ORAL ARGUMENT NOT YET SCHEDULED
Nos. 15-1050 and 15-1097

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

RUSH UNIVERSITY MEDICAL CENTER,
Petitioner,

v.

NATIONAL LABOR RELATIONS BOARD,
Respondent,

INTERNATIONAL BROTHERHOOD OF TEAMSTERS, LOCAL 743
Intervenor for Respondent.

On Petition for Review of a Decision and Order of the National Labor Relations Board

BRIEF OF *AMICI CURIAE* THE AMERICAN HOSPITAL ASSOCIATION AND THE FEDERATION OF AMERICAN HOSPITALS IN SUPPORT OF PETITIONER

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Pursuant to Circuit Rules 27(a)(4) and 28(a)(1)(A), I hereby certify that:

A. Parties And *Amici*. All parties, intervenors, and *amici* appearing in this Court are listed in the Brief for Petitioner.

B. Rulings Under Review. References to the rulings at issue appear in the Brief for Petitioner.

C. Related Cases.

References to related cases appear in the Brief for Petitioner.

Dated: June 29, 2015

s/ F. Curt Kirschner, Jr.
F. Curt Kirschner, Jr.

RULE 26.1 CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1 and Circuit Rule 26.1, counsel for *amici* states the following:

1. No *amicus curiae* has outstanding shares or debt securities in the hands of the public, and none has a parent company. No publicly held company has a 10% or greater ownership interest in any *amicus curiae*.

2. The American Hospital Association ("AHA") represents more than 5,000 hospitals, health care systems, and other health care organizations, plus 42,000 individual members.

3. The Federation of American Hospitals ("FAH") is the national representative of investor-owned or managed community hospitals and health systems throughout the United States.

Dated: June 29, 2015

s/ F. Curt Kirschner, Jr.
F. Curt Kirschner, Jr.

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GLOSSARY OF TERMS

AHA	American Hospital Association
D&DE	Acting Regional Director's Decision and Direction of Election in NLRB Case No. 13-RC-132042
FAH	Federation of American Hospitals
Final Rule	Collective Bargaining Units in the Health Care Industry, 54 Fed. Reg. 16,336 (Apr. 21, 1989)
Health Care Rule or HCR	The National Labor Relations Board's 1989 Health Care Rule, 29 C.F.R. § 103.30
NAII	Nurse Assistant II
NLRA	National Labor Relations Act, 29 U.S.C. § 151 *et seq.*
NLRB or Board	National Labor Relations Board
NPRM I	Collective Bargaining Units in the Health Care Industry, 52 Fed. Reg. 25,142 (July 2, 1987)
NPRM II	Collective Bargaining Units in the Health Care Industry, 53 Fed. Reg. 33,900 (Sept. 1, 1988)
PCT	Patient Care Technician
Rush	Petitioner Rush University Medical Center
Union	Intervenor International Brotherhood of Teamsters Local 743

STATUTES AND REGULATIONS

All pertinent statutes and regulations are contained in the Petitioner's Brief.

STATEMENT OF INTEREST[1]

This case presents important questions about how an incumbent union may organize an acute care hospital's employees. The National Labor Relations Board has deemed eight, and only eight, collective bargaining units as appropriate in acute care hospitals. 29 C.F.R. § 103.30 ("Health Care Rule" or "HCR"). Prior to the decision below (and the unreviewed Board order on which it relies), an incumbent union that represented some of the employees in one or more of these eight bargaining units and sought to represent additional employees was required to organize the balance of employees in the classifications it represented. The Board here, however, permitted the Union to organize those employees in a piecemeal fashion. If not reversed, this decision may result in serial organizing and bargaining, and concomitant disruptions in patient care, that the Board's Health Care Rule was designed to prevent. *Amici* and their members have a strong interest in the resolution of these questions, which have the potential to affect

[1] All parties consent to the filing of this brief. No party's counsel authored this brief in whole or in part; no party or party's counsel, or any person other than the amici curiae, their members, or their counsel contributed money intended to fund the preparation or submission of this brief.

significantly the operation of acute care hospitals and to diminish the quality of patient care in those institutions.

The American Hospital Association is a national not-for-profit association that represents the interests of more than 5,000 hospitals, health care systems, and other health care organizations, plus 42,000 individual members. It is the largest organization representing the interests of the Nation's hospitals. AHA members are committed to improving the health of communities they serve. The AHA educates its members on health care issues and advocates on their behalf in legislative, regulatory, and judicial fora to ensure that their perspectives are considered in formulating health policy.

The Federation of American Hospitals is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Dedicated to a market-based philosophy, the Federation provides representation and advocacy on behalf of its members to Congress, the Executive Branch, the judiciary, media, academia, accrediting organizations, and the public.

Most of AHA's member hospitals, and all of FAH's member hospitals, are subject to the National Labor Relations Act. Many member hospitals interact frequently with organized labor, in circumstances ranging from long-standing collective bargaining relationships to initial organizing campaigns. As associations

representing the interests of health care providers with acute facilities subject to the Health Care Rule, the AHA and the FAH have substantial interest in how that Rule is interpreted and applied to determine appropriate bargaining units in acute care settings.

STATEMENT OF THE CASE

I. STATEMENT OF FACTS

Amici endorse Petitioner's Statement of Facts, but highlight those facts key to the issues that *amici* address.

The Union represents a unit of approximately 700 to 800 employees in principally non-professional job classifications at Petitioner's acute care hospital. Acting Regional Director's Decision and Direction of Election ("D&DE") at 2. Prior to the union's organizing efforts at issue here, there were approximately the same number of unrepresented non-professional employees, including the 245 Patient Care Technicians ("PCT") that the Union sought to organize.

In 2004, and again in 2006, consistent with the standards the NLRB enforced at the time, the Union sought to organize *all* of these non-professional employees into the unit of employees that it represents. Board Ex. 2, ¶ 10; Board Exs. 4, 5A, 5B. It therefore twice stipulated that a unit consisting of all such non-professional employees was appropriate. *Id*. The Union lost both of those elections. During the organizing campaigns that led to these elections, however,

Petitioner received complaints from patients concerned about the disruption that the organizing activity had caused. Hearing Transcript at 312-15.

As explained further below, in 2011 the NLRB changed the legal standard applicable to organizing residual employees in an acute care setting, permitting piecemeal organization of such employees for the first time. Thereafter, the Union sought to accomplish in stages what it previously failed to accomplish all at once: to organize Petitioner's unrepresented non-professional employees. It began with the petition at issue here, seeking to represent the 245 unrepresented PCTs, and resisting Rush's effort to include, at least, the more than 60 Nurse Assistant II's ("NAII") who have virtually identical job responsibilities, supervision, and the like. *See generally* D&DE. Thereafter, the Union advertised to the remaining unrepresented employees that it would shortly "be explaining next steps" to those employees to "move forward with Union elections in their various departments." Petr. Ans. to Compl., Case 13-CA-139088, Ex. 1. The Union has since filed four additional petitions seeking to selectively organize other subsets of Petitioner's non-professional employees. *See* Principal Brief of Petitioner at 22-24.

II. PROCEDURAL HISTORY

Amici endorse Petitioner's thorough recitation of the matter's procedural history.

STANDARD OF REVIEW

Amici endorse Petitioner's statement of the standard of review, noting that "the Board's powers in respect of unit determinations are not without limits, and if its decision 'oversteps the law,' it must be reversed." *Allied Chem. & Alkali Workers, Local Union No. 1 v. Pittsburgh Plate Glass Co.*, 404 U.S. 157, 171-72 (1971). *Amici* elaborate here on the Court's authority to review an agency's interpretation of its own regulations, since the Board's decision below purported to be interpreting its Health Care Rule, 29 C.F.R. § 103.30.

The Board's interpretation of the HCR is not entitled to deference under *Auer v. Robbins*, 519 U.S. 452 (1997) and *Bowles v. Seminole Rock & Sand Co.*, 325 U.S. 410 (1945). As the Supreme Court noted earlier this term, "*Auer* deference is not an inexorable command in all cases." *Perez v. Mortgage Bankers Ass'n*, 135 S. Ct. 1199, 1208 n. 4 (2015). Rather, such deference is clearly "inappropriate 'when the agency's interpretation is plainly erroneous or inconsistent with the regulation,' or 'when there is reason to suspect that the agency's interpretation does not reflect the agency's fair and considered judgment.'" *Id.*, quoting *Christopher v. SmithKline Beecham Corp.*, 132 S. Ct. 2156, 2166 (2012). This latter circumstance may occur "when the agency's interpretation conflicts with a prior interpretation." *See Christopher*, 132 S. Ct. at 2166; *see also Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 515 (1994) ("[A]n

agency's interpretation of a . . . regulation that conflicts with a prior interpretation is entitled to considerably less deference than a consistently held agency view").[2]

SUMMARY OF ARGUMENT

When it agreed to include not-for-profit hospitals within the NLRA's coverage in 1974, Congress repeatedly expressed concern that the Board carefully consider the impact of labor activity on hospitals' unique workplaces, which exist to provide a safe, healing environment for patients. The NLRB and the courts have also recognized and embraced this principle. Thus, in promulgating the HCR, the Board acknowledged and attempted to address these concerns at all stages of the employer-union relationship, including organizing and bargaining. While it left to adjudication how to address situations in which some but not all of a hospital's employees were organized, the Board pledged to apply its HCR in those situations "insofar as practicable."

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[2] Three members of the Supreme Court have questioned the continued viability of *Auer* and *Seminole*. *See Perez*, 135 S. Ct. at 1213 (Scalia, J concurring in the judgment) ("I would therefore . . . abandon[] *Auer* and applying the Act as written. The agency is free to interpret its own regulations . . . but courts will decide – with no deference to the agency – whether that interpretation is correct"); *id.* at 1225 (Thomas, J, concurring in judgment) ("the entire line of precedent beginning with *Seminole Rock* raises serious constitutional questions and should be reconsidered"); *id.* at 1211 (Alito, J concurring in part and concurring in judgment) (Justice Alito awaits "a case in which the validity of *Seminole Rock* may be explored through full briefing and argument"). Regardless of whether deference to an agency's interpretation of its own regulations may *generally* be appropriate, no such deference is warranted here for the reasons explained below and by Petitioner.

Here, the Board abandoned that principle. Prior to the decision in this case (and the unreviewed decision that underlies it), the Board had consistently held that an incumbent union that represented some employees in one or more of the HCR's eight designated units, and wished to represent additional employees in one or more of those units must represent all residual employees who appropriately belonged in the units it represented. In other words, if an incumbent union represented some of the hospital's non-professional employees, and it sought to represent more of those employees, the Board required the union to organize *all* remaining non-professional employees, such that the resulting unit would comply with the HCR "insofar as practicable."

Here, the Board cast those long-standing principles aside, and permitted a union that had been unable to successfully organize *all* of Petitioner's unrepresented non-professional employees to organize only a small portion of them. This piecemeal organization subjects Petitioner to serial organizing and bargaining, and all of the attendant disruption that brings. That result – which the Board failed to adequately explain – is contrary to the regulatory text, the policies underlying the HCR, and precedent. Therefore, it should be set aside.

The Board's decision is also contrary to the Act's command that the Board not give the extent of the union's organization controlling weight in the unit determination. The history of Intervenor's efforts to organize Petitioner's

employees make clear that the extent of the Union's ability to organize employees was the *only* factor that the Board gave any significant weight in reaching its unit determination.

The consequences of the Board's decision here are both real and substantial. Both the Board and the courts have recognized repeatedly the need to consider the potential impact on patient care that may result from union representation in acute care hospitals. Union organizing drives, and collective bargaining negotiations that result from successful campaigns, have significant potential to disrupt a hospital's ability to provide the type of "tranquil atmosphere" that the Supreme Court has recognized as critical to a hospital's mission. *Beth Israel Hosp. v. NLRB*, 437 U.S. 483, 494-95 (1978). The Board erred in failing to consider these issues in reaching its decision, and therefore the Court should vacate the decision.

ARGUMENT

I. STATUTORY AND REGULATORY BACKGROUND

A. The History of Collective Bargaining in the Health Care Industry, and the 1974 Amendments to the NLRA

In 1947, Congress excluded not-for-profit hospitals from coverage under the National Labor Relations Act ("NLRA"), in part due to concerns about the impact that collective bargaining relationships could have on patient care. In 1974, however, Congress voted to include hospitals within the NLRA's coverage. Labor Management Relations Act, ch. 120, 61 Stat. 136. Congress also enacted several

safeguards – including required strike notices, longer notice periods for contract negotiations, and stricter mediation requirements – to protect against disruptions in patient care. *See* 29 U.S.C. § 158(d)(4)(A)-(C) (requiring longer notice of a collective bargaining agreement's termination or modification, and immediate intervention by the Federal Mediation and Conciliation Service); *id.* at § 158(g) (requiring ten days' notice of intent to strike or picket a health care institution).

In addition to these explicit statutory protections, Congress repeatedly stressed its concern that the NLRB limit the number of collective bargaining units at any given acute care facility because of concerns about how the proliferation of units may adversely affect patient care. *See* S. Rep. No. 93-766 at 3, 6 (1974), as reprinted in 1974 U.S.C.C.A.N. 3946, 3948, 3951 (expressing Congress' view that "the needs of patients in health care institutions require[s] special consideration in the Act" and recognizing the "concern for the need to avoid disruption of patient care wherever possible"). Congress therefore "stressed the need for the Board to curtail such proliferation in health care institutions." 1 Legislative History of the Coverage of Nonprofit Hospitals under the National Labor Relations Act 1974, Public 93-360 S. 3203 Comm. 411 (1974). The Committee reports stated that,

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

> trend toward broader units enunciated in Extendicare of West Virginia, 203 NLRB No. 170, 83 LRRM 1242 (1973).

S. Rep. No. 93-766, 1974 U.S.C.C.A.N. at 3959; H.R. Rep. No. 93-1051, as *reprinted in* 1974 U.S.C.A.A.N. 3946.

Both the Board and the courts have similarly recognized, in several contexts, that the health care setting is different from others, and warrants different rules. As the Board itself has stated

> [T]he primary function of a hospital is patient care[,] and [] a tranquil atmosphere is essential to the carrying out of that function. In order to provide this atmosphere, hospitals may be justified in imposing somewhat more stringent prohibitions on solicitation than are generally permitted. For example, a hospital may be warranted in prohibiting solicitation . . . in strictly patient care areas, such as the patients' rooms, operating rooms, and places where patients receive treatment, such as x-ray and therapy areas. Solicitation at any time in those areas might be unsettling to the patients – particularly those who are seriously ill and thus need quiet and peace of mind.

St. John's Hospital & School of Nursing, Inc., 222 N.L.R.B. 1150, 1150 (1976); *see also Beth Israel Hosp.*, 437 U.S. at 494-95 (approving of same); *NLRB v. Baptist Hopsital, Inc.*, 442 U.S. 773, 783 (1979) (faulting the Board for failing to adequately consider evidence in support of a hospital rule designed to "protect the patients and their families from the disquiet that might result if they perceived that the Hospital's staff had concerns other than the care of patients").

B. The NLRB's Rulemaking and the Resulting Health Care Rule

Following Congress's 1974 amendments and accompanying admonition to avoid "undue proliferation" of collective bargaining units in acute care hospitals, the Board struggled to develop a workable standard for assessing the scope of appropriate collective bargaining units in those institutions. The Board initially continued to apply traditional community of interest criteria to determine appropriate units but, after the federal courts of appeal disapproved of that approach, created a "disparity of interests" standard instead. *See Int'l Bhd. of Elec. Workers, Local Union No. 474 v. NLRB*, 814 F.2d 697, 703-05 (D.C. Cir. 1987) (describing this history); *see also* Collective Bargaining Units in the Health Care Industry, 52 Fed. Reg. 25,142-01, 25,142 (July 2, 1987) (same) ("NPRM I"). Regardless of which standard it applied, however, the Board consistently recognized that, in deciding which units were appropriate, it must consider the special issues that arise in acute care hospitals and account for concerns about continuity and quality of patient care. *See, e.g.*, *Mercy Hosps. of Sacramento, Inc.*, 217 N.L.R.B. 765, 766 (1975) (health-care unit certification "must necessarily take place against this background of avoidance of undue proliferation"); *see also id.* at 768 (the Board should avoid "administrative and labor relations problems becom[ing] involved in the delivery of health care"); *Walker Methodist Residence & Health Care Center, Inc.*, 227 N.L.R.B. 1630, 1631 (1977) (recognizing

Congressional concern "that sudden, massive strikes could endanger the life and health of patients in health care institutions").

Having failed to develop a cohesive and consistent standard that the courts of appeal would accept, in 1987 the Board invoked its rulemaking powers to determine which collective bargaining units are appropriate in acute care hospitals, noting that "[t]he focus of all appropriate unit decisions in the health care industry has been the congressional admonition against 'undue proliferation.'" NPRM I, 52 Fed. Reg. at 25,143.

The congressional concern regarding "undue proliferation" was based not merely on the *number* of collective bargaining units at a particular facility, but also on the *effects* that distinct union organizing drives and their accompanying serial negotiations could have on delivery of uninterrupted, high quality patient care. For example, the Board stated that, in assessing the number of appropriate units, it was required to consider "Congress' expressed desire to avoid proliferation in order to avoid disruption in patient care, unwarranted unit fragmentation leading to jurisdictional disputes and work stoppages, and increased costs due to whipsaw strikes and wage leapfrogging." *See id.*; *see also* Collective-Bargaining Units in the Health Care Industry, 53 Fed. Reg. 33,900, 33,904 (Sept. 1, 1988) ("NPRM II") ("if the unit is too small, it may be costly for the employer to deal with because of repetitious bargaining and/or frequent strikes, jurisdictional disputes and wage

whipsawing . . .”). These concerns, the Board stressed, exist not just in the potential for strikes, but throughout all phases of the bargaining relationship:

> It would be most undesirable to create or permit a large-scale splintering of the workforce into the numerous trades, technical disciplines, and professions typically found in health care institutions. To give each such grouping a separate voice *for organizing and negotiating* would create a never-ending round of bargaining sessions and individualized demands *not conducive to stability, industrial peace, or the smooth delivery of services to the public.*

NPRM II at 33,905 (emphasis added); *see also id.* (noting the need for groupings “large enough that unnecessary, repetitious rounds of bargaining are avoided”); *id.* at 33,908 (“the potential for a number of units does not mean that every hospital will be faced with this number of *organizing campaigns*”) (emphasis added).

The Board affirmed repeatedly that it shared Congress’ concern about the potential impact of undue proliferation of units on patient care. *See id.* at 33,905 (“we intend at all times to . . . avoid[] undue proliferation, not only because this desire was expressed in the legislative history, but also because it accords with our own view of what is appropriate in the health care industry”); Collective-Bargaining Units in the Health Care Industry, 54 Fed. Reg. 16,336, 16,346 (Apr. 21, 1989) (“Final Rule”) (noting “*our concern* about proliferation”) (emphasis added).

In the end, the Board’s HCR permits eight, and only eight, collective bargaining units in acute care hospitals. Where existing units did not conform to

these eight units, the Board decided to adjudicate each case, applying "the new rules to these situations insofar as practicable." NPRM II at 33,930; Final Rule at 16,346 ("residual or fractional units" are prohibited in health care facilities; the Board's "stated intention will be, insofar as possible, to conform new units in [] situations [with existing units] to the proposed rule."). To this end, Section 103.30(c) of the Health Care Rule states (*see* 29 C.F.R. § 103.30(c) (emphasis added)):

> Where there are existing non-conforming units in acute care hospitals, and a petition for additional units is filed pursuant to sec. 9(c)(1)(A)(i) or 9(c)(1)(B), the Board shall find appropriate *only* units which comport, insofar as practicable, with the appropriate unit set forth in paragraph (a) of this section.

The Supreme Court upheld the HCR, noting the "concern that labor unrest in the health care industry might be especially harmful to the public," but finding that the Board had reasonably accounted for this concern in promulgating the Rule. *American Hosp. Ass'n v. NLRB*, 499 U.S. 606, 615 (1991).

C. Until Recently, the Board Consistently Interpreted the HCR

The Board originally kept its promise to conform new collective bargaining units in partially-organized acute care facilities to the HCR. To be sure, the Board refused to dismantle *existing* non-conforming units, *Kaiser Foundation Hospitals*, 312 N.L.R.B. 933 (1993), or to require those units to conform to the HCR where no new employees were being organized, *Crittenton Hospital*, 328 N.L.R.B. 879

(1999). But in situations such as this one, where a union sought to organize a group of previously unrepresented employees, the Board required the resulting unit to conform, "insofar as practicable," to the HCR.

In *St. John's Hospital*, 307 N.L.R.B. 767 (1992), a union that represented skilled maintenance employees sought to organize some, but not all, of the hospital's unrepresented skilled maintenance employees into a new, separate unit. The Board held that this was improper for two reasons. *First*, if the union wished to represent any unrepresented skilled maintenance employees, the Board held that it must seek to represent *all* unrepresented skilled maintenance employees, rather than organize only some of those employees. *See id.* at 768 ("the petitioned-for unit which includes only a portion of the remaining unrepresented skilled maintenance employees is inappropriate"; "the Board requires that all unrepresented employees residual to the existing unit or units be included in an election to represent them"). *Second*, the Board held that because the union already represented hospital employees, the skilled maintenance employees, if they chose the union's representation, had to be included in the *existing* unit with the employees that the union already represented. *Id.* ("because the Petitioner already represents a nonconforming unit of skilled maintenance employees," "to represent of the remaining unrepresented skilled maintenance employees, the Petitioner must represent all the remaining skilled maintenance employees as part of its existing

unit"). In other words, the Board explicitly required an incumbent union seeking to organize additional employees to do so by organizing the balance of the employees who belonged to one or more of the eight HCR groups it already represented, thus conforming the group as much as possible to the HCR's strictures.

The Board reaffirmed this holding in *St. Mary's Duluth Clinic Health System*, 332 N.L.R.B. 1419 (2000). There, a non-incumbent union sought to represent a residual unit of previously unrepresented technical employees; another union already represented some of the technical employees. The Board described its *St. John's* decision as follows:

> The Board first held that any election to determine a representative for unrepresented skilled maintenance workers would have to include *all* the remaining skilled maintenance workers residual to the existing unit or units. The Board then went on to apply its long-settled rule that an incumbent union wishing to represent employees residual to those in its existing unit could only do so by adding them to the existing unit . . .

Id. The Board then held that the non-incumbent union could represent a residual unit of technical employees, so long as *all* unrepresented technical employees were included in the unit. *Id.* at 1421 (no undue proliferation due to "Board precedent requiring that any residual unit include *all* unrepresented employees in the particular classification at issue").

II. THE NLRB'S DECISION TO PERMIT INTERVENOR TO ADD EMPLOYEES TO A HEALTH CARE UNIT ON A PIECEMEAL BASIS PROMOTES THE VERY TYPE OF REPETITIVE ORGANIZING THAT CONGRESS AND THE BOARD'S HCR WAS TRYING TO PREVENT

A. The NLRB's Unacknowledged Departure From Its Well-Settled Rules

In 2011, the Board deviated for the first time from the long-settled principle that, at least in acute care hospitals, a union wishing to organized a residual unit of unrepresented employees must organize "*all*" unrepresented employees in the classification at issue. Thus, in *St. Vincent Charity Medical Center*, 357 N.L.R.B. No. 79 (2011), the Board permitted an incumbent union to organize a unit of seventeen phlebotomists into an existing unit of 200 technical, non-professional, skilled maintenance, and business clerical employees, leaving approximately 200 additional employees in these classifications unrepresented. *Id.*, slip op. at 1.

The Board gave three justifications for its decision. *First*, focusing myopically on the mere *number* of collective bargaining units, the Board held that adding employees to an existing unit in a piecemeal fashion, as the Board's decision permitted, did not raise any proliferation concerns, because no new units were added to the total. *Id.*, slip op. at 2. *Second*, the Board noted that the HCR, and its admonition that future organizing in partially organized facilities should comply with the Rule "insofar as practicable" did not apply, because, according to the Board, the HCR applies only when additional *units* are sought, and not where

the union merely seeks to represent additional employees. *Id.* at 2 n.8. *Finally*, the Board majority purported to distinguish *St. John's*, finding that the Board there "did not specifically address" whether the Regional Director correctly required the incumbent union to include the skilled maintenance employees that it had not originally sought to organize in the election. *Id.* at 3.

B. As Applied Here, *St. Vincent* Is Plainly Contrary to the Text and Intent of the HCR and the NLRB's Own Prior Precedents

Here, the Regional Director's certification decision, which the Board declined to review, is based entirely on *St. Vincent Hospital*. Neither the Regional Director nor the Board offered any other justification for holding, as it did here, that Intervenor should be permitted to organize only PCTs, rather than all residual non-professional employees. But *St. Vincent* is contrary to the text and intent of the HCR, and amounts to an unexplained (indeed, unacknowledged) and unjustified departure from precedent. For those reasons, the Board's certification decision is arbitrary and capricious and should be set aside.

As noted above, the Board offered essentially three justifications for its *St. Vincent* decision, but each one is so without merit as to render the Board's decision arbitrary and capricious.

First, the Board in *St. Vincent* held that permitting self-determination elections in a subset of the hospital's remaining non-professional employees created no unit proliferation issues because the employees were to be added to an

existing unit, rather than a unit of their own. Because the number of units would stay the same, the Board found no unit proliferation problem.

The Board's focus on the *number* of collective bargaining units to the exclusion of all else, however, ignores the policies that the Board itself has stated underlie the HCR and renders the decision unsupported, arbitrary, and capricious. Congress' admonitions regarding undue proliferation were not based on a simple counting of the number of collective bargaining units in an acute care facility, but rather were based on concerns about the impact of multiple units on the quality and stability of patient care. *See* S. Rep. No. 93-766 at 3, 6, 1974 U.S.C.C.A.N. at 3948, 3951 (recognizing both that the needs of patients require special consideration under the Act, and that disruption of patient care should be avoided "wherever possible"). As the Board itself correctly explained in promulgating the HCR, these concerns apply when multiple groups of employees are given "a separate voice for organizing and negotiating" contracts, which detracts from "stability, industrial peace, [and] the smooth delivery of services to the public." NPRM II at 33,905.

That is so, of course, regardless whether those groups receive "separate voice[s]" because they are part of different, separately represented collective bargaining units, or whether, as the Board permitted here, they are simply part of different organizing campaigns and bargaining efforts that ultimately become

pieces of the same collective bargaining unit. A patient whose care has been interrupted or diminished in quality because of workplace disruption is unlikely to be concerned with whether the disruption resulted because the hospital has too many collective bargaining units, or because it has been forced into too many organizing campaigns, elections, and associated negotiations, each of which raises the specter of a strike or other protected activity that may disrupt the hospital.

Regardless of whether the disruption occurs because of a separate negotiation with an incumbent union, or with a non-incumbent union, a patient's experience, and perhaps his or her health, may suffer in a manner that Congress has stated, and the Board has acknowledged, the Board has a duty to avoid. As Petitioner cogently explains (*see* Petr's Br. at 40-42), such serial organizing and negotiating is the inevitable result of the Board's decision here. The Board failed to consider these underlying policies, much less explain how its decision accounted for the concerns that they raise. For that reason alone, the decision is arbitrary and should be set aside. *Blue Man Vegas, LLC v. NLRB*, 529 F.3d 417, 420 (D.C. Cir. 2008) (bargaining unit determinations that are "arbitrary or not supported by substantial evidence in the record" will be overturned) (internal citation and quotation omitted); *Tualatin Elec., Inc. v. NLRB*, 253 F.3d 714, 717 (D.C. Cir. 2001).

Second, the Board's decision is contrary to the HCR's text, which provides that, where, as here, "there are existing non-conforming units in acute care hospitals, and a petition for additional units is filed . . . the Board shall find appropriate only units which comport, insofar as practicable, with the appropriate unit set forth in paragraph (a) of this section." 29 C.F.R. § 103.30(c). This provision requires the Board to find appropriate only a unit that "comport[s], insofar as practicable," with one of the eight units that the HCR designates.

The Board argued that this provision applies only when "a petition for additional units is filed," and that no such petition had been filed here.

The Board's overly narrow interpretation of the HCR is contrary to the regulatory text. The parties here, with the Board's approval, described the group of employees that the Union sought to organize here as a "unit" of employees, stipulating that the Union claimed to "represent the employees *in the unit described in the petition*," that the Employer "decline[d] to recognize" the Union as the representative of those employees; and that there was no collective bargaining agreement presently covering "any of the employees *in the unit sought in the petition*." *See* Board Ex. 2, ¶¶ 5, 6 (emphasis added).

The parties' stipulation is consistent with the Board's usual description of a group of employees to be organized pursuant to a self-determination election as a "unit." *See, e.g.*, 29 C.F.R. § 102.63(a) (requiring an election after a petition is

filed where the election "will reflect the free choice of employees *in an appropriate unit*") (emphasis added); *St. John's*, 307 N.L.R.B. at 767 (describing Section 103.30(c) as providing that "[w]here there are existing non-conforming units, the Rule provides that the Board will find appropriate only units which comport, insofar as practicable, with [the eight defined] units"). In light of the parties' stipulations, and the Board's own prior use of the term "unit," it is clear that a petition seeking to represent previously unrepresented employees is a "petition for additional units" as the Board has historically and usually interpreted that term. The Board's changed and erroneous contrary interpretation is not entitled to deference (*see Perez*, 135 S. Ct. at 1208 n.4), and provides no basis at all for the *St. Vincent* decision.

Finally, rather than admit that its *St. Vincent* decision overruled *St. John's*, the Board instead attempted to distinguish *St. John's*, claiming that the Board in that case did not consider whether the Regional Director was correct to require the incumbent union to include the skilled maintenance employees that it had not originally sought to organize in the self-determination election. *St. Vincent*, slip op. at 3. That is plainly not true. In *St. John's*, the Board explicitly held that it "agree[d] with the Regional Director that the petitioned-for unit which includes only a portion of the remaining unrepresented skilled maintenance employees is inappropriate" because "the Board requires that all unrepresented employees

residual to the existing unit or units be included in an election to represent them." *St. John's*, 307 N.L.R.B. at 768. Far from failing to consider whether the Regional Director was correct, the Board explicitly *did consider* that question, and *agreed with the Regional Director*.

That conclusion is obvious not only from the text of the Board's *St. John's* opinion, but also from the summary of that decision it provided in *St. Mary's*. There, the Board explicitly stated that the *St. John's* decision "held that any election to determine a representative for unrepresented skilled maintenance workers would have to include *all* the remaining skilled maintenance workers residual to the existing unit or units." *St. Mary's*, 332 N.L.R.B. at 1419. Again, far from stating that the Board "did not specifically address" whether the Regional Director correctly ordered that all residual employees in a particular classification must be included in the new unit, the Board (for the second time) made crystal clear that all such employees must be included.

Here, therefore, the Board attempted to disguise its departure from settled precedent by inventing a distinction that does not exist. In so doing, the Board failed not only to *explain* its departure from long-settled precedent; it failed even to acknowledge that departure. This Circuit has not hesitated to overturn Board action in when it engages in this conduct. *ConAgra, Inc. v. NLRB*, 117 F.3d 1435,

1443-44 (D.C. Cir. 1997) (refusing to enforce Board order that "rests on an unexplained (indeed an unacknowledged) departure from the Board's precedent").

It is therefore clear that the Board's *St. Vincent* decision is contrary to the policies underlying the HCR, the regulatory text, and precedent. It is equally clear that, absent its improper *St. Vincent* decision, the Board has no justification at all for its decision in this case. Had the Board applied the law as it existed prior to *St. Vincent* – which is *consistent* with policy, the regulatory text, and precedent – it would have dismissed the petition, or required an election including all of Petitioner's unrepresented non-professionals. Since the Board did not do so, this Court should vacate the Board's order.

C. The NLRB's Decision Is Contrary to the NLRA's Text

Under the NLRA, Congress entrusted the Board, rather than the petitioning union, with the power to determine whether a particular collective bargaining unit is appropriate. For that reason, in response to Board "decisions where the unit determined could only be supported on the basis of the extent of organization," *NLRB v. Metro. Life Ins. Co.*, 380 U.S. 438, 441 (1965), Congress amended the NLRA to provide that "[i]n determining whether a unit is appropriate[,] . . . the extent to which the employees have organized shall not be controlling," 29 U.S.C. § 159(c)(5). Section 9(c)(5) was thus designed to "strike[] at a practice of the Board by which it has set up [as] units appropriate for bargaining whatever group

or groups the petitioning union has organized." H.R. Rep. No. 80-245, at 37 (1947), *reprinted in* 1 NLRB, Legislative History of the Labor Management Relations Act 328 (1948).

Congress viewed Section 9(c)(5) as essential to "assure full freedom to workers to choose, or to refuse, to bargain collectively, as they wish." *Id.*; *see also* 29 U.S.C. § 159(b) (same). Affording too much deference to the petitioned-for unit undermines that freedom, because the union's overriding consideration in selecting a unit is its ability to win a representation election. This jeopardizes both the right of dissenting employees within that unit to refrain from organizing, and the right of excluded employees to engage in collective bargaining. *See id.* § 157. Thus, although the Board is not "prohibit[ed] . . . from considering the extent of organization as one factor . . . in its unit determination," *Metro Life Ins. Co.*, 380 U.S. at 442, "this evidence should have little weight." H.R. Rep. No. 80-245, at 37. This Circuit has held that Section 9(c)(5)'s use of the word "controlling" "has generally been thought to mean that there must be substantial factors, apart from the extent of union organization, which support the appropriateness of a unit." *Local 1325, Retail Clerks Int'l Ass'n, AFL-CIO v. NLRB*, 414 F.2d 1194, 1199 (D.C. Cir. 1969).

Here, it is plain that the "extent of the union's organization" was *the* factor supporting the Board's unit determination. *See* Employer's Post-Hearing Brief at

8-9. Before *St. Vincent*, the applicable legal standard required the Union to organize *all* of Petitioner's residual non-professional employees in a single election. The Union stipulated that a unit of these employees was appropriate twice, in 2004 and 2006. Each time, it failed to obtain the support of a majority of these employees.

In response, rather than attempt to persuade dissenting employees in the residual unit to accept representation, the Union chose to gerrymander, seeking instead the support of a smaller portion of the unrepresented non-professional employees. As explained above, permitting the Union to organize only this select group was contrary to the text of the HCR, the policies that the Board articulated in support of that Rule when it promulgated it, and settled Board precedent.

Rather than acknowledge these inconsistencies and explain its changed course, the Board instead dodged them, concluding that piecemeal organization was appropriate. But, there was no reason to do that other than "the extent to which employees ha[d] organized." The Board cited no "substantial factors" in support of its decision, other than its profoundly flawed *St. Vincent* decision and the maxim that "non-professionals presumptively share a community of interest with other non-professionals." Assuming that is true, the broader unit that the HCR dictates – consisting of all non-professionals – would likewise be an

appropriate unit; that certainly provides no reason to limit the unit to those the Union could more readily organize.

Permitting organizing in violation of Section 9(c)(5)'s admonition is inappropriate in all settings, but it is particularly inappropriate in acute care hopsitals, given the special concerns regarding continuity and quality of patient care that Congress, the courts, and the Board have repeatedly cited. This Court should not countenance the Board's decision to flout not only its own rule, but the NLRA's text, in order to permit the Union to organize piecemeal groups of employees that it was unable to organize together.

D. NLRB's Decision Will Create Substantial Disruptions in Health Care Settings that the 1974 Amendments and the HCR Were Structured to Avoid

When it decided to bring not-for-profit hospitals within the NLRA's coverage in 1974, Congress expressed substantial concern regarding the impact that doing so might have on patient care. After struggling to define the scope of appropriate collective bargaining units in the health care industry, the Board, acknowledging and adopting these concerns, promulgated the HCR. It designed the Rule to limit not only the number of collective bargaining units in acute care hospitals, but also to limit the impact of serial organizing and bargaining on patient care. Indeed, the Board has repeatedly recognized, in numerous contexts, the need for labor law to adjust itself to the health care environment, and not the other way

around. *St. John's Hospital*, 222 N.L.R.B. at 1150; *Mercy Hosps.*, 217 N.L.R.B. at 766.

In this case, the Board cast all of that history, and all of those concerns, aside in favor of a overly simplistic (and incorrect) reading of its HCR. It did so to permit a Union that had previously failed to gain the support of a majority of employees in a unit appropriate under the HCR to organize a smaller group of employees. It is clear, however, that the Union does not intend to stop there; it intends to continue organizing groups of employees one-by-one that it could not organize together.

As Petitioner has explained in detail, the consequences for its efforts to provide seamless patient care are significant and serious. Nor are they hypothetical; Petitioner offered evidence that prior organizing campaigns and periods of collective bargaining caused disruptions in patient care, resulting in complaints to hospital management from patients and their families. It is telling, and disturbing, that the Board forced Petitioner to provide this evidence through an offer of proof, rather than permitting testimonial and documentary evidence regarding the impact piecemeal organization would have on Petitioner's patients.

But the consequences *beyond* Petitioner are even more grave. There are thousands of acute care hospitals in the United States. According to the Board, each hospital with any pre-existing non-conforming collective bargaining units

should now be subject to piecemeal organizing of small groups of employees (such as the seventeen employees at issue in *St Vincent*). For each one of these small targeted groups of employees, the Hospital would face a potentially disruptive organizing drive. *St. Margaret Mercy Healthcare Ctr. v. NLRB*, 519 F.3d 373, 374 (7th Cir. 2008) (recognizing "the interest of the employers and others (such as, in this case, the hospital's patients) in being free from disruptive interferences by union organizers"). And, if the union wins the election, then the Hospital would need to bargain with the union, as the parties negotiate the incorporation of the newly organized unit into the pre-existing unit. Each one of these series of negotiations could be lengthy, leading to disruptive, but protected, activities, such as informational picketing and even strikes. And, those strikes, even if arising from negotiations directly affecting only a small number of employees, could disrupt the entire hospital. Even assuming that the incumbent unit has a collective bargaining agreement in place containing a "no strike" clause, those same employees may have a right to engage in a sympathy strike to support the newly organized workers. *Childrens Hosp. Med. Ctr. of Northern Cal. v. Cal. Nurses' Ass'n*, 283 F.3d 1188 (9th Cir. 2002)(affirming nurses' union's right to engage in sympathy strike against hospital despite collective bargaining agreement's no-strike clause).

The potential consequences of the Board's decision are real. According to the Bureau of Labor Statistics, strikes in the health care and social assistance sector accounted for 34% of major work stoppages from 2009 through 2014, as compared with 11% from manufacturing facilities. *See* News Release, U.S. Department of Labor, Bureau of Labor Statistics, Major Work Stoppages in 2014 (Feb. 11, 2015), www.bls.gov/news.release/pdf./wkstp.pdf (last visited June 26, 2015). Such disruptions threaten our hospitals' ability to provide the type of uninterrupted, quality patient care that the Supreme Court has found critical and that Congress (and the Board, at least previously) sought to protect. *St John's Hospital*, 222 N.L.R.B. at 1150; *Beth Israel Hosp.*, 437 U.S. at 494-95; *Baptist Hospital*, 442 U.S. at 783. In the decision below as well as the prior decision on which it was based, the Board failed to mention, much less consider, these concerns. For that reason, too, this Court should vacate the Board's Order.

CONCLUSION

For the foregoing reasons, *amici curiae* urge this Court to vacate the Board's Order.

Respectfully submitted,

Dated: June 29, 2015

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CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing brief complies with the type-volume limitation of Fed. R. App. P. 29(d) and Fed. R. App. P. 32(a)(7)(B) because it contains 6,964 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii) and D.C. Cir. R. 32(a)(1), as counted using the word-count function on Microsoft Word 2007 software.

This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word 2007 in 14-point Times New Roman font.

Dated: June 29, 2015

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CERTIFICATE OF SERVICE

I hereby certify that on this 29th day of June, 2015, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system, which will send an electronic notification of such filing to all parties.

s/ Jacqueline M. Holmes
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