Montefiore Hospital and Medical Center *and* New York State Federation of Physicians and Dentists, Petitioner. Cases 2-RC-18594 and 2-RC-18629

April 30, 1982

DECISION AND DIRECTION OF ELECTIONS

BY CHAIRMAN VAN DE WATER AND MEMBERS FANNING, JENKINS, AND ZIMMERMAN

Upon petitions duly filed under Section 9(c) of the National Labor Relations Act, as amended, a hearing was held before Paul Rickard, a hearing officer of the National Labor Relations Board. Following the hearing and pursuant to Section 102.67 of the National Labor Relations Board Rules and Regulations and Statements of Procedure, Series 8, as amended, the Regional Director for Region 2 issued an order transferring these cases to the Board for decision. Thereafter, the Employer and the Petitioner filed briefs in support of their respective positions.

The Board has reviewed the Hearing Officer's rulings made at the hearing and finds that they are free from prejudicial error. They are hereby affirmed.

Upon the entire record in these cases, the Board finds:

1. The Employer, Montefiore Hospital and Medical Center (herein referred to as the Medical Center or the Employer), is a New York not-for-profit corporation which operates Montefiore Hospital, located at 111 East 210th Street, Bronx, New York. The Medical Center is engaged in providing health care facilities located in and around the city of New York, most of which also are located in the Borough of the Bronx, New York. The Medical Center is engaged in providing health care and related services to the sick and the infirm. In the course and conduct of its operations, the Medical Center annually derives gross revenues in excess of $500,000 from the performance of its services and it purchases supplies and materials valued in excess of $50,000 directly from suppliers located outside the State of New York. Based on the foregoing stipulated facts, we find that the Medical Center is engaged in commerce within the meaning of the Act and that it will effectuate the purposes of the Act to assert jurisdiction herein.

2. The Petitioner is a labor organization claiming to represent certain employees of the Medical Center.

3. A question affecting commerce exists concerning the representation of certain employees of the Medical Center within the meaning of Section 9(c)(1) and Section 2(6) and (7) of the Act.

4. The Medical Center provides its health care services at several geographic locations. It has two clinical campuses, referred to as West Campus and East Campus, on which a number of hospitals are located.[1] In addition it operates various ambulatory care centers and a health service for some of New York City's correctional institutions.

The Petitioner seeks to represent staff physicians and dentists (herein referred to collectively as doctors) employed by the Medical Center. The parties are in some disagreement as to the scope and composition of any unit which may be established,[2] but their basic disagreement concerns whether the doctors are protected by the Act.

It is the Employer's position that the doctors are managerial because they participate in the formulation and implementation of policies concerning the operation of the Medical Center, and hence cannot be included in any certified unit. The Employer relies on the Supreme Court decisions in *Bell*[3] and *Yeshiva*[4] dealing with the status of managerial employees.

In *Bell*, which involved buyers in the purchasing and procurement department of a researcher and developer in the industrial sector, the Court held that managerial employees are not entitled to the benefits of the Act, and sanctioned a definition of managerial persons as those who "formulate and effectuate management policies by expressing and making operative the decisions of their employer."[5] In *Yeshiva*, which involved an academic institution, the Court found that certain faculty members were managerial. In this case we are required to apply the principles concerning managerial employees to a health care setting.

We note, initially, that the staff doctors of the Medical Center are professional employees as defined in Section 2(12) of the Act, and we have recognized that staff doctors may constitute an appropriate bargaining unit separate from other professional employees[6] even though in the health care

[1] West Campus consists of Montefiore Hospital, North Central Bronx Hospital, and Montefiore Medical Group. East Campus includes the Hospital of the Albert Einstein College of Medicine and Bronx Municipal Hospital Center composed of Jacobi and Van Etten hospitals.

[2] The Employer also contends that the health service it operates for the correctional institutions is controlled by, and intimately connected with, the city of New York, a political subdivision of the State of New York, and therefore the petition seeking a unit at this location should be dismissed.

[3] *N.L.R.B.* v. *Bell Aerospace Co.*, 416 U.S. 267 (1974).

[4] *N.L.R.B.* v. *Yeshiva University*, 444 U.S. 672 (1980).

[5] *Supra*, 416 U.S. at 288.

[6] *Montefiore Hospital and Medical Center*, 235 NLRB 241 (1978); see also *Mon Valley United Health Services*, 238 NLRB 916, 924, fn. 17 (1978), and *Ohio Valley Hospital Association*, 230 NLRB 604 (1977).

industry the Board is required to avoid the fragmentation of units.[7] As professional employees, the doctors may also be managerial, but their managerial status may not be based on decisionmaking which is part of the routine discharge of professional duties. Only if the activities of professional employees fall outside the scope of the duties routinely performed by similarly situated professionals will they be found aligned with management.[8] And in the health care context the Board must evaluate the facts of each case to determine whether decisions alleged to be managerial or supervisory are incidental to the professional's treatment of patients.[9]

Seeking to apply these principles, we consider the organization of the Medical Center and the role and responsibilities of the doctors, together with the Employer's contentions that the doctors' managerial status is shown by their participation in departmental operations, committee service, and the residents training program, and their employment on the faculty of a medical college.

The Medical Center's administrative structure is highly centralized. It has a board of trustees which appoints a president of the Medical Center. Reporting to the president is a director, who has five deputy directors responsible, respectively, for the following areas: administration, fiscal affairs, human resources, ambulatory care, and professional affairs. The director and the deputy directors constitute a senior management committee, which makes all policy for the Medical Center and all of its units. The Medical Center has a separate budget for each of its facilities, but ultimate control of financial and administrative matters pertaining to all employees rests with these deputy directors. The deputy director for human resources is responsible for setting and administering personnel and labor relations policies, including those relating to wage guidelines, overall percentages of wage increases, job titles, grievance handling, and employee benefits, for all doctors. The deputy director for ambulatory care has final authority over all outpatient services provided by the Medical Center's doctors. Other professional services provided by these doctors fall within the jurisdiction and ultimate control of the deputy director for professional affairs.

The basic professional grouping by which the Medical Center's doctors are organized is the department. The record establishes that almost all doctors employed by the Medical Center are appointed to one or more departments based on the areas of professional expertise in which they are qualified. Most of these departments, called nonunified departments, encompass all of the facilities located on one campus. Some departments, however, including such large departments as surgery and medicine, encompass doctors at facilities on both campuses. These are called unified departments.[10] Both unified and nonunified departments also encompass doctors at certain satellite facilities.

Each department is headed by a chairman or director who, subject to the approval of the deputy director for professional affairs, has the basic responsibility for hiring doctors to practice in the department. Appointments of individuals to more than one department are jointly agreed upon by the relevant department chairmen. The chairmen also evaluate department members; apportion their wage increases from an amount of money allocated by the Medical Center basically on a departmental basis; and decide how to allot employee time to the facilities within their jurisdiction.

All institutionwide policy is formulated by central administrators, and institutionwide policies appear to pervade the Medical Center's day-to-day operations, thus limiting the managerial autonomy within each department, leaving a smaller area of autonomy than was vested within the individual schools comprising Yeshiva University. This constriction of autonomy presents a significant distinguishing factor. For the purpose of this Decision, however, the crucial difference is the manner in which the Medical Center departments, as contrasted with the individual schools of Yeshiva University, are governed.

The Supreme Court found the governance of the individual schools at Yeshiva to be largely a collegial matter, with the real authority for fundamental decisions regarding management policy vested in the faculty as a group:

> The controlling consideration in this case is that the faculty of Yeshiva University exercise authority which in any other context unquestionably would be managerial. Their authority in academic matters is absolute. They decide what courses will be offered, when they will be scheduled, and to whom they will be taught. They debate and determine teaching methods, grading policies, and matriculation standards. They effectively decide which students will be admitted, retained, and graduated. On occasion their views have determined

[7] See *Mercy Hospital of Sacramento, Inc.*, 217 NLRB 765, 766 (1975), for a discussion of the legislative history of the 1974 health care amendments to the Act.

[8] See *Sutter Community Hospitals of Sacramento, Inc.*, 227 NLRB 181, 193 (1976); *Yeshiva, supra*, 444 U.S. at 690.

[9] S. Rept. 93-766, 93d Cong., 2d sess., 6 (1974); *Yeshiva, supra*, 444 U.S. at fn. 30.

[10] As of the time of the hearing, unification of the department of medicine was scheduled to be completed in 1980.

> the size of the student body, the tuition to be charged, and the location of a school. When one considers the function of a university, it is difficult to imagine decisions more managerial than these. To the extent the industrial analogy applies, the faculty determines within each school the product to be produced, the terms upon which it will be offered, and the customers who will be served.

Here, the medical and dental departments of the Medical Center are governed by the department chairmen or directors, and administered by them with the aid of subordinate supervisors called, variously, directors, chairmen, deputy chairmen, and chiefs of services.[11]

In the words of the Medical Center's deputy director for professional affairs, the department chairmen (or directors) are responsible for setting and implementing "the standards for professional care of patients, teaching [and] research in their departments . . . and to manage the activities" of their departments. Medical directors within the departments, or such other persons as serve directly under the chairmen, typically lay out schedules, assign and evaluate the doctors, and deal "with problems as they come up." In consultation with, or by authority of, the chairmen, they allocate among the doctors the total amount of money appropriated for wage increases.[12]

As a general proposition, the chairmen make every major administrative decision with respect to the operation of their departments that is not dictated from above. Staff doctors have some input, but this is only in the form of recommendations which, for the most part, the chairmen or their designees evaluate. For example, unlike the faculty in some universities, the staff does not vote on hiring decisions. Search committees often help narrow the field of consideration, but the chairmen make the final selection subject to approval, usually *pro forma*, from the central administration. Medical procedures and policies are discussed and adopted at staff meetings, but the record does not show that these become management directives to any significant extent; rather what little the record offers tends to show that the policies adopted become general guidelines, implementation of which is, to a large extent, the individual doctor's professional decision. While there is testimony concerning "medical boards" to which all the staff physicians, plus other professionals and administrators, belong, such boards neither make policy nor have any direct responsibility for the quality of patient care. There is also a faculty senate, but it functions only with respect to matters such as resident training, and not day-to-day practice in the departments.[13] Department chairmen typically make the final selection of residents, although, in some departments, they "generally" follow the recommendations of a staff committee.

In short, the department chairman makes the managerial decisions, delegating some to subordinate supervisors. He does not rubber-stamp the staff's recommendations. Rather, as one departmental supervisor testified: "[The chairman's] decisions take into account the will of the staff."

The Employer nevertheless contends that its staff doctors are managerial employees, relying on the doctors' possession of faculty appointments to the Albert Einstein College of Medicine and on their asserted collegial participation in the formulation and implementation of "medical policy,"[14] relative to academic matters and hospital administration. An important factor distinguishing the position of the doctors as faculty members here from the faculty members in *Yeshiva* is that the *Yeshiva* faculty members were full-time teaching or otherwise educationally related personnel whose collegial authority with respect to academic matters was deemed to be so closely connected with the "business" of the university that their decisions constituted governance of the institution (444 U.S. at 688). Here, on the other hand, the staff doctors are, as a whole, primarily concerned with patient care rather than academic matters; each is primarily associated with a hospital, which happens to be a teaching hospital, and only secondarily with an educational institution.[15] Further, the Petitioner seeks to represent the doctors only in their employment relationship with the Medical Center.

The specific exercise of authority by staff doctors in academic matters which the Medical Center

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[11] There are approximately 95 stipulated supervisory positions among the approximately 500 staff doctors working half time or more for the Medical Center. These supervisors, some of whom may also be managerial employees, are exclusive of the various administrators serving departments, constituent hospitals of the Medical Center, and the Medical Center itself.

[12] Each department receives annually an amount representing a certain percentage of the total of salaries for the previous year. The increases are not necessarily distributed across the board. The chairmen have, and exercise, the discretionary power to distribute these increments so as to best fulfill the needs of the department and the employees.

[13] The record does not show what the faculty senate actually does with respect to resident training.

[14] By a coincidence without legal significance, the Albert Einstein College of Medicine is affiliated with Yeshiva University. The *Yeshiva University* case did not involve the medical college.

[15] The record is silent as to whether there exists, either as part of the Medical Center's staff or as a separately employed group, a corps of doctors whose primary function is teaching. Similarly, while there is some evidence regarding the staff's participation in the training of interns and residents, there is virtually none with respect to their dealings with medical students. The interns and residents number approximately 500, as do the staff doctors who work at the Medical Center at least half time. Thus, if each of these staff doctors participated in the training of the interns and residents, the teaching ratio would be 1-to-1.

labels "managerial" consists, *inter alia*, of interviewing prospective interns and residents, evaluating their performance, and participating in the formulation of their curriculum. But such functions are not necessarily managerial. *Yeshiva, supra* at 690–691, fn. 31.[16] Moreover, while the Medical Center treats these functions as typical of the responsibilities of all staff doctors, the record indicates that they are performed by committees or by unnamed individuals. It does not provide a basis for finding that all staff doctors perform such functions, or that any identifiable individuals perform them regularly. Further, as noted earlier, the academic matters with which these activities deal do not constitute the basic "business" of the Medical Center, which is to provide health care.

The Medical Center also relies on the staff's participation in interviewing candidates for permanent staff positions, recommendations as to the purchase of new equipment, a consensus decision within the department of medicine to "encourage affiliation" with another hospital, and the adoption of medical (or dental) policy at staff meetings. While these matters lie closer to the core of the Medical Center's operations, they do not necessarily fall outside the professional duties primarily incident to patient care. Moreover, there is insufficient evidence in the record with respect to most of these staff activities to attribute them either to the entire staff or to specific individuals.[17] Many of the staff's purported managerial functions are performed by various committees within the departments. Yet, not all staff doctors are on the committees which perform such functions. In addition, many doctors are not on any departmental committee.

We cannot find, on the facts in this case, that the alleged managerial participation on which the Medical Center relies—if managerial and not professional—so aligns the staff doctors with management or places them sufficiently within the managerial structure as to warrant their exclusion. See *Yeshiva, supra* at 682–683.

Scope of Unit

This is the third Board proceeding in which the Medical Center and this Petitioner have litigated the appropriateness of bargaining units. In the earliest proceeding, the Petitioner sought and the Board found appropriate a unit limited to the doctors employed at one of the Medical Center's satellite facilities, a neighborhood clinic called the Martin Luther King, Jr., Health Center.[18] The Medical Center argued then that only a unit encompassing, with certain exceptions, all of its facilities, including the Martin Luther King, Jr., Health Center and other satellite ambulatory care facilities, was appropriate.[19] In the second proceeding, before the Board's Region 2, the Petitioner sought a unit limited to NCB. The Medical Center contended that the appropriate unit was an employerwide unit, including satellite ambulatory care facilities. The Regional Director, relying most heavily on the close ties between NCB and Montefiore Hospital, held that a unit confined to NCB was inappropriate and dismissed the petition.[20]

In the instant proceeding the Petitioner seeks a single unit comprising NCB and Montefiore Hospital (the West Campus) plus certain satellite facilities,[21] excluding the East Campus. The Petitioner is willing to proceed to an election, however, in any unit the Board finds appropriate. The Medical Center continues to argue that any appropriate unit must include both the West and East Campuses, but now contends that it would be inappropriate to include any of the satellite facilities.

There may be valid reasons, of course, for parties to change their positions with respect to the appropriateness of units, and we attach no stigma to any seeming inconsistency. As is not uncommon, both parties have taken a pragmatic approach to the unit question. The question, of course, is to what extent each pragmatic solution is also a principled one.

There is no history of bargaining for the employees sought herein. The Medical Center has a collective-bargaining agreement with District 1199, National Union of Hospital and Health Care Employees, RWDSU, AFL–CIO, which encompasses all of its employees at all its facilities in various units of service and maintenance, technical, and professional employees. The Medical Center also has contracts with the American Physical Therapist Association and a local of the Committee of Interns and Residents, which are Medical Center-wide in their coverage. In addition, the Medical Center has three contracts with the New York State Nurses Association: one covering the regis-

[16] See also *New York University*, 221 NLRB 1145, 1156 (1975).

[17] We recognize that, in *Yeshiva*, the Supreme Court resolved the uncertainty as to the possible nonmanagerial status of some faculty members by concluding that it would not draw the line between those who were managerial and those who were not, because "it is clear that the unit approved by the Board was far too broad" (*id.* at 691, fn. 31), and left this line drawing to the Board. However, we do not believe the Court intended to preclude the Board from requiring the party seeking to exclude either a whole class of employees or particular individuals as managerial to come forward with the evidence necessary to establish such exclusion.

[18] *Montefiore Hospital and Medical Center*, 235 NLRB 241 (1978). That clinic is apparently no longer part of the Medical Center.

[19] The Board did not find that such a unit would have been inappropriate.

[20] Case 2–RC–18438 (1979) (unreported in Board volumes).

[21] The parties agree on the exclusion of certain satellite facilities. One of them, Rikers Island Health Service, the subject of the consolidated Case 2–RC–18629, is discussed *infra*.

tered nurses employed at NCB, one covering those at Rikers Island, and one encompassing the remainder of the registered nurses employed by the Medical Center. The contents and duration of the nurses' contracts are the same, and they are negotiated simultaneously.

It appears that over 300 doctors are employed by the Medical Center on the West Campus. NCB is administered and staffed by the Medical Center pursuant to an "affiliation" contract with the city of New York. The Medical Center also operates the hospital of the Albert Einstein College of Medicine, at 1325 Eastchester Road, Bronx, New York, and supplies personnel to provide certain services at the Bronx Municipal Hospital Center located nearby, pursuant to agreements with Yeshiva University. These two facilities are situated about 4 miles from the West Campus and are referred to as the East Campus. In addition to the two main campuses, the Medical Center employs doctors at several smaller facilities, geographically separated from either campus, some of which are involved in these proceedings.

As a result of the Medical Center's administrative centralization, all of the doctors in its employ are subject to the same labor relations and personnel policies and benefits. Grievance handling and hiring procedures are virtually uniform regardless of the facility at which these individuals perform their duties, with one exception, doctors are paid from the same payroll. The exception is NCB, a municipal hospital, which has a separate payroll from which doctors are paid for the time spent working there. However, many doctors who receive paychecks exclusively from the centralized payroll work a substantial amount of time at NCB, which reimburses the Medical Center for such services. Similarly, employees may receive NCB paychecks for time not spent at that facility because job duties required their presence elsewhere, and NCB is appropriately reimbursed when this occurs.

Each party argues for a unit which is neither employerwide nor limited to a single location or facility, but which is different from the unit the other party urges. Neither of the parties' primary unit configurations, however, is presumptively appropriate. The Petitioner, as noted, is willing to proceed to electionin any appropriate unit. It is desirable to establish a base point from which to examine the respective unit configurations urged by each. An employerwide unit is presumptively appropriate,[22] and such units are, in fact, the first ones delineated as appropriate in Section 9(b) of the Act, upon which the Board's authority to establish collective-bargaining units rests.[23] We deem it useful, therefore, to examine the respective units the parties contend are appropriate in relation to such a presumptively appropriate unit in order to gain perspective on the parties' contentions and on the ultimate issue of the appropriate unit here.[24]

We examine first the validity of the Medical Center's contention that the satellite clinics the Petitioner seeks to include should be excluded from any unit contemplated here. At issue are two satellite clinics, the Comprehensive Health Care Center (CHCC) and the Neighborhood Family Care Center (NFCC), located approximately 7 and 5 miles, respectively, from Montefiore Hospital. Both operate under employerwide labor policies, including uniform salary guidelines. CHCC is a family care clinic funded partly from Federal sources and administered by the Medical Center under the jurisdiction of its deputy director for ambulatory care.[25] CHCC has its own director on location. He is employed by the Medical Center and is a physician as well as an administrator. There are approximately eight other physicians (six pediatricians and two internists) and two dentists. The director selects physician candidates and recommends their hire to the Medical Center's deputy director for ambulatory care and, in the case of pediatric candidates, also to the chairman of the department of pediatrics at the Medical Center. These individuals interview the recommended candidates and regularly approve the hiring of those recommended by the CHCC director. The record does not show how CHCC dentists are hired. The CHCC director administers its day-to-day operations under the general supervision of the deputy director for ambulatory care. A Medical Center associate director assists as a liaison between CHCC and the Medical Center and monitors the participation of the Medical Center in the grants that help to fund CHCC. CHCC pediatricians regularly attend or conduct rounds at Montefiore Hospital.

NFCC is a community mental health clinic, administered pursuant to a contract between the

[22] *Libbey-Owens-Ford Glass Company*, 169 NLRB 126, 127 (1968).

[23] *Western Electric Company, Inc.*, 98 NLRB 1018, 1032 (1952). See also *Mercy Hospital of Sacramento, Inc., supra.*

[24] This analytical method does not, of course, signal an abandonment of the fundamental proposition that there may be more than one appropriate way of combining employees into groups for bargaining purposes. Here, we choose to analyze the unusual and perhaps unique unit configurations sought by the respective parties with the aid of a model. We choose the employerwide unit as a model because it is a basic unit recognized by the Board since its earliest days and because, as compared to the most likely alternative presumptively appropriate unit model, the single-location unit, it more closely resembles the respective units contended for here.

[25] It is similar to the Martin Luther King, Jr., Health Center, the subject of our 1978 decision, as the latter then existed.

Medical Center and the city of New York. Its medical staff consists of approximately eight psychiatrists who, technically, are part of the Montefiore Hospital department of psychiatry, and two pediatricians. The medical director of NFCC is a psychiatrist who is responsible to his department chairman, although the extent of the chairman's involvement in the NFCC program is unclear. Administrative responsibility for the NFCC lies in part with the Medical Center's administrator of the NCB affiliation, presumably reflecting some connection between the services rendered by the Medical Center at NCB and those rendered at the NFCC mental health clinic. Subject to whatever restraints these organizational ties connote, the NFCC medical director administers the clinic, making effective recommendations with respect to hiring and professional evaluations.

We find it appropriate to include both of these satellite facilities in a unit encompassing other Medical Center facilities. The ties of CHCC to Montefiore Hospital give at least the CHCC pediatricians more than a sufficient community of interest with other Medical Center physicians to warrant their inclusion. While the ties between the Medical Center doctors and the few remaining CHCC physicians and dentists are less clearly delineated, the latter work under the same labor policies and salary guidelines, and do not appear to be so lacking in the shared community of interests as to warrant their being relegated to a separate, isolated bargaining unit. The record as to NFCC presents a picture lacking somewhat in clarity and detail. The physicians there may have a separate community of interests that is at least as significant as any community of interests they share with other Medical Center physicians. However, like the CHCC doctors, they appear to be subject to the Medical Center's uniform labor and salary policies and, in the absence of anything persuasively negating their shared community of interests, are, as the Petitioner urges, appropriately includable in a multilocation unit of Medical Center doctors.[26]

Like the relationship between the West Campus and the satellite facilities, the relationship between the West Campus and the East Campus has elements which pull both ways insofar as separateness or integration of bargaining is indicated. Only here the question is not whether an integrated unit is appropriate but whether a unit excluding the East Campus, as the Petitioner seeks as its first choice, is inappropriate. Notwithstanding that there could be more than one appropriate unit, we find that the Petitioner's primary requested unit is inappropriate.

As the Petitioner concedes, there is a sufficiently shared community of interests between the doctors on the two campuses to make an overall unit *an* appropriate unit, and we need not dwell on each of the factors justifying such a finding.[27] Rather, we shall focus on the sufficiency of the factors favoring exclusion of the East Campus. The entire set of relationships is so multifaceted, however, that none of these factors can be evaluated singly; only by analyzing them within the framework of the total degree of interconnection among the Medical Center's facilities can the solution emerge.

Thus, a moderate geographical separation of approximately 4 miles, with an estimated driving time of 15–20 minutes, is, at first blush, a factor of some importance favoring separation. However, a shuttle service is provided, indicating at least the opportunity for convenient temporary interchange on a very short-term basis. The evidence of actual interchange among the doctors defies generalization. There is a moderate amount of temporary interchange—professional obligations on both campuses—among doctors in the unified departments, as opposed to those in the nonunified departments, whose visits to the opposite campus are, on the average, much less frequent. However, even within the unified departments, notably in surgery, for which department the record is most complete, there is a great deal of variation among the doctors with respect to time-splitting between campuses, and somewhat less than half of the surgeons appear to have regular intercampus duties. In some of the unified departments regular meetings and other activities such as grand (i.e., conference or teaching) rounds include doctors from both campuses. In summary, interchange, while far from being a uniform condition of employment, is a factor which affects a substantial number of the doctors.

The existence of unified and nonunified departments injects a complicating factor for, despite the centralization of authority with respect to overall administration of the Medical Center, including labor relations, to some degree the day-to-day policy is only departmentwide. Part of this policy

[26] Cf. *City Electric, Inc.*, 225 NLRB 325 (1976); *Cardinal Timothy Manning, Roman Catholic Archbishop of the Archdiocese of Los Angeles, a Corporation Sole, et al.*, 223 NLRB 1218, 1221 (1976); *Kaiser Foundation Health Plan of Oregon*, 225 NLRB 409 (1976). In *Kaiser*, a majority of the Board held that under the facts presented there, somewhat similar to those in the instant case, the outpatient mental health clinic did not constitute an appropriate unit separate from the employer's other facilities. While Members Fanning and Jenkins dissented in that case and would have found the petitioned-for separate unit appropriate, they did not find an overall unit inappropriate there and similarly do not in the instant case.

[27] They include, in varying degrees of persuasiveness, the presumptive appropriateness of an overall unit, centralized administration including labor-related matters, similarity of skills, employerwide bargaining history for other employees, and interchange as discussed below. See *Mercy Hospitals of Sacramento, Inc.*, 217 NLRB 765 (1975).

might be considered purely a matter of professional import. Yet, another part occupies ground near the border where professional and employee interests meet, and the degree of uniformity or nonuniformity as between the campuses has some significance. Here, because we treat the issue of whether *all* the West Campus doctors have a sufficient separate community of interest, the fact that a substantial number of them belong to unified departments in which day-to-day policy is predominantly intercampus in scope diminishes the separateness of interests.

Taking the record as a whole, it would be difficult to say that the West Campus doctors have a closer community of interests with the doctors at satellite clinics CHCC and NFCC than they do with the East Campus doctors. The opposite seems more likely to be the case. Thus, the interests of the West Campus doctors and the satellite doctors are not "sufficiently distinct from those of other employees to warrant the establishment of a separate unit." *Newton-Wellesley Hospital*, 250 NLRB 409, 411 (1980).[28] Such a unit configuration, encompassing a selective combination of facilities, is, in this instance, inappropriate. Cf. *Norrwock Shoe, Division of Scoa Industries, Inc.*, 209 NLRB 843 (1974); *Marriott In-Flite Services, a Division of Marriott Corporation*, 192 NLRB 379, 380 (1971). We find that the only appropriate unit encompassing more than one facility is one that includes all the facilities either party would include. That unit consists of the West and East Campuses, CFCC, and NFCC.

Composition of Unit

The Petitioner seeks to include, in any unit found appropriate in Case 2-RC-18594, all doctors employed half time or more at facilities within the unit. Full-time employment ranges upward from 40 hours per week. The Medical Center would include all doctors who are employed 19 hours or more per week. There is no evidence of the number of doctors, if any, who work at least 19 hours but less than half time. In any event, there is no basis in the record for a finding that any such doctors have a sufficient community of interest separate from the doctors employed half time or more as to warrant their exclusion. Cf. *Mount Sinai Hospital*, 233 NLRB 507 (1977).[29] Accordingly, we shall include all doctors employed 19 hours or more per week.

Rikers Island Health Service

Rikers Island, located between the boroughs of Bronx and Queens in New York City, is the site of a number of the city's correctional institutions. To provide medical services for the approximately 5,000 inmates of these institutions, the city contracts with the Medical Center for the operation of the Rikers Island Health Service (herein the Service). The Service provides routine physical examinations to every admittee, a sick call clinic similar to those provided in the military service, several specialty clinics, an alcohol and drug detoxification program, and 24-hour emergency care. The Service is staffed, *inter alia*, by Medical Center employees, including physicians,[30] and is administered by an administrator and a medical director, both Medical Center employees. The medical director determines, within the budget limitations imposed by the contract, the number of physicians to be employed. He hires them, determines their starting salary and merit increases, evaluates them, and handles their grievances. The full-time physicians receive fringe benefits, including vacations, similar to those received by other Medical Center physicians. There is no bargaining history for the Service physicians, but registered nurses, LPNs, and other technical and clerical employees of the Service have been represented for a number of years by labor organizations which bargain with the Medical Center over their terms and conditions of employment.[31]

We need not pause long over the Medical Center's contention that the Service shares the political subdivision exemption of the city of New York pursuant to Section 2(2) of the Act. In spite of certain limitations imposed by the city, it is apparent, both from the authority exercised by the medical director and the history of bargaining with respect to other employees, that the Medical Center retains sufficient control over the terms and conditions of employment of those employed at the Service to be capable of effective bargaining. Therefore, we shall assert jurisdiction over the Medical Center's operation at the Service. See *National Transportation Service, Inc.*, 240 NLRB 565 (1979).[32]

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[28] See also *Yale University*, 184 NLRB 860, 862 (1970); *Cornell University*, 183 NLRB 329, 335-336 (1970).

[29] On the other hand, nothing in the record indicates that the parties' agreement to exclude doctors employed fewer hours per week violates any express statutory provisions nor established Board policies, and we shall not override that agreement on "community of interest" grounds. See *White Cloud Products, Inc.*, 214 NLRB 516 (1974).

[30] There are no dentists at this facility.

[31] In *Montefiore Hospital and Medical Center*, Case 2-RC-18512 (1980) (unreported in Board volumes), the Board certified the New York State Nurses Association as the representative of the registered nurses employed at the Service.

[32] In agreeing to assert jurisdiction over the Medical Center's operations at Rikers Island, Chairman Van de Water does not rely on the tionale or conclusions reached in *National Transportation Service, Inc.*, *Continued*

The parties agree that any bargaining unit of the Service physicians should be separate from the unit in Case 2–RC–18594, which we have found above to encompass a multilocation grouping. The question that remains, therefore, is the composition of the Service unit. The parties differ on whether certain physicians should be included as regular part-time employees. There are approximately 12 full-time physicians, paid on a salary basis and receiving the full range of fringe benefits, and one part-time physician receiving salary and benefits on a *pro rata* basis. Neither party questions their inclusion. The Petitioner would also include, and the Medical Center would exclude, approximately 30 other physicians who regularly work weekly shifts of either 16 or 8 hours, performing physical examinations and providing emergency care during hours when the sick call facility and the specialty clinics are closed.[33] These part-time physicians, who typically work elsewhere as hospital residents, are paid on an hourly basis and receive no fringe benefits.

The Medical Center's contention that these part-time physicians should be excluded is based on their possession of a separate community of interest because they are hourly paid, receive no fringe benefits, have no contact with the full-time physicians, and hold other full-time jobs. In other circumstances, these facts might support a finding of a sufficient separate community of interests to warrant separate representation should a labor organization seek to represent them separately. Even then, we would have to be mindful of the legislative concern over proliferation of bargaining units in the health care industry. In any event, the facts on which the Medical Center relies do not negate the common community of interests these regular part-time employees share with their professional colleagues.[34] Accordingly, we find that a unit of all full-time and regular part-time physicians employed by the Medical Center at the Rikers Island Health Service is an appropriate unit.

We therefore find the following units appropriate for the purposes of collective bargaining within the meaning of Section 9(b) of the Act:

> *In Case 2–RC–18594*:[35] All physicians and dentists regularly employed 19 hours or more per week by the Employer on its West and East Campuses in the Borough of the Bronx, New York, New York, and at the Comprehensive Health Care Center, 230 East 102nd Street, New York, New York, and the Neighborhood Family Care Center, 168th Street and Gerard Avenue, Bronx, New York, excluding guards and supervisors as defined in the Act.
>
> *In Case 2–RC–18629*: All regular full-time and part-time physicians employed by the Employer at the Rikers Island Health Service, Rikers Island, New York, New York, excluding guards and supervisors as defined in the Act.

[Direction of Elections and *Excelsior* footnote omitted from publication.]

supra. He notes the prior bargaining history for registered nurses, LPNs, and technical and clerical employees for a number of years by labor organizations and that the medical services performed here are more susceptible to a subcontracting than more essential city services like fire and police.

[33] There is, further, an additional group of physicians employed at the Service with less regularity. The parties agree that they are casual employees and should be excluded.

[34] Although they do not work *with* the full-time physicians, and in some cases work in different buildings, they work alongside the same corps of nurses with which the full-time doctors work and which is represented on a Service-wide basis.

[35] As the unit found appropriate herein is larger than the unit requested, the Petitioner is accorded a period of 10 days in which to submit the requisite showing of interest to support an election herein.