayers Local 40 (Lake Shore Hospital)*, 252 NLRB 252, 105 LRRM 1317 (1980).

<sup>111</sup> *Shelby City Health Care Corp. v. AFSCME*, 140 LRRM 2680 (6th Cir. 1992).

<sup>112</sup> *Baptist Memorial Hospital System*, 288 NLRB 1160, 1171-72 (1988); *Retail Clerks Union, Local 727 (Devon Gables Health Care Center)*, 244 NLRB 586, 587 n.5 (1979); NLRB, Report of the General Counsel, November 8, 2002, "Picketing and Striking at Health Care Institution," at <http://www.nlr.gov/nlr/press/releases/r2464.asp>.

<sup>113</sup> *Shelby City Health Care Corp. v. AFSCME*, 140 LRRM 2680 (CA6 1992).

<sup>114</sup> *West Lawrence Care Center*, 141 LRRM 1262 (NLRB September 25, 1992).

<sup>115</sup> *West Lawrence Care Center*, 141 LRRM 1262, 1263-4 (Oviatt, Member concurring and dissenting in part), September 25, 1992.

<sup>116</sup> G.C. Memo 74-49 (Aug. 20, 1974).

---

<sup>117</sup> *Mastro Plastics Corp. v. NLRB*, 350 US 270 (1956).

<sup>118</sup> Originally applicable in 8(2)(1) notice of termination situations, Senate and House Reports indicated an extension of the *Mastro Plastics* defense to 8(g) cases. See *NLRB v. Mental Health Council*, 133 LRRM 2895 citing S. Rep. No. 766, 93rd Cong., 2d Sess. 4 (1974) U.S. Code Cong & Admin. News at 3949; H.R. Rep. 1051, 93rd Cong., 2d Sess. 6 (1974).

<sup>119</sup> See, *NLRB v. Mental Health Council*, 133 LRRM at 2902-3 (refusing to apply *Mastro Plastics* exception, fearing hardship to patients); *NLRB v. Stationary Engn'rs Local 39*, 746 F.2d 530, 533, 117 LRRM 2956, 2958 (9th Cir. 1984) (enforcing NLRB's decision to enforce 8(g) against violating union); *West Lawrence Care Center*, 141 LRRM 1262 (NLRB September 25, 1992)(majority of board holding union excused due to employer's unfair labor practices) *but see*, *West Lawrence Care Center*, 141 LRRM 1262 (NLRB September 25, 1992)(Oviatt, member concurring in part and dissenting in part) (Employer's ULP not serious enough to merit excusing unions non-compliance with 8(g)).

The Institute Sponsors acknowledge and appreciate the contributions by the following persons to this paper: Section I, II, V, and VI, Peter A. Janus and Shawn P. Coyne, Siegel O'Connor, Schiff & Zangari, Hartford, Connecticut; and Sections III and IV, Jonathan P. Hiatt, Service Employees International Union, Washington, D.C.