THE DEVELOPMENT OF THE MICHIGAN NURSES ASSOCIATION'S ECONOMIC SECURITY PROGRAM

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ABSTRACT

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by Alice L. Ahmuty

Methods used by ANA in the past had proven ineffective in improving the economic status of nurses. In the 1940's there was increasing pressure from within the profession for a stronger more effective approach to raising the nurses economic position. ANA adopted in 1946 an economic security program which advocated collective bargaining as a means to achieve its goals of enhancing the nurses' economic and professional status, and of providing quality patient care. Although ANA strongly endorses collective bargaining as a means to improve employment conditions, it does not endorse strikes by nurses as an economic weapon. The state associations have the prime responsibility for implementing the program and acting as the nurses' exclusive representative in collective bargaining. The ANA gives assistance to the state associations by supplying the overall leadership for their programs, field services, assistance with educational program planning, and information on current trends in economics and

industrial relations. With the stepped up bargaining activities by state associations, ANA has launched an expansion of its envolvement in these activities.

The progress of ANA's economic security program has been impeded by such factors as the attitudes of the nurses, employer resistance, inadequate legal protection, lack of an effective economic weapon, organizational weaknesses, and too many other programs. Factors in ANA's favor includes settlement of the debate over means to achieve its goals by its acceptance of collective bargaining, favorable public sentiment, the feeling among nurses they can do something to improve employment conditions, and the development of skilled leaders. The ANA is the dominate organization in representing nurses.

After a 12-year delay, MNA adopted an economic security program as advocated by ANA. A reason for the long delay was that the ANA program was too controversial and generally unacceptable to the Michigan nurses. Following the adoption of an economic security program in 1958, MNA developed a program which was a modification of the ANA approach called a "multi-dimensional" approach. The "multi-dimensional" approach stressed flexibility--using means which best fit the situation. Collective bargaining was to be used as a last resort. The basic approaches used in the first five years were educational methods, public relations, consultation services, and representation without

collective bargaining. In only one instance did MNA attempt to utilize collective bargaining. The approach did make some progress towards the nurses' goals.

Following the passage of the Michigan Public Employees Relations Act, MNA was stimulated to include collective bargaining in its economic security program. Competition from unions and a growing awareness of the advantages of collective action resulted in increased organizational activities. The nurses are looking at the implications of organizational activity on patient care seeing it as an opportunity to improve patient care while in some instances it may impinge upon their professional judgment. A crisis was faced when MNA found it difficult to meet its commitments within its limited resources. Deciding to expand the program, a 150 percent increase in membership dues was approved and industrial relations consultants were employed to conduct the negotiations and training programs. Organizational changes have been made in order to make the program more effective.

By the end of 1967 MNA had been granted voluntary recognition in nine institutions, had experienced 18 representation elections, and had negotiated seven agreements. The MNA agreements reflect its dual collective bargaining and professional functions. MNA still has several areas to resolve. In the future, nurses will become more involved in collection bargaining activities with MNA taking on many of the characteristics and functions of a labor organization.

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HISTORICAL DEVELOPMENT - AMERICAN NURSES' ASSOCIATION ECONOMIC SECURITY PROGRAM

The American Nurses' Association functions as a federation of 54 nurses associations in the 50 states, District of Columbia, the Panama Canal Zone, and the Virgin Islands, which in turn are composed of more than 800 district nurses associations.[1] The national, state and district nurses associations form an organizational complex with each level assuming functions related to the scope of its influence and to the overall objectives of the association. The purposes of the association are the same at all levels. Briefly these are: to promote the professional and educational advancement of nurses, to further high standards of nursing service and to promote the general and economic welfare of nurses.

The ANA's policies and programs are established by the membership through representation in the ANA House of Delegates, the highest authority in the association. Each state association elects to the ANA House of Delegates

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[1] ANA, Facts About Nursing, New York; American Nurses' Association, 1966, p. 234.

three delegates-at-large and one delegate for every two hundred members. At the biennial convention, the House of Delegates elect the ANA officers and directors who are responsible for the overall administration of the association.

The ANA Board of Directors appoint members to serve on the following standing committees: (1) bylaws; (2) convention program; (3) ethical, legal and professional standards; (4) finance; (5) legislation; (6) membership promotion; (7) nominating; (8) nurses' professional registries; (9) nursing in international affairs; (10) professional credentials and personnel services; and (11) research and studies. They also appoint the members who serve on the Commission on Nursing Education, the Commission on Nursing Service, and the Commission on Economic and General Welfare. In addition to these programs, ANA has established divisions of clinical practice, occupational forums and advisory and coordinating councils.

The ANA consists of the members and associates of its constituent associations. In 1966, there were 172,591 members. In 1965 there were 825,534 registered nurses in the U. S. Membership is open only to nurses who are licensed to practice as a registered nurse. Upon admission to membership, a registered nurse becomes a member of a district association, the state association, and the national association.

Though the state association must comply with the ANA bylaws, each state association may decide for itself how it will develop its own programs. ANA policies are guides rather than mandates to the state associations.

The focus of this study is the association's economic security program. First, a background and review of the national association's program is presented. Next, the development of one state association's economic security program - the Michigan Nurses Association will be discussed.

Factors Leading to ANA Action

In 1946 the American Nurses' Association (ANA) adopted an economic security program which included collective bargaining. The objective of this program was to improve nurses' working condition through the democratic process of group action. Prior to this action ANA had an economic security program but it stopped short of collective bargaining. In fact, in the 1930's ANA discouraged membership in unions because the methods used by unions were not those advocated by the ANA and they were non-professional in nature.[2] Rather, ANA relied upon an

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[2]Joseph K. Hart, "Economic Security for Nurses" American Journal of Nursing Vol. 38 (April, 1938), pp. 391-395; editorial, "Union Membership? No." American Journal of Nursing Vol. 38 (May, 1938), p. 573; Leo B. Osterhaus, "The Effect of Unions on Hospital Management" Hospital Progress Vol. 48 (July, 1967), p. 90.

educational approach and presenting recommendations to employers. The impact of these recommendations appears to have been minimal.

Joseph K. Hart, writing in 1938, described three methods for dealing with economic conflict: (1) force or the revolutionary methods; (2) arbitration in which unions helped to define the issues; and (3) educational methods. The educational methods were for those labor situations which involved relationships of such high public importance that any cessation of service was highly undesirable and unthinkable. The educational method was advocated by the profession - by the nurses themselves. Hart further expounded on the educational approach to the nurses' economic security problems in a follow-up article.[3] The most intelligent way to fight their battles to secure economic security was for the nurses to educate the whole public, which included their employers, " . . . since what people pay for and want is usually a matter of 'educated tastes,' getting them to want and pay for nursing service is, likely, a matter of adequate education, and nurses themselves can help the most in this furthering of public education."[4]

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[3]Joseph K. Hart, "Drift - Conflict - or Education?" American Journal of Nursing Vol. 38 (May, 1938), pp. 544-548.

[4]Ibid., p. 544.

It was the opinion of that day (1938) that a nurses' union or utilizing union methods to improve nurses' salaries was "absurd." Results of a survey of a group of nurses by Hart showed two-thirds opposed a nurses' union.[5] To think of pay was unprofessional. A nurse must be devoted to service. He pointed out that "this purity of motive must never be degraded by any move on her part that would lead anyone, including herself, to suspect that she could even think of such a thing as 'pay.'"[6]

Thus, ANA did not recommend at that time membership in unions or union methods. By what means then were the nurses to use to improve their working conditions? ANA's economic security program prior to 1946 would rely primarily on an educational approach.[7] The ANA urged the state associations to assume responsibility for standards of nursing care and employment conditions. It urged the acceptance of the published ANA minimum wage and hour standards. Action was to be based on the facts secured through its program of studies. An educational program was used to promote an eight hour day. The adoption of

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[5]Joseph K. Hart, "Economic Security for Nurses," American Journal of Nursing Vol. 38 (April, 1938), p. 392.

[6]Ibid., p. 393.

[7]editorial, "Unions Membership? NO!", American Journal of Nursing Vol. 38 (May, 1938), pp. 573-574.

this recommendation by hospitals was voluntary. Cooperation with other organizations, such as the hospital associations, was encouraged to promote understanding of its problems. Factual materials were made available for use by the state and district nurses associations as well as by individual nurses.

On January 23, 1939, the ANA Board of Directors adopted the following recommendation from the ANA Committee to Study the Question of Nurse Membership in Unions:

> The American Nurses Association is urged to use every effort to arouse the interest of hospital board of managers and hospital administrators, also legislators, as well as other related and interested groups and individuals in helping to improve the working and living conditions of graduate nurses in hospitals, giving special attention to the problem of hours, incomes, and health . . .[8]

This was to be the substitute for nurses joining unions, and it provided their methods to improving their working conditions. The professional association would look after the welfare of nurses by making recommendations to nurses, their employers, and other interested parties. Recommended employment standards would be published and promoted. But the adoption of these recommendations remained voluntary, though strongly encouraged. Through education, the argument went, employers would be encouraged to take the initiative to make changes for the betterment of the nurses

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[8] _____ American Journal of Nursing Vol. 39 (May, 1939), p. 560.

working conditions. Needed improvements would be brought about by working cooperatively with other organizations and by interpreting for them the nurses' economic problems.

These techniques to improve nurses' working conditions were relatively ineffective. In 1938, an economic committee of the Minnesota Nurses' Association made proposals for improvement of salaries, working conditions, and fringe benefits. These proposals were submitted periodically to hospital administrators and boards of trustees all over the state. Competition from local unions and resistance from management contributed to limited gains.[9]

As early as 1941, the nurses in the booming industrial centers of California, faced with rising prices, shortage of personnel and long hours, demanded a stronger program.[10] They found hospitals unwilling to voluntarily raise salaries to help relieve the situation. Since the Association efforts were initially unsuccessful, some nurses joined unions. Others left the profession, and normal replacement lagged. In October, 1942, the War Labor Board

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[9]Leo B. Osterhaus, "The Effect of Unions on Hospital Management" Hospital Progress Vol. 48, Part 2: "Factors Stimulating and Inhibiting Unions" (July, 1967), p. 90.

[10]Herbert R. Northrup, "Collective Bargaining and the Professions," American Journal of Nursing Vol. 48 (March, 1948), p. 142; Osterhaus, op. cit., p. 90.

was ordered by President Roosevelt to limit all wage increases except where substandard or flagrantly inequitable conditions prevailed. Wage control heightened the nurses' problem. Low salaries were agravated by the rise in the cost of living. To obtain salary adjustments required approval by the War Labor Board.

During the wartime economy of the early 1940's, the necessity of collective action was recognized by several of the state nurses associations. Its effectiveness had been demonstrated by others. The pioneers in this development was the California Nurses Association. Under the leadership of Shirley C. Titus, executive director, the California Nurses Association set a precedent by acting as the collective bargaining agent for nurse groups in California with highly effective results.[11] To get salary adjustments for the nurses, the California Nurses Association had to make its requests through the War Labor Board. This the California Nurses Association did with the members overwhelming support. The CNA obtained from the War Labor Board a 15 per cent "Little Steel" increase in salaries. The state hospital association had been invited to join them in its request before the War Labor

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[11]ANA Manual for an Economic Security Program, 2nd ed., Economic Security Unit, 1956, p. 2.

Board but had refused.[12] The CNA went to the WLB acting "in full dignity as a professional organization and not as a labor union."[13] Following this success, the CNA continued to develop its economic security program to include the negotiation of contracts. The CNA signed contracts with hospitals and industrial plants employing nurses. Its first contract was negotiated in 1946.[14]

Though California had made some progress in improving working conditions for its nurses, working conditions still remained highly distressing generally throughout the country. The ANA had relied upon education and persuasion techniques to bring about reasonable working conditions, but this approach had not proved to be very effective. Limited gains had been made, but nurses' salaries lagged far behind those of workers with less preparation and less responsibility. The nurses had to accept what was given to them, for they were not provided with a real opportunity to participate in the determination of

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[12]Herbert R. Northrup, "Collective Bargaining and the Profession," American Journal of Nursing Vol. 48 (March, 1948), pp. 142-143; editorial, "Long on Funds--Short on Personnel," American Journal of Nursing Vol. 43 (July, 1943), p. 618; "W.L.B. Approves Salary Standards of California State Nurses Association," American Journal of Nursing Vol. 43 (July, 1943), p. 951.

[13]editorial, "Long on Funds--Short on Personnel," American Journal of Nursing Vol. 43 (July, 1943), p. 688.

[14]Manual for an Economic Security Program, 2nd ed., ANA Economic Security Unit, 1956, p. 2.

the conditions under which they worked. What did this amount to? A summary of the results are:

> (1) Employment conditions for nurses have not kept up with rapidly changing conditions - rarely have they kept pace with changes in the cost of living;
> (2) Nurses are restless and dissatisfied, and becoming increasingly articulate about their need for better economic conditions; and
> (3) Most serious of all, nursing service is endangered - both in quality and quantity - because of present unsatisfactory economic and personnel policies.[15]

The successful California experience provided the impetus for the ANA to explore the possibility of collective bargaining by its other state affiliates. The nurses employed in hospitals wanted action. Indeed, a few rebellious nurses had joined trade unions. By 1944, when the ANA House of Delegates met in Buffalo, the question "could the basic economic problems of professional workers be solved through collective bargaining" was more than an academic interest to many delegates.[16] It became recognized that improving nurses' employment conditions could be done effectively only by democratic group action. Thus, in 1946, the ANA convention gave overwhelming approval to a nationwide collective bargaining program. As a result of the pressures from within the profession, ANA has come

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[15]"The ANA Economic Security Program," American Journal of Nursing Vol. 47 (February, 1947), p. 71.

[16]Mary M. Roberts, American Nursing: History and Interpretation (New York: the Macmillan Co.), 1954, p. 405.

to accept collective bargaining as a means to improve nurses' working conditions. This acceptance was made without developing any formal alliances with organized labor. Furthermore, ANA takes the official position that it should not be considered a labor union.[17]

The introduction of collective bargaining merely alters one of the means of achieving its goal of economic security. It does not alter the goal itself. It is not new for the professional association to take an interest in the economic welfare of its members. It has been of continuing concern. It is the method - collective bargaining - that is new.

Overview of ANA's Economic Security Program

Founded in 1896, the purposes of ANA have always been to foster high standards of nursing practice, to promote the professional and educational advancement of nurses, and to promote the general welfare of nurses to the end that the people of this country will have the best possible nursing care. Thus, since the ANA was organized, its members have believed that in order to produce quality

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[17]Archie Kleingartner, "Professional Associations: An Alternative to Unions?" in Contemporary Labor Issues, eds. by Walter Fogel and Archie Kliengartner (Belmont, California: Wadsworth Publishing Co., Inc., 1966), p. 250.

nursing care satisfactory working conditions are necessary. Over the years it became more and more apparent that the exercise of leadership necessarily involved more than the use of persuasion and the making of suggestions for improvements. These procedures were not producing the desired results.

Though recognized by society in general as an effective method for obtaining economic security for employed groups, the field of industrial relations and the philosophy of collective action were new concepts for most nurses when applied to their own situation. Along with the recognition of the need and the right of nurses to better employment conditions came the recognition that nurses could not realistically depend on others to bring about improvements in their economic status. With the adoption of the economic security program by the 1946 House of Delegates, the ANA acknowledged its responsibility to assume stronger leadership in improving the economic position of its members.

Acting upon this accountability, the ANA House of Delegates in 1946 adopted the economic security program as follows:

> The American Nurses' Association believes that the several state and district nurses associations are qualified to act and should act as the exclusive agents of their respective memberships in the important fields of economic security and collective bargaining. The Association commends the excellent

> progress already made and urges all state and district nurses associations to push such a program vigorously and expeditiously.
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> Since it is the established policy of other groups, including unions, to permit membership in only one collective bargaining group, the Association believes such policy to be sound for the state and district nurses associations.[18]

The broad goal of the ANA economic security program is to improve the economic status of the nursing profession by establishing the right of nurses to a voice in decisions concerning the conditions under which they will practice their profession. Specifically, the two main purposes of the program are:

> (1) to secure for nurses, through their professional associations, protection and improvement of their economic security - reasonable and satisfactory conditions of employment; and
> (2) through accomplishing this, to assure the public that professional nursing service, of high quality and in sufficient quantity, will be available for the sick of the country.[19]

The goals of the economic security program included wider acceptance of the 40 hour week and the establishment of minimum employment standards; increased participation of nurses in the actual planning and administration of nursing service; development of state nurses associations in their role as exclusive spokesmen for nurses in matters affecting

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[18] "The ANA Economic Security Program," American Journal of Nursing Vol. 47 (February, 1947), p. 70.

[19] Ibid.

their employment; the development of collective bargaining techniques by state associations; the restriction of membership of a nurse to only one organization which can act as a bargaining agent; and the elimination of employment barriers against nurses in minority racial groups.[20]

ANA firmly endorsed collective bargaining as a means to improve employment conditions for nurses. This endorsement was made clear when the 1946 House of Delegates adopted the economic security program. The state nurses associations "should act as the exclusive agents of their respective memberships in . . . collective bargaining."[21] The ANA encourages participation in collective bargaining whenever and wherever possible. However, it cautioned that "Collective bargaining is not an end in itself. It is not the Economic Security Program. It is only one of the instruments which may be used for the achievement of the program."[22]

With this caution, ANA places high priority in promoting collective bargaining. A policy adopted in 1948 called upon the state associations to refrain from entering into "joint programs for economic security for nurses"

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[20]See Initiation of Program, policy adopted by the ANA House of Delegates, September, 1946.

[21]"The ANA Economic Security Program," American Journal of Nursing Vol. 47 (February, 1947), p. 70.

[22]Ibid.

with state hospital associations on the basis this could bring charges of company unionism.[23] There should be only a clearly responsible relationship, founded on democratic principles - no collusive or paternalistic relationships. Furthermore, the ANA called upon the American Hospital Association and its constituents to join them in implementing collective bargaining procedures in all hospitals.[24] ANA asks that the nurses be granted the rights of collective bargaining enjoyed by other members of society.

ANA efforts to extend collective bargaining included seeking legislative protection of this right for nurses. It has exerted pressure on federal and state legislative bodies for favorable legislation. Almost as soon as it was passed, the ANA has sought the removal of the exemption of nonprofit hospitals from the Taft-Hartley Act.[25] To strengthen their economic security programs, state associations are urged to promote

> " . . . 1) the elimination of the principle of exemptions of hospitals from existing state labor relations laws; and 2) the enactment of comprehensive state labor

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[23]Policy approved by the ANA Board of Directors and ANA House of Delegates, May, 1948.

[24]Resolution approved by the ANA Board of Directors, June, 1958.

[25]Resolution approved by the ANA Board of Directors, January, 1949.

> relations laws to require collective negotiations between employers and employees, including the employees' free choice of representation, and provision for mediation and arbitration."[26]

Furthermore, the concept was incorporated into their Code of Ethics. The ANA House of Delegates in June, 1958, adopted a recommendation authorizing the revision in the code of ethics that nurses should participate in establishing terms and conditions of employment as a part of their ethical duty to maintain professional standards. This action stressed the profession's feelings that concerted action by the professional association is appropriate and necessary if it is to discharge its responsibility to the public.[27] By such action, ANA committed itself to the principle of collective bargaining.

Although ANA strongly encouraged collective bargaining as a means to improve employment conditions, it does not endorse striking as a weapon of the collective bargaining process. A "No-Strike" policy was adopted in 1950 stating that nurses voluntarily relinquish the right to strike.[28] But, in return, it was felt this imposed upon employers an obligation to recognize and deal with

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[26]Policy adopted by the ANA House of Delegates, May, 1956.

[27]ANA Interpretation of the Statements of the Code For Professional Nurses.

[28]Policy adopted by the ANA House of Delegates, May, 1950.

nurses through their authorized representatives. They recognized their responsibility to provide continuous nursing service to the public - to meeting the health needs of hospitalized individuals. At the same time, they asked the employers to acknowledge their responsibility in providing good working conditions for their employees in order that the mutual goals of quality patient care can be obtained. To achieve the purpose of the economic security program, nurses have voluntarily relinquished the right to strike. All other customary and appropriate means would be used including collective bargaining.

In conjunction with the "No-Strike" policy, the ANA has adopted a "Nurses in Dispute" policy to act as a guide for nurses' conduct during dispute between employers and non-nurse employees. In effect the nurses are expected to "maintain a scrupulously neutral position" in any disputes involving other hospital employees.[29] In other words, they should avoid any participation in activities which would influence the outcome of the dispute. In case of a strike, the nurses, in their neutral position, would continue to perform their distinctive nursing functions and would not accept the assignment of duties normally

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[29]Policy adopted by the ANA House of Delegates, May, 1950.

discharged by non-nurse personnel "unless a clear and present danger to patients exists." In reality this would be a most difficult, if not impossible, position to maintain. It is clearly defined that maintenance of hospital facilities is not a nursing duty. Even today, mopping and waxing the floors or doing the laundry may be considered by some to be nursing duties. In meeting the patient's physiological needs for food there exists some ambivalency towards fulfilling dietary functions. While recognizing their own and others rights in collective bargaining, the nurses were concerned that individuals receiving their services should suffer as little as possible in labor disputes.

In advocating exclusive representation for nurses, the ANA has appropriately adopted the policy "to permit membership in only one collective bargaining group."[30] This policy meets the requirements of labor relation laws which recognize only one exclusive representative for an appropriate bargaining unit. The question of dual membership had been raised since some nurses already were members of unions. Therefore, the matter had to be made clear. Holding membership in other organizations is neither approved nor disapproved but simply discouraged when the

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[30]Policy initiating the program, adopted by the ANA House of Delegates, September, 1946.

activities of such organizations are in direct competition with the ANA economic security program. The policy does not sanction the barring of union nurses from association membership unless the particular state association is conducting an active bargaining program. For the nurse can have only one exclusive representative in collective bargaining.

In following the principles and concepts of collective bargaining, the ANA does not appoint nurses who hold the position of hospital superintendent or administrator to its Committee on Economic and General Welfare.[31] This follows the policy for state associations in their relationship to hospital associations. To avoid the possibility of a conflict of interests or charges of company domination or a collusive relationship, nurse hospital administrators are prohibited from serving on this economic security program committee.

The ANA itself does not engage in collective bargaining. Collective bargaining is the responsibility of the state associations. In implementing the program, ANA provides general direction and assistance to the state associations in developing and administering an economic

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[31]Policy approved by ANA Board of Directors, August, 1949, and reaffirmed in June, 1961.

security program.[32] To carry out this function, an economic security unit with staff personnel was established at the ANA headquarters in New York. The ANA staff help the states by assisting them in developing educational programs and workshops; by providing consultation services and technical advice in specific situations; by furnishing data not available at the state level; and by coordinating and collecting facts and other information pertinent to the program.

Recently the state associations bargaining activities have increased. Consequently, they have sought more assistance from the national headquarters. In response to these requests, the ANA has taken steps to give greater assistance to the states by becoming directly involved in bargaining activities. Whereas previously ANA had merely given support to the states, it is now entering into bargaining activities. In May, 1967, ANA decided it would assist with the representation of the 20,000 nurses employed by the federal government.[33] The staff member assigned to handle the interests of federally employed nurses

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[32]ANA A Manual For an Economic Security Program, 2nd ed., prepared by Economic Security Unit, January, 1956, pp. 3-4.

[33]"ANA to Help States Bargain with U. S. Agencies," American Journal of Nursing Vol. 67 (July, 1967), p. 1369.

would provide information on regulations and agencies in Washington; would inform states about developments in other states; and would give field assistance to state staffs in organizing local units and in negotiating agreements.

There are several problem areas which generally hinder the successfulness of the ANA economic security program. Obstacles impeding the progress of the program have been listed by Kruger to include the attitude of the nurses themselves; employer resistance; and inadequate legal protection.[34] To these, Archie Kleingartner adds lack of an effective economic weapon (no substitute for the strike); several organizational weaknesses; and too many other programs.[35]

The opposition from most hospital employers seems to be the single greatest obstacle to implementation of the economic security program. Hospital employers are greatly influenced by the national and state hospital associations. The American Hospital Association has taken the position that voluntary nonprofit hospitals should not only continue to be exempt from the Taft-Hartley Act but also should be exempted from all collective bargaining

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[34]Reprint from Monthly Labor Review, Vol. 48 (July, 1961), Daniel Kruger, "Bargaining and the Nursing Profession."

[35]Archie Kleingartner, "Nurses, Collective Bargaining and Labor Legislation," Labor Law Journal Vol. 18, (April, 1967), pp. 243-244.

legislative acts.[36] The state hospital associations have been effective in implementing the AHA position on collective bargaining. In addition, the hospital associations provides tremendous resources to individual hospitals that are resisting recognition.[37] However, it is felt that a new generation of more enlightened, better educated hospital administrators now appearing may reduce this opposition somewhat.

Legislative protection would indeed enhance the nurses organizing and bargaining activities. The lack of favorable legislation however has not prevented several states associations from gaining recognition and engaging in collective bargaining.

The attitude of the nurses themselves has been one of apathy. Furthermore, it has been observed "many members of the nursing profession are satisfied to accept uncritically the subordinate-dependent position in an authoritarian relationship."[38] Though economic security program

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[36]Leo B. Osterhaus, "The Effect of Unions On Hospital Management," Hospital Progress Vol. 48 (June, 1967), p. 72.

[37]Anne Zimmerman, "SNA Experiences with Collective Bargaining" from Addresses on Trends Affecting the ANA Economic Security Program, ANA Economic Security Conference, December 5-9, 1960, published by ANA ECU, 1961, p. 29.

[38]Harold L. Sheppard and Audrey P. Sheppard, "Paternalism in Employer-Employee Relationships," American Journal of Nursing Vol. 51 (January, 1951).

activities have increased, the nurses, as a group, still show an unwillingness to promote collective bargaining. These factors limit the success of the program.

Without a substitute for the strike, the program lacks an effective economic weapon. Recently, however, the trend has been developing towards an increasing use of mass resignations. Mass resignations are a drastic step for the nurses. It is even more drastic for employers when the nurses are able to obtain readily positions in other nearby hospitals. Two state associations, California and Pennsylvania, have recinded the no-strike pledge in order to put more teeth into their bargaining activities.[39]

Several organizational weaknesses and too many other programs are serious problems. Organizational weaknesses include lack of financial resources, inadequate communication among the different levels of the organization, and the practice of state affiliates of not entering a local situation until requested by the nurses. It appears that the ANA is trying to do too much. Collective bargaining is just one aspect of the economic security program. And, the economic security program is only part of the total program for the economic and professional

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[39]"Pennsylvania Nurses Rescind No-Strike Pledge" American Journal of Nursing Vol. 66 (November, 1966) and White Collar Report 502, A3, October 20, 1966.

enhancement of nurses. Other programs include Research, Professional Creditials and Personnel Services, Legislation, Clinical Conferences, Professional Registries, and Public Relations. As a result, no part of the program receives adequate attention. Also, too many programs dilutes the available resources which in turn limits the scope of any one program.

There are positive aspects to the ANA economic security program. These have been summarized by Archie Kleingartner.[40] The commitment to the idea of collective bargaining as the best method to improve employment conditions resolves the debate over means which paralyze many professional organizations. The nurses receive favorable public sentiment in their attempts to increase collective action. There is an increased feeling among nurses that they can do something about their working conditions through organization. The ANA has taken steps to develop skilled leaders in organization and in negotiations. Information on the economic security program has been communicated to the public and general membership. The ANA has not hesitated to use experienced "non-nurse" professionals and consultants for their purposes. Since the ANA is the single dominant organization representing nurses in all of

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[40]Archie Kleingartner, "Nurses, Collective Bargaining, and Labor Legislation," Labor Law Journal Vol. 18 (April, 1967), pp. 243-244.

their job and professional problems, there exists no sharp rivalry for members and representation as in other salaried professionals, such as the teachers. The ANA has been fairly successful in combining its responsibilities for the economic and professional enhancement of its members. While maintaining their other programs, improvements have been made in the nurses economic status. Since the professional organization conducts the negotiations, the policies and procedures are uniquely related to the needs of nurses and their employers.

MNA'S ECONOMIC SECURITY PROGRAM 1959-1965

Structure of MNA's Economic Security Program

The Michigan Nurses Association plays a unique role in the profession's program for economic security. While the ANA provides policy direction, moral support and technical assistance, and the district nurses association interprets the program to nurses and the public, MNA represents nurses in their efforts to improve employment conditions and establishes the recommended employment standards.

The district nurses associations are constituents of MNA. Each of the 50 MNA districts elects one delegate for every fifty members to the MNA House of Delegates. Districts with less than fifty members elect only one delegate. The district conducts continuing education programs, serves as spokesman for nurses in the local community's concerns with general health and welfare of the community and recruits members into the association. The districts encouraged and promoted MNA's economic security program.

It is through the state occupational sections that members formulate employment standards and institute programs to implement them. Thus, the structure of any state association should be such that the arrangements both provide for democratic participation of members of all occupational groups and protect the rights of each group to consider and vote separately on matters affecting conditions of their work.

When a nurse joins MNA, she becomes a member of an occupational section which is based upon place of employment or position in the employment situation. MNA has seven occupational sections: general duty nurses; head nurses; nursing service administrators; public health nurses; private duty nurses; office nurses; and educational administrators, consultants and teachers. Among other functions, each section is "to study the economic needs and general welfare of its members and develop desirable standards of employment."[1] Each level of nursing studies and establishes its employment standards. The section executive committee appoints a committee to draft employment standards which are reviewed and revised annually if necessary. The MNA staff advise and assist with drafting standards by compiling and interpreting related data and suggesting provisions to be considered. The suggested

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[1]MNA Bylaws Article XV Section 5 (d).

employment standards are discussed and voted on at the section's annual business meeting. The section chairman then presents the recommended employment standards to the Board of Directors. When approved by the Board of Directors they become official. Each elected section chairman serves on the Board of Directors, thereby giving occupational interests representation on it. The established sections contribute to the economic security program by continuing to review and revise statements on functions, standards and qualifications and the minimum employment standards of those nurses which are included in each respective section.

The Committee on the Economic Security Program (ESP) has as its function to submit recommendations to the Board of Directors on policies and procedures for the economic security program; to evaluate the effectiveness of the program; make recommendations for the implementation of the total program; and recommend revisions in employment standards in accordance with section recommendations.[2] The sections and the ESP committee worked together in studying employment standards and in the determination of what the employment standards for nurses should be. The committee reviewed the details related to the program, provided guidance as necessary and offered recommendations

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[2]MNA Bylaws Article XIV, Section 8.

to the Board of Directors on policies, procedures, and problem situations. It also helped to plan educational programs relating to the economics of nursing and the economic security program.

The Board of Directors, other than section chairman, are elected by the House of Delegates. The Board of Directors are responsible for managing the affairs of the MNA. The Board establishes the policies to meet the Association's goals and determine which objectives are to be given priority following the general direction of the House of Delegates. Through budget approval, the Board of Directors affect the priorities and maintains in balance the many programs needed to discharge its responsibilities to the members. In addition, the Board of Directors acts upon the recommendations and requests sent from the various committees and sections. The Board of Directors appoints the standing committees which assume specified and assigned duties, such as the Committee on the Economic Security Program. It is thus the Board of Directors which is directly responsible for the total over-all administration of the Economic Security Program.

The Board of Directors analyzes all the programs of the MNA and their relationship to one another. Any implications for the economic security program are considered in the development and adaptation of plans for all its programs. The Board of Directors appoints the

executive secretary who supervises the administration of the program. They provide for the services of legal, industrial relations, public relations and other consultants as needed. It is their responsibility to provide adequate financial resources for the implementation of the economic security program. They appoint the Committee on Economic Security Program with the duties previously stated.

The actual activities of the ESP program are assigned to one of the professional staff. The Board of Directors in April, 1960, appointed Avis Dykstra as the assistant executive secretary responsible for carrying out the program's activities. The assistant executive secretary directed the program, recommended changes or additions necessary for its proper fulfillment and kept the Board of Directors informed. She assisted the sections in the preparation of employment standards and gave guidance in their distribution and use, as well as handled the printing and mailing of them. She set up procedures to keep the program functioning smoothly and efficiently. She maintained official records and files of basic and related facts - salary data, case histories, etc. Field service was provided to groups of nurses who requested help with employment problems. Briefs and supporting data were compiled for presentation to employers. She served as the chief spokesman when representing groups of nurses; appeared at district meetings speaking on the economic

security program; conducted surveys of the employment conditions for nurses in Michigan; and called upon the consultants when needed for their advice and assistance. She worked with two very important committees - The Committee of the Economic Security Program and the Michigan Nurses Association - Michigan Hospital Association Liaison Committee.

Industrial relations, public relations and legal consultants were employed by the MNA. The industrial relations consultant, Daniel H. Kruger, assistant director, Industrial Relations Center, Michigan State University, at that time, began his services with MNA in November, 1959. The industrial relations consultant conducted surveys on the economic status of nurses; wrote articles about the program for the MNA's official publication, the Michigan Nurse; spoke to groups of nurses on the program; and participated in ESP workshops. He provided valuable services in the guidance and direction of the program by supplying his experience in research and in the use of economic data. He met frequently with the Committee on the Economic Security Program and the MNA-MHA Liaison Committee and was called upon quite often for advice on the employer-employee relationship problems.

Public relations is an essential part of the economic security program. In this area, the services of Mrs. Kay Fuller were acquired in early 1960. Not only was she

instrumental in keeping members informed through articles in the Michigan Nurse but also extremely helpful in publicizing the nurses' economic story in the public press and other news media. Public relations media was used to interpret the need for improved employment conditions and to tell this story as widely as possible.

Though MNA did not retain legal consultant specifically for the economic security program in the first few years of its operation, they did have legal services available if needed.

As for the nurses themselves, they participated in the establishing of employment standards in a democratic fashion as explained under the role of the occupational sections. The program requires the full support and interest of the nurses. The scope of the program's operations, in part, depends largely upon the specific requests from nurses for assistance with problems related to employment conditions. As Patricia Walsh, president, MNA, wrote in 1960 "In order to realize the broad goals that are envisioned in this new program, we place high value on the contribution, interest, support and participation of every member of the Association. In fact, every nurse employed in Michigan has a role in this."[3] Recommended employment

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[3]Patricia Walsh, "The What and Why of the MSNA Economic Security Program": Michigan Nurse Vol. 33 (May-June, 1960), p. 61.

standards generally are not put into effect unless the nurses themselves work to do so. Only when the nurses joined together to seek MNA help could MNA take an active part in a local agency to bring about improvements in employment conditions.

Development of the Program

Before initiating any new program, an extensive preliminary preparation usually occurs. A conditioning process to set the stage for a major change in organizational activities takes place. ANA adopted its program in 1946. Twelve years elapsed before Michigan Nurses Association initiated the program recommended by the national association. This long delay was due to the attitudes of the nurses. To the Michigan nurses, the ANA program advocating collective bargaining was too highly controversial and generally unacceptable.[4] During these 12 years, the economic security aspects for nurses in Michigan were not being overlooked entirely. But, the methods used by the MNA to improve employment conditions for the nurses were not getting effective results.

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[4]Letter to Mrs. Margaret B. Dolan, R.N., president, ANA, from Avis J. Dykstra, dated March 31, 1964.

Along with keeping current on employment conditions for nurses, the methods used were primarily recommendations and persuasion.[5] As noted each occupational section in the MNA prepared and adopted recommended personnel policies for that section. At periodic intervals, each occupational section would review and make revisions as needed. The recommended personnel policy booklets were helpful in advising employers of the employment standards set for nurses. However, they were not sufficiently effective, since the adoption of the recommended policies were strictly voluntary by the employers.[6] There appears to have been no real systematic plan of action.

Assistance was given to groups of nurses in writing personnel policies for their institutions and in interpreting them to the employer.[7] Also, at the request of the hospital administrator, the MNA would give guidance and assistance to the administration in preparing personnel policies. Though there was some accomplishment towards the improvement of the economic status of professional nurses, an analysis of the employment conditions of nurses in Michigan Hospitals showed much more needed to be done.

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[5]"Progress on MSNA's Economic Security Program," Michigan Nurse Vol. 32 (January, 1959), p. 15.

[6]"Annual Reports of Michigan State Nurses Association: Report of the Office Staff," Michigan Nurses Vol. 31 (September, 1958), p. 107.

[7]"Progress on MSNA's Economic Security Program," Michigan Nurse Vol. 32 (January, 1959), p. 15.

In early 1953, a committee on economic security consisting of three members was appointed, but it was only to be activated when matters pertaining to the economic security program arose.[8] The committee's principle function was to review the personnel policies yearly. The act was recognition of a need for action but it in itself was not strongly positive.

Some members were aware that a stronger course of action for bringing about improvements in employment standards was needed. During this period, the MNA president and staff members attended the ANA economic security workshops held annually. The leaders were becoming more conscious of the problems and were recognizing the need for an economic security program, as advocated by ANA. But, they wanted to find a "dignified fair approach" to the problem from within the profession. It was up to each state nurses association to adopt the ANA economic security program. It was the state's responsibility to represent the nurse. But, to have such a program required the support of the nurses themselves. The leadership, however, must supply the guidance and direction. It is part of their duty to prepare the nurses for making changes and keeping them informed on current trends and developments.

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[8]Emma Antcliff, "Economic Security," Michigan Nurse Vol. 25 (May, 1952), p. 75.

After attending an ANA economic security workshop in September, 1952, Mrs. Emma J. Antcliff, president, MNA, wrote in her report to the membership "as MSNA continues to consider this responsibility, the membership must contribute their views as well as financial support to a possible program within our state that will serve as a challenge to present and prospective nurses."[9] The need for a more positive and active program had been recognized by the leadership. This is the first step towards a well developed sound program. The second step is to create an understanding of the program among the membership. The membership had to see the need for and desire to have such a program before it can be effectively instituted. The members had to become aware of the trends in society to fully accept the philosophy and approach suggested by ANA. Lack of understanding leads to the unacceptability of a program. As was pointed out in the Fall of 1952 by Mrs. Porter, president, ANA, in her address to MNA's advisory council, no other program was so little understood as the ANA Economic Security Program. And that, furthermore, "Nurses should move along with the trends of time."[10] This was true of the Michigan nurses.

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[9]Emma J. Antcliff, "ANA Economic Security Workshop" Michigan Nurse Vol. 25 (November, 1952), p. 139.

[10]"ANA President Stresses Democratic Action and Need for Well-Informed Members" Michigan Nurse Vol. 26 (January, 1953), p. 3.

The ANA had adopted a program of collective action in recognition that this was an effective means to achieving its goals. But, the Michigan nurses had not fully awakened yet to the realities around them. The time had passed when an individual nurse could act alone to improve her employment conditions. It was growing very apparent that collective action was necessary. An individual nurse needed the support and backing of all the nurses - the professional organization. But, it was up to the membership to decide whether action should be taken. Since no action was taken at this time one must assume the nurses were not quite ready to proceed forward with an aggressive program. It was still too controversial and generally unacceptable.

The wheels turn however slowly. As previously, the MNA staff continued to give assistance to members on matters relating to personnel policies when requested. Little progress can be made however by stamping out little fires here and there. Or, waiting for requests which usually come when the situation reaches a desperate point.

It was not until early 1957 that the wheels really began to move. The leaders began to plan a definite educational campaign as a preliminary stage in preparing to adopt an economic security program. At the MNA Board of Directors meeting on April 16, 1957, plans for an economic security program workshop were discussed. And, the Board

of Directors decided to hold three workshops in June that year for the Board of Directors and district officers.[11] An editorial stressing an economic security program appeared in the same issue of the Michigan Nurse.[12] To make sound decisions or to plan a course of action, an individual needs information. Workshops and staff visits to district meetings were methods used to inform members on the need for an economic security program.

Comments on an economic security program began to appear regularly in the MNA's official publication, the Michigan Nurse, a year prior to the adoption of a program in 1958. The membership had to be informed and prepared to debate the issue. They were the ones to make the decision whether a program would be adopted or not. In her report to the membership, Phyllis MacKay, president, MNA, explicitly pointed out "At some date in the near future a decision should be made as to the adoption of a more active program in this state.[13] They were also "urged to become

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[11]"Board Highlights," Michigan Nurse Vol. 30 (June, 1957), p. 89; and "MSNA Sponsors Economic Security Workshops," Michigan Nurse Vol. 30 (June, 1957), p. 89.

[12]editorial, "The Economic Security Program and the Nurse," Michigan Nurse Vol. 30 (June, 1957), p. 82.

[13]Phyllis MacKay, "Report of President," Michigan Nurse Vol. 30 (September, 1957), p. 104.

familiar with the details of this program and call on the MSNA Staff for assistance with needed information."[14]

Members were informed about current situations and events. The situation was demanding a more effective means for improving nurses working conditions. In their annual report in September, 1958, the staff told the membership "a constructive, effective program of improving the economic status of the professional nurse is rather imperative."[15]

The stage had been set. It was clear that an economic security program would be a top issue at the 1958 MNA convention in October. Every effort had been made to convince all nurses of the importance of the program. Before the nurses made their decision, the topic was well covered at the convention by such speakers as William Haber, professor of Economics, University of Michigan, and May Bagwell, consultant in Industrial Relations and Economics, ANA.[16] The issue was resolved by the members authorizing the adoption of an economic security program.[17]

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[14]"Report of Office Staff," Michigan Nurse Vol. 30 (September, 1957), p. 107.

[15]"Annual Reports of Michigan State Nurses Association: Report of Office Staff," Michigan Nurse Vol. 30 (September, 1957), p. 107.

[16]From the program of the Michigan State Nurses Association, Annual Convention, October 29-31, 1958; and "Program MSNA Convention" Michigan Nurse Vol. 31 (September, 1958), p. 113.

[17]"Some Convention Highlights," Michigan Nurse Vol. 31 (November, 1958), p. 150.

The members voted that "an Economic Security Program be started by MSNA,"[18] and that the MNA dues be increased from $10.00 to $15.00. The increase in dues would be used for expanding all MNA activities and for the adoption of an economic security program.[19]

Immediately following the 1958 MNA convention, the Board of Directors appointed a special committee on Economic and General Welfare to study the problems related to employment conditions and to present recommendations for policies and procedures to be used in the economic security program.

The first two years following the action of the 1958 MNA convention may appropriately be called the planning stage. The special committee on Economic and General Welfare began studying the situation and developing recommendations for policies and procedures in order to get the program in operation. The committee under the chairmanship of Mary M. Weinschreider, received guidance and help from Hazel Gabrielson, then executive director, MNA. While the committee was busy at work developing guidelines for the program, nurses were being more fully informed about it. Direct assistance to nurses continued as in the past.

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[18] Manual of the Michigan State Nurses Association Program For Improving Personnel Standards for Professional Nurses, prepared July, 1960, p. 3.

[19] Ibid., p. 3.

To get assistance the nurses employed in an agency were requested to do the following:

> 1. Write a letter to the MSNA office stating specifically the problems upon which assistance is needed.
> 2. Since MSNA membership status of the nurses employed in that agency needs to be ascertained, a list of the employed nurses must be supplied to the MSNA offices. It is required that more than 50% of the nurses employed in the agency must be members of MSNA before any assistance can be given.[20]

Upon request, the MNA staff would proceed according to the demands of the individual situation presented and in accordance with the guidance given them by the Special Committee on Economic and General Welfare and the Board of Directors. The staff did provide assistance in response to several requests.[21]

During 1959, the Special Committee on Economic and General Welfare met three times and developed some suggested additional policies. The policies developed were:

> 1. That all agencies be encouraged to have written personnel policies. There should not be separate sets of policies for the nurses, other than those for other employees of the agency.
> 2. The Director of Nursing should always be informed and included in all activities when nurses are writing or revising personnel policies.
> 3. When a group of nurses want assistance with improvement of personnel policies, they are to submit their request in writing to the MSNA office.

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[20]"In Unity There is Strength," Michigan Nurse Vol. 32 (May-June, 1959), p. 78.

[21]"Report of MSNA Staff," Michigan Nurse Vol. 32 (September-October, 1959), p. 120.

> 4. No assistance can be given to any area agency unless more than 50% of the nurses employed are members of the MSNA. A total list of nurses employed in any agency wishing assistance must be submitted with the request for assistance to the MSNA office.[22]

Specific recommended personnel policies were also developed.

The program was actually slow in being activated. Although the membership had voted in 1958 to start a program, it was 1960 before the program really got underway. One of the greatest deterrents was to find a qualified professional nurse who would step into this relatively strange and rather foreign role.

While the year 1959 was spent developing policies, in 1960 MNA worked on the implementation of the economic security program. In April, 1960, Avis Dykstra, R.N., joined the MNA staff with the responsibility to administer the program.[23] The special committee, working with Miss Dykstra, developed a manual to serve as a guide for the program. It was accepted by the Board of Directors on August 17th. The Manual of the Michigan State Nurses Association Program for Improving Personnel Standards for Professional Nurses was distributed to all the members attending the 1960 MNA annual convention. The contents of the

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[22]"Annual Reports of MSNA: Special Committee on Economic Security Program," Michigan Nurse Vol. 32 (September-October, 1959), p. 138.

[23]"Report of the MSNA Staff," Michigan Nurse Vol. 33 (September-October, 1960), p. 115.

manual included: its purpose; the basic belief and philosophy of an Economic Security Program; the development of Economic Security in the state; the role of ANA, MSNA, and the districts; and the policies and procedures as related to the program.[24]

A strong educational program has always been a vital part of the program from the very beginning. The foundation and success of the program, it was felt, depended on a well informed membership. This was emphasized in the introduction of the manual as it stated "to accomplish the defined purpose of this program, constructive, cooperative action by a well informed membership will be needed.[25] In 1960, two special newsletters on the Economic Security Program in Michigan were sent to all members. Also, MNA sponsored four one-day conferences in Grand Rapids, Flint, Lansing and Marquette. The one-day conferences on "What is the MSNA Economic Security Program?" were held for directors of nursing, presidents of districts and executive committee members of all sections.[26]

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[24]Proceedings of the MNA annual business meeting, October 5-7, 1960, "Report of the Special Committee on Economic and General Welfare."

[25]Michigan State Nurses Association, Manual of the Michigan State Nurses Association Program for Improving Personnel Standards for Professional Nurses, prepared July, 1960, p. 1.

[26]MSNA Proceedings of the annual business meeting, October 5-7, 1960, "Report of the Special Committee on Economic and General Welfare."

The educational program not only focused on informing the membership of its own program but also on the general field of economic security. Towards this end, the universities were approached on offering non-credit courses to nurses on economics. Miss Katherine Faville, member of the Economic and General Welfare Committee, was instrumental in getting one such course started in the College of Nursing, Wayne State University in 1960.[27]

The MNA also had to keep informed. MNA needed to have information on the employment condition for professional nurses. The facts were necessary to set up the design of the program. Since the last survey to determine the employment conditions in hospitals and public health agencies was conducted in 1958, another survey was again conducted in 1960.[28] The surveys were an effort to collect more complete and up-to-date information on employment conditions for professional nurses. The program's course of action would be based on facts.

To further implementation of the program the special committee appointed a subcommittee to study how the districts would participate in the program. The subcommittee was to investigate the feasibility of having local

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[27] Ibid.

[28] Ibid.

committees on economic and general welfare organized in all districts, and the possible functions and activities that might be assumed by local committees. A pilot study in the fall of 1960 was conducted in five districts.[29]

A "Multi-dimensional" Approach

MNA modified the ANA's approach to the economic security program. It developed what was called a "multi-dimensional" approach. In the specific design of the program, flexibility was stressed. The multiplicity of the problems involved in the economics of the nursing profession coupled with the many goals of the MNA demanded a multi-dimensional approach. The design of the program was influenced: by the goals which were set; by the progress in reaching them; by the support and interests of the members; by the specific requests from the nurses for assistance in employment problems; and by the resources of MNA-time, knowledge, funds and personnel.[30] In providing its services to all nurses, MNA has tried to be as versatile

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[29]Ibid.

[30]Patricia Walsh, "The What and Why of the MSNA Economic Security Program," Michigan Nurse Vol. 33 (May-June, 1960), p. 60; Manual of the Michigan State Nurses Association Program for Improving Personnel Standards for Professional Nurses, prepared July, 1960, p. 2; and Avis J. Dykstra, "The First Five Years in the Development of Economic Security Programme," International Nursing Review, p. 46.

and flexible as possible and not be limited to any one approach but rather chose an approach to each situation which was most likely to succeed. As Avis Dykstra succintly put it "We have not limited our program to any one single approach. We have left the door open so that there is always flexibility in our planning."[31] A multi-dimensional approach provides flexibility - using means which best fits the situation. In his comments on MNA's program Daniel Kruger stated "it is this flexibility which accounts, in part, for its forward thrust."[32]

The basic approaches used for improving working conditions were education, shared information, consultation and representation.[33] The program included an educational program for the public, the nurses and the employers. It also provided consultation services for directors of nursing and hospital administrators. A cooperative approach was sought to resolve employment problems. The

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[31]Proceedings of the annual business meeting, October 31, 1962, "Report of MSNA Economic Security Program" as presented by Avis J. Dykstra.

[32]Daniel H. Kruger, "An Approach to Improving Economic and Professional Status," Michigan Nurse Vol. 37 (January-February, 1964), p. 23.

[33]"A Statement of MSNA's basic approach in the Economic Security Program," November 29, 1962 (mimeograph); and MNA The District's Role in Promoting the Economic Security Program, "Know Concepts and Approaches of MNA's Economic Security Program," April 22, 1964 (mimeograph), p. 3.

Program recommended that staff nurses have a voice in the formulation of personnel policies through a staff committee which should meet with the administration periodically, and give support and help to the director of nursing in her efforts to improve salaries and working conditions. If this approach did not produce results, the staff nurses would seek assistance from MNA. In some instances, the nurses should request MNA to be their spokesman.

MNA did not rely on collective bargaining completely as a means to improve the nurses professional and economic status. It believed "There is a need and a place for collective bargaining in selected situations, where other approaches have failed to improve the employment practices."[34] Collective bargaining would be used when necessary. Without relying solely on collective bargaining the implementation of the above approaches did help the Michigan nurses to make advances towards their goals.

Their goal was to improve the economic and professional status of nurses to the end that quality patient care can be provided. The main purpose of the program is to improve employment conditions for nurses and to relate this program to other activities of the association.

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[34]From "A Statement of MSNA's basic approach in the Economic Security Program," November 29, 1962 (mimeograph).

By doing so, it hopes to attract more young people into the profession, reduce turnover, eliminate competition between hospitals based on salaries, and improve the utilization of nursing manpower.

The policies related to the Economic Security Program have been reviewed and revised periodically. The Board of Directors has the primary responsibility for the total administration of the program. The Special Committee on Economic and General Welfare, later made a standing committee called the Committee on the Economic Security Program, provided guidance and offered recommendations to the Board of Directors on policies and procedures. A professional staff member was assigned to carry out the activities of the program. Though one staff member was assigned specific responsibility for the program, all the staff were to give attention to the over-all association activities relating to the program and to local groups of nurses who requested assistance. The program was run by registered professional nurses who were to direct the program towards the interests of registered professional nurses. The staff were authorized to call upon the consultants for assistance in the various phases of the program when necessary.

The staff was authorized to respond to requests for assistance from groups of nurses in agencies even if the percentage of membership in the MNA was low. However,

before the staff could meet with the administration of the agency there had to be more than 50% membership in the association, among the full-time employed nurses. Two reasons were offered for this policy. The membership requirements were necessary to furnish financial resources in order to supply assistance. Then too it strengthened MNA's right to speak for the nurses - their members! It was important in avoiding the embarrassing question "How can you represent the nurses when so few are members?" The nurses when making their request to the MNA had to put it in writing. Signatures of the members had to be affixed to the request.

A basic policy of the economic security program was that there should be written personnel policies in all places of employment.[35] Efforts were made to have nurses employed in an agency to be represented and to participate on the agency's committee to develop and/or revise an agency's personnel policies. It was recommended the personnel policies be reviewed annually and revised as needed, and be made available to the staff. Participation on personnel committees was a concrete demonstration of utilizing democratic methods in the decision-making process which the association was advocating.

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[35] Manual of the Michigan State Nurses Association for Improving Personnel Standards for Professional Nurses, prepared July, 1960, p. 8.

A belief, so strong in fact that it can be classified as a policy, is that "nurses can best speak for nursing."[36] The professional association was to be the official spokesman for registered professional nurses.

In 1962, the Special Committee on Economic and General Welfare reviewed a possible position on mass resignations. This action was prompted by the request of a group of nurses for assistance where the situation was such they were ready to resign their positions. The ANA had taken no official position on mass resignations. Mr. Charles Davies, acting chairman, presented to the members at the 1962 MNA annual convention the items the committee had formulated in relation to mass resignations. They were:

> 1. At this stage of our Economic Security Program we do not condone mass resignations as a threat to cripple the nursing services. Mass resignations, when used as a threat to the employer, constitutes a strike.
> 2. Mass resignations are implemented only after all other alternatives and resources for action have been explored.
> 3. Nurses who decide to resign en masse will write individual letters of resignation. They should fulfill their terms of employment and give proper notification of resignation, clearly stating their reasons for leaving.
> 4. Where mass resignations are planned there should be orderly staggering of these resignations, for example, a two week advance notice, three week advance notices, four week advance notices, and in some instances, they might take as long as a three month period.

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[36] Ibid., p. 2.

> 5. Mass resignations should be considered as terminating employment. This should not preclude re-employment if the nursing situation has improved, and the nurse chooses to re-apply for employment.[37]

The proceedings of the annual business meeting in which these were presented shows no evidence that any official House of Delegates action was taken. Rather in discussion of other issues they appeared to have been forgotten and overlooked completely. Though it appears the House of Delegates took no action, the Board of Directors did accept the statements as formulated by the Committee on Economic and General Welfare.[38]

ESP Activities

After a year of planning and developing policies, a program to educate the nurses on the economic security program's concepts and procedures was begun. In the Spring of 1960, the first conferences were held, primarily for the directors of nursing and district presidents and representatives, considered the leaders for other nurses.

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[37]Proceedings of the annual business meeting, October 31, 1962; "Report of MSNA Special Committee on Economic and General Welfare"; also see "Reports of MSNA Special Committees: Economic and General Welfare," Michigan Nurse Vol. 35 (September-October, 1962), p. 146; Luther Christman, "The Nurses Will Resign - Rather than Strike," Michigan Nurse Vol. 35 (September-October, 1962), pp. 153-154.

[38]"Deliberations of MSNA Board," Michigan Nurse Vol. 36 (January-February, 1963), p. 5.

The four one-day conferences were to explain "What is the MSNA Security Program."[39] These conferences were further supplemented by institutes such as the one held in December, 1961, co-sponsored by MNA and Michigan State University. This institute covered such topics as: "A Critical Appraisal of Employment Practices for Hospital Nurses"; "Financing Medical Care"; and "Hospital Business in Michigan."[40] Only a part of the total program, these conferences and workshops were efforts to implement the program through dissemination of the facts. By interpreting the facts it was hoped to create a greater awareness and the need to take measures to improve employment practices for nurses. They were attempts to gain greater influence in hospital administration through more knowledgeable directors of nursing in order that they would be instrumental in making the changes needed.

But, the directors of nursing were not the only ones to be educated. There were many other nurses too. The Board of Directors and the staff participated in numerous district nurses meetings to spread information

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[39]"Report of the MSNA Staff," Michigan Nurse Vol. 33 (September-October, 1960), p. 115; and "Report of Special Committee on Economic and General Welfare," as recorded in the proceedings of the annual business meeting, October 5, 1960.

[40]"MSNA Staff Report," Michigan Nurse Vol. 35 (September-October, 1962), p. 131.

about the program. For example, in 1963 it was reported that formal presentation on the economic security program were given at eight district meetings and two state universities.[41]

To increase the nurses knowledge in the economics of the nursing profession non-credit courses were held by local universities in the field of economic security. In the Fall of 1960, the course "Labor Management Problems for Nurses" was conducted in the College of Nursing, Wayne State University. Focusing extensively on collective bargaining techniques, it was attended by nine registered nurses.[42] It was repeated in the Fall of 1961. A similar course was offered at Michigan State University in the Spring of 1961. It was a ten week course on "Economics for the Nursing Profession" attended by seventeen registered nurses.[43] The courses were repeated regularly with increasing number of nurses attending them. In the Fall of 1965 Wayne State University conducted "Hospital Nurses

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[41]"Annual Reports of Michigan State Nurses Association: MSNA Staff," Michigan Nurse Vol. 36 (September-October, 1963), p. 127.

[42]Proceedings of the annual business meeting, October 5, 1960; and "Annual Reports of MSNA: Special Committee Reports, Economic and General Welfare," Michigan Nurse Vol. 34 (September-October, 1961), p. 144.

[43]Proceedings of the annual business meeting, October 19, 1961; and "Annual Reports of MSNA: Special Committee Reports, Economic and General Welfare," Michigan Nurse Vol. 34 (September-October, 1961), p. 144.

Course in Labor Relations" with sixty-five registered nurses enrolled. Also, Michigan State University conducted a course entitled "Economics and Labor Relations in the Nursing Profession" with twenty-eight registered nurses participating.[44] The strong interest developed on these topics had brought many requests for a repetition of the courses on economics for nurses.

Since the adoption of the program, MNA has strongly felt the need for informing the public about the adverse conditions nurses were working under - the critical shortage of registered professional nurses, low salaries, improper utilization of nursing personnel. It wanted the public, the users of nursing services, to know what they may expect by way of nursing care. They had a right to know why professional nurses found it difficult to provide the kind of care patients have a right to expect. MNA utilized every possible opportunity through various media to inform the public of the professional concern about the quality of patient care.[45]

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[44]"Annual Reports of Michigan Nurses Association: MNA Staff," Michigan Nurse Vol. 39 (September-October, 1966), p. 8.

[45]Avis J. Dykstra, "What's Happening in ESP," Michigan Nurse Vol. 36 (March-April, 1963), pp. 35-36; and Avis J. Dykstra, "The First Five Years - Development of an Economic Security Programme," International Nursing Review Vol. 12 (March-April, 1965), pp. 47-48.

A comprehensive public education program was beyond the means of MNA. When sources for funds failed to appear, MNA requested ANA to explore the possibility for a nation-wide public information campaign. This was done through a resolution submitted by MNA at the 1960 ANA convention. The resolution, which was passed, called for a national public relations campaign to pave the way for improving the economic status of nurses throughout the country.[46] In 1962, MNA submitted another resolution at the ANA convention calling for ANA assistance in promoting a public information campaign. In response to this, ANA developed informational materials and slides to help focus public attention on the economic problems in nursing. These were distributed to and used by the districts with supplemental facts prepared by MNA.[47]

An MNA committee on public relations worked with Mrs. Kay Fuller, MNA public relations consultant, in the promotion of the program to the public. Regional conferences were held for district public relations representatives in order to help the districts in interpreting the

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[46]Kay Fuller, "1960 Roundup - MSNA Style," Michigan Nurse Vol. 34 (January-February, 1961), p. 3.

[47]editorial, "Operation: Speak Up for Nursing," Michigan Nurse Vol. 36 (September-October, 1963), p. 122.

nurses problems to the public.[48] From the very beginning MNA has considered this a vital part of its economic security program as did ANA. To give this aspect a strong start the theme of its 1959 convention was "Professional Progress Through Public Relations."[49]

In early 1960, an approach was made to the Michigan Hospital Association. It was felt appropriate to initiate and establish a more suitable working relationship and liaison activity with the Michigan Hospital Association. MNA's main objective in developing liaison activity with the MHA was to provide an avenue of open communications with hospital administrators. It was an endeavor to help minimize misunderstandings and misinterpretations for both groups. The liaison activity was looked upon as a cooperative approach to help improve employment practices and to effectuate desirable changes.

The discussions of the liaison committee centered around a variety of subjects. But, as may be expected, the focus was primarily centered on the nurses' concern for improved salaries and working conditions, particularly

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[48]"Committee Reports; Public Relations," Michigan Nurse Vol. 35 (September-October, 1962), pp. 144-145; see also subsequent annual reports published in the September-October issues of the Michigan Nurse.

[49]"Michigan State Nurses Association Convention Program," as published in the Michigan Nurse Vol. 32 (September-October, 1959), pp. 131-132.

in the early period. As summarized from minutes and reports of these meetings the topics discussed covered: increase in nurses' salaries; providing nurses with written copies of personnel policies; informing employees on the problems of hospital costs; retirement program for nurses; employment standards for regular part time employees; contracts; resolving a particular problem in a certain institution; and legislation. Other areas of mutual interests were also discussed such as the need for working together for improved patient care; for more effective utilization of nursing personnel; and for changes in nursing education. It seems to be agreed that communications with the MHA did help to facilitate and expedite the hospitals implementing MNA's current recommended employment standards.

There is no doubt there have been differences between both groups. However, the opportunity for objective discussion of differences of opinion has been viewed as being healthy. The MHA however is a stronger more powerful organization than MNA. As a consequence, the relationship between the two organizations has not been as equals. But, rather MHA has tended to dominate and have greater influence than the nurses would have preferred.

The MNA-MHA liaison committee was unique and attracted national attention. A committee of this type was not common to state nurses associations. At the 1964 MNA convention, Avis Dykstra reported that ten states had made

inquiries because of the national reputation of the successful working of this particular committee.[50] In response to inquiries regarding the functions of this committee, Dorothy Cornelius, executive secretary, Ohio Nurses Association, and first vice-president, ANA, attended the September 9, 1964, meeting of the MNA-MHA liaison committee. She wanted to see at first hand the committee in operation and determine how, if possible, to start similar committees in other states.

Another aspect of the economic security program activities included conducting periodic surveys in order to assess the climate in which the ESP would be developed. In April, 1960, an opinion survey on registered nurse shortages and low salaries was sent to 1000 leading citizens and key groups throughout Michigan in the fields of government, health, and the press.[51] The cover letter solicited their understanding and support. They were asked their advice as to how they viewed nursing's economic problems and what they thought would be the most effective approaches for seeking improvements. Most responses

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[50]From the proceedings of the annual business meeting of the MNA House of Delegates, October, 1964, "Report of the MNA-MHA Liaison Committee."

[51]Kay Fuller, "1960 Roundup - MSNA Style," Michigan Nurse Vol. 34 (January-February, 1961), p. 3.

indicated that many of the leaders were sympathetic to the nursing problems and advised that the profession itself had to take a strong stand to bring about necessary changes.

Groups of nurses were surveyed, too, to ascertain how they viewed the role of the professional association in exerting appropriate pressures to bring about salary improvements. Their response was that the professional association must assume strong leadership and help nurses throughout the state by utilizing various types of approaches and collective action. Studies such as the one conducted by Daniel Kruger, MNA industrial relations consultant, in 1960 on the economic status of registered professional nurses,[52] helped to pinpoint the major problems as the nurses saw them. These were the problems the economic security program had to work on. Through surveys and questionnaires, MNA identified the concerns of the nurses so that it could plan a course of action for resolving these problems.

To have complete and up-to-date information on the employment conditions for registered professional nurses, MNA conducted annual surveys on salaries and fringe benefits in all Michigan Hospitals and public health agencies.

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[52]Daniel H. Kruger, "The Professional Nurse Speaks Out," Michigan Nurse Vol. 33 (July-August, 1960), pp. 94-95.

These surveys were conducted with the assistance of MNA's industrial relations consultant and students from Michigan State University. These surveys showed there was great need for improvements in nurses employment conditions.

MNA provided assistance to nurses primarily in two ways - (1) consultative services to directors of nursing, and (2) representation of nurses.

The director of nursing is administratively charged with the responsibility for submitting periodic budget requests for the nursing department which includes salary recommendations and other requests for improved personnel policies. In such a situation, MNA gave the director of nursing assistance by compiling salary data; by preparing special reports; and by preparing materials which would help the director of nursing in presenting her case to the administrator, personnel director or the board of trustees. This situation is the traditional method of economic security action in which the director of nursing interprets the necessity for salary revisions through the channels of command.

Another approach was working directly with groups of nurses. The type of assistance rendered depended upon the situation. In any instance, it was suggested the nurses work through the director of nursing first in requesting improved working conditions. If this failed to bring results, the nurses were then to call upon MNA for further

assistance. Where results failed to materialize by working through the proper channels the nurses were to inform the director of nursing they were seeking help from MNA. On the one hand, the staff action could be interpreted as being supportive to the director of nursing, particularly when she had tried to bring about improvements but unsuccessfully. In many hospitals the director of nursing could do little to bring about needed improvements. If the director of nursing was in agreement with what the nurses wanted then she would most likely interpret it as a supportive act. On the other hand, the staff action could be interpreted as a threat to the director of nursing by showing up her inefficiencies and her weakness. The reaction would possibly hinder or even block any action by the staff.

The type of assistance given nurses were consultant services and/or representation by serving as their official spokesman. In each case, upon request for assistance, an MNA representative met with the nurses to ascertain the scope of their problems and then assessed how best to proceed to get the desired improvements. At a general meeting with the entire staff of nurses in an agency, the MNA representative interpreted the policies and procedures relating to the economic security program. At this time too, the concept and principle of collective action was promoted and interpreted.

Consultation services consisted of mainly helping the local group of nurses get organized and recommending the procedure they should follow to resolve their problems. In other words, the group acted on its own with only advice from MNA. In addition, MNA would supply them with informational material and economic data as indicated. For example, MNA's recommended employment standards booklet would be sent to them to compare with their present personnel policies. The local group collected much of their own data and put their requests in writing to be presented to the employer. Representatives from the local group would meet with the employer to present and discuss the nurses requests. Any action taken depended upon the employer's receptivity and voluntary adoption of the recommendations. The nurses' efforts depended, in part, on their ability to sell their recommendations.

When MNA acted as the official spokesman, it became more involved at all stages of preparation and representation. MNA representative would meet with the nurses' committee to identify critical areas of needs and drafted the requests. In addition to the data collected by MNA, the nurses' committee gathered data more specific to the institution such as staff turnover. MNA prepared and printed the final brief or report. In meetings with employers, whether an administrator, board of trustees, city council or county board of supervisors, the MNA representative was

the spokesman for the nurses. Though collective action was the method used, no actual collective bargaining took place. Rather, the nurses relied on rational decisions based on the facts they presented. It was expected the nurses' recommendations would be acted upon and adopted by employers.

CHART I

OFFICIAL REPRESENTATION BY MNA
1961-1965

	Hospitals	Public Health Departments	Other Agencies
1961	6	4	2
1962	7	3	
1963	2	1	
1964	7	4	
1965	3	3	

Source: annual reports published in the Michigan Nurse

Chart I shows the number of institutions in which MNA served as the official representative over a five year period. In each instance, a written report or brief was prepared and the special recommendations with supporting data submitted to the employer. It must be remembered there was only one staff person assigned to carry out the duties and responsibilities of the economic security program.

In addition to serving as the official spokesman in these institutions, the MNA representative each year filled numerous requests for consultation from directors of nursing. In 1963, consultant services were provided to nine (9) directors of nursing. The number of directors of nursing given consultant services were not always available, therefore it is not possible to determine the full extent these services were provided.

To these activities should be added the special assistance given to groups of nurses and individuals each year. For instance, in 1963 not only did MNA serve as official spokesman for two (2) hospitals and one (1) public health department, provide consultant services for nine (9) directors of nursing, and gave special assistance to groups of nurses in their place of employment in five (5) districts, Greater Detroit District, Bay District, Muskegon District, Van Buren District and St. Joseph District.[53] Among other duties in 1963 the staff person gave presentations on the economic security program at 8 district meetings, 2 state universities and an Indiana public health nurses workshop.

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[53]"Annual Report of Michigan State Nurses Association: MSNA Staff," Michigan Nurse Vol. 36 (September-October, 1963), p. 127.

MNA worked with some groups of nurses on a continuous basis over the years. The most notable of these is the Highland Park General Hospital Nurses.[54] Not only did MNA officially represent them continuously since 1962 but they also were the first and only group for which MNA sought a written contract prior to the passage of the Michigan Public Employees Relations Act in 1965. The nurses from Highland Park General Hospital first requested assistance from the MNA in January, 1962. The spark which sent the nurses to their professional association was an invitation from the American Federation State County and Municipal Employees, AFL-CIO, to join the union. Instead, they met and voted to utilize the professional association as their "spokesman."

When MNA became involved the situation was such that it had become increasingly difficult to maintain or upgrade the standards of nursing at Highland Park General Hospital. The nurses salaries were low and inequitable by both internal and external comparisons. The nurses were performing many non-nursing functions such as cleaning units for discharged patients and clerical duties. Aides would refuse to perform functions because it was alleged

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[54]Jeanne E. White, "Highland Park Story," Michigan Nurse Vol. 40 (January-February, 1967), pp. 15, 17 & 20. In addition, much information was obtained through interviews and conversations with the nurses employed at Highland Park General Hospital; and materials on file in MNA office.

that it was not in their job description. The union represented all employees except professional nurses. Furthermore, many budgeted positions for registered professional nurses were empty.

Following the first meeting with the MNA representative, about two months was spent by the professional nurse committee of Highland Park General Hospital and the MNA representative gathering data, outlining problems, and drafting requests. On March 29, 1962, the first formal meeting was held with representatives from the professional nurse committee, MNA, and the hospital administrator. In the next few months, the nurses were involved in a series of meetings with the hospital and the various Highland Park city officials. Among the requests sought was recognition of MNA, a contract, and salary increases, a high priority item. All requests were denied. On June 6th the committee presented a signed petition threatening a mass resignation of the professional nurses if no favorable action was forthcoming. A special meeting was called on June 15th with the mayor, the city personnel director, the hospital administrator, the MNA representative and the nurses committee. It was mutually agreed at this meeting that the City of Highland Park would enter into a written agreement with MNA. Also, special consideration would be given for a salary revision. The nurses did receive the salary increase. But, the written agreement, promised in

2 or 3 months, was not signed for another four years. During these four years, many meetings took place between the nurses, the hospital administrator and city officials. The nurses were persistent and gradually improvements were made.

Omitting the contract and threat of mass resignations, the situation and circumstances were similar to others confronted by Avis Dykstra during her years of work in the MNA's economic security program. Among them were Detroit Health Department, Pontiac General Hospital, Wayne County General Hospital, and Bay County Health Department, to name a few.

Measurement of Success

What is the criteria for success? If it is the number of collective bargaining agreements, which the ANA program emphasizes, then it would have to be said that the MNA program has not been successful for the first five years of effort. But, the MNA program did not claim collective bargaining as its prime tool. Therefore the number of collective bargaining agreements cannot be used as a measure of success in this case.

One of the stated goals is to improve the economic status of nurses. Progress towards this end would be one indication of success. As Chart II shows there have been improvements in the average beginning monthly salary paid

CHART II

SALARY INCREASES IN THE STATEWIDE AVERAGE MINIMUM MONTHLY SALARIES PAID TO GENERAL DUTY NURSES IN MICHIGAN*

1960 - 1965

Year	Average Minimum	$ Increase	% Increase
1960	$315.00		
1961	331.40	$16.40	5.2%
1962	344.70	13.30	4.0%
1963	359.30	14.60	4.2%
1964	381.17	21.87	6.1%
1965	396.68	15.51	4.1%

*Source of data MNA salary survey 1960-1967

to the general duty nurse. Between 1960 and 1965, nursing salaries in Michigan improved by 23%. Thus, a look at the 1965 salary as compared to 1960 indicates that economically substantial progress had been made. From 1961 to 1965 the nurses salaries increased 16.5%. By comparison the teachers salaries in Michigan between 1961 to 1965 increased 9.7%, $388.70 per month (12 month basis) to $430.41.[55]

[55]Statistics calculated from the table "Teacher Salary Schedule data 1961-62 through 1966-67," p. XI in Teacher Salary Study 1966-1967, East Lansing, Michigan: Michigan Education Association, 1966.

In review, these improvements came about with only minimum official representation by MNA. At most MNA officially represented nurses in 12 agencies in any one year, not enough to make any significant impact. Great reliance was put on the nurses themselves to initiate and effect changes, either through their position as directors of nursing or through collective action by the staff nurses. MNA's liaison activity with the Michigan Hospital Association was probably, in part, a contributing factor in its economic success.

Not all the criteria for success can be tangibly measured. Daniel Kruger, MNA's economic consultant, listed the criteria for measuring progress in the program as being:

- whether employers are providing employment opportunities under which quality nursing care can be provided.
- whether employers of nurses accord them dignity and respect.
- whether employers are willing, in good faith, to work with nurses to the end that the quality of nursing care is enhanced and improved.
- whether there are written and well-defined personnel practices in operation.
- whether professional nurses are more willing to speak out on matters affecting their professional and economic status.
- whether the profession is developing the necessary leadership in all parts of the state.
- whether there are improvements in the economic status of professional nurses in Michigan.[56]

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[56]Daniel H. Kruger, "An Approach to Improving Economic and Professional Status," Michigan Nurse Vol. 37 (January-February, 1964), p. 23.

The last criteria has already been discussed. Developing leadership and a willingness to speak out on matters affecting them are important for they effect the first three measurements of progress. The ability and willingness to speak out depends, in part, on knowing the facts. Educating the nurses on the economic facts of life has been a large part of MNA's program. Not only were annual surveys on employment conditions conducted but the results were published so they were available for all the nurses. After getting the facts its knowing what to do with them. Publicity through the Michigan Nurse, presentations at district meetings and personal contacts with local groups helped to create a greater awareness that something could be done and the way it could be done. The number of requests for MNA assistance is evidence that there was an increasing awareness among the professional nurses. This awareness led to the development of leadership and a willingness to speak out.

Sometimes necessity helps to bring out qualities and abilities thought not present among the membership. MNA had only one person assigned to the economic security program. With approximately 300 hospitals and 60 public health agencies not counting the other institutions employing nurses, it was too much for one person to handle. MNA had to rely on individual efforts. Consequently, as Avis Dykstra observed from her years in charge of the program

"more and more, they [nurses] are exerting the necessary initiative and leadership to help effect desirable changes."[57] Initiative and greater interest in economic security for nurses shows up in the increased number of nurses attending courses on labor relations at the state universities. As presented earlier, the number of nurses who participated in these courses at Wayne State University and Michigan State University in 1965 were 65 and 28, respectfully, as compared to 9 and 17 in 1961.

While it is difficult to appraise accurately the accomplishments of MNA's economic security program for the first five years, it does seem progress as a whole had been made. Greater accomplishments were limited by the amount of resources available for the economic security program. An increased tempo did not come until labor relations legislation was enacted which permitted collective bargaining in the public sector.

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[57]"Annual Reports of Michigan State Nurses Association: MSNA Staff," Michigan Nurse Vol. 36 (September-October, 1963), p. 127.

IMPACT OF THE MICHIGAN LABOR RELATIONS ACTS

Pertinent Provisions

On July 23, 1965, Governor George Romney signed the Public Employees Relations Act (PERA) which gave public employees in Michigan the right to organize and to choose an exclusive bargaining representative to represent them in bargaining over hours, wages and working conditions. The public employers are required to bargain with the exclusive bargaining representative. The Michigan Labor Mediation Act (LMA) was also amended so that the Michigan Labor Mediation Board had the power to hold an election for representation in the private hospital area. Previously, the LMA had only a special mediation procedure for hospital disputes. There was no specific provision for hospitals to select an exclusive representative. Prior to 1965, the public employees were covered by the Hutchinson Act which prohibited strikes by Public employees. The Hutchinson Act also had a mediation process which provided that the majority of any group of employees could seek mediation of grievances.

The Public Employees Relations Act (PERA) retains the prohibition against strikes by public employees (Section 2). But, the automatic termination provision and the very severe penalties on reemployment have been eliminated. PERA provides that the public employer may discipline an employee who does strike in violation of the prohibition against striking. The discipline imposed can go as far as discharge. However, the public employee, if he feels he did not violate the provisions of PERA, has a right to a hearing "with the officer or body having power to remove or discipline such employee." (Section 6.) In other words, he has a right to a hearing by the public employer. Then, if he is still not satisfied he has the right to appeal to the circuit court to determine whether the discipline action is supported by sufficient evidence. The term strike, as defined in PERA, means concerted action with others to abstain from work for the purpose of influencing or coercing a change in working conditions or compensation.

Following the ANA policy the Michigan nurses have voluntarily relinquished the right to strike. Therefore, it would seem this provision would have little applicability to the nurses. This, of course, could change if the nurses after reviewing their position rescinded their no-strike policy, which has been done by the Pennsylvania and California nurses associations. There is no indication

however MNA will do so. What happens is the individual nurse resigns when conditions become unbearable and obtains employment elsewhere without difficulty. The positions are there. On only three occasions known have the nurses in Michigan resorted to the threat of mass resignations.[1] Though some question whether such a measure constitutes a strike or not, it has entirely different implications. A resignation, as intended, is the permanent severance from an employer and the giving up of all invested rights in the position. It indicates the individual has no intention of working for that employer any longer and is free to seek employment elsewhere. Withdrawal from unpleasant working conditions is an option open for nurses.

It is MNA's objective to improve working conditions in order to attract nurses into active employment and to discourage nurses from leaving their profession. Both PERA and LMA provide a medium for MNA to achieve this objective. PERA protects the right of public employees to organize. The provision granting this right or organize is Section 9 which states:

> It shall be lawful for public employees to organize together or to form, join or assist in labor organizations, to engage in lawful concerted activities for the purpose of collective negotiation or bargaining

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[1]Highland Park General Hospital in 1962, Coldwater Community Hospital in 1965 and Detroit General Hospital in 1967.

> or other mutual aid and protection, or to negotiate or bargain collectively with their public employers through representatives of their own free choice.

Thus, under PERA, publicly employed nurses have the right to form or join a labor organization. MNA meets the qualifications and has been recognized as a labor organization. Thereby, the nurses have the right to engage in organizational activities for the purpose of collective bargaining.

Both acts set up the mechanism whereby employees may choose a collective bargaining representative. To be the exclusive representative MNA must be designated or selected by the majority of employees in an appropriate bargaining unit. Recognition as the exclusive representative for a bargaining unit of nurses may be obtained through voluntary recognition by the employer or through selection by an election.

To obtain voluntary recognition, the labor organization must show that a majority of the employees in a unit wish that organization to represent them for collective bargaining purposes. For this purpose, MNA had printed authorization cards for the nurses to sign. Upon signing the cards, the nurses authorized MNA to be their collective bargaining representative. The nurses do not have to be MNA members to sign the cards. However, they all are expected to become members. At first, a petition form had been used by MNA but later switched to the printed authorization card. Proof of membership or the intent of

membership such as applications for membership cards, could possibly be used. Once a majority of the nurses have signed the authorization cards, MNA may request voluntary recognition from the employer. An employer may request proof that a majority of the nurses have designated MNA to be their representative. A meeting then may be held during which the employer examines the authorization cards and checks them with his record of employees. Thereupon, the employer may grant voluntary recognition to MNA if satisfied a majority of nurses have truly authorized MNA to be their representative. The bargaining unit must be defined however, and mutually acceptable to both parties. The recognition and definition of the bargaining unit is put in writing. Most often it has been an exchange of letters. In the case of Alpena General Hospital, MNA wrote requesting recognition. The Board of Trustees adopted a resolution recognizing MNA as the exclusive collective bargaining representative. Then the hospital administrator wrote a letter to MNA stating it had been recognized and the bargaining unit was defined.

If voluntary recognition is not granted, MNA may file a petition for an election with the Michigan Labor Mediation Board. Petition for election is authorized under Section 12 of PERA and under Section 27 of LMA. The labor organization is required to show it has thirty percent or more of the employees in an appropriate unit who have

designated it as their bargaining representative. Thus, MNA must obtain signed authorization cards from at least thirty percent of the nurses in any claimed bargaining unit. To avoid embarrassment because of the high turnover rate among nurses and to make a strong showing of strength MNA has usually not petitioned for an election unless fifty percent or more of the nurses have signed authorization cards. As noted above this is not required by law.

When a petition is filed, the MLMB schedules an informal hearing with both the employer and the labor organization. If there is no question on the appropriateness of the bargaining unit and the proper showing of interest is demonstrated, a consent election can take place. The parties sign an agreement for the consent election. A secret ballot election is then conducted by the MLMB at a time and place agreed upon by the parties. If there is disagreement on the bargaining unit or some other point in representation, then a formal hearing is held to resolve the contested issues. Depending upon its findings, the MLMB may dismiss the petition or direct an election be held. Where MNA has not been granted voluntary recognition, the employers have agreed to a consent election. An organization can intervene in an election if ten percent of the employees wish to be represented by it. MNA intervened for the nurses at Genesee Memorial Hospital when council 25, AFSCME petitioned the MLMB to represent the nurses and

was placed upon the ballot along with the union. By setting up the mechanism whereby employees may choose a collective bargaining representative, the Acts eliminate much strife between employers and employees and between rival labor organizations.

Section 14 of PERA and Section 29 of LMA are of importance. They state "An election shall not be directed in any bargaining unit . . . within which, in the preceding 12-month period, a valid election has been held." Should MNA win the election, it means for a one year period no other labor organization can petition for representation and no group can petition for decertification. MNA thereby has time to negotiate an agreement without interference from other labor organizations. Should MNA lose an election, no organization can petition for an election for a one year period. During this time there is the possibility the nurses may lose interest in MNA representation altogether or it gives time for another labor organization to recruit the nurses into its membership.

Of particular significance to some Michigan nurses is the "contract bar" provision included under Section 14 of PERA and Section 29 of LMA. "No election shall be directed in any bargaining unit or subdivision thereof where there is in force and effect a valid collective bargaining agreement which was not prematurely extended and which is of fixed duration." Thereby, nurses who find

themselves being represented by a union in a conglomerate bargaining unit must remain in that bargaining unit for the duration of the agreement. A conglomerate bargaining unit includes several different occupations such as dietary employees, maintenance employees, laundry employees, nurses aides, licensed practical nurses, etc. And such is the case in at least one instance, the public health nurses, City of Grand Rapids, represented by Local 1061, AFSCME. There is a stipulated period of time prior to the agreement's expiration during which the nurses can petition to be excluded from the union.

In the matter of an appropriate bargaining unit, Section 13 of PERA provides that:

> The board shall decide in each case, in order to insure public employees the full benefit of their right to self-organization, to collective bargaining and otherwise to effectuate the policies of this act, the unit appropriate for the purposes of collective bargaining as provided in section 9e of Act No. 176 of the Public Acts of 1939. . . .

and Section 9e of Act 176 of Public Acts of 1939 as amended (LMA) provides:

> The board, after consultation with the parties, shall determine such a bargaining unit as will best secure to the employees their right of collective bargaining. The unit shall be either of one employer . . . not holding executive or supervisory positions . . . Provided, however, that if the groups of employees involved in the dispute has been recognized by the employer or identified by certification, contract, or past practice, as a unit for collective bargaining, the board may adopt such unit.

The MLMB decides on a case by case basis, on its own merits,

an appropriate bargaining unit. The appropriate bargaining unit must insure the public employees their full right to organize, and to collection bargaining.

The parties involved are encouraged to reach a mutual agreement on the appropriate bargaining unit. If they are not able to do so, the MLMB is authorized to hold a formal hearing to determine the appropriate unit. For an election to be conducted by the MLMB, the bargaining unit must not violate the provisions of the Acts. For instance, supervisors may not be included in a bargaining unit with non-supervisory employees. For this reason MNA has agreed to accept two bargaining units for nurses rather than the preferred all inclusive unit. A determining factor on the appropriateness of a bargaining unit is a community of interest among the employees, a prime factor used to resolve the issue in two cases involving MNA and the Michigan Association of Nurse Anesthetists.[2] The MLMB concluded the nurse anesthetists did share a community of interests in common with other registered nurses.

PERA, under Section 15, requires that a public employer must bargain collectively with the exclusive bargaining representative of the employees in an appropriate

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[2]In the matter of Highland Park General Hospital and Michigan Association of Nurse Anesthetists and Michigan Nurses Association, MLMB case No. R66L-429; In the matter of Alpena General Hospital, and Michigan Association of Nurse Anesthetists and Michigan Nurses Association, MLMB case No. R66L-432.

bargaining unit. This is a new concept in the public area. Never before in Michigan have public employers been required to bargain with their employees. The refusal to engage in collective bargaining is an unfair labor practice for which the MLMB is vested with the power to issue a cease and desist order. Collective bargaining is the mutual obligation of both the employer and the employees exclusive representative. They must "meet at reasonable times and confer in good faith with respect to wages, hours, and other terms and conditions of employment. . . ." Furthermore, it is "the execution of a written contract, ordinance or resolution incorporating any agreement reached if requested by either party. . . ." But, it does not mean either party is compelled to agree to a proposal or to make a concession. To the nurses at Highland Park General Hospital, Section 15 of PERA had the utmost importance. MNA had been seeking a contract with the City of Highland Park on behalf of the nurses since January, 1962. Its efforts were to no avail as the employer was not required "to make and enter into collective bargaining agreements" with their employees exclusive representatives. With PERA, the nurses finally did obtain their collective bargaining agreement which they had been struggling to get for four years. Under the LMA, the private hospital employer is also required to bargain collectively with the exclusive bargaining representative and execute an agreement.

As already mentioned, the refusal to bargain collectively with the public employees' exclusive representative is an unfair labor practice under PERA Section 10e. The public employer's conduct must show his duty to bargain as described in Section 15 of PERA. That is, his conduct must indicate he is negotiating in good faith with the intention of reaching an agreement. The LMA has the same requirement. The prohibited unfair labor practices are fundamental ground rules in the collective bargaining relationship. They are designed to protect the employee by restricting certain employer activities. In addition to not refusing to bargain collectively as required by the Acts, employers must not interfere with employees when they are organizing or bargaining collectively according to the Acts; engage in "company unionism"; discriminate in hiring or in other conditions of employment among employees to encourage or discourage labor organization membership; or discriminate against employees filing charges or giving evidence under the Acts. The MLMB is provided remedies for unfair labor practices under both acts.

The Effects on the Nurses

In Michigan there are 244 non-federal hospitals which would come under both the Public Employees Relations Act and the Labor Mediation Act, 156 voluntary non-profit

hospitals, 58 county or city owned hospitals, 22 state hospitals and 8 proprietary hospitals.[3] There are also 53 extended care facilities. In addition, there are 45 county or city operated public health agencies and 32 osteopathic hospitals.[4] Altogether there are 374 hospitals and other health institutions in Michigan.

In 1966, there were 22,005 registered nurses employed in Michigan. Of these, 15,423 were employed in hospitals and other health institutions, and 1,049 were employed in public health (see Chart III). Accordingly a large majority of the employed registered nurses were effected by these two acts.

The Acts generated a great deal of interest on the part of the nurses. At the MNA's 1965 annual convention, many hours were spent discussing their meaning, interpretation and implications for the nurses. Robert Howlett, chairman, Michigan Labor Mediation Board, interpreted the acts. Implications of this legislation for the nurses was discussed by Daniel Kruger, MNA economic consultant, and Thomas Walsh, MNA legal consultant.[5] As Mr. Walsh explained it was not whether or not the nurses wanted to be represented

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[3]Figures obtained from Hospitals, Vol. 40, Guide Issue, Part II, August 1, 1966, pp. 112-119 and p. 454.

[4]Figures obtained from MNA.

[5]Proceedings of the MNA annual business meeting, October 26, 1965.

CHART III

1966 INVENTORY OF REGISTERED NURSES IN MICHIGAN* BY TYPE OF POSITION

Field of Employment of Those Actively Employed in Nursing	Total	General Duty Staff	Head Nurse or Assistant	Instructor	Supervisor or Assistant	Consultant	Administrator or Assistant	Other	Not Reported
Hospital or Other Institution	15,423	8,797	2,997	220	2,007	29	533	409	431
School of Nursing	768	13	14	600	11	10	105	6	9
Private Duty	945	-	-	-	-	-	-	945	-
Public Health	1,049	729	30	28	102	61	53	6	40
School Nurse	324	246	22	-	16	20	18	2	-
Industrial Nurse	1,129	902	134	1	67	6	14	5	-
Office Nurse	1,865	1,629	175	-	33	2	25	1	-
Other	52	12	3	2	1	7	2	25	-
Not Reported	450	115	44	15	50	1	19	3	203
TOTAL	22,005	12,443	3,419	866	2,287	136	769	1,402	683

*Source: Michigan Board of Nursing.

Activity Status of All Registered Nurses	
Employed	22,005
Not Employed	13,184
Not Reported	2,308
TOTAL	37,497

in collective bargaining but who was going to represent them. The MNA House of Delegates responded by authorizing MNA to act as the exclusive representative for registered nurses.

The decision was made with the knowledge that the unions had already begun to organize and obtain recognition for conglomerate bargaining units, which included registered nurses. Labor organizations, mainly the American Federation State, County and Municipal Employees (AFSCME), AFL-CIO, had already started to recruit new members among hospital employees. In at least two agencies the union defined the bargaining unit so broadly that it included the registered nurses.[6] In October, 1965 in Wayne County, Metropolitan Council 23, AFSCME, AFL-CIO, filed a petition with the Michigan Labor Mediation Board (MLMB) for an election to certify it as representing all Wayne County employees excluding Road Commission employees, seasonal, supervisory and craft employees, doctors, cooks and cafeteria employees. If the registered nurses had not taken prompt action to be excluded they would have found themselves in a mass conglomerate bargaining unit. Local 1061, AFSCME, asked the City of Grand Rapids for recognition as the exclusive bargaining representative for virtually all of the City's non-uniformed

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[6]Thomas C. Walsh, "Who Will Speak for Nurses?" Michigan Nurse, Vol. 38, (November-December, 1965), p. 3; Letters to MLMB from Thomas C. Walsh, MNA legal counsel, dated October 13 and 15, 1965.

employees. The recognition was granted and 23 public health nurses, caught unprepared to cope with the situation, found themselves being represented by a labor organization which they did not want.[7]

Hospital administrators have attempted to include registered nurses in the union's proposed bargaining unit of non-professional employees. Instances where hospital employers wanted to include registered nurses in the union's proposed bargaining unit were War Memorial Hospital, Sault Ste. Marie; St. Luke's Hospital, Marquette; St. Joseph's Hospital, Hancock; Grand View Hospital, Ironwood; and Gratiot Community Hospital, Alma.[8] Such administrators apparently were using the registered nurses in an attempt to keep the unions out. The idea was to include them so they could vote against the union and thus defeat them. However, in a

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[7]"'Railroad' Into Union Irks Grand Rapids Public Health Nurses," Grand Rapids Press, September 20, 1965.

[8]War Memorial Hospital and American Federation State, County and Municipal Employees, AFL-CIO, MLMB Case No. R66 J-381, July 12, 1967; St. Joseph's Hospital and American Federation of State, County and Municipal Employees, AFL-CIO, MLMB Case No. R66 L-438, July 12, 1967; St. Luke's Hospital and American Federation of State, County and Municipal Employees, AFL-CIO, MLMB Case No. R66 L-439, July 12, 1967; Grand View Hospital and American Federation of State, County and Municipal Employees, AFL-CIO, MLMB Case No. R66 J-386, July 12, 1967; and Grand View Hospital and Michigan Nurses Association, MLMB Case No. R66 K-405, July 12, 1967; and letter to MNA from the Registered Nurses of Gratiot Community Hospital dated July 12, 1966. The employees of Gratiot Community Hospital, voluntary non-profit, were being organized by Council 55, AFSCME, AFL-CIO.

broadly defined bargaining unit of hospital employees the registered nurses usually are in a minority. Their vote would have little effect on the outcome of a representation election. It seems that in order to achieve their objective of keeping the union out, the hospitals were willing to manipulate the registered nurses for their own self interests.

Once included in a conglomerate bargaining unit, such as was defined by the union in Wayne County and Grand Rapids, the nurses felt that their professional and economic interests would not be adequately interpreted and represented. Union negotiators, in their view, lacked the necessary knowledge and understanding of the nursing profession. More important to the patient and the hospital, a conglomerate unit would disrupt and create confusion in the health care authority structure. At Sunshine Hospital, Grand Rapids, nurses aides are the official representatives for the registered professional nurses.[9] Under the Nurse Practice Act registered professional nurses must direct and supervise nurses aides. In this awkward situation, the nurses aide, whom the registered nurse must evaluate and discipline, speaks for the registered nurse on her economic and other conditions of employment as well as in the grievance procedure.

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[9]Information obtained from interviews with registered nurses employed at Sunshine Hospital, Grand Rapids, being represented by Kent County Employees Association, and MNA staff.

Unions, primarily AFSCME locals, have also sought to organize the nurses. Council 29, AFSCME, AFL-CIO, contacted and held meetings with nurses from Genesee Memorial Hospital in the fall of 1966 and in October, 1966 petitioned the MLMB to represent 31 registered nurses. Though the MNA intervened on behalf of its members, the election was lost to the union.[10] In Midland, Michigan, the husband of one of the nurses was approached by a union to organize the car salesmen and the nurses. This incident stimulated the nurses there to organize and to be represented by MNA. Unions are always looking for new sources from which to recruit members, thus the MNA finds itself in competition with the unions for membership and representation among the nurses. If the professional association is not able to produce improved economic results, the nurses will become disgruntled with their professional association and may turn to the union. In fact, a few nurses have already done so. As a general rule, though, most nurses prefer to be represented by their professional association.

Increasingly nurses have sought MNA as their representative. In November, 1965, there were three MNA local units, in November, 1966, sixteen. And by November, 1967,

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[10]Report to MNA ad hoc committee on the Economic Security Program from Rosemary T. Hanamey, R.N., assistant executive secretary, MNA, dated March 17, 1967 summarizing Genesee Memorial Hospital events.

there were 47 local units.[11] These 47 local units represent approximately 4,000 registered nurses. In part, the impetus in nurses turning to MNA for assistance has been union activity in health agencies. For instance, in 1966, ten requests for MNA as a bargaining representative came from groups where there was union activity.

Union membership for nurses, it is felt, would jeopardize their professional status. Many nurses view union tactics such as the strike as unprofessional. Many nurses still believe collective bargaining is incompatible with professional ethics. However, they feel if it is a question of who will represent them, then most nurses prefer to be represented by MNA. Consequently, in an effort to protect themselves from the "union" nurses turned to MNA. This was the case at Alpena General Hospital. As one of the nurses put it we turned to MNA "to protect ourselves from being represented by a labor union instead of our professional association." Their request came after being informed that the United Stone and Allied Products Workers of America would be organizing the employees at Alpena General Hospital. This reaction occurred in other groups too where there was union activity. It is primarily a defensive act, a matter of keeping out of the union.

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[11]Figures obtained from MNA's reports on "Current Status of Local Unit Activities" and MNA Fact Sheet, dated November 9, 1967 (mimeo).

Not all requests came from nurses threatened by union membership drives. Nurses began to recognize that they had an effective means to improve their economic and professional status. Collective action backed by MNA had its value in achieving the nurses' goal. The situation at Little Traverse Hospital in Petoskey required action. As described by Mrs. Kathleen VanderWeele, R.N.:

> Our Staff Council was organized because of the prevalence of low and inequitable salaries, poor delineation of job classifications, outmoded personnel policies, and increasingly low morale of professional workers. The need for an organization backed by MNA was apparent when individuals and small groups were unable to correct these conditions by appeals to the hospital administrator through proper channels.[12]

The nurses see collective bargaining as a means to correct poor administrative practices and thereby improve patient care. They are demanding a stronger voice in the determination of the conditions under which they will work. Even so, the nurses for the most part are still timid in resorting to collective bargaining.

Nurses are raising the question as to how organizational activity and collective bargaining will affect patient care. For some it is a means to upgrade nursing practice. Through participation in determining employment standards, the nurses begin to feel more professional. And

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[12]Mrs. Kathleen VanderWeele "Staff Council do Produce!" Michigan Nurse, Vol. 39, (November-December, 1966), p. 12.

accordingly, she assumes greater responsibility to see that professional standards, competence and behavior is maintained with the result of improved patient care. In discussing the reasons for a staff council, Avis Dykstra explains this phenomena:

> When staff nurses are involved and have some voice in making decisions, they will assume greater responsibility for carrying out the program because, they, too, have an investment in the total process.[13]

Nurses who attempt to upgrade nursing practice by eliminating non-nursing functions from their duties. To this end, nurses have negotiated into their contracts provisions stating non-nursing functions be transferred to other appropriate departments. For instance, the cleaning of patients' units after discharge would be the function of the housekeeping department. Serving meal trays would be done by the dietary department rather than the nurses. By eliminating these non-nursing duties, the nurse would be able to spend more time in providing direct patient care and in the teaching and supervision of non-professional nursing service personnel. Some of the non-nursing functions have fallen upon the nurse by the mere fact that the nurse is always present--24 hours a day, seven days a week. When others go home, the nurse is still there. In this area, the nurse often is expected to dispense drugs from

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[13]Avis J. Dykstra, "The Staff Council--Forum for Improving Communications Within Nursing Service," Michigan Nurse, Vol. 39, (July-August, 1966), p. 3.

the pharmacy after the pharmacist goes home at 5 P.M. Not only is this not a nursing function but it is illegal under two Michigan laws--the Nursing Practice Act and the Pharmacy Act. Even more important from the patient's standpoint is the time spent away from the patient. From an administrative and economic view, it is poor utilization of nursing manpower. Here, too, through collective bargaining nurses have taken measures to correct this illegal practice and at the same time improving the quality of patient care.

But, the nurses are not the only employees involved in organizational activities and collective bargaining. What about the other employees? How will their activities effect patient care? There are some indications that organization of non-professional employees could impinge upon the registered nurses' professional judgment, particularly in determining which person should carry out a nursing assignment. In one hospital, even though it was within the aide's realm of duties, an aide refused to carry out an assignment because, according to the union, it was not in her job description. A non-professional employee union may therefore be able to exert great influence in what constitutes its members' job functions and duties. This influence could restrict the registered nurses' professional judgment in making patient care assignments. The effects on patient care would be indirect, in that what the others

refuse to do the registered nurse usually ends up adding it to her duties. There is, however, no reason to believe that the organization of non-professional employees would necessarily have adverse affects on patient care.

The Acts also have effected MNA as an organization and in its approach to its economic security program. Collective bargaining added an important dimension to MNA's economic security program. Since the adoption of its economic security program in 1958, the MNA had used a variety of approaches to reach the nurses' goal--to improve the professional and economic status of nurses to the end that quality patient care can be provided. MNA's attitude toward collective bargaining was to use it as a last resort. It believed, "There is a need and a place for collective bargaining in selected situations, where other approaches have failed to improve the employment practices."[14]

After the passage of PERA, MNA requested and received recognition as a labor organization within the meaning of the Act. Almost immediately several groups of nurses, threatened by inclusion in a union, requested MNA to intervene in their behalf. Within a year requests for MNA as a collective bargaining representative started to come from nurses not threatened by union membership drives. By the end of 1966, MNA was fully committed to engaging in collective bargaining.

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[14]From "A Statement on MSNA's Basic Approach in the Economic Security Program," November 29, 1962.

During 1966, assistance to local groups with their employment problems was a mixture of formal representation (negotiating contracts) and informal representation. Collective bargaining had not become fully integrated as an MNA norm. Not only were the nurses themselves reluctant to accept the idea of collective bargaining but MNA itself was hesitant to accept it as the only means for representing its members. For one thing it was an expensive and a time consuming process and MNA had limited resources. To expand its activities would require an increase in membership or in dues or both, both of which had proven to be difficult tasks in the past. Secondly, there was the problem of sufficient qualified staff to do the job. There were not enough nurses trained in collective bargaining processes. It was felt that outsiders were not likely to understand the unique problems in nursing. Then, there was the question of whether collective bargaining would be the best way to represent the nurses. Would a contract with higher salaries and better working conditions necessarily improve the quality of patient care? Were the benefits received worth the time and effort and expense?

However, by 1967, with increased pressure from the membership, the success achieved in the already negotiated agreements, and the threat of union competition, the MNA as an organization came to accept the necessity for collective bargaining. Though reluctantly, it has now become an accepted way to represent the nurses.

In November, 1965, MNA represented only three local groups in collective bargaining. During 1966 there was a substantial increase in the number of requests for the MNA's assistance and for official representation. These requests required an increasing amount of staff time to attend meetings with the local groups scattered over a wide area, to supervise representation elections, attend hearings and conferences with the MLMB, and to assist with the drafting and the negotiating of a contract. It became a serious problem, rather a crisis, to meet these demands for services within the available resources. The situation became very acute in early 1967. MNA had overextended its commitments to local units. It therefore had to make some vital decisions about the direction and continuance of the economic security program. Since its inception the economic security program has continued to be a chief topic at the Board of Directors meetings.

To survive an organization must be able to react to changing conditions by changing itself. It must anticipate environmental changes by altering its own policies and structure in time to meet new conditions as they arise. Since "the organization grows fastest where the force tending to destroy it is strongest"[15] MNA has focused primarily

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[15]Mason Haire, Modern Organization Theory, (New York: John Wiley & Sons, Inc., 1967), p. 95.

on its economic security program. The Board of Directors had to make the major decision whether to continue the economic security program or get out. The prime factor in deciding to continue was that if the professional association did not represent the nurses the union would.

If the MNA was to continue assuming its role as the leader for nurses it must expand its efforts. The Board of Directors expressed its fear that if the MNA lost the right to represent nurses in their economic security program, it would lose the right to assume a voice for nurses on many other issues. At the March, 1967 Board of Directors meeting, Mitchell Biedul, Industrial Relations Staff Services, Inc., of Detroit, stated, "That the UAW and other unions are waiting for MNA to make a tactical error such as lack of cohesiveness or lack of keeping faith with the organization members."[15] If MNA did not continue its economic security program and the nurses were unionized, then only a skeleton organization would be left because nurses would not pay MNA dues as well as union dues. If this were the case MNA would lose its membership and would not be an effective association. The survival of MNA, it was concluded, depended upon representing nurses in collective bargaining. MNA would continue its program. This decision necessitated employing additional help. To do so,

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[16]Minutes of MNA Board of Directors, March 23, 1967, p. 3.

required financial resources which MNA did not have. However, after analyzing the situation, deficit financing was decided upon temporarily to meet the immediate needs. For long range continuation and financing, a dues increase was proposed so that MNA could hire industrial relations consultants to act as negotiators to represent the nurses.

At the special Board of Directors meeting in February, 1967, an ad hoc committee was appointed to consider three things: (1) expanding the economic security program, (2) employing outside assistance to handle negotiations, and (3) exploring the means to finance the program.[17] Since the staff was not able to handle the increased workload in representing the nurses seeking representation, MNA turned to outside assistance by employing industrial relations consultants.[18] The main reason was to get experienced persons to do the negotiations for the nurses already organized. Most nurses, including the staff, were not experienced in negotiations. It was felt only experienced negotiators should conduct the negotiations if they were to be done properly.

Later, the ad hoc committee was established on a more permanent basis and was called the Steering Committee

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[17]Minutes of the special Board of Directors meeting, February 21, 1967; "Board Highlights," Michigan Nurse, Vol. 40 (July-August, 1967), p. 12.

[18]Minutes of the Board of Directors meeting, March 23, 1967; "Board Highlights," Michigan Nurse, Vol. 40 (July-August, 1967), p. 13.

for the Economic Security Program. At the same time, the standing committee on the economic security program was inactivated by the Board of Directors for at least a year and perhaps indefinitely. Since the Steering Committee were members of the Board of Directors, it was felt the Steering Committee could give better direction to the program and could make decisions on policies which the economic security program committee could not. The latter could only make recommendations. This maneuver helped to speed up the decision-making process and eliminated a cumbersome step in the communication system. This action represents a structural change in the organization.

The economic security program committee had the following functions: to submit recommendations to the Board of Directors on policies and procedures for the economic security program; to evaluate the effectiveness of the economic security program; to make recommendations for the implementation of the total program; and to recommend revisions in employment standards in accordance with Section recommendations. Since it was inactivated, it now has no function. The Steering Committee was made responsible for the administration and development of the economic security program. In its administrative capacity it would make decisions for the conduct of the program within the existing policies; make recommendations for changes in policies as they apply to the economic security program; set priorities

and time tables for economic security program activities; develop and establish criteria for evaluation of the program. In addition, the Steering Committee was charged with the responsibility to improve coordination and communications by establishing guidelines for relationships between the consultants and the staff; to plan for the preparation and dissimination of informational materials; and to coordinate their activities with other committees as needed.[19]

The structural change tends to centralize the decision-making process. The Steering Committee now replaces the previous decision-making mechanism for establishing the standards of employment. The Steering Committee decides what the standards should be. These are then approved by the full Board of Directors. This eliminated one form of democratic participation provided to nurses through their Section function of determining employment standards. However, it does not eliminate democratic participation by local units being represented by the MNA. The local unit of nurses decides what should be included in an agreement, usually in consultation with MNA representatives, and before it is accepted the local unit ratifies the contents.

When the number of local units requesting MNA as their collective bargaining representative reached such

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[19]Summarized from the minutes of the Steering Committee on the Economic Security program.

proportions that the staff found the workload unmanageable, the Board of Directors took action. The Industrial Relations Staff Services, Inc. of Detroit were employed to assist in furthering the development of a program to meet the needs of nurses in MNA's economic security program. A one-year contract was signed with them in June, 1967.[20] The consultants assist MNA in the planning, the developing and the designing of all phases of the economic security program. They provide advice and assistance to the Steering Committee. Through them, experienced negotiators are supplied to negotiate contracts for the nurses. The consultants develop programs, conduct training sessions, and otherwise prepare the nurses' negotiating teams for participating in collective bargaining activities. MNA's intent is to utilize the consultant services until it can perform these functions itself. The nurses generally accepted the idea of using non-nurse negotiators. At least they have not voiced strong objections to them. A few, though, do object on the basis that "nurses should speak for nurses."

In order to more efficiently and effectively represent the nurses in the approximately 600 agencies employing registered nurses, a regional approach is being

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[20]"Annual Reports of Michigan Nurses Association: MNA Staff," Michigan Nurse, Vol. 40, (September-October, 1967), p. 8.

suggested.[21] The concept has been presented to the Michigan Hospital Association through the MNA-MHA Liaison committee. The general impression seems to be that MHA is receptive to the idea. A master contract would be negotiated for each region with supplements for the unique needs of each individual agency. Before implementing this plan, much more of the details need to be investigated and worked out. Fourteen regions have been proposed which would be based on an area of similar economic conditions. Eventually, MNA would establish an office within each region staffed with at least one individual who would handle the economic security program activities for that region. At the present time, MNA is utilizing the regional concept to a limited extent, primarily for training sessions and workshops.

Further structural changes are proposed and under serious consideration. It has been proposed that the economic security program be separated from the association. At the 1967 MNA Convention, the House of Delegates adopted a resolution that the Board of Directors "act as expediously as possible to separate the Economic Security Program from

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[21]The regional approach as developed by the Steering Committee with the assistance of Industrial Relations Staff Services was first presented at the District President's Workshop at Mackinac Island in July, 1967. And it was presented by Jessie V. Pergrin, President, MNA, to MNA House of Delegates on October 10, 1967. "President Pergrin Challenges Delegates," Michigan Nurse, Vol. 41, (January-February, 1968), p. 3 and 19.

the regular activities of the Michigan Nurses Association."[22] In other words, the economic security program should be conducted by an organization not identifiable as the professional association. As a labor organization, employers are refusing to send nurses to MNA's educational programs dealing with clinical matters. To do so, would put them in a position of permitting other employees to attend activities of other labor organizations. Furthermore, it would leave them open to an unfair labor practice charge by other labor organizations. Under the proposed arrangement the professional association would not be considered a "union." It would mean, it is also argued, a more effective program by separating the professional and collective bargaining functions.

The plans for the separation have been worked out only tentatively. At the present time, the proposed plans call for appointing the Steering Committee as the Board of Directors of the MNA economic security program until the 1968 MNA convention. At that time the MNA House of Delegates would elect a Board of Directors for the MNA economic security program. The MNA economic security program would have its own executive director. MNA control over the new organization would be through the MNA House of Delegates.

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[22]Proceedings of the MNA House of Delegates, October 13, 1967; see also "Resolutions adopted by the 1967 House of Delegates," Michigan Nurse, Vol. 40, (November-December, 1967), p. 12.

Membership in MNA would be a condition to belonging to the new organization with directors of nursing and assistant directors of nursing excluded. The adoption of these plans await final approval by the MNA Board of Directors.

Summary

Changes in the external environment created internal pressures within MNA for changes. When the state legislature passed an Act granting public employees the right to engage in collective bargaining a chain of reactions occurred within the MNA. Nurses, not wanting to be included in a union, requested representation by MNA. Others soon followed suit. Collective bargaining representation has added a new dimension to the MNA's economic security program. As more and more nurses requested representation the staff workload became unmanageable which in turn created great stress in meeting these demands adequately. The threat of the union is ever present. MNA found it increasingly difficult to meet the demands of the nurses for representation with its available resources.

With the situation becoming critical, a special Board of Directors meeting was held to consider whether to continue its economic security program or not. It was decided the survival of MNA depended upon continuing the program. An ad hoc committee was then appointed to consider the expansion of the program. And, industrial

relations consultants were employed to conduct the negotiations. The ad hoc committee was established on a more permanent basis as the Steering Committee for the Economic Security Program, replacing the standing committee for economic security program. This change in the organizational structure tends to centralize the decision-making process. The industrial relations consultants have been employed to fill the gap temporarily for sufficient and experienced staff personnel to conduct training sessions and negotiations. In efforts to find means to run the program more efficiently and effectively, a regional approach to representation is being suggested and a proposed reorganization is under consideration.

EXPERIENCE UNDER THE ACTS

Recognition

By December, 1967, MNA had been certified as the exclusive representative through a consent election or granted voluntary recognition in 24 institutions. Of these 9 were voluntary recognitions and 15 were through election and certification. Shown in Chart IV is the number of institutions where MNA is the exclusive representative for the registered nurses.

CHART IV

NUMBER OF INSTITUTIONS IN WHICH MNA IS THE EXCLUSIVE REPRESENTATIVE FOR REGISTERED NURSES

Year	Voluntary Recognition	Election & Certification
1965	1	
1966	4	4
1967	4	11
	9	15

These institutions are geographically dispersed throughout the state. However, the majority of them (16) are in the lower half of the lower peninsula. The upper half of the lower peninsula and the upper peninsula are evenly divided, each have 4 institutions in which MNA is the exclusive representative for the registered nurses.

MNA in 1966 and 1967 petitioned for elections in 18 institutions. Chart V shows the results of these elections. MNA won 15 and lost 3. The majority of the elections were won by a wide margin. Only one election was relatively close.

Of the 3 elections lost, one was where a union had petitioned to represent the same group of registered nurses. The nurses at Genesee Memorial Hospital voted in favor of the AFSCME, Council 25, 16 - 7. It would appear the nurses did want representation; it was a matter of choosing a representative whom they thought would provide the most attention to their needs and the best service. As one nurse had expressed to the MNA representative, she did not personally care which organization won the election as long as someone could represent them.[1] The union was more active in campaigning among the nurses. MNA operated under a philosophy of voluntarism and did not actively organize.

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[1]Letter to Mr. Thomas C. Walsh, MNA legal counsel, from Rosemary T. Hanemey, R.N., assistant executive secretary, MNA, dated January 5, 1967.

CHART V

RESULTS OF MNA ELECTIONS FOR REPRESENTATION

Date	Place	No. of Nurses	Number of Votes Yes	No	Challenge	Other
3/18/66	Dickinson Co. Hospitals	71	51	7		
10/25/66	Gratiot Community Hospital	39	31	1		
10/31/66	City of Detroit	392	280	11		
12/28/66	City of Flint	296	211	3		6
2/17/67	Genesee Memorial Hospital	30	7	16*	1	
6/26/67	County of St. Clair	11	11	0	3	
9/07/67	Midland Hospital Unit I	101	61	11		
	Unit II	17	12	5		
9/20/67	Genesee County Health Department	14	13	0		
9/21/67	Memorial Hospital of Mason County	35	30	3		
9/29/67	Kalamazoo County Health Department	14	14	0		
10/03/67	Ionia Memorial Hospital	30	20	4		
10/11/67	Grand View Hospital	22	19	1		
10/27/67	American Red Cross, SE Chapter	44	18	22		
11/10/67	Pipp Community Hospital	16	10	0		
11/21/67	Fairmount Hospital	10	5	0		
12/13/67	Lansing General Hospital	51	22	16		
12/14/67	University of Michigan Hospital	459	111	143		
12/20/67	Grace Hospital, Northwest	299	115	12		

*Votes were for Council 25, AFSCME, AFL-CIO.

There were no other labor organizations on the ballot in the other 2 elections lost by MNA. These were relatively close elections - American Red Cross, SE Chapter 18 - 22 and University of Michigan 111 - 143. Factors influencing the American Red Cross election were a strong employer's campaign against the need for MNA representation and a lack of cohesiveness among the nurses. Many of the nurses are part time and they often work in units spread out over a wide area which complicated the organizing efforts.

The University of Michigan Medical Center is a large complex organization. Its size also complicated the nurses organizing efforts. The nurses staff council was still in the embryo stage. Temporary officers had been selected. The council's chairman felt all the nurses were not fully informed, though general meetings had been held and a special newsletter had been sent to each nurse. Many of the nurses were not sure what representation meant or did not see the need for it. The loss of these elections underscores that groundwork must be carefully laid before an election. Nurses do not vote out of ignorance simply to be represented by MNA. What they do not understand they will not vote for. It is probably the same difficulty experienced by other organizations in trying to organize professionals and white collar workers. It indicates the organizational activities are vital to success in representing the nurses.

Bargaining Units

MNA's official position on bargaining units for registered nurses was that "supervisors, head nurses and general duty nurses have a community of interests as members of the nursing team directly involved in patient care and should be included in the same unit."[2] Directors of nursing and assistant directors of nursing, it conceded, were appropriately excluded. The Act excludes supervisors from a non-supervisory employee bargaining unit, but it is rather vague on the definition of a supervisor.

MNA has 14 bargaining units which may be called all inclusive. The bargaining unit includes all registered nurses employed by the agency except the director of nursing and assistant director of nursing. It is significant to note these all inclusive bargaining units are in the smaller agencies. The largest of these units includes only 61 nurses. Six units include public health nurses only. The size of the public health units range from 5 to 19 nurses. Two are a combination of a public health department and a medical care facility under a county employer, with 11 nurses in one and 30 in the other. The

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[2]As stated in "Collective Bargaining - Are We Large Enough?" by Rosemary T. Hanamey, in the Michigan Nurse Vol. 39 (March-April, 1966), p. 4. This position was reiterated at informal conferences, hearings, and at the various MNA committee meetings.

other 6 units include nurses employed by rather small hospitals with unit size ranging from 8 to 61 nurses. In small hospitals, regardless of the position title, the nurse most likely performs functions of a general duty nurse, head nurse and supervisor all combined into one position or alternately working in each capacity. Thereby, there is no real distinction between the various nursing levels. Then, too, being a small group, there is a tendency to form a close colleague type relationship. The same would apply to the small public health departments. On the basis of this close community relationship among the nurses, employers have recognized an all inclusive unit excluding only the director of nursing. The trend in larger agencies, those employing approximately 100 or more nurses, has been 2 bargaining units.

One of the first situations in which the appropriateness of MNA's bargaining was questioned was by the City of Detroit. In an informal conference on July 6, 1966, the City of Detroit raised the question on the appropriateness of the bargaining unit.[3] The City argued that supervisory nurses were not eligible to belong in the bargaining unit. MNA maintained that the Act did not

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[3]MNA, Report of informal conference re "MNA's petition to represent the registered nurses employed by the City of Detroit," July 6, 1966, as recorded by Rosemary T. Hanamey, R.N., Assistant Executive Secretary, MNA.

clearly define supervisors, and that nursing supervisors had a strong community of interest with other nursing personnel since their function was chiefly a clinical one rather than a managerial one. The comparison of working supervisors and foremen in industry to nursing supervisors were not legitimate comparisons. Furthermore, precedents had been set in other situations where head nurses and general duty nurses were accepted in one unit. After much discussion and many caucuses, the City of Detroit took the position that head nurses and all classifications above should be excluded. Since MNA maintained the only exclusions they would agree to would be the director of nursing and the assistant director of nursing, a formal hearing was scheduled. The City would have preferred the continuation of their previous relationship with MNA without formal collective bargaining.

The formal hearing to determine the appropriate bargaining unit in Detroit was scheduled by the MLMB on October 4, 1966. An informal discussion was held prior to the formal hearing. The MLMB usually attempts to get the parties to agree mutually on the bargaining unit if at all possible without having to conduct a formal hearing. In this case the parties were able to come to a mutual agreement on the bargaining unit without the formal hearing. The informal discussion centered on the criteria used to

determine a "true supervisor."[4] The MLMB trial examiner made reference to the definition of a supervisor used by the National Labor Relations Board. Though the MLMB had not as yet made any official decision on the definition of a supervisor, it was highly probable the MLMB would follow the NLRB guidelines. Following some discussion on this point, the City of Detroit proposed that there be two bargaining units, one for the general duty nurses and the other for head nurses and supervisors. The director of nursing and assistant directors of nursing would be excluded from both units. The City indicated that the acceptance of the two bargaining units would be the only manner in which MNA could gain representation of the supervisory groups in accordance with the law. In order to represent as many registered nurses as possible MNA agreed to the two bargaining units which included both full time and part time nurses. The election which followed was held in units defined as follows:

Unit I

General Staff Nurse
General Staff Nurse - relief
Staff Nurse-in-Charge
Communicable disease Nurse
Junior Public Health Nurse
Public Health Nurse
Senior Public Health Nurse (interim)

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[4]MNA, report of informal conference re "The determination of the bargaining unit - registered nurses - City of Detroit," October 4, 1966, as recorded by Rosemary T. Hanamey.

Unit II

Head Hospital Nurse
Supervisor of Hospital Nurses
Nurse Instructor
Head Public Health Nurse (interim)
Supervisor of Public Health Nurses (interim)
Supervising Public Health Nurse
District Supervision Public Health Nurse
Public Health Nursing Consultant

The same issue was raised during the negotiations between MNA and the City of Highland Park, which had granted MNA voluntary recognition. The issue was resolved at one of the final negotiation sessions in early November, 1966, with the assistance of a MLMB mediator. Two bargaining units were agreed upon, one for staff nurses and the other for all other positions including the director of nursing.[5] This same bargaining unit pattern has been accepted in the City of Flint and County of Wayne.

MNA has accepted the concept of two bargaining units without contesting the issue in a formal hearing. The MLMB in determining the appropriate bargaining unit has generally followed the guidelines and precedents of the National Labor Relations Board. In applying the NLRB guidelines, Daniel Kruger, MNA consultant, pointed out that all nurses except the director of nursing and assistant directors of nursing constitute an appropriate

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[5]MNA, "Current Status of Activities with Local Units," November 10, 1966 (Mimeograph), and interviews with MNA staff.

bargaining unit.[6] Historically, MNA had been recognized as the official spokesman for all the nurses. All the nurses share a community of interest. Their hours of work and working conditions are similar and there is an interrelationship in their salaries. MNA for many years had established the employment standards for all nursing positions which were published in its booklet "Recommended Qualifications and Employment Standards for Professional Nurse Positions." The general duty nurses, head nurses and nursing supervisors desired representation by MNA. And, especially in clinical matters, all nurses are usually interchangeable.

The crux of the issue, however, lies in the interpretation of a supervisor. MNA maintains the position that the comparison of supervisors in industry to nursing supervisors are not appropriate since there are basic differences in their functions. The nursing supervisor performs chiefly clinical functions rather than managerial functions. Under the Taft-Hartley Act, a supervisor is defined as a person with the authority to hire or to discharge employees or to effectively recommend such action.

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[6]As discussed in the brief prepared by Daniel H. Kruger for MNA which was to have been presented at the formal MLMB hearing scheduled on October 4, 1966, but cancelled when the parties reached agreement, and in his article "The Appropriate Bargaining Unit for Professional Nurses," Labor Law Journal Vol. 19, January, 1968.

In other state jurisdictions, it has been found nursing supervisors and head nurses do not quite measure up to this definition, though they do perform limited administrative functions.[7] MNA concluded general duty nurses, head nurses and nursing supervisors should be included in the same bargaining unit. Great care needs to be taken in applying the definition of a supervisor as used in industry to a nursing supervisor. In essence, all nurses, regardless of position title, may be considered supervisors in that they all supervise to a greater or lesser extent. Even the general duty nurses must provide supervision to the auxiliary personnel (licensed practical nurses, aides and orderlies) who work under their direction. Thus, it would seem, the appropriate bargaining unit would include all nurses except the director of nursing and the assistant directors of nursing. As Kruger pointed out "The State Labor Mediation Board must therefore take into account not only the guidelines and precedents borrowed from the NLRB, but it must look beyond them."[8]

In at least 4 hospitals, the employers have questioned the appropriateness of the union's proposed bargaining unit on the basis that the registered nurses should

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[7]For further discussion on this point see Daniel H. Kruger's article "The Appropriate Bargaining Unit for Professional Nurses" in the January, 1968, issue of Labor Law Journal.

[8]Ibid.

also be included. Consequently, formal hearings were held to determine the appropriate bargaining units.[9] MNA was involved in only one hearing, Grand View Hospital, where MNA had petitioned to represent the nurses. In all the cases, the arguments presented and the decisions reached were very similar. The hospitals contended that

> the work of the nursing services groups is basically interchangeable, with the admitted exception of certain functions which are, by statute or custom, performed exclusively by registered nurses or licensed practical nurses. For this reason, the Hospital advances the argument that registered nurses must not be severed, for purposes of any potential collective bargaining, from the other groups with which they are functionally integrated.[10]

In presenting its evidence on the interchangeability of nursing service personnel, the hospital related it only to registered nurses and licensed practical nurses.

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[9]War Memorial Hospital and American Federation of State, County and Municipal Employees, AFL-CIO, MLMB Case No. R66 J-381 (July, 12, 1967), hearing held on February 6, 1967; St. Luke's Hospital and American Federation of State, County and Municipal Employees, AFL-CIO, MLMB Case No. R66 L-439 (July 12, 1967), hearing held on February 8, 1967; St. Joseph's Hospital and American Federation of State, County and Municipal Employees, AFL-CIO, MLMB Case No. R66 L-438 (July, 12, 1967), hearing held on February 10, 1967; Grand View Hospital and Michigan Nurses Association, MLMB Case No. R66 K-405 (July 12, 1967), and Grand View Hospital and American Federation of State, County and Municipal Employees, AFL-CIO, MLMB Case No. R66 J-386 (July 12, 1967), hearing held on February 13, 1967.

[10]War Memorial Hospital and American Federation of State, County and Municipal Employees, AFL-CIO, MLMB Case No. R66 J-381 (July 12, 1967).

No attempt was made to demonstrate the interchangeability of functions between the registered nurse and nurse aide and orderlies. The MLMB did not agree with the hospital's view. They found in their experience with hospital personnel structure that "the basic duties of the five occupational groups within the broad heading of 'nursing services' are [not] functionally interchangeable."[11] Furthermore, the MLMB concluded that registered nurses meet the definition of a true profession and therefore should be excluded from the non-professional unit. MNA has been certified as the exclusive collective bargaining representative for the registered nurses employed by Grand View Hospital, and has petitioned for an election at War Memorial Hospital and St. Luke's Hospital. These cases suggest one means which employers would use to keep the unions out. As suggested earlier the employer's intent appears to have been to have the nurses vote against the union thereby the union would be defeated in the election. Apparently, they did not consider what would happen if the union had won the election and the detrimental effects it would have on the professionals and the hospital. Their endeavors boomeranged. Not only have the non-professionals continued to

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[11] Ibid.

pursue representation but the nurses, who had not previously considered it, also have pursued representation by the MNA.

In two instances where MNA had obtained exclusive representation for hospital nurses including nurse anesthetists, the nurse anesthetists petitioned the MLMB to be represented by the Michigan Association of Nurse Anesthetists. The first case occurred at Highland Park General Hospital.[12] Since 1962 MNA had been recognized as the exclusive bargaining representative for an appropriate unit composed of all the nurses employed by Highland Park General Hospital. Recognition was reaffirmed by the Council of the City of Highland Park in January, 1966. A series of collective bargaining sessions culminated in a collective bargaining agreement. The agreement was ratified by MNA on November 23, 1966. All the nurse anesthetists were present at the ratification meeting. The Council of the City of Highland Park passed a resolution on December 5th authorizing the Mayor and the City Clerk to execute the written agreement. The agreement required the payment

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[12]In the matter of Highland Park General Hospital and Michigan Association of Nurse Anesthetists and Michigan Nurses Association, MLMB Case No. R66 L-429, 1967, and MNA "Report on Hearing re Highland Park General Hospital Nurse Anesthetists, Michigan Labor Mediation Board," March 21, 1967, as reported by Alice L. Ahmuty, R.N., Assistant Executive Secretary, MNA.

of salary increases retroactive to June 1, 1966. Also on December 5th, the Michigan Association of Nurse Anesthetists filed a petition with the MLMB.

The MLMB scheduled a hearing to resolve the issues whether the severance of the nurse anesthetists from the bargaining unit was prohibited by a contract bar and the appropriateness of the bargaining unit. On the contract bar issue, the MLMB held that "where a contract has been executed on the same day that a petition has been filed, such contract will bar an election if it is effective immediately or retroactively and the employer has not been informed at the time of execution that a petition has been filed."[13] This was the issue in this case. On the appropriateness of the bargaining unit, the MLMB concluded the Michigan Association of Nurse Anesthetists "failed to demonstrate sufficient differentiation of community of interest between the nurse anesthetists and other registered nurses to warrant the destruction and fragmentation"[14] of MNA's bargaining unit and therefore dismissed the petition.

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[13] In the matter of Highland Park General Hospital and Michigan Association of Nurse Anesthetists and Michigan Nurses Association, MLMB Case No. R66 L-429, 1967.

[14] Ibid.

Also on December 5, 1966, the Michigan Association of Nurse Anesthetists filed a petition for a separate bargaining unit for the Alpena General Hospital nurse anesthetists.[15] The only issue here was the appropriateness of the bargaining unit. The agreement between Alpena General Hospital and MNA was ratified and signed in January, 1967. The Hospital's Board of Trustees had granted voluntary recognition on December 30, 1965. The recognition included all the registered nurses except the director of nursing, and assistant directors of nursing. Later, the chief nurse anesthetist was excluded since he was considered supervisory personnel. All the nurse anesthetists employed by the Hospital in early December, 1965, had signed the document petitioning MNA to be their bargaining representative. The Michigan Association of Nurse Anesthetist's argument again was that the nurse anesthetists did not share a common community of interest with other nurses. The MLMB dismissed the petition for election for

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[15]In the matter of Alpena General Hospital, and Michigan Association of Nurses Anesthetists and Michigan Nurses Association, MLMB Case No. R66 L-432, November 7, 1967. MNA "Report of a hearing regarding nurse anesthetists employed at Alpena General Hospital VS MNA" June 21, 1967, as reported by Eleanor M. Tromp, R.N., Executive Secretary, MNA, and MNA "Report of Labor Mediation Board Hearing, Alpena General Hospital, Alpena, Michigan" July 11, 1967, as reported by Alice L. Ahmuty, R.N., Assistant Executive Secretary, MNA.

the same reason stated in the Highland Park General Hospital decision. The nurse anesthetists had failed to show they did not share a community of interest in common with other nurses.

The nurse anesthetists at the individual agencies were quite willing to be represented by MNA. Not until the Michigan Association of Nurse Anesthetists decided in the summer of 1966 that it should be representing the nurse anesthetists did these jurisdictional disputes begin. The Michigan Association of Nurse Anesthetists was very adamant in their position that MNA should not represent the nurse anesthetists.[16] The hospitals were caught in the middle of this tug-o-war between the two Associations. When the MLMB decisions came out in favor of MNA, the nurse anesthetists threatened to resign unless released from MNA's bargaining unit.[17] The threat was not carried out at Highland Park General Hospital. However, after the second opinion in favor of MNA, the nurse anesthetists not only threatened to resign but the Michigan Association of Nurse Anesthetists requested a reconsideration of the MLMB's decision. In view of the difficulty in replacing

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[16]Interviews with MNA staff and the labor relations representative, Michigan Association of Nurse Anesthetists.

[17]Letters, telegrams and other communications to MNA from the two hospitals.

them, the hospital supported their request. The MLMB told the two Associations that unless they could settle their differences between them, which they would prefer, then they would have no other choice but to reconsider the case.

Shortly after these disputes began and before the hearings, MNA had approached the Michigan Association of Nurse Anesthetists with the proposal that the two Associations work together. From a financial standpoint and for simplicity of representation, it would be better for the nurse anesthetists to remain in the bargaining unit with the other nurses. However, the Michigan Association of Nurse Anesthetists stood pat on its position and would not make any compromises. And MNA would not give up representing its newly acquired members. Only after the hearings and with pressure from the MLMB to settle their own differences, were the two Associations able to reach some kind of an agreement. They finally agreed that the nurse anesthetists would make their own choice as to which organization would represent them.[18] There will still be a contest between the two Associations but at least not to the point where it would disrupt hospital services.

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[18]Interviews with MNA staff. See also "MNA Signs Agreement with Nurse Anesthetists," Michigan Nurse Vol. 41 (March-April, 1968), p. 16.

Bargaining Activities

Simultaneously with obtaining representation through MNA, the nurses form a local unit, usually called a Nurses Staff Council, if they have not already done so. In the beginning, temporary officers have been elected or appointed to carry out the functions of the group until a formal organization can be established. Once the bylaws have been adopted and the regular officers elected, the nurses staff council is ready to operate. The nurses staff councils function as an affiliate of MNA with the prime purpose of improving employment conditions for the nurses.[19] A membership campaign is a must for each nurses staff council if there is not a 75% membership among the nurses employed in the agency. The costliness of representing nurses in collective bargaining prompted the MNA House of Delegates at the 1966 annual convention to take action. The resulting policy was that there had to be at least 75% membership in MNA before MNA would negotiate for them.[20]

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[19]For further information on the nurses staff councils see MNA, Getting Started in ESP, Lansing, Michigan, Michigan Nurses Association Economic Security Program, 1967; ANA, The Local Unit, Key to Your Economic Security Program, New York: Economic Security Unit ANA, 1955; ANA, Chairing a Local Unit, New York, ANA Economic Security Unit, 1957; Barbara G. Schutt, "The Local Unit - A Place for Strength and Growth," American Journal of Nursing Vol. 53 (April, 1953).

[20]Proceedings of the MNA House of Delegates, October 13, 1966. The action taken at the MNA 1966 convention is also summarized in "Nursing in a Changing World," Michigan Nurse Vol. 39 (November-December, 1966), p. 2.

It is a stringent requirement, but one which the nurses felt justified. The nurses being represented should help carry the financial burden of providing representation services. In some instances, it has been a difficult chore to obtain the membership requirement, especially in the larger agencies.

The nurses staff council officers, consisting of a chairman, vice-chairman, secretary and treasurer, generally compose the negotiating committee along with an MNA representative. In some cases, other members may also be designated to serve on the negotiating committee in order to provide a cross-sectional representation. During the pre-negotiation period, the negotiating committees collect basic information on the agency; gather data on salaries and other benefits; outline their problems; and draft proposals with MNA assistance. The negotiating committee keeps in touch with the nurses through meetings or individual contact to learn their problems and needs and, in turn, to keep them informed of their progress. MNA representatives work closely with the negotiating committees giving them assistance and guidance. Training sessions are conducted to prepare them for the actual negotiations. In the training sessions, the rationale for proposals are discussed and strategies for the negotiations are planned.

In the smaller singular agencies, the local negotiating structure is not as complex as in the larger agencies or multi-agencies. Alpena General Hospital, Gratiot Community Hospital and Dickinson County Hospitals would be among those agencies classified as a small single agency. The bargaining unit is typically all inclusive with less than 65 nurses. In such units it is not difficult to maintain close relationships with and open communications among the nurses. The four officers of the nurses staff council serve as the executive committee and the negotiating committee. In all instances, the MNA representative acts as the chief negotiator. The MNA representative has been its legal consultant or experienced negotiators supplied by its industrial relations consultants.

In the larger agencies, two bargaining units is the general rule, one for general duty nurses and the other for head nurses and supervisors. Each bargaining unit has its own organization. When Highland Park General Hospital separated its nurses into two bargaining units, the nurses form two organizations, the Professional Registered Nurses' Committee of Highland Park General Hospital, Unit I and Unit II. Each has its own elected officers who serve on the negotiating team with the MNA representative. The two committees work together in their preparations for negotiations. Since the nurses started out as one group in negotiations, the practice has been carried over. The

units bargain jointly with the employer in matters which affect both. There are only a few matters which are not of mutual concern, such as head nurse salaries.

The Economic Association of Registered Nurses (E.A.R.N.) is the organization formed in the multi-agencies of the City of Detroit. Each agency - Herman Kiefer, Maybury, Detroit General, the Public Health Department, Prescad, Detroit House of Correction and Human Resource Commission - has its own nurses staff council. Representatives, usually officers, from each agency compose the negotiating committee of E.A.R.N. In the County of Wayne, the organization is similar. The Professional Nurses Committee is comprised of the nurses staff councils in each agency - the Public Health Department, Wayne County General Hospital, the Psychiatric Division, the Infirmary Division, Youth Home, D. J. Healy Children's Center, and the Child Development Center (formerly the Training school). Each nurses staff council elects members to the Board of Directors of the Professional Nurses Committee which acts also as the negotiating committee. E.A.R.N. and the Wayne County Professional Nurses Committee are divided into Unit I and Unit II. Both units hold joint meetings regarding most matters. The Wayne County nurses have not proceeded into formal collective bargaining as yet. The delay has been due to an internal dispute within the county government on who was the bargaining agent for the county.

The negotiations for Unit I and Unit II of E.A.R.N. have been carried out simultaneously with the City of Detroit. The broader the bargaining unit, the greater has been the problem of maintaining unity and of agreeing on a position.

The negotiating period has varied widely. In one case, the complete agreement was negotiated in three days of discussion over a two week period. Sending the employer a complete proposed agreement with exchange of counter-proposals by mail before hand expedited the process. Other negotiations have lasted much longer, generally from 4-6 months to approximately 1 year. Nurses, tending to be "green" in the process, find the experience most frustrating. They tend to become impatient with the delays and some of the employer tactics. At Highland Park General Hospital, it was necessary to call in a mediator during the final negotiation sessions in 1966. The mediator's presence was again required in 1967 for the negotiations on the agreement's reopener. In November, 1967, the negotiations with the City of Detroit proceeded into mediation and factfinding. The factfinding request was later withdrawn. The third MNA negotiations which have required mediation has been with St. Clair County. The St. Clair County bargaining unit is a single unit composed of the nurses employed by the health department and the medical care facility. St. Clair County negotiations have proceeded to factfinding.

During the negotiation sessions, the MNA representative acts as the spokesman for the negotiating team. The MNA representative has been its assistant executive secretary (a registered nurse), its legal consultant or a negotiator supplied by the Industrial Relations Staff Services. The spokesman's main responsibility has been presenting the proposals and explaining data to justify them. The nurses on the local units negotiating committee supplemented or elaborated upon the spokesman's remarks. They would present explanations that were related to professional performance, the association policy or the way nurses employed felt about the subject being discussed. As a rule, anyone on the committee was free to ask a question, make an observation or speak on an issue. Though the MNA representative does most of the speaking, the nurses are the ones who make the final decisions. Once the negotiating committee have concluded an agreement it is presented to the entire local unit membership for ratification.

Generally the negotiations sessions are conducted during the day with a few lasting into the late evening. The employers grant the negotiating committee time off with pay for bargaining. However, the negotiating committee must be kept to a reasonable number. The City of Flint grants to three representatives from the local unit leave with pay for the purpose of meeting with other city

employees for the formulation of requests to be submitted in negotiations with the city and the hospital. In addition three negotiating committee members are granted leave with pay to participate in negotiations. Alpena General Hospital gives the nurses time with pay but it must not exceed 80 hours. Additional time is granted but without pay. Dickinson County Hospitals and Highland Park General Hospital grants only half the time off with pay for bargaining.

Agreements

MNA signed its first collective bargaining agreement on December 6, 1966. By December, 1967, MNA had signed seven agreements. The seven agreements cover 512 registered nurses. The list below shows the employer, the date the agreements were signed and the number of nurses covered by each agreement.

All the agreements include provisions for association security and payroll deduction for dues. Alpena General and Dickinson County Hospitals' agreements have a union shop clause - that is membership in the association is a condition of employment. The registered nurses have to be MNA members or become members of MNA within 30 days after the signing of the agreement or within 30 days after employment. Gratiot Community Hospital has a maintenance of membership provision. It was found all the registered

nurses there were MNA members. The City of Flint and City of Highland Park agreements have a modified union shop clause. The registered nurses who were members at the time the agreement was signed have to maintain their MNA membership and new employees have to become members. Payroll deduction covers dues payment for the ANA, MNA and the district nurses associations. A few include the payment of the local unit dues.

Institution	Date Signed	No. Registered Nurses Covered
Highland Park General Hospital		
Unit I	12/06/66	74
Unit II	12/06/66	28
Dickinson County Hospitals	12/31/66	52
Alpena General Hospital	1/26/67	61
Gratiot Community Hospital	10/05/67	40
Hurley Hospital, City of Flint		
Unit I	8/31/67	230
Flint Public Health Department	8/31/67	27
		512

Salary increases negotiated for general duty nurses are shown in Chart VI. The percentage increase ranged from 5.1% to 19.0%. All of the agreements provide for automatic periodic increases up to the maximum for each nurse classification. Shift differentials for evenings and nights varied from $0.80 per 8 hour shift to $4.00 per shift. On call pay clauses for nurses in the operating room included

$1.00 per day on call; $5.00 per day and $25.00 per month for being on call. Three agreements provided for a pay differential for a higher level of educational preparation, $10 more per month for a Bachelor of science in nursing and $20 more for a Masters of science.

CHART VI

STARTING SALARY INCREASES PER MONTH FOR GENERAL DUTY NURSES NEGOTIATED IN MNA AGREEMENTS

			$increase	%increase
Highland Park General Hospital				
December, 1966	$482.70	to $540.36	$63.66	12.0%
July, 1967	540.36	to 576.00	35.64	6.6%
Dickinson County Hospitals				
December, 1966	370.00	to 440.00	70.00	19.0%
Alpena General Hospital				
January, 1967	390.00	to 450.00	60.00	15.5%
Gratiot Community Hospital				
October, 1967	521.72	to 548.63	26.91	5.1%
Hurley Hospital, Flint				
August, 1967	514.60	to 548.08	33.48	6.5%
Flint Public Health Department				
August, 1967	533.50	to 591.76	58.26	10.9%

Overtime compensation was at time and a half or compensatory time off. At Highland Park General Hospital nurses receive premium pay for working on the 6th and 7th consecutive days without time off. At Hurley Hospital nurses may work no more than 7 consecutive days without the nurses' written request. All agreements provided at least 6 holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day. Two included 7 holidays and one added Lincoln's Birthday, Washington's Birthday and Veterans Day making a total of 9 holidays. Holiday pay arrangements were double time, time and a half plus a day off, and straight compensatory time off.

Two weeks vacation after one year's employments was standard. One agreement grants three weeks after three years with the others granting three weeks after five years. One grants four weeks after ten years and five weeks after twenty years.

All agreements provided for a rather comprehensive health program of a pre-employment physical examination, laboratory tests, innoculation shots, and an annual tuberculin test and/or chest x-ray. All also provided for a retirement plan. With one exception coverage was made for Blue Cross-Blue Shield insurance, life insurance and liability insurance, usually with the employer paying the full amounts of the insurance premiums. The agreements

included leaves of absences without pay provisions for personal, maternity, military and association business. Emergency or bereavement leave was granted with pay up to three days. One agreement granted a "public office leave." Two agreements permit an educational leave for up to two years. Five agreements grant 12 days sick leave per year with the other two granting 18 days per year. Two provide for unlimited accumulation of sick leave. The others allow sick leave to accumulate to a range from 60 days to 120 days. The City of Flint agreement provides that upon retirement the nurse will be paid 1 day for each unused sick leave for up to 60 days and 1/2 day for each unused sick leave day in excess of 120 days.

The seven agreements include an "In-Staff Promotion" clause. Promotions would be offered to the present staff first before recruiting from the "outside." Seniority is only one factor considered in promotions. Other factors are educational qualifications and ability. They all also include clauses on maintenance of discipline, non discrimination, and termination of employment.

A provision titled "Role of the Nurse" is present in all the agreements. These clauses attempt to eliminate non-nursing functions from nursing duties, "in order to free the registered nurses for their primary responsibility of patient care." Broadly, the parties agree that, except in an emergency or unordinary situation, nursing personnel

are not responsible for delivery of laundry, dispensing and delivery of drugs, serving dietary trays, and cleaning patients' units. In the public health department, the non-nursing functions are filing, typing and other routine clerical functions. Only in one instance does the clause deviate from the above. This agreement simply states "routine lack of professional recognition or individual instances of non-professional assignments of work or duties can be subject to the greivance procedure."

Special conferences clauses are found in all the agreements. Special conferences may be called by either party to discuss important matters which can be resolved by a meeting between the employer and the officers of the nurses staff council. The Hurley Hospital agreement provides for a "Professional Practices Committee." Along with the director of nursing the committee consists of three registered nurses from Unit I and four from Unit II, two head nurses and two faculty members. It is to meet monthly to review professional nursing practices at the hospital, to discuss staffing patterns for the various units and to review the continuing development of orientation practices and procedures.

Other provisions with a professional flavor are time allowance for attendance at professional meetings (not including meetings devoted primarily to collective bargaining) and reimbursement for educational courses to

enhance the nurse's professional standing. Two agreements provide reimbursement up to $150 per year, one up to $250 per year and another reimburses one-half the costs of tuition and books.

All the agreements contained a greivance procedure to cover disputes arising from the interpretation or proper application of the terms of the agreements. The number of steps varies as well as the time limits. The steps range from 4 steps to 6 steps. The first three steps in each are very similar.

Step one - immediate supervisor and nurse, informal, verbal, time for answer 2 days or 5 days.

Step two - Director of Nursing, in writing, written reply in 3 days, 5 days, or 7 days.

Step three - Director of agency (in one to personnel officer), written reply in 5 days, 10 days, 12 days or 14 days.

Greivances are processed by a Professional Rights and Responsibilities (PR&R) committee after the informal level. The PR&R committee members are granted time with pay to process greivances. MNA representatives may be called in at step three and above. Step four in several agreements is final and binding arbitration with a choice in choosing an arbitrator, either mutually agree on an individual or select one through the American Arbitration Association. In one agreement step four of the greivance procedure goes

to the hospital administrator. The next step is a request for consideration by an Appeal Board composed of two members designated by the hospital and two members designated by the Association. If it is not settled here, then it goes on to the sixth and final step, final and binding arbitration.

The City of Flint greivance procedures do not provide for arbitration. The first three steps are like those stated above and basically the same for both the Hurley Hospital and the City health department. In the Hurley Hospital agreement, the fourth step calls for a Review Board consideration of the greivance. The Association must file for the Review Board consideration within thirty days after receipt of reply in step three. The hospital director and the Association each name 1 member of the Review Board and they select a 3rd member who serves as a chairman. The Review Board considers the information, may hold hearings, and recommend alternative solutions to the problem causing the greivance. They make a written report of findings, facts and recommendations. Within five days after receiving the report the president of the nurses staff council and the hospital director meet and review the report. If they agree on the method resolving the greivance, it is reduced to writing, signed and action taken accordingly. Step five, the director forwards the report to the Hospital Board of Managers. A committee of

the Board of Managers meet with the Association representatives within 21 days. The committee makes a report to the Board of Managers who take action to dispose of the grievance and notifies the Association of the action taken.

In the Flint health department agreement, under step four the grievance is appealed to the City Manager which may then be referred to the Civil Service Commission or an Advisory Board of four city employees, two selected by each party. If not settled at this point, step five calls for MLMB mediation. The MLMB studies the case and makes final recommendations to the City Manager. The decision is final subject to review by the Flint City Commission.

In case of an impasse during negotiations, the procedure provided for in the Public Employees Relations Act would be followed. Either the collective bargaining representative or the employer may petition the MLMB for mediation of the issues in dispute. The MLMB appoints a mediator to assist the parties in settling their differences and resolving the issues. If the parties do not reach agreement through mediation, then factfinding hearings may be held. The factfinders recommendations are not binding on the parties. Under the Labor Mediation Act, the parties request to MLMB to mediate the dispute. If mediations fail to resolve the dispute, a special commission is appointed by the governor to take testimony and make

recommendations for settlement of the dispute. After the special commission report has been submitted, the parties must continue bargaining for at least 10 days with mediation assistance. The parties are urged to submit the disputed issue to voluntary arbitration. The parties are allowed to lockout or strike only after they have followed the procedure specified by the Act.

In all agreements, MNA pledges that it will not engage in strikes or other action that "would involve suspension of work that may disturb or interfere with the welfare of patients, or the operation of the hospital."

The agreements are of 1 or 3 year duration. Two agreements are of 1 year duration with the remainder being for 3 years. All contain provisions for automatic renewal unless either party gave notice. The 3 year agreements contain a reopener for salaries and other economic matters annually.

The agreements reflect generally the dual roles of the MNA namely collective bargaining and professional.

PROBLEM AREAS

One of the factors limiting the effectiveness of the economic security program is the amount of resources MNA has been able to provide. There has only been one full time person assigned to work with the program since it began. In a state as large as Michigan one full time staff member is scarcely able to handle the work load if nurses requesting assistance are to receive effective representation. As organizing activity increased under PERA, all the staff members became involved in representation activities. This situation could not be sustained for any length of time if other professional functions were to be maintained. Recruitment for more personnel to work with the program has been complicated by two factors - limited financial resources and the availability of individuals with experience in collective bargaining within the profession.

Financial resources comes primarily from membership dues. More funds are obtainable through an increase in membership or in dues. Although membership increased from 7,429 in 1966 to 9,741 in 1967, a 20% increase, it was not substantial enough to supply the revenue needed to finance completely the expanded activities and meet the rising costs.

The membership has never been willing to decrease the number of clinical conferences, workshops and educational programs sponsored by MNA, nor eliminate other services. One action taken to alleviate the financial problem somewhat was the 75% membership requirement before negotiations would begin for a local unit. With the expansion of collective bargaining and the employment of an industrial relations firm and negotiators, MNA found it necessary to increase its dues. This was done at the 1967 MNA House of Delegates annual convention. Dues were raised from $20 to $50 per year, a 150% increase.

MNA resolved its immediate staffing problem by employing "outsiders" to conduct training sessions and the negotiations. So far it has proven difficult to find and recruit registered nurses interested enough and willing to assume these functions. A registered nurse with knowledge of and experience in collective bargaining is very rare. Without this source readily available, MNA will have to train the nurses in this area as it recruits them, a process which will take time. The nurses from the local units could conduct the negotiations themselves, rather than an MNA representative. As yet, they have been extremely reluctant to do so primarily because they feel they lack the necessary skills to discuss the issues effectively with the employer. At least one local unit however has done this quite effectively. If the regional concept

with master agreements is adopted, additional staff at the state or regional level would be necessary to coordinate the collective bargaining activities. Staff recruitment will probably continue to be a problem for the next several years.

The question arises too about the use of "outside" negotiators. MNA's philosophy has been that it is desirable to have nurses in charge of and implementing the economic security program. Nurses should speak for nurses. The reliance on non-nurses to carry out the program should be kept to a minimum. It is felt also that nurses more fully understand the problems of nurses and the peculiarities of the hospital structure and functions. Many of the nurses primary concerns which are brought up during negotiations pertain directly to professional nursing practices and patient care. Non-nurse negotiators are not familiar at all with nursing practices. Therefore, the nurse must speak on this area or instruct the non-nurse negotiator thoroughly enough on a specific practice for him to understand and present it effectively. The question boils down to - should the "outsider" be used in an advisory and training capacity only? This question MNA must answer. If the answer is in the negative, it will necessitate an adjustment in MNA's present philosophy, "nurses can best speak for nursing." If affirmative, MNA will find it necessary to develop and train the nurses to conduct their own negotiations.

Another problem area is the use of the term "union." Registered nurses are extremely sensitive to the MNA being referred to as a "union." Sometimes employers have challenged the nurses that the MNA is nothing but a "union" in an attempt to discredit MNA, to discourage membership, and discourage nurses from organizing.[1] The challenge is couched in such a way that it is not professional to engage in collective bargaining. It is an effort to deter the nurses from improving their economic and personal security through collective bargaining. It implies collective bargaining and professionalism are incompatible. There is no evidence to support such a claim. As Archie Kleingartner has stated "Collective bargaining as such is probably irrelevant to whether an occupational group maintains professional standards or not."[2] Rather, nurses are likely to organize to protect their professional status. Even so, nurses as a rule do not like MNA being referred to as

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[1]Such a challenge is not unique to Michigan nurses. It is an argument faced by other state associations, too. And, editorials have been written on the topic in the various nurses' publications. For example, see "The Differences Between an Association and a Union," New York State Nurse Vol. 35 (January, 1963), p. 2. Also reprinted in the Michigan Nurse Vol. 40 (July-August, 1967), p. 19.

[2]Archie Kleingartner, "Nurses, Collective Bargaining and Labor Legislation," Labor Law Journal Vol. 18 (April, 1967), p. 245.

a "union." The emotionalism generated by employers in their claim has, to some extent, been successful in discouraging nurses from organizing. The fear of losing their professionalism has made some nurses reluctant to organize - to unionize!

The union threat is very real in the area of competition for members. One is the American Federation of State, County, and Municipal Employees. This threat of union competition prompted MNA to expand its economic security program and to take a more aggressive approach in organizing the nurses. However, if MNA wants to represent all the Michigan nurses, as it has declared, it must become more effective in organizing and representing them. AFSCME is not simply lurking on the sidelines waiting but has explicitly shown its intent to recruit nurses. They successfully recruited and now represent the nurses employed by Genesee Memorial Hospital in Flint. In an article, in the Michigan AFL-CIO News, Max Goree claims MNA has failed its members in securing for them professional recognition and adequate salaries, that nurses are fed up with "professionalism propaganda" and that they are demanding more militancy. He concludes "This militancy is finding direction and stability through experienced and responsible leaders of THE AMERICAN FEDERATION OF STATE

COUNTY and MUNICIPAL EMPLOYEES UNION, AFL-CIO."[3] There is no doubt AFSCME competes with MNA for members. Nor, is there any reason to doubt that other unions will compete also. Thus, if MNA wants to be the exclusive representative for all nurses it must seize the initiative and actively organize the nurses rather than wait for them to voluntarily request it, as has been the practice in the past.

There is still evidence of the internal conflict for some nurses who cannot condone collective bargaining by members of a professional organization. Some are still ambivalent towards collective bargaining. Others approach it timidly and hesitantly. Acceptance of a paternalistic relationship with hospital administrators and doctors has been an obstacle to overcome. These attitudes among the nurses, if they continue, will slow the progress of MNA's economic security program. Nurses must support this program enthusiastically if the program is to be accelerated.

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[3]Max Goree, "Registered Nurses & Collective Bargaining," Michigan AFL-CIO News, Friday, May 19, 1967.

FUTURE OUTLOOK

There is little doubt that collective bargaining will continue to have a tremendous impact on the nurses. Collective bargaining most likely will become more accepted by both the nurses and their employers. The nurses will become more involved in collective bargaining with increasing numbers covered by agreements. The impact of collective bargaining will have a spillover effect in those institutions where nurses are not now organized. Employers will provide better salaries and working conditions in order to minimize the possibilities of nurses organizing for the purpose of collective bargaining. In all likelihood, MNA will not recind its no-strike policy. However, mass resignations may be utilized more often. A more aggressive approach to the economic security program will have to be demonstrated in the future. MNA will need to take the initiative to actively organize the nurses for collective bargaining.

As a consequence of collective bargaining, the quality of nursing practice and nursing service will in all probability improve inasmuch as nurses will become more involved in decisions that will affect this goal. By participating in establishing their working conditions,

nurses assume greater professional responsibility. They can no longer remain apathetic to or pass the blame for their situation onto others. Professional practice is highly intertwined with economic security activities. Professional practice problems frequently arise during negotiations, and will most likely arise under the administration of the agreements. Consequently, MNA will probably have to employ a nurse specifically to develop guidelines and to give counsel to local units on professional practice problems.

As MNA became more involved in collective bargaining, it was necessary to employ industrial relations consultants to negotiate and advise local units. The nurses will expect MNA to supply more technical assistance in the future. MNA will continue assuming the characteristics and functions of a traditional labor organization. As noted some structural changes already have been made to accommodate its collective bargaining functions. Additional structural changes are likely to be made in order to develop a more effective program.

Under both the Public Employees Relations Act and the Labor Mediation Act, the nurses have a right to be represented for collective bargaining purposes. Collective bargaining is a tool through which the nurses can improve their economic status and enhance their professional status. Code 10 of the "Code For Professional Nurses" states "The

nurse, acting through the professional organization, participates responsibly in establishing terms and conditions of employment." According to their professional code of ethics therefore the nurses have a responsibility to act and implement employment standards through representation by the Michigan Nurses Association, their official spokesman.

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