CRNAs and the National Labor Relations Act

As the physician glut continues, many CRNAs are faced with combating restrictions on their practice. These include requirements that regional anesthetics may be administered only by anesthesiologists or that an anesthesiologist must be present for induction, emergence or various other events. As we know, there is no factual basis to support these restrictions, and typically, they are adopted without any discussion, as if no one would have any reason to object.

In many cases, nurse anesthetists who have longstanding relationships with surgeons, hospital administrators and others within hospital settings have been able to object successfully to the imposition of these restrictions. For others, antitrust suits have been used. Some lawyers have suggested a third approach based on the National Labor Relations Act (NLRA).

This approach has not received widespread use, primarily because:

1. Some CRNAs believe it is unprofessional to form a labor union
2. Congressionally imposed restrictions on “proliferation” of unions in hospital settings often make it difficult to form unions which would represent CRNAs appropriately.

Ironically, when restrictions on CRNA practice become severe enough, the National Labor Relations Act may offer a unique solution.

Whether formation of a labor union by CRNAs is appropriate or not is best left to the judgment of the CRNAs involved. In some instances, formation of a union would not be helpful in resolving disputes with hospitals or professional staff. In other instances, for example in communities where nurses or groups of physicians already are organized, the community may already have accepted the idea of unions representing professions. This avenue was opened in 1974 with an amendment to the National Labor Relations Act to cover employees of “any hospital, convalescent hospital, health maintenance organization, health clinic, nursing home, extended care facility or other institution devoted to the care of sick or aged persons.”

When Congress amended the labor act to cover employees of non-profit health care institutions, it expressed concern about the harm the public would
suffer from multiple bargaining units in hospitals. Recognizing that the National Labor Relations Board (NLRB) should be permitted some flexibility in unit determination, Congress rejected a proposal to amend Section 9 of the National Labor Relations Act by limiting the numbers of bargaining units to four and specifying this composition. Nevertheless, it expressed its concern by stating "due consideration should be given by the NLRB to preventing proliferation of bargaining units in the health care industry." (NLRB v Frederick Memorial Hospital 691 F2d. 191 (1982).

Separate recognition of nurse anesthetists

Normally, an appropriate unit or collective bargaining representative is determined by considering the "community of interest" of a particular group and seeing if there are sufficient differences to distinguish the group from a larger collective bargaining unit. In the case of nurse anesthetists, without the Congressional concern regarding "proliferation," one could well argue that they should be considered as their own bargaining unit.

Nurse anesthetists have special credentials and unique practice settings. In many hospitals, nurse anesthesia is a separate unit. Payment for CRNA services often is independently computed and paid to the hospital. Very few other nursing groups directly compete on a financial basis with the medical specialty that often supervises them. For this reason, it might be expected that nurse anesthetists interested in forming a collective bargaining unit would be recognized separately.

Separate recognition of nurse anesthetists as their own appropriate bargaining unit has been extremely difficult, because of the Congressional restriction on proliferation of health care groups. In fact, one of the tactics hospitals have used in diluting the bargaining power of nursing unions is to attempt to have the collective bargaining unit represent so many diverse groups that it is difficult for the collective bargaining representative to establish an agenda or effectively bargain on real problems.

A bargaining unit representing all nurses within a hospital might be so overwhelmed with issues that the concerns of CRNAs about supervision become lost.

In several cases, hospitals have complained that recognition of a collective bargaining unit representing only registered nurses might not be broad enough and that "only a unit composed of all the hospital's professional employees is appropriate." (NLRB v Frederick Memorial Hospital, 691, F2d. 194). A union representing both nurses and physicians would be unable to handle disputes between nurses and physicians. Moreover, a bargaining unit which consisted of physicians and nurses would be very difficult to organize because of the lack of a community of interest between the two groups.

NLRB's interpretation

For the past two years, the NLRB has been attempting to deal with the uncertainty created by the Congressional directive by adopting a new rule. The hospitals have lobbied for a rule which would provide that they have no more than two collective bargaining units, one representing professional employees (consisting of physicians and nurses) and another for all non-professional employees.

The NLRB has proposed a rule creating eight classifications, each of which could form its own union:

1. All registered nurses.
2. Skilled maintenance employees.
4. Physicians.
5. All other professionals.
6. Technicals, including LPNs.
7. Service and maintenance.

As might be expected, the proposal generated significant opposition from hospitals and their lobbyists.

In recognition that in some circumstances even a collective bargaining unit consisting of all registered nurses may be too large to offer effective representation of CRNAs and that in other circumstances it might be appropriate for CRNAs to be included in a group which might consist of physicians or to be separately recognized on their own, AANA suggested to the NLRB, on October 14, 1988, that the NLRB retain for itself the right to treat CRNAs on a case-by-case method.

Notwithstanding what the NLRB might do, there is a very interesting footnote to this problem, which suggests that if anesthesiologists' restrictions become severe enough, a unique solution may be used. In many hospitals, the anesthesia departments have incorporated separately, so that all of the anesthesiologists work for a professional corporation that enters into contracts or agreements with the hospital. At the same time, the nurse anesthetists either are employees of the professional corporation or remain employed by the hospital. If nurse anesthetists are employees of the anesthesiologists' corporation, they clearly may form their own collective bargaining unit, because they usually will be the only or the majority of the employees of the anesthesiologists. A more difficult problem has
arisen where the nurse anesthetists remain hospital employees but work under restrictions imposed by anesthesiologists not employed by the hospital.

Under the National Labor Relations Act, there is a doctrine of "joint employer," which may be of real assistance in these cases. The doctrine is set forth in Sun-Maid Growers of California v NLRB, 618 F 2d. 56 (1980) in which the NLRB determined (and was upheld by the U.S. Court of Appeals for the Ninth Circuit) that employees who are employed by one group, but effectively are controlled by another, are employees of joint employers and are entitled to be recognized by themselves.

For example, hospital-employed CRNAs who are supervised by anesthesiologists who have formed an independent corporation might be employees of a joint employer. Such CRNAs could constitute their own collective bargaining unit, if the restrictions are so severe that the anesthesiologists are exercising rights normally exercised by an employer. This would allow the CRNAs to organize and form their own union without regard to whether they normally would be included with other employees of the hospital under NLRB rules. Once the union was formed, federal law requires the employer to bargain in good faith over working conditions—introducing communication into areas that many anesthesiologists believe are of no interest to CRNAs.

Of course, like everything else in the law, formation of a union carries its own special risks, and CRNAs should find competent labor lawyers before they start on this path.

ACKNOWLEDGEMENT

The author would like to thank George Shea, Esq., Sherbourne, Massachusetts, for inspiring and assisting with this article.