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COLLECTIVE BARGAINING IN THE MICHIGAN NURSING PROFESSION

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ABSTRACT

COLLECTIVE BARGAINING IN THE
MICHIGAN NURSING PROFESSION

By

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The nursing profession has begun to accept unionism as a legitimate mechanisim in advancing its constituents' professional and economic interests in negotiating with hospital employers. To evaluate the impact of unionism in the profession, information on nursing wage levels, educational backgrounds and collective bargaining practices was solicited from Michigan hospitals. The intent of the research was to identify some of the reasons for the profession's increasing acceptance of collective bargaining in the hospital sector, and examine the effects collective bargaining has had on the hospital-nurse employment relationship. Data collected in the survey indicated that while has grown in in acceptance at all levels of the hospital nursing hierarchy, it has been most successful in the lower skill levels. Its success at these levels has been such that it may be in danger of extinguishing itself by increasing the cost of unionized labor to a point where it is no longer feasible for hospitals to employ significant numbers of unionized nonprofessional or lower skill nursing personnel.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF ABBREVIATIONS

AMCBWNA	Amalgamated Meat Cutters and Butchers of North America
AFGE	American Federation of Government Employees
AFSCME	American Federation of State, County and Municipal Employees
AFT	American Federation of Teachers
AFL-CIO	American Federation of Labor-Congress of Industrial Organizations
ANA	American Nurses' Association
BLS	Bureau of Labor Statistics
CNA	California Nurses' Association
CWA	Communication Workers of America
DHEW	Department of Health, Education and Welfare
FMCS	Federal Mediation and Conciliation Service
FNHP	Federation of Nurses and Health Professionals (AFT)
FTE	Full-time equivalent positions
GDAHC	Greater Detroit Area Hospital Council
HMO	Health maintenance organization
HELP	Health Employee Labor Program (SEIU-TEAMSTERS)
HREBIU	Hotel, Restaurant Employees and Bartenders Union
IAM	International Association of Machinists and Aerospace Workers
IUOE	International Union of Operating Engineers
LIUNA	Laborers' International Union of North America
LMA	Labor Mediation Act (Michigan)
MCHIS	Michigan Cooperative Health Information Service
MERC	Michigan Employment Relations Commission
MLPNA	Michigan Licensed Practical Nurses' Association
MNA	Michigan Nurses' Association
NFLPN	National Federation of Licensed Practical Nurses
NLRA	National Labor Relations Act
NLRB	National Labor Relations Board
NWLB	National War Labor Board
OPEIU	Office and Professional Employees International Union
PA	Public Act(s)
PERA	Public Employment Relations Act
RIFT	Rhode Island State Federation of Teachers
SEIU	Service Employees International Union
TEAMSTERS	International Brotherhood of Teamsters, Chauffers, Warehousemen and Helpers of America
UPIU	United Paperworkers International Union
USWA	United Steelworkers of America

INTRODUCTION

> Hospital wages and other employee benefits are rapidly rising to industrial levels, bargaining rights are being extended, and unionism is spreading. Many of these developments are long overdue. But there is no accompanying rise in labor productivity to help pay for the rising labor costs. Nor has an effective alternative to the strike, as a method of settling contract disputes, been achieved. A crises — not only of money but of lives — is in the making.
>
> Anne Sommers[1]

Anne Sommers' synopsis of the labor scene in hospital settings is eleven years old. In an area of labor relations that has undergone tremendous transitions in the last quarter century, detailed descriptions or accurate summations of prevailing conditions in the labor-management forum have frequently bordered upon obsolescence within months of their release or publication. Sommers' brief but to-the-point analysis is an exception to this rule. The message it conveyed has withstood the test of time, and is as true today as it was over a decade ago.[2] Organizaed labor is expanding its scope and reaching out to industries traditionally specialized in their functions and activities, such as the hospital industry. At no other time in American history has the hospital more fully felt the impact of the union

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[1]Anne Sommers, Hospital Regulation: The Dilemma of Public Policy (Princeton, N.J.: Industrial Relations Section of Princeton University, 1969), p. 228.

[2]Ibid.

movement than in the past several years.[3] A November, 1974 article in Supervisor Nurse stated that "Unionization -- or the threat of it -- is gradually forcing hospital management to change either its philosophy of the purchasing and handling of labor, or its attitude toward collective bargaining and organized labor."[4] Unlike the long history of labor-management relations in industrial settings, collective bargaining is a relatively contemporary development in American hospitals. The number of hospital workers represented by labor organizations in the late 1960s was approximately 9 percent. By mid 1977, the proportion of hospital employees under union contracts generally exceeded 20 percent.[5]

Since 1929, the health care industry has consumed an increasing share of the gross national product, accounting for over $162 billion in expenditures in 1977 (8.8 percent of the gross national product for that year), and is predicted to reach a spending level of $280 billion by 1982.[6] Per capita spending in the industry has more than quintupled since 1960, from approximately $142 to over $737.[7] These figures demonstrate the important social, political and economic impact

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[3]Susan Levine, "Unionization in Hospitals," Supervisor Nurse 5 (November 1974): 61.

[4]Ibid.

[5]Richard U. Miller, "Hospitals," in Collective Bargaining: Contemporary American Experience, ed. Gerald G. Sommers (Madison, WI: Industrial Relations Research Association, 1980), p. 373.

[6]Ibid.

[7]Ibid., p. 374.

of the industry, and underscore the importance of understanding the complexities of the labor-management issues which have emerged as collective bargaining has become more established in the industry.

Clearly, collective bargaining has an important role in the health care industry and nursing profession for a number of reasons. First, since labor costs constitute upwards of sixty percent of the total cost in the health care industry, negotiated settlements often have, or are portrayed to have unsettling effects on cost containment efforts.[8] Secondly, the need for the continuous delivery of health care services in hospitals places a premium on the maintenance of the labor-management relationship and the ability of the relevant vehicles for conflict resolution to function successfully. Third, considering the industry's status as a service industry blending mixtures of public and private ownership of resources, no single existing industrial relations model is totally adequate for either describing health care collective bargaining or for formulating and evaluating policies to deal with its problems. Finally, when it comes down to confronting employers with legitimate demands in the one way that simply cannot be ignored -- by striking -- many nurses have had to face the cognitively dissonant dilemma of sacrificing their desires for improved employment conditions in the name of "professional dignity." In this respect, the relatively recent advent of unionism in the nursing profession is an

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[8]Ibid., p. 375.

appropriate indication of the choice nurses have traditionally adopted (i.e. "professional dignity" has increasingly been outweighed by desires for better employment conditions). However, other factors besides the "professional dignity" or "status" arguments exist to help explain the slow development of unionism in the health care field.

Organized labor has been preoccupied with more lucrative fields (eg. automotive, transportation, steel, mining, etc.), and top labor officials have shown disinterest in the hospital industry. Unions have historically been discouraged from concentrating on hospitals because of their size and location.[9] The lack of legislation facilitation unionization in hospitals in most states has been another obstacle to the spread of hospital unionization. The Taft-Hartley Act of 1947 excluded nonprofit hospitals from its provisions which protected or encouraged collective bargaining. However, this exception was removed in August of 1974. The nature of the hospital work force itself is quite important. Hospital nursing staffs have been characterized by high turnover rates, at least partially attributable to the fact that (historically) the vast majority of nurses are female, and working temporarily or in careers

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[9]Many small hospitals are located in small, non-union communities, and two-thirds of all short term hospitals average 200 or fewer beds. Levine, "Unionization in Hospitals," p. 66. At the time of the MSU Nursing Survey, 63 percent of the hospital facilities were under 200 beds, and 43.6 percent of the facilities were located in cities of less than 10,000 in population. "Michigan State University School of Labor and Industrial Relations Nursing Survey," East Lansing, MI.: 1980. (Report prepared for hospital administrators containing a summary of the data obtained through the survey), Table 2.

characterized by relatively short terms of continuous duration.[10] The reluctance of unions to organize industries with large numbers of minority group workers has also impeded widespread unionization.[11] The nurses' professional associations have also been involved in stifling the growth of unionism among nurses. As early as 1937, the American Nurses' Association (ANA) was recommending against nurses becoming members of unions, maintaining that "in their professional associations, nurses have the instruments best fitted and equipped to improve every phase of their working and professional lives."[12] Finally, one of

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[10]According to a 1979 National League for Nursing study on nurses from baccalaureate nursing programs, only 46.7 percent of the graduates were working as full-time nurses five years after their graduation, and 36.6 percent of the graduates reported working as full-time nurses ten years after their graduation. "Nurse Career-Patterns Study," Hospital Topics 57 (May/June 1979); pp. 5-9.

[11]David R. Matlack, "Goals and Trends in the Unionization of Health Professionals," Hospital Progress 53 (February 1972), p. 40; and Leo B. Osterhaus, "The Effect of Unions on Hospital Management: Part II: Factors Stimulating and Inhibiting Unions," Hospital Progress 48 (July 1967), pp. 78-79.

[12]It should be noted that while the cited example of the ANA as being officially on record at one time as discouraging union membership, the example occurred in 1937, with the organization "apparently fearful of inroads by the burgeoning unions." The ANA was not blind to the deterioration of nursing conditions, nor were they advocating total subordination to employers insofar as the terms and conditions of employment were concerned. Shortly afterward (in 1938), the ANA urged the State nurses' associations to "assume the responsibility in their communities for standards of care and employment conditions." Although the state associations enjoyed "little success" in following through on these policies, the seeds were planted for the ANA economic security program, whose objectives were "to secure for nurses . . . protection and improvement of their economic security; reasonable and satisfactory conditions of employment and . . . to assure . . . nursing service of high quality." Thus, while the ANA was discouraging unionization, it was also becoming involved in attempts to negotiate terms and conditions of employment with nursing employers.
Daniel H. Kruger, "Bargaining and the Nursing Profession," Monthly Labor Review 84 (July 1961), 699-701.

the major obstacles in the path of nursing and/or hospital unionism has been the resistance of hospital administrators and directors, and the other "professionals" working with nurses.

From 1947 to 1974, nonprofit hospitals operated outside the coverage of the National Labor Relations Act (NLRA). Their exemption from the Act fostered a "no holds barred" approach to collective bargaining that encouraged conflict between hospitals and their employees. In the absence of a legal framework governing the bargaining environment, several negative conditions influencing the employer-employee relationship flourished; employer paternalism at best, blatently unfair labor practices in the opposite extreme.

Up to this point, the evolution of unionism in hospitals and in the nursing profession has been treated on a more or less interchangeable basis. In actuality, they are separate events, but by no means are they mutually exclusive. The primary reason for examining the two subjects in the same vein is simple; they are both integral constituents of the health care industry, and they maintain a type of symbiotic employer-employee relationship in which hospitals would be hard-pressed to function without nurses, and nurses would be equally hard-pressed to obtain employment without hospitals.

In August, 1976, the Michigan Cooperative Health Information System (MCHIS) reported that 70.4 percent of the active registered nurses (RNs)[13] and 71.5 percent of the active

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[13] Licensed Health Occupations, Michigan, Nurses, 1975, (Lansing, MI: Michigan Cooperative Health Information System, Michigan Department of Public Health, 1976), p. 17.

licensed practical nurses in the state were employed in hospitals.[14] In December, 1978, the MCHIS reported that 70.0 percent of the active RNs in Michigan were employed in hospitals.[15] The U.S. Department of Health, Education and Welfare (DHEW) has estimated that as of June 1, 1974, 74.6 percent of the RNS in the United States were employed in hospitals and nursing homes, while roughly half of the LPNs were hospital-employed.[16] A 1979 National League for Nursing Report on the career patterns of nurses graduating from baccalaureate nursing programs found sixty-six percent of the graduates entering hospital employment.[17] Each of these reports indicated that nursing homes were the second largest or most common primary employment setting for nursing personnel. One common trend surfaces in all of these reports -- hospitals are the largest employers of nursing personnel in the health care field, frequently employing as many as nine times the numbers of nurses accounted for in the second most common employment categories. This is particularly true among the more skilled positions in the nursing hierarchy. Public health agencies, nursing homes, homes for the aged and convalescent centers frequently have staffing mixtures that rely heavily

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[14] Ibid., p. 33.

[15] Licensed Health Occupations, Michigan, Registered Nurses, 1977, (Lansing, MI: Michigan Cooperative Health Information System, Michigan Department of Public Health, 1978), p. 13.

[16] U.S. Department of Health, Education and Welfare, Health Resource Statistics, 1976-1977.

[17] "Nurse Career-Patterns Study," p. 6.

upon LPNs, aides and orderlies employed under the direction of RNs employed in supervisory roles. Other fields of employment include schools, occupational and industrial health settings, doctor's offices and private duty settings.

Primarily due to the relative case of obtaining data on a large number of subjects through the use of a questionnaire mailed to nursing employers throughout the state, hospital-employed nurses are the primary focus of this study. Reinforcing the decision to concentrate on hospital-employed nurses is the fact that they are the largest individual primary employment setting classification.

The Michigan State University School of Labor and Industrial Relations Nursing Survey (MSU Survey) was conducted through the use of a one-page questionnaire which is included in the Appendix. The length of the questionnaire was deliberately limited to a two-sided one-page form, since it was felt that a long and complex questionnaire would substantially impair the return rate. The questionnaire was designed to solicit information on prevailing conditions in the Michigan hospital-nurse employment setting, and was mailed to administrators and directors in every Michigan hospital.[18]

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[18]The original mailing list used in the MSU Survey was taken from the 1978 American Hospital Association Guide to the Health Care Field (Chicago: AHA, 1978), pp. A110-A118.

The MSU Survey questionnaire is largely patterned around the one-page questionnaire used by Karen Sue Hawley in her 1967 Economics of Collective Bargaining by Nurses. Hawley's questionnaire and accompanying material was primarily concerned with nursing salary and educational levels, and hospital characteristics. Absent from Hawley's questionnaire was any material soliciting information on benefit levels, collective bargaining and work stoppages. The MSU Survey questionnaire represents a synthesis of Hawley's solicitation format and additional inquiries intended to provide data on areas not examined by Hawley.

The intent of the MSU Survey and the accompanying research contained in this study is to identify and examine some of the reasons for the increased interest by nursing profession in organized labor (and vice versa), and arrive at some answers to the questions of whether union representation has proved to be quantitatively advantageous for hospital-employed nursing personnel. This study empirically examines the labor-management relationship in the Michigan nursing profession, and is not intended to provide a statistically definitive confirmation or contradiction to the several relevant hypotheses that are examined throughout the text. While the key issue of this study revolves around whether union representation has proved to be quantitatively advantageous for hospital-employed nursing personnel, several ancillary issues and/or questions are open to examination.

Although published reports and data obtained through reviewing the pertinent literature provide a valuable supplement to the MSU Survey, much of the ensuing analysis is based on information recorded in the returned MSU Survey questionnaires. The primary issue addressed in the questionnaire is that of whether nurses represented by unions in collective bargaining agreements for their (hospital) employers are in a quantitatively superior position relative to their nonunion counterparts in terms of salary, shift differentials and benefit packages.

Information obtained through the questionnaires also indicates the areas in which union organizing efforts have

been most (and least successful). This applies to the location of the hospitals, their size and types of control. In the same token, the questionnaires indicate which divisions of nursing personnel (head nurses, RNs, LPNs or aides) have been most receptive to unionization.

In terms of the wage and benefit packages being offered to nursing personnel by hospitals, the hourly salaries, educational assistance programs, hiring bonuses, shift differentials and full- versus part-time fringe benefit offerings are examined.

Nursing staff aggregate educational backgrounds are surveyed, leading to possible generalizations regarding the unionization preferences of nurses from differing educational backgrounds.

Finally, information obtained through the returned questionnaires revels which labor organizations have been most active in organizing and representing nursing personnel in Michigan hospitals, and information on the nature of the various hospital and nursing staff collective bargaining agreements, including the duration of the agreements, the expiration dates, etc.

It should be noted that much (if not all) of the data contained in this document has been addressed by independent research efforts of labor organizations, hospital associations and their constituents, and professional associations representing employees' interests in the industry. The American Hospital Association publishes a yearly guide containing

information on hospital characteristics, inpatient and personnel data. The Michigan Hospital Association collects salary data from its members and maintains a comprehensive annual summary of state industry wage levels. Other hospital groups cooperate in the exchange of information regarding union organizing efforts and trends. Professional nursing associations collect data on nursing wage and educational levels. Labor unions may also collect and analyze extensive economic data. However, substantial problems arise in accessing and collecting data from these sources, and presenting it in a meaningful format. There has not been a significant willingness on the part of many of these organizations to disseminate the data they collect (beyond their own membership or constituency), leaving a void in the current collection of labor relations data.

Facilities and organizations in the health care industry have demonstrated a great deal of concern regarding the confidentiality of constituent bodies. The possibility that information collected by members of the industry may fall into unintended hands and be used in ways viewed as detrimental to industry participants frequently limits the access to existing data. For these reasons, the collection of wage and benefit data and information regarding past, present or anticipated unionization efforts aimed at hospitals can be a sensitive and arduous task. However, the void in the existing and accessible body of literature regarding the collective bargaining relationship between hospitals and nurses would

seem to justify the effort to draw together data from the various participants in the hospital-employee relationship, and present it in such a manner that it becomes a positive addition to the existing body of relevant literature.

Definitions

The terms that are used and abbreviated extensively throughout this study are defined in the following alphabetical list.

Aides: See "Nurse Aides and Assistants."

Collective Bargaining: Negotiations between a labor union or organization and an employer for a written labor contract covering the terms and conditions of employment.

Federally Controlled Hospitals: Hospitals administered, staffed and directed by a department or agency of the Federal government. In Michigan, the hospitals falling into this category that are included in the analysis are administered by the Veterans Administration and the Department of Justice.

Fringe Benefits: The term applied to benefits in addition to the direct wages paid to employees. It includes such items as sick pay, insurance benefits, pension benefits, shift differentials, educational assistance, and other similar benefits.

General Duty Registered Nurses (RNs): Nurses who have graduated from a formal program of nursing education (hospital-affiliated diploma schools, associate, or baccalaureate programs) and have been licensed by the appropriate State authority. RNs are the most highly educated nurses with the widest scope of responsibilities, potentially including all aspects of nursing care. In Michigan, RNs must meet the educational requirements, pass a nationally standardized written examination, and be licensed by the State Board of Nursing. The Board may grant a license to a nurse duly licensed as a RN in another state, territory or country, if the applicant's qualifications are deemed equivalent to those required in Michigan.

Head Nurses: Nurses (generally RNs) who are responsible for the nursing service and patient care on one organized nursing unit. While "head nurses" may be active at several levels in the hospital organization chart, for the purposes of this study, the term refers only to those nurses with immediate supervisory responsibilities over general duty nurses. They may or may not perform general duty tasks in addition to their first-line supervisory roles.

Hospitals: Institutions whose primary function is to provide inpatient services, diagnostic and therapeutic, for a variety of medical conditions, both surgical and non-surgical. They may be classified by length of stay (short-term or long-term), as teaching or nonteaching, by major type of service (psychiatric, rehabilitation, general, etc.), and by control (government, federal, state or local, non-profit, propritary). No distinction is made in the study between allopathic and osteopathic hospitals. Hospitals under the direct control of the U.S. Air Force, or other military services were not included in the analysis.

Labor Unions and/or Organizations: Organizations representing employees for the purposes of dealing with the employers concerning labor disputes, wages, hours of employment, grievances or other conditions of employment.

Licensed Practical Nurses (LPNs): Nurses who have practical experience in the provision of nursing care, but are not graduates of a formal program of nursing education. Their work is performed under the supervision of either a RN or a physician. To practice in Michigan, LPNs must be licensed by the State Board of Nursing. For a license to be granted, the Board requires a high school diploma or its equivalent, the completion of a practical education program (usually 12 months in duration), and the passage of a written exam.

Locally Controlled Hospitals: Hospitals administered and directed by a county, city, or dully controlled by a city and county, or a hospital district or authority.

LPN: see "Licensed Practical Nurses."

Non-profit Hospitals: Hospitals administered by any corporation or association in which no part of the net earnings inures to the benefit of any private shareholder or individual.

Nurse Aides and Assistants (aides): Auxiliary nursing workers who function as assistants to RNS and LPNs in providing less skilled nursing services and patient care assignments. Traditionally, "nurse aides" have been women, and "orderlies" and "attendants" have been men.[19] For the purposes of this study, "aides" is a generic term that refers to nurse aides, orderlies, and attendants.

Nursing Personnel: The blanket phrase refering to RNs, LPNs, and aides, unless otherwise noted.

Proprietary (profit-making) Hospitals: Hospitals administered by a corporation or association in which any portion of the net earnings of the institution inures to the benefit of any private shareholder or individual.

Religious Hospitals: Hospitals administered and directed under the authority of religious orders or denominations. In Michigan, all of these institutions are administered or controlled on a religious/non-profit basis.

RNs: see "General Duty Registered Nurses."

State Hospitals: Hospitals administered and directed by the Michigan Department of Mental Health.

Supervisors: see "Head Nurses" unless otherwise noted.

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[19]U.S. Department of Health, Education and Welfare, Health Resource Statistics, p. 167.

CHAPTER II. LITERATURE REVIEW

Perhaps the most obvious difficulty or void in the existing body of literature dealing with labor relations in the health care industry is the lack of material comprehensive enough in design that the multifaceted nature of collective bargaining in the industry is fully addressed. While the literature addressing distinct aspects of collective bargaining in the hospital sector is voluminous, few efforts at synthesizing the material have been made. This examination of current labor relations in the hospital sector attempts to address the area in a more comprehensive nature than heretofore has generally been the case. An effort is made to provide conclusions that may be combined to overcome the generally fractionalized nature of the existing literature.

Correlations between salaries and hospital bed sizes, types of control and union status have been addressed by other researchers, but attempts to synthesize this material have been limited. Changing trends in nursing educational backgrounds have been addressed previously, but accessible summaries of these (as well as other trends) have been limited. Besides the material on educational and salary histories, the impact of unionism on nursing wage levels is addressed in a more direct way than has previously existed. Several other wage related issues are addressed, including, the failure of hospital wages to exhibit major (real) increases since the 1960s, the differing success labor organizations have had in organizing various skill levels in the nursing hierarchy, and

the wage levels in hospitals operated under differing control types. The primary thrust of the research contained in this document is aimed at answering the question of whether the advent and growth of unionism in the hospital sector has proved to be quantitatively advantageous for members of the nursing profession.

Similar to many questions in the disciplines of economics and collective bargaining, the answers to queries involving alterations in nurses' economic status due to collective bargaining activity are neither absolute nor definitive in that they can only be interpreted from a singular point of view. Specific information concerning the economic status of nurses engaged in hospital-based employment is examined at length in the literature as well as the MSU Survey in order to lend support to some theoretical assumptions concerning nursing and collective bargaining, while disproving or casting other assumptions in a more suspicious light.

Several collective bargaining trends in the profession are reviewed based on the existing literature and MSU Survey data. Changes in the lengths of collective bargaining agreements between hospitals and nursing personnel are examined, with the results tending to confirm the general trend toward longer agreements. The immediate and direct impacts of Public Law 93-360 upon union organizing in Michigan hospitals, as well as work stoppage activity and the relative performance of unions and professional associations are examined.

Perhaps the most significant contribution of the MSU Survey to the body of literature addressing collective bargaining and labor relations is that it provides an easily accessible and comprehensive body of data depicting actual field conditions, presented against a background of relevant contemporary literature. When viewed in concert with the supporting material, the MSU Survey results confirm some commonly adhered to assumptions regarding labor relations activity in the nursing profession, and provide new conclusions with far-reaching implications regarding the future of unionism in the (hospital) industry. Because of the carefully documented results of the MSU Survey, and the ease of accessing the results for future researchers (as opposed to restricting access to the data), the greatest value of the material may lie in its potential use as a cornerstone against which future collective bargaining conditions in the profession may be measured or evaluated.

In developing the MSU Survey's methodological critique, four major sources were drawn upon. Three of the four sources concentrate on the appropriate formulation of evaluation designs and their application in contemporary programs and economic settings. The other source, by Stephen Issac and William Michael, is a leading technical handbook on statistical techniques, data analysis and measurement, and research methods.[20]

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[20]Stephen Issac and William B. Michael, Handbook in Research Evaluation, (San Diego: Edits Publishers, 1971).

Carol Weiss' publications on evaluation methodology address themselves to utilizing the results of evaluations, and the purposes for undertaking evaluative studies.[21] The thrust of Weiss' material is directed at applying various evaluation techniques to social programs. Edward Suchman provides a set of guidelines and reference points to consider in developing an evaluation or survey program.[22]

Perhaps the closest study to the MSU Survey in terms of style and methodological approach is Karen S. Hawley's Economics of Collective Bargaining by Nurses.[23] Hawley used a questionnaire soliciting information on hospital characteristics, nursing salary and educational levels, for all hospitals in Iowa. While Hawley addressed collective bargaining by nurses in her text, the focus of her research on the hospital-nurse relationship was aimed at supply and demand questions in the nursing labor market, rather than the broader examination of the relationship from a collective bargaining viewpoint used in the MSU Survey. However, Hawley's basic premise of compiling data for use in an examination of the hospital-nurse employment relationship through a comprehensive state-wide hospital survey was a relatively direct methodological or theoretical forerunner of the MSU Survey. Several

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[21]Carol H. Weiss, Evaluating Action Programs, (Boston: Allyn and Bacon, Inc., 1972); Evaluation Research, (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1972).

[22]Edward Suchman, Evaluation Research: Principles and Practice in Public Service and Social Action Programs, (New York: Russel Sage Foundation, 1967).

[23]Karen Sue Hawley, Economics of Collective Bargaining by Nurses, (Ames, Iowa: Industrial Relations Center, Iowa State University, 1967).

other recent texts and journal articles provided general overviews of the development and structure of collective bargaining among hospital-employed nurses.

Norman Metzger and Dennis Pointer authored one of the major texts addressing employee relations in the health care industry.[24] Particularly notable in this publication are the chapters on the development of collective employee activity in the industry, and the legal environment hospitals operate in. Metzger and Pointer document the contemporary history of collective bargaining in the industry from shortly after 1900, tracing the involvement of the key professional and labor organizations in the growth of unionization in the hospital sector. Their review of hospital coverage under federal labor law (prior to P.L. 93-360) is relatively comprehensive, while their discussion of state labor laws impacting the hospital-nurse employment relationship also provides a useful tool from which the wide range of pre-P.L. 93-360 legal environments may be examined.

The research of Richard U. Miller is widely borrowed upon in this thesis.[25] Miller's work contained in Gerald Sommers' compilation of material on collective bargaining comprehensively addresses collective bargaining in hospitals,

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[24]Norman Metzger and Dennis D. Pointer, Labor-Management Relations in the Health Services Industry, (Washington, DC: The Science and Health Publications, Inc., 1972).

[25]Miller, "Hospitals,".

providing historical data, information on the organizations active in representing hospital employees, wage and benefit levels, and labor-management conflict in hospitals. Miller found labor market structures in the hospital industry fluid, unionization uneven and bargaining outcomes frequently uncertain, possibly due to collective bargaining's relatively recent arrival in the industry. Miller's research also indicated that while hospital unionization has significantly increased in the past two decades, the momentum of the initial growth has not maintained in the 1970s, and the growth that has occured has been quite limited geographically. Other impacts of hospital bargaining found by Miller included increasing levels of conflict arising from the insertion of patient care demands into the bargaining dialogue, an increasing willingness to strike and continual potential for conflict due to hospital administrator's strong anti-union stances.

Ronald L. Miller has examined the development and structure of collective bargaining among RNs by reviewing the involvement of the ANA in collective bargaining between hospitals and RNs.[26] Miller theorized that the militant activism of some of the ANA affiliates produced improvements in the employment conditions for RNs in general. Even though there have been widely-scattered improvements

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[26]Ronald L. Miller, "Development and Structure of Collective Bargaining Among Registered Nurses," Personnel Journal 50 (February-March 1971), 134-140, 158, 218-225.

in employment conditions either directly or indirectly attributable to collective bargaining among RNs, Miller concluded that (as of 1971) RNs -- particularly those in administrative, supervisory or educational positions -- still showed no strong tendencies to accept and support collective representation. Although his articles preceded Richard Miller's "Hospitals" by approximately nine years, both authors found that attempts to bring questions regarding professional practices into collective bargaining have been relatively unsuccessful.

The evolving trends in hospital unionization and their future implications have been addressed in several recent journal articles. Susan Levine indicated that unionization is either directly or indirectly forcing hospital management reevaluate its philosophy of purchasing and handling labor, and its attitude toward collective bargaining.[27] Levine cited research supporting the conclusion that unionization in the hospital sector (either real or threatened) has had several relatively specific impacts. Written personnel policies have been established or improved. Administrators have become more sophisticated in utilizing their personnel more effectively with a greater willingness to secure sound legal advice in the employee relations area, and less paternalistic in their dealings with employees. With the

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[27]Levine, "Unionization in Hospitals," pp. 61-75.

possibility of unionism present, hospital management may find it more advantageous in the long run to manage their employees in such a way that union representation offers little appeal.

Changing trends in union activity in the hospital sector have been addressed by Gail Bentivengna.[28] Bentivengna found that while union activity among hospital employees has been concentrated in a few industrial states (particularly in the west coast, industrial northeast and Great Lakes region), increasing activity has also been noted in smaller hospitals in small towns lacking significant industrial bases. This trend has become increasingly evident in southeastern, western and southern states. Bentivengna cited the increasing importance of "quality of life" issues among the largely professional hospital work force. The integration of work with other activities was also addressed in view of the high percentage of women employees in the industry and their desire for flexible working hours and extended leaves of absence for education and a variety of other personal reasons.

Jerome Koncel addressed the increasing demands of professional employees in hospitals -- improved economic standards and corresponding improvements in professional and patient care standards -- and the employees' increasing assertiveness in pursuing those demands as evidenced by the

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[28]Gail Bentivengna, "Labor Relations: Union Activity Increases Among Professionals," Hospitals 53 (April 1, 1979), pp. 131-139.

increasingly common willingness to resort to strike action. Koncel's research indicated that nurses are seeking union representation to make their voices heard and seriously considered by hospital management (in addition to improvements in wage levels and working conditions).

Daniel Kruger has examined the development of bargaining in the nursing profession using the ANA's historical invovlement as a focal point.[29] Although published approximately twenty years prior to the MSU Survey, Kruger's material is applicable for several reasons. Discussing the subject matter included in many of the contemporary collective bargaining agreements, Kruger found that the extension of coverage to the various positions in the nursing hierarchy frequently varied between agreements. Some only included staff nurses, others covered all professional nurses performing nursing services, including supervisors but excluding directors and assistant directors of nursing. Current literature indicates that the variance in the inclusion of supervisory nurses (i.e. nurses not directly involved in patient care, such as educational coordinators and instructors, etc.) is still common. Kruger's research examining the ANA also indicated that agreements were usually of one- or two-year durations, and that none of the two-year agreements contained reopening clauses. MSU Survey findings indicate that since

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[29]Kruger, "Bargaining and the Nursing Profession," pp. 699-705.

1960, the trend has been toward longer agreement durations, occasionally with wage reopener clauses.

Kruger also cited several problems and prospects regarding collective bargaining in the nursing profession that have proved to be increasingly important over time. Included in his discussion was the nurses' view of unionism and aspects of collective bargaining as being unprofessional and incompatible with professional ethics and prestige, exceptional employer resistance to the use of collective bargaining, and inadequate legal protection covering collective bargaining in the health care field.

Paul Frenzen's research supported the conclusion that the 1974 amendment to the National Labor Relations Act encouraged the growth of unionism in the hospital sector.[30] Organizing activity following the amendments was particularly heavy in nonprofit facilities, whose labor relations status was reclassified by the 1974 amendments.

The 1974 amendments (P.L. 93-360) to the NLRA were definitively analyzed by Yvonne Bryant, whose findings concurred with those arrived at by Frenzen, i.e. that union organizing attempts in health care facilities have significantly increased since the passage of the 1974 amendments placing all non-government health care institutions under the

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[30]Paul D. Frenzen, "Survey Updates Unionization Activities," Hospitals 52 (August 1, 1978), pp. 93-104.

provisions of the NLRA.[31] Brynat's findings indicated that the initial success unions had in organizing drives following the 1974 amendments was relatively short-lived. In the first ten months following the amendments, unions won approximately sixty percent of the elections conducted, fifty-eight percent in the next twelve months, and only forty-seven percent during the next seven months. Thus, Bryant's statistics indicated that the trend toward union representation victories taking place around 1975 gradually began to reverse itself.

Although published prior to the passage of the 1974 amendments, Dennis Pointer's critique of public policy dealing with labor relations in the health care sector provided an extensive review of the frequently conflicting federal and state labor law environments, and concluded that a revision in the legal framework was necessary.[32]

Examining another legal issue in the health care industry, William Emanuel and Robert Legros have addressed the issue of whether members of a religious congregation employed in a hospital are eligible for inclusion in a collective bargaining unit.[33] Although their research found that the NLRB and the

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[31]Yvonne N. Bryant, "Labor Relations in Health Care Institutions: An Analysis of Public Law 93-360," Journal of Nursing Administration 8 (March 1978), pp. 28-29.

[32]Dennis D. Pointer, "Hospital Labor Relations Legislation: An Examination and Critique of Public Policy," Hospital Progress 54 (January 1973), pp. 71-76.

[33]William J. Emanuel and Robert Legros, "Sisters as Union Members: What Do the NLRB and Courts Say?" Hospital Progress 59 (January 1978), pp. 46-54.

appellate courts are more in conflict than in harmony on the issue of including members of religious congregations in hospital collective bargaining units, the NLRB has generally found that the members of a religious congregation employed in a hospital affiliated with that congregation are unlikely to be included in a bargaining unit there. However, this question did not appear to be one of great magnitude in the MSU Survey, in which less than ten percent of the reporting facilities indicated that they had any nursing staff members who belonged to religious orders.

Several journal articles addressed the issue of appropriate bargaining units in health care facilities. Daniel Kruger has reviewed the principal factors considered by the NLRB in nursing bargaining unit determinations.[34] In examining several unit determination cases, Kruger found that the Michigan Employment Relations Commission (called the Labor Mediation Board at the publication date of Kruger's article) has generally followed the guidelines and precedents established by the NLRB. Kruger reviewed the factors relevant in making a unit determination decision, and concluded that in unit determination decisions in professional nursing, occupational titles do not have the same significance of meaning they possess in business and industry. Rather, the functions of professional nurses are of key importance in

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[34]Daniel H. Kruger, "The Appropriate Bargaining Unit for Professional Nurses," Labor Law Journal 19 (January 1968), pp. 3-11.

bargaining unit determination issues, as well as other factors normally considered by the NLRB.

Stephen Pepe and Robert L. Murphy have reviewed NLRB guidelines covering appropriate bargaining units in the health care industry, citing the four NLRB cases whose outcomes comprised the NLRB positions(s) on appropriate health care bargaining units.[35] Pepe has also written on the legislative history and rationale of the NLRB in addressing these questions.[36]

In his examination of the scope and composition of health care bargaining units, Wayne Emerson concentrated on the ANA position on nursing unit determinations, and the question of whether RNS be included with other professional employees.[37]

Writing on unit determinations in the public sector, Michael Moore and James Chiodini reviewed the basic criteria in bargaining unit determinations and the key factors affecting the choice of a bargaining unit structure.[38] State laws covering bargaining units and their implementation were addressed in their work on the public sector.

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[35]Stephen P. Pepe and Robert L. Murphy, "The NLRB Decisions on Appropriate Bargaining Units," Hospital Progress 58 (August 1975), pp. 36-43, 69.

[36]Stephen P. Pepe, "Appropriate Health Care Bargaining Units: An Unsettled Question," Hospital Progress 58 (January 1977), pp. 48-54.

[37]Wayne L. Emerson, "Appropriate Bargaining Units for Health Care Professional Employees," Journal of Nursing Administration 8 (September 1978), pp. 10-15.

[38]Michael L. Moore and James Chiodina, "Unit Determination Criteria in Public Sector Employment Relations," Journal of Collective Negotiations 8 (March 1979), pp. 235-252.

Discussing the inclusion of supervisory personnel in bargaining units, Virginia Cleland traced the history of regulations affecting supervisors' bargaining unit status, including several cases in which differing outcomes were arrived at in determining supervisory personnel's place in collective bargaining.[39]

The debate concerning the question of whether nurses can function as professionals and (at the same time) union members without violating the tenets of either role has been addressed by Betty Hopping.[40] Hopping identified the irritants that encourage employees to seek union representation, the ideals unionism is based on, and the idealogical foundation of professionalism in nursing. Hopping concluded that the fundamental difference between unionism and professionalism is the method by which each exerts control over its members, and that unionism ignores or supresses merit, experimentation and camaraderie between professional and employer. Also writing on the issue of professionalism in nursing, Anthony Lee has indicated that physicians overwhelmingly disapprove of unionism among nurses.[41] Physicians surveyed by Lee indicated that unionization among nurses leads to deteriorating patient care and (deteriorating) nursing attitudes toward their employer.

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[39]Virginia S. Cleland, "The Supervisor in Collective Bargaining," Journal of Nursing Administration 4 (September-October 1974), pp. 33-35.

[40]Betty Hopping, "Professionalism and Unionism: Conflicting Ideologies," Nursing Forum 15 (Fall 1976), pp. 372-383.

[41]Anthony A. Lee, "How Nurses Rate with MDs," RN 42 (July 1979), pp. 26-29.

Examining the issue of professionalism in nursing from a different perspective, Norma Grand concluded that the major barrier to collective action in the field has been the "professional" self-concept nurses have had, and their corresponding reliance on employers' paternalism.[42] Grand felt that collective action designed to improve nursing working conditions has succeeded, although the "professional" justification for strike action -- that improved benefits and working conditions are directly correlated with better patient care -- has an inherent disadvantage; namely, that when working conditions are poor, the quality of nursing care also deteriorates. Grand also traced the involvement of the ANA in collective bargaining, and the decline of employer paternalism.

John Lawrence addressed barriers to collective bargaining, and called apathy among nurses the profession's most widespread threat.[43] Lawrence identified the second-class role of women in American society, the voluntary subjection to, and dominance by physicians and administrators, and political inaction as the primary obstacles faced by the nursing profession.

Joseph Alutto and James Belasco surveyed RNs in three general hospitals (religious, county and community) in western New York, exploring militant attitudes among

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[42] Norma K. Grand, "Nursing Ideologies and Collective Bargaining," Journal of Nursing Administration 3 (March-April 1973), pp. 29-32.

[43] John C. Lawrence, "Confronting Nurses' Political Apathy," Nursing Forum 15 (Fall 1976), pp. 363-371.

white-collar workers.[44] Through the use of a questionnaire soliciting information on the subjects' opinions of strikes, collective bargaining and unionism by professionals, the authors found that while nurses had a relatively unfavorable view of collective bargaining and professional associations, their attitudes toward strikes and union representation by professionals was somewhat favorable. Younger nurses tended to evaluate strikes and unions more favorably than their older professional counterparts, and age was the single best predictor of attitudinal militancy, although marital status, type of employer, seniority and personal characteristics were also examined as predictors of attidunal militancy.

Lynn Donovan's survey of nursing attitudes on striking concluded that the strongest justification for resorting to strike action is better patient care, but salaries and working conditions were also prominent reasons cited for striking.[45]

In their examination of work stoppages in the health care industry, Pointer and Metzger found a significant correlation between the extent of collective employee activity (i.e. recognition requests and current negotiations), and the incidence of work stoppages.[46] Spontaneous work stoppage activity in

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[44]Joseph Alutto and James A. Belasco, "Determinants of Attitudinal Militancy Among Nurses and Teachers," Industrial and Labor Relations Review 27 (January 1974), pp. 216-227.

[45]Lynn Donovan, "Is Nursing Ripe for a Union Explosion," RN 41 (May 1978), pp. 63-68.

[46]Dennis D. Pointer and Norman Metzger, "Work Stoppages in the Hospital Industry: A Preliminary Profile and Analysis," Hospital Administration (Speing 1972), pp. 9-24.

the absence of union or professional association presence was minimal. While federal hospitals were reported as having almost no work stoppage activity, a relatively high degree of conflict was reported by state and local hospitals, somewhat surprising considering that a majority of states granting public employees organizational and collective bargaining rights also (like the federal government) prohibit strikes. Pointer and Metzger felt the explanation for this was the ANA and the American Federation of State, County and Municipal Employees (AFSCME) use of mass resignations and sick calls in state and local facilities, circumventing "no strike" laws while pressing recognitial and employment demands in these facilities. Higher incidents of work stoppages were also correlated with recognition requests (versus hospitals with negotiated agreements), increasing hospital bed sizes, and geographic location -- hospitals in the Pacific, east northcentral and west northcentral accounted for a particularly high percentage of stoppages, while southern hospitals reported relatively low numbers of stoppages.

Examining the difficulties faced by mid-level nursing service personnel in work stoppages, Ada Jacox solicited information from participants in a 1965 Ohio hospital work stoppage that centered around wages, compulsory membership in the state nurses' association, and the inclusion of head nurses in the bargaining unit.[47] Jacox concluded that more

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[47]Ada Jacox, "Conflicting Loyalties in Collective Bargaining: An Empirical Illustration," Journal of Nursing Administration 1 (September-October 1971): 19-24.

than any other group, head nurses were caught between conflicting loyalties and expectations of the hospital administration and staff nurses. Whatever the reasons and influences affecting their decisions, nurses caught in the conflicting tensions expressed feelings of guilt for either having failed to support colleagues, administration and nursing superiors opposing the work stoppage, or having left patients. At the conclusion of the conflict, many head nurses were left with feelings of frustration and disappointment, largely residual effects of their conflicting loyalties.

Michael Miller traced the historical development of nurses' right to strike, and arrived at several conclusions.[48] Miller's material indicated that the working relationship between professional nurses and their employers is in a state of deterioration, and that most nursing employers believe that relatively high turnover rates will resolve tensions between themselves and their employees. Miller pointed to compulsory arbitration as the most acceptable alternative to strike action.

Myron Fottler examined wage levels in metropolitan hospitals between 1966 and 1972, attempting to discern the impact of unionism on nursing wages.[49] Fottler found that the union impact had been significant, particularly in private

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[48]Michael H. Miller, "Nurses' Right to Strike," Journal of Nursing Administration 5 (February 1975), pp. 35-39.

[49]Myron D. Fottler, "The Union Impact on Hospital Wages," Industrial and Labor Relations Review 30 (April 1977), pp. 342-255.

hospitals, raising overall wages between four and eight percent. Consistent with other studies and generally held assumptions, his findings indicated that unions tend to organize the largest and most easily accessible organizations, and that their greatest impact occurs in the early stages of organizing (economic theorists tend to minimize the union impact in the long run, emphasizing market forces as the primary wage determinant). Also brought out in his study was the difficulty in measuring spillover effects (i.e. employer wage decisions resulting from the threat of unionism), but to the extent that these employer reactions to the threat of unionism exist and employer raise wages to forestall unionism, union-nonunion wage comparisions understate the union impact. While Fottler indicated that unionism has impacted hospital wage levels, its impact on overall hospital costs for the period studied appeared to be in the range of between one and two percent, thus not a significant contribution to recent inflationary trends in the hospital industry.

The difficulty in measuring spillover effects resulting from actual or perceived threats of unionism to nonunion facilities has been addressed by Daniel Mitchell, who theorized that unions might potentially have no pay-raising impact.[50] It is Mitchell's contention that employers might offer a wage figure in negotiations so artificially low that

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[50]Daniel J. Mitchell, Unions, Wages and Inflation, Washington, DC: The Brookings Institution, 1980).

the finally agreed upon figure would be equivalent to what they would have unilaterally determined without the union. In measuring the union impact on wages, Mitchell observed that while union earnings for broad groups of workers are usually higher than nonunion earnings in the American labor market, other forces leading to above-average salaries make blanket observations questionable, particularly when applied to specific industries. Some of these forces, and the determinants of wage rates were discussed in his publication.

Jack Stieber and Adolf Sturmthal have addressed the histories and activities of the ANA in varying extents.[51] Stieber's work was the more extensive of the two in the nursing area, examining not only the ANA history, policies and current activities, but the state affiliates' collective bargaining background, particularly that of the Michigan Nurses' Association (MNA).

Doris McLaughlin studies the history and extent of union activity in the Michigan nursing profession, concentrating on the role the state legislature and courts have played in collective bargaining in the state.[52]

The impact of the 1974 health care amendments to the NLRA, and their impact on employment relationships in the health

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[51]Jack Stieber, Public Employee Unionism: Structure, Growth, and Policy, (Washington, DC: The Brookings Institution, 1973; Adolf Sturmthal, White-collar Trade Unions, (Urbana, IL: University of Illinois Press, 1966).

[52]Doris B. McLaughlin, Michigan Labor: A Brief History from 1818 to the Present, (Ann Arbor, MI: Institute of Labor and Industrial Relations, University of Michigan-Wayne State University, 1970).

care industry have been assessed by Andria Knapp.[53] Her work included extensive reviews of the legal framework governing the health care industry, the history of the NLRB decisions effecting the industry and their impacts, the Congressional intent behind the 1974 amendments, and the role of the Federal Mediation and Conciliation Service (FMCS) in the industry.

In a work somewhat similar to that of Knapp, Jerold Jacobsen has examined the role of the FMCS, the NLRB, and the major case decisions affecting the employee-employer relationship in the health care industry in light of the 1974 amendments.[54]

John Fossum has summarized many of the basic areas in industrial relations particular to the health care field.[55] His material has been expanded upon by William Werther and Carol Lockhart, whose publication details the responsibilities and obligations of employers and employees in health care facilities with regard to collective bargaining under the NLRA.[56] A clear picture of the roles of the relevant parties and the ways these roles affect the collective bargaining relationship, and a summary of the "emerging forces in

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[53]Andria S. Knapp, Labor Relations Law Problems in Hospitals and the Health Care Industry, (Chicago: American Bar Association Section on Labor Relations Law, 1977).

[54]Jerold D. Jacobsen, Labor Relations in the Health Care Industry, (New York: Practising Law Institute, 1977).

[55]John A. Fossum, Labor Relations: Development, Structure, Process, (Dallas, TX: Business Publications, Inc., 1979).

[56]William B. Werther and Carol Ann Lockhart, Labor Relations in the Health Professions, (Boston: Little, Brown and Co., 1976).

labor relations" is included in Werther and Lockhart's work.[57]

Gail Hallas used questionnaires and interviews with Florida nurses to examine the current state of nurses' attitudes toward their employers and their profession.[58] Hallas found that hospital-related issues -- inadequate staffing levels, poor employer-employee communication, poor administration, morale, wages and patient care -- were of significant importance in causing nurses to leave hospital employment, and frequently, the entire profession. Attitudes of nurses toward their professional association were also examined, and found to be frequently critical of their association's activities and the benefits generated from their membership, essentially constituting another reason to leave the profession.

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[57] Ibid.

[58] Gail G. Hallas, "Why Nurses Are Giving It Up," RN 43 (July 1980), pp. 17-25.

CHAPTER III. METHODOLOGY

MSU Survey Design

With the basic reasons for studying collective bargaining in the nursing profession enumerated in the introduction, some attention should be paid to the methodological framework employed in the MSU Survey. The goal of this study was to empirically examine the labor-management relationship in the Michigan nursing industry, concentrating on the hospital-employed nurses. To gather information on this subject, a questionnaire was developed and mailed to administrators and directors in every Michigan hospital.

The questionnaire and an accompanying cover letter was mailed on August 13, 1979, to 247 hospitals in Michigan. This 247 hospital population represented all of the facilities in the state that were listed in the 1978 American Hospital Association Guide to the Health Care Field (AHA Guide). A stamped, self-addressed return envelope was included with each questionnaire to encourage prompt responses. Return envelopes used in the first mailing included the respondent's name, to reduce any possible confusion and duplication of effort in arriving at an appropriate follow-up mailing list. The initial mailing requested that the questionnaire by completed and returned by August 31, 1979, giving hospital officials eighteen days to reply.

Eighty-five administrators returned the questionnaire by the August 31, 1979, target date. However, several incomplete

forms were returned, and other respondents informed us that they would not respond to the MSU Survey without the endorsement of the Greater Detroit Area Hospital Council (GDAHC). Because of the time involved in the GDAHC endorsement procedure, one follow-up mailing was made on August 31, 1979, to all non-GDAHC hospitals that had not responded to the initial mailing. This follow-up included another questionnaire and cover letter further explaining the MSU Survey, and requested a return of the completed questionnaire by September 14, 1979; two weeks after the date of the follow-up mailing. This mailing also included a stamped, self-addressed return envelope, although the hospital names were not printed on them as they had been in the initial mailing. It was felt that the lack of the respondent's name on the envelope might aid the return rates by further encouraging respondent anonymity.

Post cards were sent to GDAHC members informing them of the decision to delay their follow-up mailing pending the endorsement ruling of the GDAHC Questionnaire Review Subcommittee. The GDAHC approved a recommendation to endorse the questionnaire on September 27, 1979, on two conditions. The first condition stipulated that the confidentiality of the responding institutions be protected by eliminating any cells used in tables contained in data summary prepared for the hospitals containing less than four units (hospitals). In the second condition, it was agreed that the difficulties of comparing data on cities of roughly equivalent populations in

metropolitan (or urban) and rural areas would be addressed in any data summary prepared for the responding hospitals.

Another copy of the questionnaire and an accompanying cover letter including these conditions was sent to GDAHC-member hospitals on October 3, 1979, requesting that the enclosed questionnaires be returned by October 15, 1979. Once again, stamped, self-addressed return envelopes were included in that mailing. This follow-up also omitted any identification of the respondent on the return envelope.

Additionally, letters and questionnaires were sent to two hospitals currently in operation, but not included in the AHA Guide from which the original population had been chosen.[59] The addition of these two facilities brought the total number of hospitals solicited to 249.

From the figure of 249, an effective population of 243 hospital facilities was arrived at. The two military hospitals in Michigan were excluded from the analysis, and four other facilities returned questionnaires or letters informing us that they had closed, or ceased hospital operations.[60] This attrition eliminated a total of six hospitals from the

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[59]Heritage Hospital (Taylor), and Olin Health Center (East Lansing) were omitted from the list included in the AHA Guide.

[60]Columbia Medical Hospital and Nursing Home (Detroit), the Salvation Army William Booth Memorial Hospital (Detroit), the Salvation Army William Booth Memorial Hospital (Grand Rapids), and Devine Infant Hospital (Wakefield) replied that they had closed or discontinued hospital operations.

original population solicited (249 hospitals), leaving the effective population of 243 facilities.

The two follow-up mailings (one to GDAHC members and one to nonmembers) yielded 53 usable responses, for a total of 132 usable responses, or a return rate of 54.3 percent. While several of the questionnaires were returned as late as mid-January, 1980, they were excluded from the analysis. Thus, the findings of the MSU Survey are based on 132 responses from 243 facilities, or a 54.3 percent return rate.

Table 1 compares the composition of the MSU Survey population and the 132 usable responses according to the hospital location (by city size), bed size, and type of control. The largest number of hospital facilities (43.6 percent) were located in cities of less than 10,000 in population. A breakdown of the returned questionnaires shows a striking similarity in that 42.4 percent of the usable returns were from hospitals located in these smaller cities. Solicitations and returns from this city size category were within 1.2 percent of comprising equal proportions of their totals. The second largest number of hospitals were located in the largest cities in Michigan (100,000-plus in population). This was also reflected in the responses. The remaining third (32.1 percent) of the hospitals solicited were relatively evenly distributed in cities ranging from 10,000 up to 100,000 in population. Returned questionnaires reflected a similar pattern, with a slightly higher response rate from the cities of 10,000 to 25,000 in population.

TABLE 1

QUESTIONNAIRE COMPOSITION ACCORDING TO CITY SIZE, BED SIZE, AND TYPE OF CONTROL

Category	Questionnaires mailed		Questtionnaires returned[b]	
	Number	Percent	Number	Percent
City Size[a]:				
less than 10,000	106	43.6	56	42.4
10,000 to 24,999	27	11.1	22	16.7
25,000 to 49,999	27	11.1	12	9.1
50,000 to 99,999	24	9.9	17	12.9
100,000-plus	59	24.3	25	18.9
Totals	243	100.0	132	100.0
	Number	Percent[c]	Number	Percent
Bed Size:				
1-100	99	40.7	61	46.2
101-200	54	22.2	23	17.4
201-300	35	14.4	18	13.6
301-400	17	7.0	8	6.1
401-plus	38	15.6	22	16.7
Totals	243	99.9	132	100.0
	Number	Percent	Number	Percent[c]
Control:				
Proprietary	5	2.0	1	0.8
Non-profit	145	59.7	77	58.3
Religious	-	-	-	-
Federal gov't.	6	2.5	4	3.0
State gov't.	14	5.8	10	7.6
Local gov't.	53	21.8	25	18.9
Non-profit/Religious	20	8.2	7	5.3
Other	-	-	4	3.0
Info. not given	-	-	2	1.5
Totals	243	100.0	243	99.9

[a]City sizes are categorized by population.

[b]Refers only to fully or partially usable questionnaires.

[c]Does not add to 100 due to rounding.

A comparison of the mailed and returned questionnaire composition according to hospital bed sizes is consistent with the comparison drawn in the city size category. The largest number of mailings and returns were to and from hospitals of fewer than 100 beds. Hospitals of 101-200 beds were the next largest subpopulation, and had the second largest number of returned questionnaires. The smallest category was the 301-400 bed size hospital. Only 7 percent of the questionnaires were mailed to these facilities, and they accounted for 6.1 percent of the returned questionnaires.

In the 243 hospital survey population, 165, or 67.9 percent of the facilities were controlled on a non-profit or non-profit/religious basis.[61] The breakdown of the returned questionnaires provided in Table 1 indicates that 86, or 66.1 percent were from these non-profit hospitals.[62] In the effective population surveyed, 30.1 percent of the facilities were controlled by federal, state, or local government authorities. Governmentally controlled hospitals accounted for 29.9 percent of the total returns, a difference of less than one percent. In both cases,

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[61]All of the hospitals in Michigan administered by religious groups operate on a non-profit basis.

[62]Data included in the AHA Guide classifies religiously administered in Michigan as being non-profit/religious. Hence, no questionnaires were sent to "religious" facilities. However, two institutions indicated their control as singularly "religious" on the questionnaire. These respondents were classified as "non-profit/religious."

local government authorities controlled over 60 percent of all of the governmentally administered facilities.

Viewed in total, Table 1 exhibits substantial similarities between the compositions of the solicited population and the return population. In no category do deviations exist between the composition of the hospitals solicited and the hospitals responding to the MSU Survey that are large enough to cast doubt upon the representativeness of the MSU Survey and its results.

Table 2 exhibits the response rates categorized on the basis of city sizes (in population), bed sizes, and types of hospital control. As was the case in Table 1, no substantial deviations exist in the response rate that would seriously impinge upon the representativeness or accuracy of the information obtained through the MSU Survey. Hospitals in cities of 10,000 to 25,000 and 50,000 to 100,000 in population show higher return rates than the total population. Hospitals of 101-200 beds were the only category with a return rate of more or less than ten percentage points from the overall 54.3 percent return rate. In terms of hospital control types, the major category — non-profit and non/profit/religious hospitals — had a 52.1 percent return rate, only 2.2 percent less than the total return rate. Proprietary hospitals had the lowest return rate (20.0 percent), buth they only comprised 2 percent of the total number of facilities solicited. State

TABLE 2

RESPONSE RATE ACCORDING TO CITY SIZE, BED SIZE, AND TYPE OF HOSPITAL CONTROL

Category	Facilities solicited	Usable responses	Return rate
City size[a]:			
less than 10,000	106	56	52.8
10,000 up to 25,000	27	22	81.5
25,000 up to 50,000	27	12	44.4
50,000 up to 100,000	24	17	70.8
100,000-plus	59	25	42.4
Totals	243	132	54.3
Bed size:			
1-100	99	61	61.6
101-200	54	23	42.6
201-300	35	18	51.4
301-400	17	8	47.0
401-plus	38	22	57.9
Totals	243	132	54.3
Control:			
Proprietary	5	1	20.0
Non-profit	145	77	53.1
Religious	-	2	-
Federal gov't.	6	4	66.7
State gov't.	14	10	71.4
Local gov't.	53	25	47.2
Non-profit/Religious	20	7	35.0
Other	-	4	-
Info. not given	-	2	-
Totals	243	132	54.3

[a]City sizes are categorized by population.

and federal hospitals are somewhat overrepresented, with respective return rates of 71.4 and 66.7 percent.

In summary, the MSU Survey solicited information from every nonmilitary hospital in Michigan over a several week period, and received usable data from 54.3 percent of the

hospitals. Roughly 44 percent of the hospitals solicited were located in relatively small cities. Slightly less than 25 percent of the hospitals were located in cities of over 100,000 on population.[63] The remaining third (32.1 percent) were evenly distributed between cities of 10,000 to 100,000 in population. The composition of the returned questionnaires reflected a corresponding trend. The similarities in the compositions of the mailed and returned questionnaires applied to the hospital bed size and control-type categories as well. At no point did the respective compositions appear skewed enough to indicate cause for concern over the representativeness of the data gathered by the solicitation efforts.

Response rates shown in Table 2 were similarly encouraging. Some underrepresentation was evident from hospitals located in the largest city sizes, and state-administered hospitals. However, no obvious evidence exists in the response rates that would indict the ability of the MSU Survey to portray an accu-ate informational portrait of the actual hospital population in Michigan.

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[63]The city size category of 100,000-plus in population was the largest in the questionnaire. The seven cities falling into this category include Detroit (1,513,601), Grand Rapids (197,649), Flint (193,317), Warren (179,260), Lansing (131,403), Livonia (110,109), and Dearborn (104,199). Newspaper Enterprise Association, Inc., The World Almanac and Book of Facts 1979 (New York: Newspaper Enterprise Association, Inc., 1978), p. 230.

Methodological Implications

The need for evaluation or examination rarely occurs in an atmosphere of complacency. In the same vein, problematic areas in employee relations are the settings wholly appropriate for examination and evaluation. The basic rationale for evaluation is that it provides information for action, and contributes to the rationalization of decision-making. Although it may serve other functions, such as knowledge-building or theory-testing, its primary justification is its addition to improved decision-making, adding weight to the thrust for positive change or future directions in programs, policies, professional relationships, occupational groups, etc.[64] However, in "real world" settings, indefective examination and/or evaluation is not always practical or possible.[65] In discussing the pitfalls in the evaluation of social action programs in contemporary settings, Peter H. Rossi has stated that "while it is true that in a Panglossian best of all possible worlds, the best of all possible research designs can be employed, in a comprised real world, full of evils as it is, it is necessary to make due with what is possible within the limits of time and resources."[66]

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[64]Carol H. Weiss, ed., Evaluating Action Programs: Readings in Social Action and Evaluation (Boston: Allyn and Bacon, Inc., 1972), pp. 318-320.

[65]Peter H. Rossi, Evaluating Action Programs, ed., by Carol H. Weiss (Boston: Allyn and Bacon, Inc., 1972), p. 232.

[66]Ibid.

While classic experimental designs have "prestige, power, and symmetry," evaluations employing quasi-experimental or non-experimental designs often have the overriding virtue of feasibility.[67] The evaluator who attempts classic experimental design in evaluating programs of conditions and "encounters obstacles and fouls up is less productive than the one who adapts his designs . . . to the possibilities."[68] Examination employing nonexperimental schemes "can produce good results that are sufficiently convincing for many practical purposes (and) . . . be full of detail and imagery, provacative and rich in insight," offering more information than would have been available without any study at all.[69]

The "case and field study" research methodology employed in this study offers the additional advantages of being particularly useful as background information for planning major investigations in the hospital-nurse employment setting. Because it is intensive, it brings to light "important variables, processes, and interactions that deserve more extensive attention," and pioneers new ground, often acting as the source of "fruitful hypotheses for further study."[70]

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[67]Carol H. Weiss, Evaluation Research (Englewood Cliffs, NJ: Prentice-Hall, Inc., 1972), p. 73.

[68]Ibid.

[69]Ibid., pp. 73-73.

70Stephen Isaac and William B. Michael, Handbook in Research Evaluation (San Diego: Edits Publishers, 1971), p. 20.

Finally, the case study data provided in this study provides useful anecdotes or examples to illustrate more generalized statistical findings.[71]

Substantial efforts have been made to limit the possible threats to the validity and reliability of the MSU Survey. However, several possible threats are inherent in a survey of this type, and these methodological questions merit some attention.

A measure's reliability refers to the degree to which the measure may be depended upon to secure consistent results upon repeated applications. Therefore, the reliability of the MSU Survey indicates the probability of obtaining analogus results upon repeated uses of the questionnaire. For example, if the questionnaire was distributed at several chronological intervals in a time series evaluation or design, and yielded substantially dissimilar results (beyond variations that could be explained by changing wage settlements, increasing union organizing activity, hospital expansion, etc.), its reliability would be open to question. In analyzing the MSU Survey's reliability, three primary sources of unreliability should be considered.[72]

Subject reliability refers to the subject's mood, motovation, etc., and how these factors may affect his or her attitudes and behavior regarding a survey.

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[71] Ibid.

[72] Edward Suchman, Evaluation Research: Principles and Practice in Public Service and Social Action Programs, (New York: Russel Sage Foundation, 1967), pp. 115-131.

Situational reliability refers to the conditions under which the survey measurements are made. Some circumstances or conditions may tend to produce results that are not reflective of the actual conditions in the population being studied.

Instrument reliability includes both subject and situational reliability factors combining to produce an evaluative instrument (the questionnaire) of low reliability. For example, a poorly worded interview or questionnaire (especially ambiguous or leading inquiries) may lead to a random variation in the responses.

Reliability criteria have traditionally represented the dependability or stability aspect of an evaluation, referring to the evaluative instrument's freedom from random and unsystematic error. The results of systematic error could be consistent, and therefore reliable. This type of chance variation "is present in all evaluation and constitutes an important aspect of any measuring instrument or procedure."[73]

Reliability is a necessary condition for validity. An evaluative technique unable to replicate its results upon continued applications because of large random errors obviously cannot be used to measure anything, and therefore cannot

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[73]Ibid., p. 116. A slightly expanded discussion of the relevant reliability and validity aspects is included in L. Kirk Handren, "Methodological Aspects and Comments on the Evaluative Design of the MSU Nursing Survey," East Lansing, MI, 1980. (Mimeographed paper supplementing the actual thesis.)

be used to measure anything, and therefore cannot have any validity. Validity refers to the degree to which a measuring instrument succeeds in doing what it purports to do.

Validity problems are inherent in all measurement. Edward Suchman has arrived at a three point check for attempting to increase survey validity.[74] First, factors tending to produce unbiased measurement should be emphasized. Additionally, checks against which one may determine the degree of validity present should be included (if possible), and attempts should be made to correct known sources of invalidity.

The MSU Survey questionnaire was limited in length and scope for several reasons. Because it was felt that a long and complex questionnaire would significantly reduce the rate of return, the length was deliberately limited to a two-sided one-page form. The first four questions solicited information on the hospital characteristics (location, size, control and personnel counts). Questions six through nine and eleven through thirteen solicited information on wage and benefit levels for full- and part-time nursing personnel. Questions fourteen through twenty-one requested information on the hospital-nursing staff collective bargaining history and activity. Question five requested data on the number of nurses belonging to religious orders, and number ten requested an aggregate breakdown on the nurses' educational backgrounds. The questions were arranged in related groups to lend some

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[74] Suchman, Evaluation Research, p. 126.

continuity to the questionnaire format, and simplify the process of retriving and recording the information to the greatest extent possible.

Attempts were made to phrase the questions in the most neutral language possible, avoiding subjectivity in the questions and answers whenever possible. In most cases, questions were either multiple choice, or answerable with figures or brief factual data (e.g. organization names, contract expiration dates, etc.). While every effort was made to state the questions as clearly as possible, any mail survey involves the possibility of misinterpretation between the solicitor and the survey respondent.

Question number two requests the type of hospital control. The multiple choice question offered six control types, and asked that all the applicable types of control be indicated. The question was intended to divulge the primary source of control (i.e. was it a "state hospital," "city hospital," etc.). Some methodological or classification problems arose from this, and were allieviated in several ways. Some questionnaires indicated the sole source of control as religious, while others indicated dual religious/non-profit control. Because of this, and the data from the AHA Guide, which indicated that all of the hospitals in the survey population under religious control were in fact religious/non-profit facilities, the seven forms in question were classified as "non-profit/religious" facilities.

Other returned questionnaires indicated control by a combination of the federal, state and/or local governments. To a certain extent, this is a perfectly valid answer. Hospital facilities may be accredited, licensed, or reimbursed by all of these governmental levels (or their agencies), but in each case, there is a primary type of control. Two returned questionnaires contained no response to the question on control, and four returns submitted control types that did not fit into any of the listed categories.

Question number three requested personnel counts in the hospitals (excluding medical interns, residents and trainees).[75] Information gained through compiling the answers to this question allowed other data in the study to be tabulated according to the hospital sizes in terms of personnel (versus hospital bed sizes). The personnel counts obtained form a type of aggregate average. Actual counts fluctuate daily, but when viewed in aggregate form, the reported figures provide clues as to the personnel levels maintained by the hospitals.

Question six requested data on monthly salary levels. However, large numbers of questionnaires were returned with hourly rather than monthly data. Because of this, the analysis of wage levels contained in this study was performed in hourly, rather than monthly terms. To convert the reported

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[75]The NLRB has held that hospital interns and resident physicians have no collective bargaining rights under Taft-Hartley, because they are not "employees" within the meaning of the law, but students pursuing a graduate medical education. Cedars-Sinai Medical Center (223 NLRB 251, 1976).

monthly salary figures to hourly earnings, the monthly numbers were divided by 160, or the equivalent of four 40-hour weeks (one month). Other requests on the questionnaire soliciting wage information were originally stated in hourly terms.

Several answers to question number sixteen brought another methodological question to light. Number sixteen requested the record of formal organizational attempts by unions directed at nursing personnel since 1970. Some answers indicated that no formal records of every attempt exist or were kept, and that the answer relied upon the respondent's memory. Another possible problem exists in this question in the language used. The question requests data on the "formal efforts by a labor organization to organize . . . nursing personnel." Defining the term "formal efforts by a labor organization" was left to the discretion of the respondents. For the purposes of this study, informal discussions with, or inquiries by labor organizations regarding the organizational status and/or desires of the nurses do not qualify as organizing efforts. These instances are difficult or impossible to document, and the seriousness of these efforts is largely a matter of opinion. "Formal efforts" by labor organizations referred to efforts in which employees (of the hospital) were involved in organized solicitation efforts with the knowledge and consent of the union, or union representatives or agents (with the knowledge of the hospital administration) actively

solicited the support of nurses for the purposes of electing a collective bargaining representative.

In a mail survey of this type, there is little that can be done by the researcher to assure the subject reliability, aside from offering the respondents the greatest degree of cooperation possible. In this regard, the respondents of the MSU Survey were promised a report of the data collected through the use of the questionnaire, and that the data would be discussed in aggregate form. All information obtained through the survey was treated confidentially, assuring the greatest degree of anonymity possible. Administrators responding to the MSU Survey were promised a copy of the aggregate findings upon their request. No serious subject reliability threats seem present.

One of the goals in developing the questionnaire was to inject as much objectivity into the measuring instrument as was possible. The questionnaire allows little room for editorializing, and provides a factual base of information to work with.

None of the conditions under which the MSU Survey was conducted seem indicative of a possible bias, or reflective of innaccurate field conditions that could prove harmful to the situational reliability. However, in applying the MSU Survey in a reliable and valid manner, it is important to remember that the results are based upon hospital-employed nursing personnel in a specific geographic region, and are

not necessarily reflective of nursing employment conditions in nonhospital employment settings. The failure to consider this condition could easily invalidate potential applications of the findings.[76]

Several factors support the conclusions that the research in the MSU Survey is valid. It provides an objective data base for the examination of the several assumptions regarding the hospital-nurse employment relationship that are included in this study. However, it is important to keep in mind that fact that the MSU Survey is not intended to provide a statistically significant confirmation or contradiction of the relevant topics discussed in this study. At each step in the interpretation and application of the MSU Survey and accompanying research, it must be remembered that the object of the studies was to empirically examine the labor-management relationship in the Michigan nursing profession.

There can be little argument as to the veracity of the MSU Survey's sampling validity. The solicitation of data from from all of the nonmilitary hospital facilities was a

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[76]There is no reason to doubt that the methodology employed in the MSU Nursing Survey could be broadened to include all employers of nurses in a larger geographic area. However, to accomplisy such a survey, considerable additional resources would be necessary.

luxury that eliminated any serious challenge to the selection of the sample population.[77]

The MSU Survey analysts cannot lay claim to being totally without bias or preconveived attitudes on the subject of collective bargaining or employee relations in the nursing profession. Obviously, without interests and perceptions of the subject under study, the MSU Survey and ensuing research would not have taken place. However, the objective data collection technique, stressing factual, documented information lends itself quite well to an unbiased analysis. Naturally, the respondent's attitudes toward the MSU Survey could not be controlled, and the nature of the information requested from the respondents is admittedly controversial and highly sensitive, but no evidence has been encountered to indicate that members of the sample population deliberately concealed information, or provided inaccurate information. Nor is there any reason to believe the administrative conditions (i.e. the auspices of the MSU Survey, etc.) led to invalid findings.

Theoretically, a threat to the MSU Survey's validity does exist in the technique used to classify the responding

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[77]The MSU Survey originally solicited information from all of the hospital facilities in Michigan, including the military installations. However, because these facilities are staffed by military personnel, and are subject to different regulations governing the employer-employee relationship (and have policies restricting the type of information they can release), they were excluded from the analysis. For the purposes of the MSU Survey, "military" facilities refer to the hospitals administered and staffed by military personnel from the U.S. Army, Navy, or Air Force. Veterans Administration hospitals are included in the research under the classification of "federally controlled" hospitals.

hospitals according to location or city size. This classification method is actually demographic rather than geographic, as it is done according to a city's population. The first question in the questionnaire addressed the hospitals' location, offering five city sizes (from 100,000-plus, to less than 10,000), and requested the respondent to indicate the correct category. This type of classification could theoretically lead to difficulties arising from the comparison of data on cities of similar population in metropolitan versus rural areas. For example, a hospital located in a city with a small population, but which is actually part of, or surrounded by a large metropolitan or urban area could appear to be located in a rural or nonurban area. However, cases of this actually happening in Michigan are exceptions to the rule. An examination of the geographic distribution of hospitals in the state shows that the hospitals located in suburban areas tend to be located in suburban municipalities with populations large enough to keep the findings relatively distortion free.

In choosing city sizes as the method of demographically classifying facilities, the theoretical issue of noncomparable data on cities equivalent in population, but located in rural or urban regions should be considered. However, it was felt that the advantages accruing from this method of classification, including its convenience for administrators to deal with in answering the questionnaire, its basically representative nature, the ease of presentation and the overall

representativeness of the actual demographic environment outweighed the problem of rural-urban inconsistencies.

In summary, the MSU Survey is not immune to the threats to valid and reliable inference. Some of the wording contained in the questionnaire (particularly in regard to the recent history or records of union organizing activity), the conversion of the salary data to hourly figures, and the delay in the follow-up mailing to GDAHC hospitals should all be considered in evaluating the reliability and validity of the data. However, none of these conditions seem significant enough to impair the ability of the research to present an accurate empirical examination of the labor-management conditions between Michigan hospitals and their nursing personnel.

In further regard to the reliability and validity of the study's findings, the degree of their accuracy is linked to their application. The case study or single project evaluation is the prisoner of its setting. The evaluation is confined to observing effects at one time and place, under the conditions of the moment. It is difficult to determine the lengths to which the observed results may be generalized and applied to other situations. Broad sweeping generalizations based upon information contained in this study that are applied to superficially related (but actually differing) environments are of questionable validity until appropriate follow-up or augmentive research is accomplished.

While some case studies are particularly vulnerable to subjective biases, the wide sample used in the MSU Survey counteracts potentially serious questions of subjectivity.

A characteristic of evaluative research is that it takes place in action settings.[78] The MSU Survey is no exception to this rule. Information was solicited from action oriented environments, in which the research was a matter of secondary priority. To succeed in this environment, the evaluation had to adapt itself to the "real world" environment, and disrupt the respondents' routine operations as little as possible. When viewed in the context of investigating and evaluating a contemporary real world action oriented setting, and synthesizing the resultant data into an objective study, finding the right mix of detail and condensation, the research does indeed emerge as a valid, reliable addition to the existing body of information on labor-management relations.

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[78]Weiss, Evaluation Research, p. 92.

CHAPTER IV. MSU SURVEY FINDINGS

Nursing Personnel Belonging to Religious Orders

Twelve of the 132 responding hospitals (9.1 percent) replied that they had nursing staff members who belonged to religious orders. Six of these hospitals were located in cities of 100,000-plus in population, and eight were 401-bed or larger facilities. Of the twelve facilities reporting members of religious orders on their nursing staffs, only four reported the hospital control type as being religious. Table 3 illustrates these figures.

TABLE 3

CHARACTERISTICS OF HOSPITALS REPORTING MEMBERS OF RELIGIOUS ORDERS ON THEIR NURSING STAFFS

City size	hospitals	Control	hospitals	Beds	hospitals	RNs in relig. orders	hospitals
under 10,000	2	Religious	4	1-100	1	under 1%	5
10,000-25,000	3	Non-Prof.	6	101-200	2	1 to 2.5%	3
50,000-100,000	2	Federal	1	300-400	1	2.5 to 3%	2
100,000-plus	5	Local	1	401+	8	other	2
Total	12	Total	12	Total	12	Total	12

SOURCE: MSU Survey Data.

The largest percentage of RNs reported by any hospital as belonging to religious orders was 4 (percent), but this was a facility with only sixty-two full-time equivalent (FTE) RN

positions.[79] Thus, only two or three RNs in this hospital were actually members of a religious order.

Three hospitals replied that the information regarding their nurses' memberships in religious orders was unknown. One facility did not answer the question (number five on the questionnaire), and one facility answered "N/A." The one hospital under local control in Table 3 reported that none of their RNs were members of religious orders, but "some aides" were members. A total of 115 hospitals (87.1 percent of the respondents) replied that none of their nursing personnel were members of religious orders.

The information obtained on nurses' memberships in religious orders indicates that very few hospitals employ, or rely on members of religious orders to staff their nursing departments. In a minor way, this would seem to be indicative of the evolution of the profession in the United States from

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[79]Full-time equivalent (FTE) positions refer to forty hour per week positions or budget slots. In the questionnaire, they were arrived at by adding the reported numbers of full-time nurses actually employed, and the numbers of budgeted full-time vacancies. Also, two part-time employees or openings are equal to one FTE position.

its early stages, when members of religious orders were quite active in providing hospital nursing services.[80]

The presence of members of religious orders does not seem to effect the union or collective bargaining status of their hospital-employers. Six of the 12 hospitals reporting members of religious orders among their nursing employees also reported their nursing personnel as unionized. In five of those cases, the RNs were unionized.

Apparently, the presence of members of religious orders on hospital nursing staffs is relatively isolated, and has a negligible impact on the collective bargaining process.

Education

While 81 percent of the responses provided answers to the MSU Survey questionnaire concerning educational backgrounds of their nursing personnel, several difficulties arose in compiling the data in a valid format. The questionnaire requested the percentages of respondents' RNs with baccalaureate degrees

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[80]Historically, it was not uncommon for hospitals operated by, or in cooperation with, the Catholic Church to utilize substantial numbers of nuns in the provision of nursing services. The Seventh Day Adventist Church has also been directly involved in the administration of several hospitals located worldwide. However, this church has been actively involved in divesting itself of its hospital operations — none of which are, or have been located in Michigan. Because nuns and/or members of the Seventh Day Adventist Church may eschew union membership on religious grounds, the MSU Survey solicited information on the religious composition of hospital nursing staffs to arrive at a conclusion regarding the effect (if any) a significant number of nurses belonging to a religious order would have on the hospital-nursing staff collective bargaining status.

plus at least one year of post-graduate training; baccalaureate degrees; associate degrees and hospital diplomas. The intent of the questionnaire was to solicit percentage figures that accurately portrayed the aggregate educational backgrounds of the responding facilities. Several questionnaires contained circled figures, indicating that they were estimates.[81] Roughly 20 percent of the responding facilities failed to include any answer to the query, and answers that were provided were frequently in absolute, rather than percentage terms. Because of the extensive interpreting necessary to reduce the data to a common and meaningful form, and the associated reliability and validity threats that are inherent in such interpretations, alternate data prepared by the MCHIS describing the educational backgrounds of active RNs in Michigan is relied upon in this report.

In 1978, the MCHIS reported that the numbers of graduates of associate degree programs had shown noticeable increases since 1960. Table 4 provides information on the educational backgrounds of the active RNs in Michigan, according to their years of graduation. While the percentages reported in Table 4 vary widely according to the graduation years, less than 3 percent of the RNs graduating prior to 1960 received

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[81]The sixth question in the questionnaire requested data on wage and salary schedules, and asked respondents to "circle each figure which is an estimate." Several completed questionnaires were returned with answers to questions aside from number six circled, indicating estimates rather than documented factual data. Nursing educational levels were circled in several cases.

TABLE 4

DISTRIBUTION OF ACTIVE RNs IN MICHIGAN (1977) ACCORDING TO INITIAL NURSING EDUCATION AND YEAR OF GRADUATION

Initial Nursing Education	Year of Graduation										
	All Years	Before 1935	1935-1939	1940-1944	1945-1949	1950-1954	1955-1959	1960-1964	1965-1969	1970-1974	1975-1977
Estimated number active	40,255	482	1,206	2,403	3,890	3,613	3,863	4,118	5,876	9,573	5,231
All types	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Associate Deg.[1]	19.2	0.2	0.2	0.2	0.6	0.8	2.7	7.7	16.2	41.3	45.2
Hosp. Diploma	67.2	99.1	98.7	97.8	96.4	92.3	85.9	79.0	67.1	39.8	31.5
Baccalaureate	13.5	0.7	1.2	. 2.0	3.0	6.9	11.4	13.3	16.7	19.0	23.3

[1]Associate degree programs generally started after 1950, so responses giving the year of graduation before 1950 probably represent reporting errors.

SOURCE: Michigan Cooperative Health Information System, Michigan Registered Nurses, 1977 (Lansing, MI. Michigan Department of Public Health, 1978), p. 44.

associate degrees (less than 1 percent prior to 1955). In each successive graduation group since 1960, the proportions coming from associate degree programs have increased. Using the intervals from Table 4, the proportion of active RNs in Michigan from associate degree programs has more than doubled every four years, from the 1950-1954 period, to 1970-1974. By 1977, 45.2 percent of the active RNs in Michigan were from associate degree programs.[82] The chief significance of this statistic lies in the fact that, for the first time, hospital diploma graduates were displaced as the largest group of active RNs.

A 1976 MCHIS report further substantiated this changing trend in the educational preparation of the active Michigan RNs. Although the report was compiled from data collected two years earlier than the 1978 MCHIS document, the trend toward increasing numbers of associate degree holders was becoming increasingly evident, particularly among younger nurses whose entrance into the labor market has been relatively recent. Data from the 1976 MCHIS report is reproduced in Table 5. Information from Table 5 illustrates the increasing tendency of younger nurses to have graduated from associate degree programs.

How have educational preparations affected income levels? According to a February, 1980, report in RN magazine, they

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[82]The 45.2 percent figure refers to the initial type of nursing education. The 1977 MCHIS report cited in the text documented the fact that a small percentage of the active RNs held higher nursing degrees in addition to their initial educational qualifications.

TABLE 6

DISTRIBUTION OF ACTIVE MICHIGAN RNs BY EDUCATIONAL PREPARATION AND AGE, 1977 [a]

Age Group	Active RNs	Educational Preparation (percent distribution)				
		Hosp. Diploma	Associate Degree	Baccal. plus	Not Given	Total
All Ages	35,996	66.2	14.9	17.0	1.8	100.0
Under 25 years	3,973	50.5	31.4	17.7	0.9	100.0
25 to 29 years	7,136	52.1	22.1	25.0	0.9	100.0
30 to 34 years	5,090	62.7	15.8	20.5	0.9	100.0
35 to 39 years	4,055	65.5	16.1	16.8	1.6	100.0
40 to 44 years	3,910	70.1	12.4	15.5	2.1	100.0
45 to 49 years	3,804	77.3	8.0	12.5	2.2	100.0
50 to 54 years	3,654	80.9	5.3	11.1	2.7	100.0
55 to 59 years	2,332	82.5	4.3	10.0	3.2	100.0
60 to 64 years	1,517	83.0	2.6	10.5	4.0	100.0
65-plus years	522	82.5	1.0	9.4	7.1	100.0
Not given	3	-	-	-	-	-

[a] Percent distributions are based on State-wide MCHIS surveys.

SOURCE: Michigan Cooperative Health Information System, Michigan Nurses, 1975 (Lansing, MI.: Michigan Department of Public Health, 1976), p. 18.

really have not made much difference. While baccalaureate graduates have reported higher mean incomes than associate degree graduates, experienced hospital diploma nurses are still "slightly ahead in the economic sweepstakes."[83]

Salaries

The MSU Survey addressed itself to several areas in terms of wages and benefits. In these areas, information was solicited on gross earnings (which were converted to gross hourly earnings in the analysis), shift differentials, starting salary and continuing education incentives, full- versus part-time benefit packages, and the designs of the benefit packages.

The issue of salary and benefit levels and the data obtained on them raises questions about the value society assigns to the nursing profession.[84] Despite significant wage increases over the last ten years, hospital wage levels continue to be relatively low. In 1968, BLS statistics ranked the industry next to last of ten major industries.[85] In spite of the rapid expansion in the industry since that time, hospital wage levels have failed to show corresponding increases.

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[83]Lynn Donovan, "What Increases Income Most?" RN 42 (February 1980): p. 28.

[84]Andrea L. Lucas, "What's Nursing Worth?" RN 43 (January 1980): p. 32.

[85]Miller, "Hospitals," p. 380.

Fringe benefits have also suffered in comparison with other industries. In December, 1978, the United States Chamber of Commerce reported that an average of 36.7 percent of all private industry's payroll costs were accounted for by fringe benefit expenditures in 1977.[86] Hospital fringe benefit costs were 25.7 percent on the average, the lowest for the twenty-one industries surveyed.[87]

On a more personal level, salary levels provide a benchmark against which individuals evaluate their career situations. Recent studies have indicated that income is the fourth most common reason among RNs for changing jobs, and the first most common reason for contemplating a change.[88] While such intangible job factors as a "sense of achievement, knowing you help others, intellectual stimulation and fellowship with colleagues" have all been mentioned above salaries on nursing hierarchies of needs, income levels manage to surface above these others as tangible, de jure obtainable issues in the collective bargaining forum.

A national survey of nursing personnel salary levels by Andrea Lucas published in January, 1980, estimated nurses' mean income at $6.78 per hour.[90] However, the regional mean

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[86]Ibid.

[87]BNA, Daily Labor Report, December 18, 1978, pp. B1-B20.

[88]Donovan, "What Nurses Want," RN 43 (April 1980): p. 26.

[89]Ibid., p. 24.

[90]Lucas, "What's Nursing Worth?" p. 32.

for the Great Lakes region (Wisconsin, Illinois, Indiana, Ohio and Michigan) was $7.04 per hour. Table 6 illustrates the survey findings on a geographical basis.

TABLE 6

REGIONAL MEAN HOURLY NURSING SALARIES, UNITED STATES, 1980

Region	Hourly mean income[a]	Region	Hourly mean income[a]
Far West	$7.92 (+16.8%)	Plains States	$6.57 (-3.1%)
Great Lakes	$7.04 (+3.8%)	Mideast	$6.48 (-4.4%)
New England	$6.88 (-1.5%)	Southeast	$6.43 (-5.2%)
Midsouth	$6.64 (-2.1%)	South Atlantic	$6.43 (-5.2%)
Rocky Mountains	$6.63 (-2.2%)	Total	$6.78

[a]Parenthetical figures indicate the percentage difference from the national mean in each region.

SOURCE: Andrea L. Lucas, "What's Nursing Worth?" RN 43 (January 1980): p. 35.

The survey population for Table 6 was a maxture of RNs (92 percent) and LPNs and LVNs (8 percent).[91] Almost 22 percent of Lucas' survey population reported their primary places of employment as "non-hospital" settings, while 78.3 percent reported hospitals as their place of employment. The significance of this data is two-fold. First, the mean hourly salaries are bound to be slightly lower than corresponding means in strictly RN surveys, due to the 8 percent mixture of LPNs and LVNs. Second, because almost 80 percent of the respondents in the survey were employed in hospitals, the

[91]Licensed Vocational Nurses (LVNs) have the same educational and professional standing as LPNs. In California and Texas, LPNs are referred to as LVNs.

figures are highly reflective of hospital (rather than public or occupational health, private duty, etc.) pay scales.

Table 7 illustrates the mean average hourly wages for selected nursing personnel in Michigan hospitals. As would be expected, head nurses were at the top of the four-step salary scale, with average hourly earnings of $7.44. Staff RNs were next on the scale, at $6.50, followed by LPNs ($4.95) and aides (3.99).

TABLE 7

MEAN AVERAGE HOURLY WAGES, MICHIGAN HOSPITALS, 1979

Position	Mean average hourly rate	Number of hospitals reporting
Head Nurse (RN)	$7.44	110
RN (Staff)	$6.50	128
LPN	$4.95	130
Aide	$3.99	49

SOURCE: Michigan Hourly Compensation Survey, January 1979.

Data obtained in the MSU Survey provided further evidence of the relatively high nursing salary levels in the Great Lakes Region. General duty RNs were reportedly receiving hourly salaries ranging from $2.78 to $13.97. Table 8 contains a summary of the data concerning mean hourly nursing wages.

TABLE 8

MEAN HOURLY NURSING WAGE LEVELS, MICHIGAN HOSPITALS, FALL 1979

Position	Average Minimum	Average Maximum	Average Mean
Head Nurse	$7.52	$9.05	$8.26
RN (Staff)	$6.45	$7.87	$7.27
LPN	$4.95	$6.08	$5.48
Aide	$3.95	$4.79	$4.44

Note: See Appendix, Table C, 1, for supplementary data on these wage levels.

SOURCE: MSU Survey Data.

The figures reported for each nursing position exhibit increases of roughly 11 percent over corresponding figures in Table 7. While the Table 7 figures were contained in a 1979 publication, the data was actually collected almost a year prior to the MSU Survey, at least partially accounting for the across the board increase in the salary figures. Average mean levels for LPNs were 23.4 percent above the hourly figures for the aides. There was a 32.6 percent increase in the average mean levels for RNs over LPNs, and a 13.6 percent increase in the head nurses' hourly mean above that of RNs. The figures in Table 8 are based upon sample populations roughly equivalent to those in Table 7.

In each nursing position listed in Table 8, the average hourly maximum rates are between 20 and 23 percent above the minimum levels. Thus, given the current salary figures from Table 8, newly employed nursing personnel in Michigan hospitals can anticipate their future earning potential to

peak at roughly 20 percent above their starting rate. Unfortunately, the MSU Survey was not able to measure the number of years necessary for the nursing personnel to reach their respective income ceilings. What is the likelihood that hospital-employed nurses will remain employed at a facility long enough to reach the maximum salary levels? Probably not very great. Table 9, from the 1978 MCHIS report on RNs, compares the age compositions of RNs in five employment settings. The data contained in the table supports the generally accepted hypothesis that nurses (RNs in this case) frequently enter the labor market in hospital settings, but repeatedly leave their initial positions for other hospitals or areas of employment. In three of the four employment categories listed in Table 9 (other than hospitals), the percentages of active RNs actually increased with increasing age levels (prior to the 60-plus years category). However, hospital employment became less common with advancing age.

TABLE 9

PERCENT DISTRIBUTION OF ACTIVE RNs IN MICHIGAN BY AGE IN SELECTED EMPLOYMENT SETTINGS, 1977

Employment Setting	All Ages	Age				
		20-29	30-39	40-49	50-59	60+
Hospital	100	36.8	28.8	17.7	13.4	3.2
Pvt. Duty[1]	100	13.1	19.7	23.5	23.9	19.8
Schools	100	6.4	19.3	29.8	31.8	12.7
Occpt. Hlth[2]	100	5.6	20.2	26.8	35.4	11.9
Other[3]	100	15.6	39.7	23.8	15.6	5.4

[1]Abbreviation for Private Duty Nursing.

[2]Abbreviation for Occupational Health Nursing.

[3]Excludes employment in nursing homes, nursing schools, offices, community health centers, or self-employment.

SOURCE: Michigan Comprehensive Health Information System, Registered Nurses, 1977, (Lansing, MI: Michigan Department of Public Health, 1978), p. 50.

An April, 1980 national survey of professional nursing goals by Lynn Donovan revealed that 40 percent of the nursing labor force drops out of the job market at some point in their careers.[92] Nine percent leave the profession entirely, 4.4 percent drop out because of job frustrations, 1.5 percent because of long hours, and 2.4 percent because of the demands of the job.[93] In addition to this alarmingly high attrition factor, contemporary nurses exhibit strong tendencies to switch jobs within their specific employment categories. Today's nurse holds her first hospital staff job an average

[92]Donovan, "What Nurses Want," p. 29.

[93]Ibid.

of 2.3 years; her second, 2.33; her third, 2.76; her fourth, 3.37.[94] Hospital staff nurses responding to Donovan's professional goals survey had been in their present jobs an average of 3.89 years. These rapid turnover rates do not represent promotions or transfers. There was a 75 to 85 percent chance that the nurse was also changing employers in his or her job switch.[95] Donovan found that "job 'expectancy' or duration for the profession as a whole stood at three years and ten months between (job) changes (in 1980)."[96] While nurses 45-plus years of age have averaged seven full years at each job they've held, nurses in the 25-to-34 and 35-to-44 year old age groups have held their jobs for only 2.6 and 3.9 years, respectively.[97] Viewed in total, this information leads to several conclusions.

The hospital-employed nursing attrition rate is far higher than the prevailing rate in other nursing employment settings. The profession as a whole is characterized by an exceptionally high drop out rate (40 percent), either permanently, or for spans that frequently range from one to ten years.[98]

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[94]Ibid., p. 27.

[95]Ibid., p. 29.

[96]Ibid.

[97]Ibid.

[98]Inherent in the assumption that "the percentage of hospital staff RNs receiving maximum hourly salaries due to their extensive tenure is relatively small" is the further assumption that hourly maximum salary levels are at least partially based on continuous or cumulative institutional lengths of service (as well as performance evaluations, etc.).

Contemporary nurses, particularly those in hospitals and under age forty-five are virtually in constant movement in the labor market. Hospital staff nurses frequently hold their first four jobs an average of less than three years apiece, and switch employers with each change about 80 percent of the time. The high turnover rates seem to be related to several factors; labor market conditions that find employers in substantial competition for the limited supply of nursing personnel (encouraging high rates of mobility throughout the market), the high stress levels and demands upon nurses in hospitals relative to other avenues of nursing employment, and the relative youth of hospital-employed nurses that allows them to pursue numerous alternative career options. These factors all support the conclusion that the percentage of hospital staff nurses receiving the maximum hourly salary due to their continuous length of service is relatively small.[99] In spite of the rapid nursing turnover rates in hospitals, it is theoretically possible that nurses could reach maximum salary levels more frequently than the evidence presented on this topic leads one to believe. A salary schedule offering maximum wage levels within two or three years of employment would make maximum levels relatively

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[99]Hospital staff nurses responding to, and serving as the survey population of the 1980 RN Survey edited by Andrea L. Lucas exhibited the following characteristics: 92 percent were RNs, 8 percent were LPNs or LVNs; 78.3 percent were employed in hospitals, 21.7 percent in nonhospital settings; 20.7 percent were covered under union contracts, 79.3 percent were nonunion. Lucas, "What's Nursing Worth?", p. 39.

easy to obtain as far as lengths of service are concerned. In the presence of such a schedule, maximum salaries would be attainable even for the new job hopping enterants into the nursing labor market.

Some evidence also exists to support the conclusion that experience has a relatively negligible impact on nursing income levels. A February, 1980, income survey by Donovan indicated that its "most shocking finding" was that "chances are better than even you'll (hospital staff nurses) never make much more than a beginner."[100] Donovan's 1980 income survey suggested that "despite some slow, steady gains, about two-thirds of the 1,595 nurse respondents earned between $10,000 and $15,000 a year — regardless of the length of time in the field."[101] More specifically, this survey found that 72.9 percent of the new graduates entering hospital service are receiving between $5.00 and $7.50 per hour, yet more than half of the respondents with fifteen-plus years of experience make "the same $5.00 to $7.50 that most graduates are commanding in less than a year."[102]

Donovan's 1980 income survey concluded that "if you're (hospital staff nurses) not interested in a promotion or career advancement, and prefer to simply 'do' nursing, chances are better than ever that you'll never wind up making much

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[100]Donovan' "What Increases Income Most?" p. 28.

[101]Ibid.

[102]Ibid., p. 30.

more than a beginner."[103] Although Michigan is located in the second highest paying region in the country for nurses, this generalization probably holds true in the state. MSU Survey figures indicated that the average mean hourly wage for head nurses (from Table 8) was only 9.8 percent above the average minimum. The mean for RNs was 12.7 percent above their average minimum. The mean for LPNs was 10.7 percent above their average minimum, and the aide mean 12.4 percent above the average minimum levels. This information further reinforces the picture that the nursing salary growth potential in Michigan hospitals in quite limited. While average maximum hourly rates are roughly 20 percent above the minimum (or starting) levels, the average wage rates are roughly 11 percent above the minimum levels.

Whether or not working in a large hospital is more challenging, stimulating, and generally satisfying may be open to debate. But there is little doubt about the financially quantifiable rewards employment in larger facilities brings, whether compared with small-hospital salaries, or with national and regional mean wage levels.

Donovan's 1980 income survey reported that the mean hourly nursing salaries in hospitals from 50-199 beds were 6.2 percent lower than the national mean, while hourly means for 200-399 bed and 440-plus bed hospitals were 2.2 and 6.2 percent above the national mean, respectively. Table 10 examines the

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[103] Ibid.

mean salary levels of full-time nursing personnel employed in hospitals responding to the MSU Survey. It supports the hypothesis that nursing salaries tend to increase in larger hospitals (relative to smaller facilities). Almost without exception, the hourly wage levels reported in each nursing category increased with each corresponding increase in the hospital bed size. Average mean salaries for head nurses were 26.5 percent higher in the largest (401-plus beds) hospitals than in the 1-100 bed facilities. Hourly RN means increased 18.3 percent, LPNs 23.4 percent, and aides 35.9 percent over the same increase in bed sizes. The LPN category was the only one in which there were not straight line wage increases with each increase in hospital bed sizes. However, in the case of the LPNs, wage levels did show overall increases from the 1-100 to the 401-plus bed size hospitals.

The trend toward larger salaries in larger hospitals that was demonstrated on a national level in Donovan's 1980 income survey was confirmed and expanded upon by the MSU Survey. The MSU Survey findings in this area, summarized in Tables 10 and 11, indicate that the small hospital-small salary versus large hospital-large salary syndrome is probably more prevalent in Michigan than the rest of the country (on the average).

TABLE 10

HOURLY SALARY LEVELS OF FULL-TIME NURSING PERSONNEL IN MICHIGAN HOSPITALS BY HOSPITAL BED SIZE, 1979

Nursing Position	1-100 beds	101-200 beds	201-300 beds	301-400 beds	401+ beds
Head nurse					
Average minimum	$7.06	$7.30	$8.05	$8.04	$8.33
Average maximum	$8.23	$8.62	$9.49	$9.83	$10.82
Average mean	$7.59	$8.00	$8.80	$9.15	$9.60
Registered nurse					
Average minimum	$6.19	$6.29	$6.48	$6.84	$7.12
Average maximum	$7.36	$7.47	$8.30	$8.40	$8.98
Average mean	$6.88	$6.94	$7.66	$7.79	$8.14
Licensed practical nurse					
Average minimum	$4.68	$4.70	$5.37	$5.25	$5.49
Average maximum	$5.69	$5.58	$6.41	$6.71	$6.98
Average mean	$5.06	$5.02	$5.93	$5.77	$6.00
Nurse aides & assistants					
Average minimum	$3.62	$3.88	$4.11	$4.27	$4.63
Average maximum	$4.27	$4.59	$4.99	$5.33	$5.94
Average mean	$4.01	$4.26	$4.63	$4.86	$5.45

SOURCE: MSU Survery Data.

TABLE 11

MEAN HOURLY SALARY LEVEL DIFFERENTIALS BY HOSPITAL SIZE AND NURSING POSITION

Survey nursing position	Salary differentials above/below the mean				
	50-100 beds	1-100 beds	mean salary	400-plus beds	401-plus beds
1980 RN Survey[a]	-6.2%	x	$6.77	+6.2%	x
MSU Survey					
head nurse	x	-8.0%	$8.26	x	+16.2%
RN	x	-5.4%	$7.27	x	+12.0%
LPN	x	-7.7%	$5.48	x	+9.5%
Aide	x	-9.7%	$4.44	x	+22.7%

[a]Survey figures based on a 92 percent RN and 8 percent LPN population. See Donovan, "What Increases Income Most?" RN 43 (January 1980).

Table 11 indicates the aggregate mean salary levels reported in the two surveys, and the percentages above and below the aggregate mean that the means in the selected bed size categories were calculated as being. The mean hourly salary levels reported in the MSU Survey in hospitals from 1-100 beds were from roughly 5 to 10 percent below the aggregate means, while the salaries in the 401-plus bed category ranged from 9.5 to 22.7 percent above the aggregate mean (depending on the nursing position).

Donovan's 1980 income survey found that small hospitals (50-100 beds) averaged 6.2 percent below the aggregate mean hourly salary, while larger facilities (400-plus beds) averaged 6.2 percent above the aggregate. Given this trend toward smaller salaries in smaller facilities, it is not surprising that the MSU Survey showed lower means in the small hospital category, possibly due to the inclusion of the one to

forty-nine bed facilities that were not included in calculating the data for the Donovan survey. The fact that Michigan is located in a relatively high (nursing) salary region of the country partially explains the higher means reported in the 401-plus bed category. It should also be noted that several of the respondents in the MSU Survey were hospitals considerably larger than the 401-bed minimum in this category, frequently ranging over twice this size.

The ownership or control of the hospitals also seems to have some bearing on the salaries of nurses. Andrea Lucas' 1980 RN Survey on nursing income found marked differences in the mean hourly salaries of nurses in different sectors of the hospital industry. Table 12 illustrates these findings.

TABLE 12

NATIONAL MEAN HOURLY NURSING SALARIES BY HOSPITAL CONTROL, 1979-80

Hospital control	mean hourly salary	percent above or below mean
Proprietary	$6.64	-1.9%
Private/non-profit	$6.98	+3.1%
University	$7.25	+7.1%
Community	$6.67	-1.5%
Aggregate mean	$6.77	

SOURCE: Andrea L. Lucas, "What's Nursing Worth?" RN, January 1980, p. 36.

According to Table 12, university hospitals had the highest mean hourly salary, 7.1 percent above the national institutional mean of $6.77 per hour. Private non-profit hospitals had mean hourly salaries that were 3.1 percent above the aggregate mean, respectively. Table 13 examines the corresponding data

for Michigan. It should be noted that the figures in Tables 12 and 13 represent roughly equivalent groups. Ninety-two percent of the nurses represented in Table 12 were RNs, 8 percent were LPNs or LVNs. All of the nurses represented in Table 13 were RNs.

Although the MSU Survey did not classify hospital control types using the "university" and "community" categories, a "local government" classification was included in the MSU Survey questionnaire. State hospitals paid the highest mean hourly salaries in Michigan, almost 14 percent above the aggregate mean. Federal government hospitals had the next highest hourly salaries, approximately 6 percent above the aggregate mean. Private non-profit hospitals, whose mean RN salary was 3.1 percent above the national aggregate mean (Table 12) were less than half a percent above the aggregate mean in Michigan. Proprietary and local government hospitals both had mean hourly RN salaries that were below the aggregate mean, with local government facilities the lowest of all the categories (6.4 percent below the aggregate mean). While there were overall increases in the mean hourly salary in Table 13 from the smaller to the larger hospitals, the pattern was not as consistent as it was when the hospitals were simply categorized according to size (as they were in Table 10). When the type of hospital control was taken into consideration, occasional exceptions to the small hospital-small pay rule surfaced. For example, non-profit hospital's mean RN hourly

TABLE 13

MEAN HOURLY MICHIGAN RN SALARIES BY TYPE OF HOSPITAL CONTROL AND BED SIZE, 1979.

Control	hospital bed size					
	1-100	101-200	201-300	301-400	401-plus	Total
Proprietary n	$7.06 n=1	—	—	—	—	$7.06 n=1
Non-profit n	$7.13 n=23	$6.99 n=13	$7.81 n=11	$7.18 n=4	$7.97 n=6	$7.32 n=57
Religious n	—	$6.22 n=3	$6.80 n=1	$8.11 n=1	$8.33 n=4	$7.43 n=9
Federal gov't. n	—	—	$7.14 n=1	$8.30 n=1	$7.81 n=1	$7.75 n=3
State gov't. n	$8.07 n=1	$7.50 n=2	—	—	$8.89 n=3	$8.29 n=6
Local gov't n	$6.39 n=13	$7.02 n=4	$7.38 n=1	$9.40 n=1	$7.64 n=2	$6.82 n=21
Other no info. n	$6.71 n=5	—	—	—	$7.56 n=1	$6.85 n=6
Total n	$6.88 n=43	$6.94 n=22	$7.66 n=14	$7.79 n=7	$8.14 n=17	$7.27 n=103

SOURCE: MSU Survey Data.

salaries actually decreased in two categories, in spite of the fact that the bed size categories that preceded them were smaller. While the column totals in Table 13 showed increasing salary levels with each increase in the hospital bed sizes, some exceptions to this pattern surface when the type of hospital control is taken into account. Salary figures actually fell in the state hospital category when bed sizes increased from 1-100 to 101-200.

State hospitals had the highest mean hourly RN salaries, averaging $8.29, or 14.9 percent above the aggregate mean. The six state hospital responses providing complete information on this subject represent 42.8 percent of the state hospitals currently operating in Michigan. RNs in federal hospitals in Michigan averaged $7.75 per hour, 6.6 percent above that aggregate. Religiously administered hospitals averaged $7.43 per hour, 2.3 percent above the aggregate. Nonprofit hospitals (the largest single group) had an hourly mean RN salary of $7.32, less than one percent above the aggregate mean. The lone proprietary hospital responding to the MSU Survey (there were five proprietary hospitals in Michigan at the time of the Survey) reported a mean hourly RN salary of $7.06, 2.9 percent below the aggregate mean. Locally controlled hospitals in Michigan reportedly paid the lowest salaries to RNs, with a $6.28 hourly mean, 6.3 percent below the aggregate mean. It is interesting to note that in both Donovan's 1980 income survey and the MSU Survey, proprietary and community or locally controlled hospitals were

the lowest paying facilities in the RN category, while non-profit hospitals (the largest group in both surveys) paid hourly RN salaries slightly above the aggregate mean levels.

The Union Impact on Salaries

Perhaps the most crucial observations to come out of the MSU Survey concern the impact of unionism on the salary levels of nurses employed in Michigan hospitals. This data conflicts with the findings reported by Lucas regarding the financial benefits of union representation.

Table 14, reprinted from Lucas' 1980 findings, indicates that on a national level, RNs represented in a collective bargaining agreement with their hospital employers by either a union or professional association were receiving higher hourly salaries than their nonunion counterparts. The nurses responding to this survey working full-time in facilities where collective bargaining agreements existed reported salaries approximately 10 percent higher than those nurses employed in hospitals in which there was no hospital-RN collective bargaining agreement.

TABLE 14

NATIONAL UNION/NONUNION FULL-TIME HOURLY NURSING SALARIES, 1979

Contract status	mean hourly salary	% above/below national mean
Unionized nurses	$7.33	+8.1%
Non-union nurses	$6.66	-1.8%

SOURCE: Andrea L. Lucas, "What's Nursing Worth?" RN, January 1980, p. 37.

Mean union salaries were $7.33 per hour, as opposed to a $6.66 nonunion hourly figure.

Lucas' 1980 survey discovered some interesting salary trends within the ranks of the full-time unionized nurses. It appears that full-time general duty RNs covered by "AFL-CIO, Teamseters, state or federal employee unions, or other non-professional association" contracts earned an average of 20 percent more than the mean for all the full-time general duty RNs questioned.[104] Lucas noted that the non-professional association contracts tended to be with hospitals located in major metropolitan areas, offering a partial explanation for the high wage settlements. The nurses represented by professional associations reportedly earned an average of only 3.4 percent more than the mean for all full-time general duty RNs.

Questions on the attitudes of nurses toward the efficacy of their collective bargaining agents also revealed some interesting responses. A contradiction arose between the actual salaries made by RNs represented in collective bargaining agreements, and their opinions of these salaries. Only 55 percent of the general duty RNs covered by collective bargaining agreements felt that their contracts had won them better pay. The remaining 45 percent of the unionized general duty RNs felt that they were not paid any more than nurses in general, although this group actually earned an average of

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[104]Lucas, "What's Nursing Worth?" p. 83.

$7.22 per hour, more than 6 percent above the national mean. From these results, it seems apparent that unionism among nurses (primarily RNs) on the national level is suffering from a puzzeling image problem. While it has been quantitatively demonstrated that unionism has secured financial gains from nurses, even those who have profited through representation frequently persist in the belief that they are not paid any more than "nurses in general."[105]

In 1977, Myron D. Fottler appraised the impact of unions on the wages of nonprofessional hospital employees in metropolitan areas from 1966 to 1972.[106] His analysis showed that the union impact had been significant, raising wages by about 4 to 8 percent, and that the impact had been greater in private rather than public hospitals. Fottler's findings confirmed the widely accepted belief that unions tend to organize the largest and most easily accessible hospitals, frequently clustered in metropolitan areas. Fottler also considered two other points in his discussion on the union impact on hospital wages.

Economic theorists tend to minimize the union impact in long run terms, preferring to emphasize market forces as the primary wage determinant.[107] Relevant to this argument of

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[105] Ibid.

[106] Myron D. Fottler, "The Union Impact on Hospital Wages," Industrial and Labor Relations Review 30 (April 1977), pp. 342-355.

[107] See Fottler, The Union Impact, p. 348, and David McCord Wright, ed., The Impact of the Union (New York: Harcourt-Brace, 1951), for a collection of several economic theorists' views of union vs. market force impacts on wage levels.

unionism versus labor market forces are the supply and demand functions in the nursing profession. In Michigan, the market for skilled nursing talent over the past several years has been such that significant shortage conditions on the aggregate level have existed. Because the question of the severity of the nursing shortage is such a complex one, it is not fully addressed here, other than to state that "real shortages" as opposed to surplus conditions have existed. These prevailing conditions would certainly support the conclusion that labor market conditions cannot be discounted or excluded when considering the various conditions impacting nursing salaries.

It is also impossible to definitively measure the impact of unionism on the nursing profession in any type of controlled laboratory-type setting. The preceding discussion on the methodology of the MSU Survey brought to bear an emphasis on the fact that the basic rationale for evaluation and research is to provide information for action, and that in real world settings, indefectible research methodologies are not always possible. Given this fact, it is important to consider that although hospital unionism is a relatively recent phenomenon, it cannot be isolated or reduced to terms that permit clearly delineated and mutually exclusive comparisons of employment conditions in unionized and nonunion settings. The mere coexistence of union and nonunion facilities renders such comparisons impossible. Spillover effects, specifically the decisions that result from the threats of unionism to nonunion

facilities, are difficult (if not impossible) to measure. To the extent that nonunion employers' decisions and policies regarding their employees are based at least partially upon the reaction to the threat (either real or imagined) of impending union organization efforts in their facilities, the comparison of wage levels and employment conditions in union and nonunion hospitals must certainly understate the union impact.[108] Additionally, studies that concentrate on wages, readily lending themselves to relatively limited quantitative comparisons rather than total employment conditions may fail to fully reflect the actual employee preferences concerning unionism. A case of this was evident in Lucas' 1980 survey, when 45 percent of the nurses surveyed who were represented in collective bargaining agreements and maintained salary levels that were 6 percent above the aggregate mean indicated that they did not feel union representation had been financially advantageous for them. In this case, merely examining mean salary levels would fail to provide a valid evaluation of employee preferences.

Table 15 compares the mean hourly salaries of unionized and nonunion full-time general duty RNs, LPNs, and aides employed in Michigan hospitals responding to the MSU Survey. General duty RNs, the most skilled of the three nursing positions examined in Table 15, maintained higher average mean and maximum salaries in nonunion hospitals. Average minimum

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[108]Fottler, "The Union Impact," p. 350.

TABLE 15

HOURLY SALARY LEVELS OF UNIONIZED AND NONUNION FULL-TIME RNS, LPNS, AND AIDES EMPLOYED IN MICHIGAN HOSPITALS, 1979

Nursing position	Unionized[a]	Nonunion[a]	Differential[b]	Totals[a]
General duty RNs				
Average minimum	$6.54 (39)	$6.41 (83)	+13	$6.45 (122)
Average maximum	$7.75 (39)	$7.92 (79)	-17	$7.87 (118)
Average mean	$7.11 (34)	$7.35 (69)	-24	$7.27 (103)
LPNs				
Average minimum	$5.08 (46)	$4.87 (78)	+21	$4.95 (124)
Average maximum	$6.02 (46)	$6.09 (75)	-07	$6.06 (121)
Average mean	$5.58 (36)	$5.43 (67)	+15	$5.48 (103)
Aides				
Average minimum	$4.18 (51)	$3.78 (70)	+40	$3.95 (121)
Average maximum	$4.96 (51)	$4.66 (66)	+30	$4.79 (117)
Average mean	$4.59 (41)	$4.33 (60)	+26	$4.44 (101)

[a]Parenthetical numbers indicate the number of observations the averaged figures are based on.

[b]Column figures indicate the differential in cents between the unionized and nonunion hourly salaries, and are calculated by subtracting the nonunion figures from the union figures. Thus, a +13 indicates that union hourly salaries are an average of thirteen cents per hour higher than nonunion salaries in the same category.

SOURCE: MSU Survey Data.

salaries among RNs were higher in unionized facilities. Average minimums for both LPNs and aides were also higher in unionized facilities. From this evidence, it seems apparent that union representation has proved to be demonstratably advantageous for nursing personnel at all three skill levels in terms of winning increased minimum or starting salary levels. While unionism has made inroads in increasing the various minimum salary levels, its performance in securing corresponding increases in salaries over and aside from the average minimums for the unionized nursing personnel has been largely inefficacious. As was previously mentioned in discussing the spillover effects of unionism, the performance of unions in securing overall salary increases in the nursing professional and hospital industry is veritably impossible to measure. However, the performance of unions in Michigan hospitals in securing salary increases for unionized nurses -- particularly those at the higher skill levels -- above nonunion nurses has not been particularly good.

Nonunion RNs had higher average mean and maximum hourly salaries than their unionized counterparts. Nonunion RN mean hourly salaries were 3.4 percent above comparable union figures. Nonunion RN average maximum hourly salary levels were 2.2 percent above comparable union figures. Average minimum salaries among nonunion RNs were 2 percent less than unionized RNs.

Nonunion LPNs maximum hourly salaries were 1.2 percent higher than their unionized counterparts. Unionized LPNs'

mean and minimum salaries were 2.8 and 4.3 percent above the comparable nonunion figures, respectively. From these aggregate figures, it seems fair to assume that unionization has had more positive results in securing salary increases for LPNs than it has RNs. However, average maximum salary levels among LPNs were higher in nonunion settings.

In each nursing category, union members reported average minimum salaries that were between 2 and 10.6 percent higher than their nonunion counterparts. However, average maximum salary levels among the RNs and LPNs were high in nonunion facilities, as was the mean RN salary. This data supports the conclusion that unions have been successful in winning better minimum wages, and better wages in general among lower skilled employees in the nursing field (within hospitals), but have not demonstrated widespread effectiveness in securing further increases among higher skill level nursing personnel.

An examination of the spread in salaries between nursing levels also leads to some interesting conclusions. The mean hourly RN salary was 32.7 percent above the mean LPN salary, which was 23.4 percent above the mean aide salary. However, the (total) average LPN salary was 19.4 percent more than that of the average unionized aide. Undoubtedly, as the difference between the aides and LPNs respective salary levels becomes less, the substitution of LPNs for aides will become more common. Economic theory would dictate that decreasing the salary differentials between the three nursing skill categories

examined in Table 15 would lead to increasing attempts by hospitals to affect nursing staff mixtures favoring more highly skilled or educated personnel, and substantially limit the demand for less skilled nursing personnel (within the hospital sector). Theoretically, if union representation was successful in winning salary increases for LPNs that were substantial enough to put them in the same salary bracket with RNs, there would logically be a substitution effect toward RNs and away from LPNs (at least insofar as attempts by hospitals to attract more highly skilled nursing personnel are concerned). Continued advances in the aide salary levels as a direct result of union representation efforts could trigger such a substitution effect (encouraging administrators to employ more LPNs and fewer aides). For all practical purposes, the results obtained through the MSU Survey indicate that unionism may be in danger of effectively pricing itself out of the labor market in the one area that it seems to have been most successful (the aide category). Increasing salary compression between skill levels is bound to lead to increasing substitution effects in the relevant labor markets favoring more highly skilled personnel. Additionally, substantial financially quantifiable benefits received by one nursing position or level are bound to enhance the bargaining position of the nurses in higher skill positions. For example, if aides were to win substantial salary increases through their collective bargaining efforts, LPNs employed in the same facility would be able to lay claim to the argument that their larger investments in

terms of training, and their wider range of technical abilities entitles them to corresponding salary adjustments in order to maintain their superior position on the institutional salary schedule. In the event that LPNs were awarded salary increases based on this logic, RNs would then be in a position to perpetuate these bargaining demands. Ironically, in the hypothetical case, the nurses in a position to receive the spill-over effects from the initial wage settlement would benefit, yet the nurses actually bargaining for the initial wage increase could be running the risk of pricing themselves out of the labor market by drawing their salaries to levels competing with the next highest skill level. The MSU Survey findings indicate that this may be occurring in Michigan hospitals between aides and LPNs.

Another point to consider that is illustrated in Table 15 is that the major financial advantages stemming from union representation appear to be concentrated in the lower skill levels in the professional hierarchy, an area with little growth potential in the labor force.

Tables 16, 17 &18 further examine the union-nonunion salary levels of RNs, LPNs, and aides. Viewed in total, the findings illustrated in these tables are consistent with those reported in Table 15. In the three nursing staff categories examined in these tables, the only area visibly improved in terms of salary due to union representation is that of the aide. Unionized aides showed consistently higher average salary levels. However, the trend for RNs and LPNs is directly opposite this.

TABLE 16

UNION/NONUNION HOURLY RN SALARIES IN MICHIGAN HOSPITALS, BY HOSPITAL BED SIZE, 1979

Bed Size	Unionized[a]	Nonunion[a]
1-100 Beds		
Average minimum	$6.38 (+.26)	$6.12
Average maximum	$7.23	$7.41 (+.18)
Average mean	$6.82	$6.90 (+.08)
101-200 Beds		
Average minimum	$6.35 (+.12)	$6.23
Average maximum	$7.41	$7.52 (+.11)
Average mean	$6.92	$6.95 (+1.03)
201-300 Beds		
Average minimum	$6.90 (+.79)	$6.11
Average maximum	$8.22	$8.37 (+.15)
Average mean	$6.42	$8.34 (+.19)
301-400 Beds		
Average minimum	$5.93	$7.14 (+1.21)
Average maximum	$7.60	$8.71 (+1.11)
Average mean	$6.42	$8.34 (+1.92)
401-plus Beds		
Average minimum	$7.00	$7.15 (+.15)
Average maximum	$9.21 (+.31)	$8.90 (
Average mean	$7.92	$8.21 (+.29)

[a]Parenthesized figures indicate the difference in dollars between unionized and nonunion hourly salaries, and are calculated by subtracting the smaller hourly figure from the larger, and recording the difference in the column containing the larger figure in each category.

Note: See Appendix, Table D, for supplementary data on these wage levels.

SOURCE: MSU Survey Data.

TABLE 17

UNION/NONUNION HOURLY LPN SALARIES IN MICHIGAN HOSPITALS, BY HOSPITAL BED SIZE, 1979

Bed Size	Unionized[a]	Nonunion[a]
1-100 Beds		
Average minimum	$4.87 (+.27)	$4.60
Average maximun	$5.25	$5.88 (+.63)
Average mean	$5.02	$5.08 (+.06)
101-200 Beds		
Average minimum	$4.64	$4.76 (+.12)
Average maximum	$5.34	$5.80 (+.46)
Average mean	$5.13	$5.37 (+.24)
201-300 Beds		
Average minimum	$5.37	$5.37
Average maximum	$6.43 (+.04)	$6.39
Average mean	$5.91	$5.94 (+.03)
301-400 Beds		
Average minimum	$5.12	$5.30 (+.18)
Average maximum	$5.12	$5.47 (+.35)
Average mean	$5.55	$5.86 (+.31)
401-plus beds		
Average minimum	$5.75 (+.45)	$5.30
Average maximum	$7.70 (+1.25)	$6.45
Average mean	$7.02 ($1.03)	$5.99

[a]Parenthesized figures indicate the difference in dollars between unionized and nonunion hourly salaries, and are calculated by subtracting the smaller hourly figure from the larger, and recording the difference in the column containing the larger figure in each category.

Note: See Appendix, Table E, for supplementary data on these wage levels.

SOURCE: MSU Survey Data.

TABLE 18

UNION/NONUNION HOURLY AIDE SALARIES IN MICHIGAN HOSPITALS, BY HOSPITAL BED SIZE, 1979

Bed Size	Unionized[a]	Nonunion[a]
1-100 Beds		
Average minimum	$3.87 (+.37)	$3.50
Average maximum	$4.44 (+.25)	$4.19
Average mean	$4.14 (+.19)	$3.95
101-200 Beds		
Average minimum	$3.93 (+.10)	$3.83
Average maximum	$4.45	$4.73 (+.28)
Average mean	$4.21	$4.30 (+.09)
201-300 Beds		
Average minimum	$4.36 (+.61)	$3.75
Average maximum	$4.99	$5.01 (+.02)
Average mean	$4,69 (+.16)	$4.53
301-400 Beds		
Average minimum	$4.55 (+.37)	$4.18
Average maximum	$5.87 (+.76)	$5.11
Average mean	$4.98 (+.17)	$4.81
401-plus Beds		
Average minimum	$4.68 (+.11)	$4.57
Average maximum	$6.09 (+.32)	$5.77
Average mean	$5.74 (+.52)	$5.22

[a]Parenthesized figures indicate the difference in dollars between unionized and nonunion hourly salaries, and are calculated by subtracting the smaller hourly figure from the larger, and recording the difference in the column containing the larger figure in each category.

Note: See Appendix, Table F, for supplementary data on thses wage levels.

SOURCE: MSU Survey Data.

Table 16 illustrates the RN hourly salary levels of full-time general duty RNs in the hospitals responding to the MSU Survey. As would be expected, the salary levels generally increased with increasing bed sizes. Average minimum salary levels were from 12 to 79 cents per hour higher in the unionized 1-300 bed hospitals. Nonunion facilities in this size category paid consistently higher mean and maximum hourly salary levels. Nonunion hospitals in the 301-400 bed range reported substantially larger minimum, maximum and mean hourly salaries; over one dollar per hour in each case above the corresponding union figure.

The largest hospital size category — the 401-plus bed hospitals, showed an exception to the trends that were consistent in the other facilities. Unionized hospitals in the 401-plus bed category had higher average maximum salaries, while nonunion facilities exhibited higher minimum and mean salary figures.

Table 17 illustrated the hourly salary levels among full-time hospital-employed LPNs. In the largest hospitals, unionized LPNs were receiving higher minimum, maximum, and mean salaries, ranging from 45 cents to $1.25 per hour above the comparable nonunion figures. However, in all the other hospital categories (1-300 beds), the nonunion LPNs were consistently paid higher salaries.

This data could be indicative of the overall strength of unionized LPNs. The larger hospitals, located in larger

metropolitan areas have proved to be relatively successful targets for LPNs in achieving their collective bargaining demands. Nonunion LPNs in every other hospital size category have reported higher LPN wage levels than their unionized counterparts.

Table 18 contains the full-time aide hourly salary comparison between hospitals with unionized and nonunion aides, based on the responses from the MSU Survey. The table examines the lowest of the three skill levels dealt with in Tables 16-18, and is illustrative of the success unionism has enjoyed in this nursing category in securing salary increases for its members.

As was the case with RNs and LPNs, aide salaries were larger in larger hospitals. The union-nonunion mean hourly salary spread was also the largest in the 401-plus bed size hospitals, indicative of the furthered success unionism has had in large metropolitan hospitals among aides.

Some mention should be made of the fact that the increasing and decreasing salary levels in all three nursing categories examined in Tables 16-18 are not necessarily solely due to the presence or lack of union representation. In each case, the salary levels tended to increase with increasingly large hospital facilities, regardless of the presence or absence of unions. However, in the case of the LPNs (Table 17), the non-union hospitals consistently reported higher wage levels in every size category except the largest (401-plus beds). In

this (401-plus bed) category, union wage levels were clearly higher, indicating that the impact of unionism on LPN salaries in the largest hospitals has indeed been significant. In the aide category, unionized facilities generally reported higher wage levels, regardless of the hospital size. Given this data, it would be reasonable to conclude that unionism has had its greatest direct impact on this nursing level. Within the largest hospitals, unionism among aides had its largest mean salary spread (52 cents per hour) over the comparable non-union facilities. This is indicative of the fact that hospital size as well as unionism figured prominently in determining these salary levels.

Lucas' 1980 income survey reported that full-time general duty nurses covered by AFL-CIO, Teamsters, state or federal employee unions, or other non-professional association contracts earned an average of 20 percent more than the mean for all full-time general duty nurses. Full-time general duty nurses covered by professional association contracts earned an average of only 3.4 percent more than the aggregate mean.[109]

Evidence confirming these findings in Michigan is mixed. Table 19 indicates that among RNs in Michigan hospitals, the non-professional associations have had more success in securing

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[109]Lucas' 1980income survey did add that the number of respondents identifying their specific bargaining organization was "too small to serve as the basis for a firm conclusion," and that the tendency of nonprofessional association collective bargaining agents to be located in major metropolitan areas may account for some of the salary differentials. Lucas, "What's Nursing Worth?" p. 83.

salary increases for their members than the professional Michigan Nurses' Association (MNA) has had in winning salary advances for its members.

TABLE 19

MSU SURVEY MEAN HOURLY FULL-TIME NURSING SALARIES BY BARGAINING AGENT TYPE AND NURSING POSITION, 1979

	Nonunion	Profes-sional assn.	Non-pro. assn.	Aggregate
RN	$7.35	$7.14	$7.46	$7.27
LPN	$5.43	$5.65	$5.53	$5.48
Aide	$4.33	--	$4.63	$4.44

Note: See Appendix, Table G-7 for supplementary data on these wage levels.

SOURCE: MSU Survey Data.

However, this conclusion is based on a relatively small sample (see Table 20), and many of the respondents indicating the MNA as the collective bargaining agent for their RNs were smaller hospitals, which were inclined to have lower overall average salaries.

According to the MSU Survey, the LPNs represented by their professional organization — the Michigan Licensed Practical Nurses Association (MLPNA), actually had higher mean hourly salaries than the LPNs represented by non-professional associations.

RNs represented by the MNA had lower mean hourly salaries than both the corresponding aggregate and nonunion figures. Table 20 indicates that a large percentage of LPNs represented by the MLPNA are employed in smaller hospitals. Only 7.1

percent of the MSU Survey respondents indicating the MLPNA as the bargaining agent for their LPNs were facilities of over 300 beds, while 26.6 percent of the respondents indicating non-professional associations or organizations as the representative for their LPNs were over 300 beds. Once again, consideration must be given to the fact that these figures (from Table 20) are based on a relatively small number of respondents, and are therefore open to challenge.

TABLE 20

RN AND LPN PROFESSIONAL/NON-PROFESSIONAL BARGAINING REPRESENTATIVE STATUS, BY HOSPITAL BED SIZE, 1979

	RN				LPN			
	MNA		Non-pro. assn.		MLPNA		Non-pro. assn.	
Bed size	#	%	#	%	#	%	#	%
1-100	8	33.3	1	16.7	4	28.6	11	36.7
101-200	6	25.0	2	33.3	4	28.6	7	23.3
201-300	6	25.0	1	16.7	5	35.7	4	13.3
301-400	2	8.3	-	-	1	7.1	1	3.3
401-plus	2	8.3	2	33.3	-	-	7	23.3
Total	24	99.9	6	100.0	14	100.0	30	99.9

SOURCE: MSU Survey Data.

Shift Differentials

The MSU Survey requested data on afternoon and night shift differentials in percentage-of-hourly-earnings and dollars-per-hour terms. Table 21 illustrates the findings arrived at through tabulating the responses to the questionnaire's shift differential inquiries.

TABLE 21

RN SHIFT DIFFERENTIALS ACCORDING TO UNION STATUS AND HOSPITAL SIZE, 1979

Bed Size / Shift	Percentage of Hourly Earnings			Dollars per Hour		
	Union	Nonunion	Total	Union	Nonunion	Total
1-100 Beds						
Afternoon	5.0	7.1	6.9	.35	.27	.29
Night	7.0	8.0	7.9	.42	.39	.40
101-200 Beds						
Afternoon	6.5	6.8	6.7	.42	.40	.41
Night	6.5	6.4	6.4	.45	.41	.43
201-300 Beds						
Afternoon	8.7	8.5	8.6	.61	.35	.46
Night	10.0	8.5	9.1	.75	.35	.50
301-400 Beds						
Afternoon	--	9.0	9.0	.25	.64	.56
Night	--	9.0	9.0	.50	.70	.66
401+ Beds						
Afternoon	9.3	6.5	7.0	.45	.43	.43
Night	11.3	6.5	7.4	.45	.45	.45
All Hospitals						
Afternoon	8.2	7.1	7.3	.42	.34	.37
Night	9.7	7.3	7.7	.48	.42	.44

SOURCE: MSU Survey Data.

As might be expected, the differentials tended to increase in size with corresponding increases in hospital bed sizes, thus reflecting the salary trends that vary with differing hospital sizes. However, the evidence supporting the conclusions that afternoon and night shift differentials (or premiums) tend to increase with increasing hospital sizes, or that RN shift differentials in RN-unionized hospitals are larger than comparable nonunion RN figures, is mixed.

The largest afternoon and night shift differentials reported in dollar terms were in the 301-400 bed hospitals. In percentage terms, the 301-400 bed range also had the highest total average (between afternoon and night shifts) differentials, at nine percent of the hourly wage. The smallest average percentage differentials were reported in the 101-200 bed hospitals. Dollar per hour differentials were the smallest in the 1-100 bed range. Data substantiating the shift differential figures is based on information provided by 131 of the 132 respondents, or 53.9 percent of the total survey population.

Viewed in terms of union-nonunion comparisons, the aggregate totals for both the percentage and dollar differential figures (in the bottom row of Table 21) indicated that unionized RNs are receiving afternoon and night shift premiums ranging from roughly one to 2.5 percent, or six to eight cents per hour larger than their nonunion counterparts. Further supporting the conclusion that union representation seems to have aided RNs in securing improved shift differential packages from their hospital employers is the fact that, with the

exception of the 301-400 bed hospitals (which only comprise seven percent of the total hospital population), three-quarters of the union-nonunion shift premium comparisons made in Table 21 indicated higher shift premiums being paid to unionized RNs. However, some evidence conflicting with this superficially pro-union data is also contained in Table 21, and cannot be ignored.

The MSU Survey respondents reported shift premiums in one of two methods, percentages or actual dollars (ten of the 131 responding hospitals provided shift premium data in both percentage and dollar terms). It is in the comparison of the reported percentage figures versus the corresponding dollar amounts that some conflicting signals arise. In the 1-100 bed category, nonunion hospitals reported hourly shift premiums from one to 2.1 percentage points higher than the comparable union figures. However, hospitals in the same category reporting their shift premiums in dollar terms indicated that the unionized RNs received three to eight cents per hour more than nonunion RNs. In the largest hospital size category (401-plus beds), inconsistencies exist between the dollar and percentage figures reported for unionized RNs. However, the comparable nonunion and total figures appeared to be consistent. While these curious configurations in Table 21 do not necessarily negate or nullify the conclusions arising from the table's contents, they do constitute a caveat regarding any unlimited or nonjudicious use of the relevant data.

Night shift differentials were consistently equal to, or higher than the accompanying afternoon figures. Nonunion 101-200 bed hospitals were the only facilities reporting afternoon shift premiums in excess of their night premiums. However, hospitals in the same category reporting in dollar per hour terms exhibited the normal trends — slightly higher union differentials, and night differentials slightly higher than the afternoon levels.

Among hospitals reporting shift differentials in percentage terms, the afternoon premiums ranged from four to eleven percent. Typical afternoon shift premiums fell into the five to ten percent range. In dollar terms, afternoon differentials ranged from five to eighty-five cents per hour, night differentials from five to fourteen percent, and ten cents to one dollar per hour. Three respondents indicated that they only offered a shift premium to RNs scheduled for the night shift; afternoon shift RNs being paid the regular rates.

MSU Survey respondents also indicated varying policies in awarding shift premiums to their nursing staff members. Three-quarters of the respondents indicated that their shift differentials were offered to RNs, LPNs and aides (i.e. no difference in the amount of the premium based on the nursing position was reported). Twenty percent of the respondents indicated that the shift premium differed with the nursing position (RNs receiving higher amounts than LPNs, who received higher amounts than aides). Two of the 132 respondents

indicated that they offered additional premiums for weekends worked. One respondent indicated a shift premium structure varying with both the nursing position, and whether the shift worked was a weekday or weekend. Only one respondent reported a shift premium formula steped according to seniority.

Educational Incentives

A relatively wide range of policies were reported by MSU Survey respondents regarding their nursing staff's academic backgrounds and their continuing education programs. According to the Survey responses, slightly more than half of the nurses held hospital diplomas, approximately thirty percent held associate degrees, and 12.4 percent had graduated from baccalaureate (nursing) programs. There appears to be an increasing competition on the part of hospital administrators to attract baccalaureate degree holders to their hospitals. The Survey questionnaire asked whether respondents granted starting salary incentives to baccalaureate general duty nurses above starting salary levels for nurses with hospital diplomas. Table 22 contains the responses to this question. Almost thirty-three percent of the respondents indicated that they did provide starting salary incentives to general duty RNs when the job applicant had a baccalaureate degree rather than a hospital diploma. There did not appear to be a great deal of difference between unionized and nonunion facilities in this practice. Nonunion hospitals in the 1-100 bed range

TABLE 22

HOSPITALS OFFERING STARTING SALARY INCENTIVES TO RNs WITH BACCALAUREATE DEGREES OVER HOSPITAL DIPLMAS[a]

Hospital Bed Size	Union		Nonunion		Totals	
1-100	1/16	6.2%	10.42	23.8%	11/58	19.0%
101-200	5/10	50.0%	4/13	30.8%	9/23	39.1%
201-300	5/ 8	62.5%	5/10	50.0%	10/18	55.6%
301-400	1/ 2	50.0%	3/ 6	50.0%	4/ 8	50.0%
400+	2/ 5	40.0%	6/16	37.5%	8/21	38.1%
Totals	14/41	34.1%	28/87	32.2%	42/128	32.8%

[a] Cell figures represent the number of hospitals offering incentives; the total number in each category, and; the individual cell percentages.

SOURCE: MSU Survery Data.

TABLE 23

HOSPITALS OFFERING STARTING SALARY INCENTIVES TO RNs WITH ASSOCIATE DEGREES RATHER THAN HOSPITAL DIPLOMAS[a]

Hospital Bed Size	Union		Nonunion		Totals	
1-100	0/15	-	6/42	14.3%	6/57	10.5%
101-200	0/10	-	1/13	7.7%	1/23	4.3%
201-300	0/ 7	-	0/10	-	0/17	-
301-400	0/ 2	-	0/ 5	-	0/ 7	-
401+	0/ 5	-	3/16	18.7%	3/21	14.3%
Totals	0/39	-	10/86	11.6%	10/125	8.0%

[a] Cell figures represent the number of hospitals offering incentives; the total number in each category, and; the individual cell percentages.

SOURCE: MSU Survey Data.

were more likely to offer the baccalaureate incentive than the comparable unionized facilities, but beyond the 1-100 bed range there was little difference in the offering of this benefit between the union and nonunion hospitals. Viewed in total, approximately one-third of the respondents indicated a strong enough desire to attract baccalaureate nurses, or willingness to compete with other facilities in recruiting these nurses, to be willing to offer financial incentives to them. The desire to recruit associate degree trained nurses did not appear to be as great.

Table 23 illustrates the MSU Survey respondents' collective willingness to offer starting salary incentives to associate degree nurses above the starting levels for hospital diploma nurses. Clearly, it was not as common to extend the policy of offering starting salary incentives to associate degree nurses as it was to baccalaureate nurses. Only eight percent of the respondents indicated that they offered the educational salary incentives to associate degree holders. The few nonunion hospitals replying that they did offer these incentives to associate degree nurses were either relatively small, or quite large facilities.

Almost two-thirds of the MSU Survey respondents indicated that they offered financial incentives to nursing staff members to increase their education while employed. Table 24 illustrates the Survey findings in this area. There appeared to be little difference between the union and nonunion

facilities in terms of the institutional policies in this area. The practice of offering financial assistance for continuing education efforts was also relatively common throughout the various hospital sizes, although the smaller facilities (1-100 beds) were somewhat less prone to offer benefits in this area.

TABLE 24

HOSPITALS OFFERING FINANCIAL INCENTIVES TO THEIR RNs TO INCREASE THEIR EDUCATION, BY HOSPITAL SIZE AND UNION STATUS[a]

Hospital Bed Size	Union		Nonunion		Totals	
1-100	9/16	56.2%	25/45	55.5%	34/61	55.7%
101-200	5/10	50.0%	10/13	76.9%	15/23	65.2%
201-300	8/ 8	100.0%	8/10	80.0%	16/18	88.9%
301-400	2/ 2	100.0%	4/ 6	66.7%	6/ 8	75.0%
401+	3/ 5	60.0%	11/17	64.7%	14/22	63.6%
Totals	27/41	65.0%	58/91	63.7%	85/132	64.4%

[a]Cell figures represent the number of hospitals offering incentives; the total number in each category; and the individual cell percentages.

SOURCE: MSU Survey Data.

Comments on the returned MSU Survey questionnaires indicated that a variety of the educational assistance plans were being offered. Cost reimbursement for relevant course work and loan assistance programs were the most frequently mentioned types of assistance. The amounts of assistance differed, from limited loan programs to extensive scholarship and reimbursement programs. A summary of the continuing education cost reimbursement programs is included in the Appendix.

Financial aid packages were generally designed on a per-semister or -term, yearly, credit hour basis, or some combination of these. In addition to conventional reimbursement formulas and/or programs, several unique methods of reimbursement were reported. However, most of the reimbursement or aid plans included three common aspects. First, prior administrative approval for educational expenses outside of the hospital-provided programs was normally necessary. Secondly, educational work had to be job or career related. Finally, while a few hospitals reported that they reimbursed nursing staff members for all direct and incidental expenses incurred in pursuing a program of continuing education, the standard hospital policy was to place a limit or ceiling on the amounts of assistance available. Beyond these three elements, several significant variations in the reimbursement plans were reported.

Three hospitals reported tuition reimbursements based upon the grade received in the particular course (in each case, no reimbursement was offered if a grade below C was earned). Several respondents' aid packages provided full or three-quarter reimbursement for full-time employees, and smaller prorated packages for part-time employees. One facility reported reimbursement levels of seventy-five percent for night shift nurses, and fifty percent for the afternoon shift (day shift reimbursements — if any — were not reported); an obvious effort to provide incentives for employees to work

odd-hour shifts. One plan provided for full-tuition refunds for up to forty-five credit hours to complete undergraduate or advanced degree nursing programs. However, the financial aid had to be repaid to the hospital if the degree was not completed within four years of the commencement of studies, or before the termination of employment with the hospital. No noticeible patterns were evident between the union and nonunion hospital continuing education reimbursement programs. One respondent whose RNs and LPNs were not unionized, but whose aides were (unionized), reported a reimbursement program covering seventy-five percent of costs with a ceiling of three hundred dollars per semester for the unionized employees (aides), and one-half of this (37.5 percent with a ceiling of three hundred dollars per semester) for part-time and/or nonunion employees. This was one case where union representation appeared to have financially improved the position of unionized nursing personnel relative to the nonunion nursing personnel at the same facility.

Work release programs, seminar and conference reimbursements (as well as travel and incidental expenses for these programs), and inservice programs were also frequently reported among the hospitals offering various assistance programs.

Fringe Benefits

The limited scope and size of the questionnaire makes it difficult to compare the specific benefit package offerings

on a union/nonunion basis. The questionnaire wording also limits such comparisons. The MSU Survey examined full- versus part-time benefit packages on the basis of what was offered to the entire nursing staff. No delineations were made between RN, LPN, and aide benefit packages. Because many of the unionized facilities were actually only unionized by one or two, rather than all of the nursing categories, many blanket union versus nonunion comparisons are difficult on the basis of the MSU Survey information alone. However, among hospitals reporting all their nursing categories (RNs, LPNs, aides) as unionized, 75.9 percent indicated that part-time nurses were offered a fringe benefit package prorated on an "hours worked" basis, and 13.8 percent indicated that part-time nurses were offered a reduced fringe benefit package not calculated on an hours worked basis. The remaining 10.3 percent either did not reply to the fringe benefit question, or indicated other methods of calculating their nursing fringe benefit packages.

Tables 25 and 26 illustrate the findings of the MSU Survey on the methods with which full- and part-time benefit packages were calculated (it assumes full-time employees receive complete or full-time benefit packages). Table 25, examining part-time nursing fringe benefit packages, indicates that part-time nursing personnel received full-time benefit packages prorated on an hourly basis in 68.2 percent of the hospitals.

TABLE 25

PART-TIME NURSING PERSONNEL FRINGE BENEFIT PACKAGES BY HOSPITAL BED SIZE, 1979.

Part-time fringe benefit package (FBP) status	1-100 beds	101-200 beds	201-300 beds	301-400 beds	401+ beds	TOTAL
Not offered a FBP	1	1	1			3
Offered a FBP prorated on an hours worked basis	45	14	13	6	12	90
Offered a smaller FBP than full-time, but not calculated on an hours worked basis	7	3	2	1	6	19
Offered full-time FBP if desired; must make individual financial contributions	1	1				2
Offered full-time FBP; no financial contributions required	2				1	3
Info. not given	3	1	1		1	6
Other	2	3	1	1	2	9
Totals	61	23	18	8	22	132

SOURCE: MSU Survey Data.

TABLE 26

FULL AND PART-TIME HOSPITAL NURSING PERSONNEL FRINGE BENEFIT PACKAGE SELECTION POLICIES BY UNION STATUS, 1979

Nursing personnel offered a choice in the selection of their benefit package	Non-union	Unionized Nursing Personnel							TOTALS
		RNs LPNs aides	RNs only	LPNs only	aides	RNs LPNs	RNs aides	LPNs aides	
full and part-time	20	16	2			1	1	8	48
full time only	3	1			1				5
part-time only		1							1
no choice offered to full or part-time	43	16			6	4	1	4	74
info. not provided	3							1	4
TOTALS	69	34	2	0	7	5	2	13	132

SOURCE: MSU Survey Data.

This was more than four times the next most common method, which was the assignment of smaller benefit packages (not calculated on an hours worked basis) than the full-time nurses received. A total of 14.4 percent of the responding hospitals reported such arrangements.

Only 2.3 percent of the MSU Survey respondents reported offering part-time nursing personnel the standard full-time benefit packages without any additional financial contributions or copayments from the recipients. Another 2.3 percent of the respondents indicated that part-time nursing personnel were not offered a fringe benefit package. However, in two of these reported cases, respondents indicated that their benefits were only withheld if employees worked less than twenty and thirty hours per week, respectively.

Not all of the respondents calculated their benefit packages according to one of the formulas given in the questionnaire. In 6.8 percent of the reported cases, a combination of the choices in question thirteen of the MSU Survey questionnaire were indicated. All but one of these cases indicated that part-time nursing personnel were offered their choice of a reduced and prorated package, or a standard full-time package under the condition they make additional financial contributions or copayments.

Because of the extremely wide range of employee benefits available, ranging from subsidized parking privileges to vacations and health insurance programs, the MSU Survey did

not request listings of specifically offered benefits. Rather, the formula with which the benefits were distributed between full- and part-time nursing personnel (previously described), and the degree of choice in the selection of the benefit package was investigated.

Table 26 illustrates the findings of the MSU Survey regarding the degrees of selectivity available to full- versus part-time nurses in choosing the mixture or makeup of their benefit plans. Approximately 56 percent of the MSU Survey respondents indicated that they did not offer any choice in the selection of their nursing fringe benefit packages. Almost 41 percent of the respondents indicated that they did offer a choice to their nurses in the selection of their respective benefit packages. Of the nonunion (no unionized nursing personnel) respondents providing information in this area, 30.3 percent allowed both full- and part-time nurses some choice in the selection of their benefit package, 4.5 percent only offered a choice to full-time nurses, and 65.1 percent did not offer any choices. Of the respondents with one or more division of nursing personnel represented by a union, 45.2 percent reported offering both full- and part-time nurses some choice in the selection of their benefit package, 3.2 percent only offered a choice to full-time nurses, 1.6 percent only offered a choice to part-time nurses, and 50.0 percent did not offer any choices.

Providing nursing personnel with some choice in the selection of their benefit package was more common in hospitals

with one or more unionized division of nursing personnel than in the nonunion (nursing) hospitals.

Only five of the 132 respondents (3.8 percent) indicated that they only offered a choice in the selection of their benefit packages to full-tine nurses. Less than one percent replied that they only offered a choice to part-time nurses. Respondent comments indicated that various health insurance policies (generally HMOs versus traditional forms of coverage) were the most common option in the fringe benefit package.

Several respondents indicated that their life and long term disability insurance plans were either not offered to part-time nursing personnel, or were offered on a hours worked basis, requiring financial contributions from the part-time employees interested in receiving this benefit. Part-time employees were also required to make financial contributions to their medical and/or dental insurance plans in several institutions. Several options in health insurance coverage were reported, with part-tine nursing personnel frequently having to make some type of contribution to the plans.

There did not appear to be any significant difference between the hospitals of varying sizes in terms of their policies regarding the offering and selectivity in their fringe benefit packages.

Conclusions

Hospital wage and benefit levels are relatively low when compared with other major industries. Although rather

substantial differences exist in income levels between geographic regions across the country, average wage and benefit packages have not increased in correspondence with the expansion in the hospital industry that has occurred over the past fifteen years. However, the Great Lakes region in general, and Michigan in particular, is one of the highest paying areas in the country for nursing personnel. The MSU Survey data indicated that hospital-employed RNs in Michigan had hourly mean income levels that were approximately 7 percent above corresponding national levels.

The income potential for general duty RNs in Michigan hospitals is somewhat limited. MSU Survey data indicated that nursing income levels (for hospital-employed nurses) peak at roughly 20 percent above minimum, or starting levels. Several consequences seem to be directly linked to the low income levels and earning potential in the nursing profession.

The attrition rate in the nursing profession is inordinately high. It is difficult, if not impossible, to envision another profession in which approximately 40 percent of the practioners either abandon the occupation altogether, or leave the labor force for time spans frequently ranging from one to ten years. Although the limited earning potential is a major reason for such temporary respites from the profession, other factors are commonly cited in examining the profession's drop out rate. In the hospital sector, high stress levels, and the relative youth of nursing personnel that allows or

encourages substantial choice in pursuing alternative employment or career opportunities frequently plays a major role in nursing career choices. Besides relatively low income levels, the inability of many hospitals to successfully combat high turnover rates among their nursing personnal may be explained by the considerable shortage of nurses — particularly those at the higher skill levels — who are both able and willing to "sell" their services in the labor market. The labor shortage conditions necessitate employers' "bidding" against each other for the services of skilled nursing personnel, encouraging high rates of job mobility.

Wage levels may be correlated with several factors: hospital sizes, the type of hospital control, hospital locations, and union status. Consistent with national trends, MSU Survey data supported the conclusion that nursing salary levels generally increase with corresponding increases in hospital bed sizes. When categorized according to bed size, average nursing wage levels increased as much as 36 percent from the smallest (1-100 bed) to the largest (401-plus bed) hospitals.

In Michigan, state and federal hospitals had the highest average RN wage levels, followed by nonprofit, proprietary and locally controlled facilities; the latter two paying mean RN wage levels below the aggregate average. Lucas' 1980 income survey supported these findings. While some different hospital control categories were used, Lucas' results indicated that "community" and proprietary hospitals were at the

lower (below average) rungs of the wage scale, while university and non-profit facilities averaged from 3.1 to 7.1 percent above the aggregate mean hourly wage levels.

Nationally, evidence suggests that nurses represented by unions or professional associations have wage levels approximately 10 percent above their nonunion counterparts, and RNs represented by AFL-CIO affiliates, the Teamsters, state or federal employee unions, or other non-professional associations earn 20 percent more than the mean for all full-time general duty RNs. Nurses represented by professional associations only earned 3.4 percent more than the aggregate mean. It should be noted that the success unions have had nationally in obtaining wage increases may be partially explained by their tendency to place a relatively high priority on organizing large hospitals in metropolitan areas — facilities that tend to have higher pay scales regardless of their employees' union status.

In spite of the apparent quantitative advantages stemming from representation by unions and professional associations in collective bargaining, many nurses represented by unions and professional associations reject the idea that their involvement in the collective bargaining process has secured advantageous wage settlements. Forty-five percent of the nurses represented in collective bargaining agreements surveyed by Lucas felt that their collective bargaining efforts had not resulted in better than average wage settlements — although

their earnings were actually more than 6 percent above the national mean.

The MSU Survey data indicated that within the nursing hierarchy, union membership has been the most directly advantageous for aides, followed by LPNs and RNs. While minimum wage levels among unionized personnel were higher in each of the three skill levels, nonunion RNs exhibited higher average and maximum wage levels, and nonunion LPNs exhibited higher maximum wage levels. The data supports the conclusion that unionism among Michigan hospital-employed nurses has been most successful in securing wage increases at the low skill levels of the nursing hierarchy (aides and LPNs), and least successful among the more highly skilled nursing personnel (RNs). The major conclusion that may be drawn from this is that unionism in Michigan hospitals (among nursing personnel) may be in danger of effectively pricing itself out of the labor market. Continued advances in the wage levels of low-skill nursing personnel and corresponding increases in salary compression between the skill levels is bound to lead to increasing substitution effects in the nursing hierarchy favoring more highly skilled nursing personnel. At the same time, reductions in the low-skill nursing labor force could be expected. Hence, the paradox of unionism's current success in the nursing field; until unions achieve a similar degree of success in representing highly skilled nursing personnel, they run the risk of pricing their constituency out of the labor market.

Although unionized RNs reportedly received higher afternoon and night shift differentials than nonunion RNs, the differences were not significant enough to support any definitive conclusions supporting unions' success in acquiring superior differentials for their members relative to comparable nonunion packages. Like salaries, shift differentials tended to increase with increasing hospital (bed) sizes.

The educational backgrounds of nursing personnel were relatively stable across union and nonunion facilities. Approximately two-thirds of the hospitals responding to the MSU Survey offered some type of financial incentive or reimbursement to nurses choosing to increase or continue their education while employed. Once again, little difference was apparent in the practices in this area between union and nonunion hospitals. Roughly 33 percent of the respondents indicated that they provided a starting salary incentive or bonus for nurses with baccalaureate degrees (rather than nursing program diplomas). Fewer than 10 percent offered similar incentives to RNs with associate degrees rather than hospital diplomas.

V. NURSING UNION ACTIVITY IN MICHIGAN HOSPITALS

Introduction

The penetration of unionism into the Michigan hospital-nurse employment setting was examined in terms of the number of facilities that reported unionized nursing personnel, and their location (city size), type of control, size, and the number of full-time nursing positions the various labor organizations represented. By viewing the union and professional association membership data in these terms, it is possible to draw conclusions regarding the success unionism has had in organizing both institutions and numbers of employees.

The MSU Survey questionnaire requested the number of full-time nurses employed, plus the number of budgeted vacancies for each nursing position (head nurse, RN, LPN and aide). By combining these two figures -- the positions filled plus the positions vacant -- the number of full-time equivalent positions, or FTEs was arrived at. Forty-nine percent of the 243 hospital population provided FTE data, and tables categorizing the number of FTE positions in each nursing category by city size, hospital bed size and type of control are included in the Appendix.

Organizational Patterns

Table 27 indicates the numbers and percentages of FTE nursing positions represented by the various unions and state professional associations.

TABLE 27

UNION REPRESENTATION IN MSU SRUVEY RESPONDENTS BY NURSING CATEGORY

Labor Organizations	Number of Hospitals							
	Head RNs		RNs		LPNs		Aides	
	#	%*	#	%*	#	%*	#	%*
AFGE			2	1.5	3	2.3	3	2.3
AFSCME			2	1.5	15	11.4	22	16.7
INDEPENDENT			9	6.8	6	4.5	4	3.0
IUOE							1	0.7
TEAMSTERS			1	0.7				
MLPNA					14	10.6		
MNA	2	1.5	25	18.9				
OPEIU							2	1.5
SEIU					8	6.1	18	13.6
STEELWORKERS			2	1.5	3	2.3	3	2.3
TOTALS	2	1.5	41	31.1	49	37.1	53	40.1

SOURCE: MSU Survey Data

*Based on 132 MSU Survey responses.

TABLE 28

UNION REPRESENTATION OF FTE POSITIONS BY NURSING CATEGORY, 1979

Labor Organizations	Number & Percentage of FTE Positions							
	Head RNs		RNs		LPNs		Aides	
	FTEs	%	FTEs	%	FTEs	%	FTEs	%
AFGE			306	3.3	179	3.4	505	6.2
AFSCME			77	0.8	596	11.4	1896	23.2
Independent			304	3.2	207	4.0	578	7.1
IUOE							198	2.4
TEAMSTERS			177	1.9				
MLPNA					511	9.8		
MNA	16	1.3	2250	24.1				
OPEIU							45	0.5
SEIU					376	7.2	766	9.4
STEELWORKERS			5	0.1	36	0.7	33	0.4
Union Totals	16	1.3	3119	33.4	1905	36.6	4020	49.2
Nonunion Totals	1230	98.7	6229	66.6	3304	63.4	4106	50.8
AGGREGATE TOTALS	1246	100.0	9348	100.0	5209	100.0	8180	100.0

SOURCE: MSU Survey Data.

Only two responding facilities specifically mentioned that their head nurses were organized. Both of these hospitals reported that the Michigan Nurses Association (MNA) represented their head nurses.

Besides the state professional association (the MNA), four other national labor organizations and several independent organizations were reported as the collective bargaining agents for RNs. The American Federation of Government Employees (AFGE), the American Federation of State, County, and Municipal Employees (AFSCME), the International Brotherhood of Teamsters, Chauffers, Warehousemen and Helpers of America (Teamsters), and the United Steelworkers of America (Steelworkers) were reported by MSU Survey respondents as collective bargaining representatives for their RNs.

The Michigan Licensed Practical Nurses Association, which is the state professional association for LPNs, the AFGE, the AFSCME, Service Employees International Union (SEIU), and the Teamsters were reported as the representatives for LPNs (as well as local independent groups). The AFSCME and the MLPNA were the largest two representatives in terms of FTE positions represented.

The two state professional associations, the MNA and the MLPNA, appear to have experienced considerably differing levels of success in organizing their respective professional groups. According to the MSU Survey respondents, the MNA represents almost one-quarter (24.1 percent) of the RN FTE hospital

positions in Michigan. Moreover, 72.1 percent of the RN FTE positions that are unionized are represented by the MNA. Almost nineteen percent of the MSU Survey respondents indicated that the MNA was the RN collective bargaining agent in their hospital. The MLPNA does not appear to have been as successful. The MLPNA represents slightly less than 10 percent of the LPN FTE hospital positions in Michigan. Of the 1,905 unionized LPN FTE positions represented by MSU Survey respondents, the MLPNA only represented 26.8 percent, or slightly over one quarter of the unionzed LPN FTEs. Only 10.6 percent of the MSU Survey respondents indicated that the MLPNA was the LPN collective bargaining agent at their hospital.

Among the RNs, the MNA was clearly the most common, or largest representative in terms of hospitals and FTE positions represented. The AFGE was the next largest RN representative, although they only represented 3.3 percent of the total RN FTE positions, and were active in only two hospitals.

The AFSCME was reported as the largest representative of both LPNs and aides. Although theAFSCME represented aides in only four more hospitals than the SEIU (the second most common representative among the aides), they represented more than twice the number of aide FTE positions accounted for by the SEIU, indicating thatthey have been rather successful in organizing hospitals with relatively large numbers of aides. The aides were also represented in various hospitals by the AFGE, International Union of Operating Engineers (IUOE), Office

and Professional Employees International Union (OPEIU), and the Steelworkers, as well as several independent organizations. Aides were not represented by any "professional association," as was the case with the RNs and LPNs.

An examination of the aide unionization trends from Tables 27 and 28 indicates that the AFGE, AFSCME, IUOE and independent labor organizations have been active in hospitals with larger numbers of aides. Each of these organizations represented a larger percentage of FTE aide positions than they did hospital facilities. For example, the AFGE only represented aides in 2.3 percent of the responding facilities, yet these facilities accounted for 6.2 percent of the FTE aide positions. The OPEIU, SEIU and the Steelworkers exhibited an opposite trend. These three organizations were active in a larger percentage of facilities than they represented in FTE terms. For example, although the Steelworkers represented aides in 2.3 percent of the responding hospitals, they accounted for less than half of one percent of the FTE aide positions. The SEIU has fared a little better among the LPNs, accounting for 7.2 percent of the total FTE positions in 6.1 percent of the responding facilities.

Hospitals in cities with populations of 10,000-25,000 reported consistently high percentages of organized nurses. Respondents in this city size category reported the highest percentages of organized RNs and LPNs, and the percentage of respondents with unionized aides was approximately ten percent above the average for all the responding facilities.

TABLE 29

UNION STATUS OF MSU SURVEY RESPONDENT'S RNs, LPNs, AND AIDES BY LOCATION (CITY SIZE)

Hospital Nursing Staffs	City Size (in population) less than 10,000		10,000-25,000		25,000-50,000		50,000-100,000		100,000+		Totals	
General Duty RNs	#	%	#	%	#	%	#	%	#	%	#	%
Covered by a CBA[a]	14	25.0	9	40.9	3	25.0	5	29.4	10	40.0	41	31.1
No CBA	41	73.2	13	59.1	8	66.7	12	70.6	15	60.0	89	67.4
Info. not given	1	1.8	-	-	1	8.3	-	-	-	-	2	1.5
RN Totals	56	100.0	22	100.0	12	100.0	17	100.0	25	100.0	132	100.0
LPNs	#	%	#	%	#	%	#	%	#	%	#	%
Covered by a CBA	19	33.9	11	50.0	2	16.7	7	41.2	11	44.0	50	37.9
No CBA	36	64.3	11	50.0	9	75.0	10	58.8	14	56.0	80	60.6
Info. not given	1	1.8	-	-	1	8.3	-	-	-	-	2	1.5
LPN Totals	56	100.0	22	100.0	12	100.0	17	100.0	25	100.0	132	100.0
Aides	#	%	#	%	#	%	#	%	#	%	#	%
Covered by a CBA	16	28.6	11	50.0	4	33.3	9	52.9	13	52.0	53	40.0
No CBA	39	69.6	11	50.0	7	58.3	8	47.1	12	48.0	77	58.3
Info. not given	1	1.8	-	-	1	8.3	-	-	-	-	2	1.5
Aide Totals	56	100.0	22	100.0	12	99.9	17	100.0	25	100.0	132	99.9

[a]Abbreviation for Collective Bargaining Agreement.

SOURCE: MSU Survey Data.

TABLE 30

UNION STATUS OF MSU SURVEY RESPONDENTS' RNs, LPNs, AND AIDES BY HOSPITAL BED SIZE

	Hospital Bed Size											
	1-100		101-200		201-300		301-400		400+		Totals	
General Duty RNs	#	%	#	%	#	%	#	%	#	%	#	%
Covered by a CBA[a]	13	21.3	13	56.5	8	44.4	2	25.0	5	22.7	41	31.1
No CBA	47	77.0	10	43.5	9	50.0	6	75.0	17	77.3	89	67.4
Info. not given	1	1.6	–	–	1	5.5	–	–	–	–	2	1.5
RN Totals	61	99.9	23	100.0	18	99.9	8	100.0	22	100.0	132	100.0
LPNs	#	%	#	%	#	%	#	%	#	%	#	%
Covered by a CBA	19	31.3	11	47.8	9	50.0	2	25.0	9	40.9	50	37.9
No CBA	41	67.2	12	52.8	8	44.4	6	75.0	13	59.1	80	60.6
Info. not given	1	1.6	–	–	1	5.5	–	–	–	–	2	1.5
LPN Totals	61	99.9	23	100.0	18	99.9	8	100.0	22	100.0	132	100.0
Aides	#	%	#	%	#	%	#	%	#	%	#	%
Covered by a CBA	19	31.1	11	47.8	10	55.5	2	25.0	11	50.0	53	40.1
No CBA	41	67.2	12	52.2	7	38.9	6	75.0	11	50.0	77	58.3
Info. not given	1	1.6	–	–	1	5.5	–	–	–	–	2	1.5
Aide Totals	61	99.9	23	100.0	18	99.9	8	100.0	22	100.0	132	99.9

[a]Abbreviation for Collective Bargaining Agreement.

SOURCE: MSU Survey Data.

The largest city size category (100,000-plus in population) includes (in descending order of population) Detroit, Grand Rapids, Flint, Warren, Lansing, Livonia, and Dearborn. The percentages of organized RNs, LPNs and aides was the second highest in this city size category. The percentage of organized nursing personnel reported by hospitals located in such cities was from approximately 6 to 12 percent higher than the cumulative average. Otherwise, the size of the city the hospitals were located in did not appear to have a significant effect on whether or not the facilities were unionized by their nurses. RNs in the other three city size categories in Table 29 were more nonunion than the cumulative average for all the responding hospitals. The facilities located in cities of less than 10,000 and 25,000-50,000 in population were the only ones reporting percentages of union LPNs below the cumulative average of 37.9 percent.

From Table 29, two generalizations may be made regarding the corollaries between the percentages of hospitals with unionized nurses, and their locations in terms of city sizes. First, hospitals located in the several largest cities in Michigan (with populations of over 100,000) tend to be among the most highly unionized in the state. Second, the nursing staffs in hospitals located in the smallest cities in the state tend to have the lowest rates of unionism; from roughly four to eleven percent below the average for the entire state.

Even fewer generalizations can be drawn regarding the relationship between the bed size of the facilities and whether

or not their nurses are organized for the purposes of collective bargaining. Table 30 illustrates the percentages of MSU Survey respondents with unionized RNs, LPNs, and aides according to the hospital bed size. The least amount of union representation among RNs appears to be in the 1-100 bed hospitals. These smaller hospitals also had relatively low percentages of unionized facilities in the LPN and aide categories, although the least unionized facilities (25 percent unionized and 75 percent nonunion) in the LPN and aide categories were the relatively large 301-400 bed hospitals.

Table 31 illustrates the percentage of MSU Survey respondents with unionized RNs, LPNs and aides according to the type of hospital control. The largest category were facilities controlled on a non-profit basis. Approximately 58 percent of the MSU Survey respondents were nonprofit facilities, and these hospitals reported from 2.5 to 6.7 percent fewer collective bargaining agreements with their RNs, LPNs and aides than the cumulative averages for all the respondents. The respondents under local or federal government control reported the highest levels of unionism. A substantially larger percentage of these two types of activities had collective bargaining agreements with their RNs, LPNs and aides. Respondents in the state and religious control categories reported the lowest numbers of hospital-nurse collective bargaining agreements. An exception in these two categories were the LPNs in the religious facilities. Only 37.7 percent of the total number of respondents

TABLE 31

UNION STATUS OF MSU SURVEY RESPONDENT'S RNs, LPNs, AND AIDES ACCORDING TO HOSPITAL CONTROL TYPE

	Type of Hospital Control							
	Pro-prietary		Non-profit		Religious		Federal Gov't.	
General Duty RNs	#	%	#	%	#	%	#	%
Covered by a CBA[a]	-	-	22	28.6	2	22.2	2	50.0
No CBA	1	100.0	54	70.1	7	77.8	2	50.0
Info. not given	-	-	1	1.3	-	-	-	-
RN Totals	1	100.0	77	100.0	9	100.0	4	100.0
LPNs	#	%	#	%	#	%	#	%
Covered by a CBA	-	-	24	31.2	4	44.4	3	75.0
No CBA	1	100.0	52	67.5	5	55.5	1	25.0
Info. not given	-	-	1	1.3	-	-	-	-
LPN Totals	1	100.0	77	100.0	9	99.9	4	100.0
Aides	#	%	#	%	#	%	#	%
Covered by a CBA	-	-	27	35.1	2	22.2	4	100.0
No CBA	1	100.0	49	63.6	7	77.8	-	-
Info. not given	-	-	1	1.3	-	-	-	-
Aide Totals	1	100.0	77	100.0	9	100.0	4	100.0

[a]Abbreviation for Collective Bargaining Agreement

SOURCE: MSU Survey Data.

TABLE 31 - Continued

State Government		Local Government		Other		Info. not given		Totals	
#	%	#	%	#	%	#	%%	#	%
2	20.0	13	52.0	-	-	-	-	41	31.1
8	80.0	11	44.0	4	100.0	2	100.0	89	67.4
-	-	1	4.0	-	-	-	-	2	1.5
10	100.0	25	100.0	4	100.0	2	100.0	132	100.1
#	%	#	%	#	%	#	%	#	%
3	30.0	16	64.0	-	-	-	-	50	37.9
7	70.0	8	32.0	4	100.0	2	100.0	80	60.6
-	-	1	4.0	-	-	-	-	2	1.5
10	100.0	25	100.0	4	100.0	2	100.0	132	100.0
#	%	#	%	#	%	#	%	##	%
4	40.0	15	60.0	1	25.0	-	-	53	40.1
6	60.0	9	36.0	3	75.0	2	100.0	77	58.3
-	-	1	4.0	-	-	-	--	2	1.5
10	100.0	25	100.0	4	100.0	2	100.0	100	100.0

reported collective bargaining agreements with their LPNs, but 44.4 percent of the religious hospitals reported LPN agreements. However, this was the only case in the religious or state hospitals in which more than the cumulative average of collective bargaining agreements were reported.

The one responding proprietary facility was a small hospital not unionized by any division of personnel.

Unsuccessful Organizing Attempts

The MSU Survey questionnaire requested information on whether or not the hospitals' nursing staffs had ever been represented by a collective bargaining agent other than the current representatives, and whether there had been any formal attempts by labor organizations to organize their nurses for the purposes of securing a collective bargaining agreement.

Twelve respondents reported that there had been organizing drives at their hospitals aimed at nursing personnel that had proved unsuccessful. Two respondents indicated that union organizing attempts were currently in process at the time of the MSU Survey. A summary of these efforts is included in the Appendix.

Three labor organizations were reported attempting to organize nursing personnel that were not indicated by any of the respondents as currently representing members of their nursing staffs. The United Food and Commercial Workers International Union reportedly attempted to organize nurses in a 174-bed non-profit hospital on two different occasions since

1973, but lost the representation elections both times. The International Association of Machinists and Aerospace Workers (IAM) reportedly tried to organize nurses at a 485-bed nonprofit hospital (whose aides were already represented by the IUOE), but the union lost the representation election. In 1975, an attempt was made to organize a 554-bed non-profit hospital by the Hotel, Restaurant Employees and Bartenders International Union, but the employees rejected the union. That facility reported formal organizing attempts by four different unions since 1971. One of these groups, the SEIU, attempted to organize the hospital's nurses on two different occasions, in 1972 and 1978. Two other facilities reported as many as four different labor organizations initiating organizing drives aimed at the nurses.

MSU Survey respondents reported the SEIU attempting and failing to organize nursing personnel at various facilities on eight separate occasions. The AFSCME reportedly attempted four different organizing drives resulting in failure (to win representation rights), with another drive in process at the time of the MSU Survey. The MNA, MLPNA, and the Teamsers were each indicated by respondents as initiating two unsuccessful organizing drives.

Of the fourteen facilities reporting a total of twenty-six unsuccessful or incomplete organizing attempts, ten (71.4 percent) were nonprofit. At least nineteen of the twenty-six reported incomplete or unsuccessful formal organizing attempts (73.1 percent) occurred in non-profit hospitals. One unsuccessful organizing attempt was reported in a state hospital;

one in a religious hospital, and one in a local government controlled hospital.

Almost half (46.1 percent) of the unsuccessful or incomplete organizing drives were reported by 400-plus bed hospitals. Hospitals in the 201-300 bed range reported 19.2 percent of the unsuccessful and/or incomplete attempts. Respondents in the 301-400 and 1-100 bed categories reported 15.4 and 16.5 percent of the unsuccessful and/or incomplete organizing drives, respectively. The lowest number of organizing drives was reported by the 101-200 bed hospitals. Only 7.7 percent of the total number of organizing drives were reported by these hospitals.

TABLE 32

UNSUCCESSFUL UNION ORGANIZING DRIVES BY YEAR AND HOSPITAL TYPE

Year	Hospital Type	Organizational Drives Number	Percentage
1971	non-profit	1	4.2
1972	"	1	4.2
1973	"	1	4.2
1975	"	1	4.2
1976	local gov't.	1	4.2
1977	non-profit	4	14.7
1978	"	6	25.0
	religious	1	4.2
1979	non-profit	1	4.2
. . . . .			
no	state gov't.	1	4.2
-date-	?	4	16.7
given	non-profit	2	8.3
Total		24	100.3

SOURCE: MSU Survey Data.

Table 32 matches the organizing drives with the years they took place. It does not include the two reported incomplete drives in progress at the time of the Survey.

Of the formal organizational attempts reported by MSU Survey respondents that are included in Table 32 and were reported with a specific date, 70.6 percent occurred since 1977. Initially, this might lead one to believe that union organizational activity has substantially increased in the past three years relative to the entire 1970-1980 period. However, seven of the Table 32 drives (included below the dotted line) did not include specific dates, and several other respondents reported that no formal records were kept of the union activity that had taken place at their institution. For these reasons, the Table 32 data undoubtedly represents an undercount of the formal union organization drives aimed at hospital nursing personnel, and the validity of the trend toward increasing activity in the past three years is also open to question.

Work Stoppages

The final question on the MSU Survey questionnaire requested whether the respondents had experienced any strikes or work stoppages by their nursing personnel. Sixteen respondents (12.1 percent) reported work stoppages by at least one division of their nursing personnel. A summary of the reported work stoppages is included in the Appendix.

The sixteen respondents reporting work interruptions indicated a total of eighteen separate incidents, and nine of

the incidents involved more than one division of nursing personnel (e.g., LPNs and aides).

Of the twenty-eight reported work interruptions by various divisions of nursing personnel (several occurring simultaneously within the same institution), eighteen (64.3 percent) took place in non-profit hospitals, six (21.4 percent) occurred in local hospitals, three (10.7 percent) were reported by religious hospitals, and one (3.6 percent) was reported by a state facility. No work stoppages were reported by federal or proprietary facilities.

Table 33 illustrates the chronological order of the reported work stoppages. Only two incidents were reported from 1979. However, it should be remembered that the MSU Survey was distributed between August and October of 1979, with usable responses from GDAHC affiliates returned as late as October 15, 1979. Thus, roughly 2.5 months in 1979 are not accounted for from any of the MSU Survey respondents belonging to the GDAHC in Table 33, and all non-GDAHC members were required to respond by August 31, 1979, so these respondents excluded any work stoppages from the final four months of 1979.

What Table 33 does show is that even with the probability of a 1979 undercount, 78.6 percent of the reported work stoppages have occurred since 1976 (an average of 5.5 per year). Only 21.4 percent of the total occurred in the preceding eight-year period of 1968 to 1975, an average of .75 incidents per year.

TABLE 33

YEARLY NURSING WORK STOPPAGES REPORTED BY MSU SURVEY RESPONDENTS

Year	Number	Percentage	Year	Number	Percentage
1979*	3	10.7	1972	1	3.6
1978	7	25.0	1971	2	7.1
1977	8	28.6	1970	1	3.6
1976	4	14.3	1968	1	3.6
1975	1	3.6	TOTAL	28	100.1

*Includes all work stoppages reported by non-GDAHC members occurring prior to August 13, 1979, and all stoppages reported by GDAHC members occurring prior to October 14, 1979.

SOURCE: MSU Survey Data.

This evidence points to a substantial increase in strike activity over the past five years. A logical conclusion arising from this data might be that there has been a notable increase in the militancy of nurses, or an increased willingness to resort to tactics including the strike to achieve bargaining demands.

The length of the work stoppages ranged from one shift to as long as thirty-three months (1,004 days). However, the thirty-three month stoppage was roughly twenty-nine months longer than the next longest strike. When the thirty-three month incident is included in the calculations, the average work interruption was 66.0 days. However, when the thirty-three month strike was deleted from the calculations, the average work stoppage dropped to 31.3 days, a more realistic figure. The median length work interruption was 25.5 days. Approximately twenty-one percent of the work stoppages were less than five days, while 39.3 percent were thirty or more days in length.

TABLE 34

NURSING WORK STOPPAGES (in days) ACCORDING TO HOSPITAL CONTROL, 1979

Type of Facility	Number of incidents	Average length	Median length	--Range-- Shortest	Longest	--Years-- Earliest	Latest
State/Local	5	6.76	2.0	1 shift	26	1970	1979
Nonprofit	11	113.4	30.0	13	990*	1972	1979

*Reported as 33 months. Figure of 990 days based on an average 3-day month.

SOURCE: MSU Survey Data.

Hospitals in the 101-200 and 401-plus bed category reported 28.6 percent of the work stoppages, and the 1-100 and 201-300 bed categories each reported 21.4 percent of the work stoppages. None of the eight respondents in the 301-400 bed category reported any work interruptions.

Agreement Durations

One hundred twenty-two MSU Survey respondents provided information on the length or duration of their hospital-nursing staff collective bargaining agreements. Agreement durations ranged from one to four years. In 84.4 percent of the reported cases, agreement lengths were two or three years. Half of the reported agreements were three-year contracts.

Five three-year agreements with two-year wage reopening clauses were reported. This amounted to 4.1 percent of the total number of reported agreements. The actual number of agreements with wage reopeners may be higher, due at least partially to the fact that the MSU Survey questionnaire did not specifically request whether the collective bargaining agreements did or did not contain wage reopeners.

RN, LPN, and aide collective bargaining agreement durations were relatively consistent. Roughly half of the agreements reported in each nursing category covered a three-year period. Approximately thirty to forty percent in each category were two-year agreements.

Years of Union Representation

MSU Survey subjects were asked to indicate the number of years their nursing personnel had been represented for the purposes of collective bargaining. Respondents with unionized aides reported the longest average number of years of representation, 8.68. LPNs had been represented for an average of 8.09 years, and RNs 7.58 years. Approximately one-half a year separated each of the averages. There was no substantial difference between the length of time the unions and the professional associations had represented their members. Table 34 illustrates the number of years the unions and professional associations have actively represented nurses in Michigan hospitals.

Local and federal hospitals have reportedly been unionized the longest of any of the reporting hospital control categories. Aides and LPNs in federal hospitals averaged 12.8 and 12.5 years of representation, respectively. State hospitals reporting unionized personnel indicated that aides have been represented an average of 3.5 years, RNs 2.5 years, and LPNs only one year.

The longest tenure or representation in terms of years was seventeen, reportedly by aides in a non-profit facility. In six of eleven possible cases (54.4 percent), federal hospitals responding to the MSU Survey reported that their RNs, LPNs or aides had been represented for fourteen or fifteen years, or "since '64." The advent of the labor organizations gaining

TABLE 35

COLLECTIVE BARGAINING AGENT TENURES BY HOSPITAL CONTROL TYPE, 1979

	Number Reporting	Average Number of Years
RNs		
Professional Association (MNA)	23	7.61
Union(s)	14	7.53
Totals	37	7.58
Hospital Type		
Nonprofit (nonsectarian)	18	7.08
Local	13	9.00
Federal	2	8.00
State	2	2.50
Religious	2	7.50
LPNs		
Professional Ass'n. (MLPNA)	11	7.91
Union(s)	37	8.15
Totals	48	8.09
Hospital Type		
Nonprofit (nonsectarian)	22	7.34
Local	16	9.19
Federal	4	12.50
State	3	1.00
Religious	3	9.00
Aides		
Union(s)	53	8.68
Totals	53	8.68
Hospital Type		
Nonprofit (nonsectarian)	26	8.35
Local	15	9.73
Federal	5	12.80
State	4	3.50
Religious	3	6.33

SOURCE: MSU Survey data.

recognition in these federal facilities was preceded by Executive Order 10988. The 1962 order signed into law by President Kennedy constituted the first official recognition on the part of the federal government that its employees were entitled to join unions and bargain collectively with the executive agencies forwhich they worked.[110]

Non-profit and religious hospitals generally reported average lengths of union representation by their nursing staffs that closely approximated the overall averages.

Professional Associations and Unions

When the American Nurses Association (ANA) was founded in 1896, one of its objectives was to "promote the usefulness and honor, the financial and other interests of the nursing profession."[111] However, it was not until fifty years later that the ANA formally developed a "Long-range, comprehensive program of collective action designed to attract and retain nurses in the profession, and improve their working conditions."[112] Prior to the institution of the so-called economic security program, recommendations to employers were the primary techniques used by nurses to improve their working conditions.[113]

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[110]Arthur A. Sloan and Fred Whitney, Labor Relations, 3rd ed. (Englewood Cliffs, N.J., 1977), p. 39.

[111]Kruger, "Bargaining and the Nursing Profession," p. 699.

[112]Ibid.

[113]Ibid.

Not surprisingly, this course of action proved to be largely ineffective. Efforts to obtain higher salaries, better working conditions and an improved status in the employment relationship were frequently viewed as unethical and/or unprofessional by nurses themselves.

In spite of the then-prevalent reluctance on the part of nurses to take collective action in an attempt to secure concessions from their employers, some nursing personnel were attempting to organize themselves for the purposes of bargaining collectively with their employers. According to a 1919 New York newspaper account: "Uncovering another sore in the body social, the hospital attendants of New York, whose occupation is one of the most backward in the ranks of professional labor, have decided to organize and to start propaganda showing up the degrading conditions under which they work . . . The work day is 12 hours; the wages $36 a month . . . meals are often unwholesome and the conditions of work dangerous . . ."[114] Union organizing leaflets (presumably discussing the same employees) described the employment conditions in hospitals as being "as difficult and tiresome, if not more, than work in any other trade . . . (attendants) do not get a minute of rest during their work . . . (and) are in danger of contracting the various diseases . . ."[115]

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[114]"Working in Hospitals: Then and Now," 1199 News (September 1976, special issue), p. 31.

[115]Ibid.

For the most part, the mass organizing drives of the 1930s and 1940s bypassed hospital employees.[116] Apparently fearful of inroads by burgeoning unions, the ANA recommended in 1937 that nurses not become members of unions at that time, maintaining that "in their professional associations nurses have the instruments best fitted and equipped to improve every phase of their working and professional lives."[117]

At the same time (1937-1938), organizing activity by trade unions was initiated among RNs, forcing the existing professional association affiliates to pay greater attention to their members' financial demands, and responded to the rapid changes in the nature of nursing care (from home service to institutional employment).[118] The new trade union competition led the ANA (in 1938) to urge its affiliated state associations to assume greater responsibilities in their jurisdictions for the development and implementations of standards regarding nursing and employment conditions of nurses.[119] District nurses' associations were to receive assistance from their state affiliates, who in turn received policy recommendations and

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[116]Major exceptions to the lack of union organizing drives in hospitals in the 1930s and 1940s occurred in San Francisco, where some hospital engineers and institutional workers were organized as early as 1936, and in Minneapolis-St. Paul, according to Miller in "Hospitals," p. 391; Levine, Unionization in Hospitals, p. 63.

[117]Kruger, "Bargaining and the Nursing Profession," p. 699.

[118]Miller, "Development of Bargaining," p. 135.

[119]Miller, "Development of Bargaining," p. 135; Kruger, "Bargaining and the Nursing Profession," p. 699.

information from the national association (the ANA).[120] This organizational framework for action met with little success.[121]

A major breakthrough in the aversion of nurses to organize to secure economic advances occurred during World War II. Up to this time, the state nurses' associations had been quite unsuccessful in obtaining hospitals' acceptance of association-established nursing wage scales. The national wage policy and wage freeze order of October 3, 1942, by President Roosevelt reinforced the hospitals' and state hospital associations' opposition to upward wage adjustments, adding another obsticle to improving nurses' economic status through the collective bargaining process. Among the resolutions adopted at the 1942 ANA convention was a measure urging the ANA and the National Leage of Nursing Education to assume the leadership in developing and implementing salaryschedules and personnel standards for general staff nurses.[122]

The California Nurses' Association petitioned the National War Labor Board (NWLB) for assistance in securing upward salary adjustments, acting "in full dignity as a professional organization and not as a labor union."[123] In 1943, the NWLB approved the increases sought by the CNA.[124] Following their success before the NWLB and responding to mounting attempts by trade

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[120]Kruger, "Bargaining and the Nursing Profession," p. 699.

[121]Ibid.

[122]Ibid., p. 700.

[123]Ibid.

[124]Miller, "Development of Bargaining," p. 135.

unions to organize RNs, the CNA signed its first collective bargaining agreement with San Francisco Bay area hospitals in 1946.[125]

The 1946 biennial ANA convention gave birth to the Economic Security Program, whose objectives were two-fold: "to secure for nurses, through their professional associations, protection and improvement of their economic security, reasonable and satisfactory conditions of employment, and . . . to assure the public that professional nursing service of high quality and in sufficient quantity will be available for the sick of the country."[126] The innovation of the Economic Security Program in an effort to improve economic conditions signified a shift in the ANA's approach to hospital-nurse employment conditions. Adopted unanimously at the 1947 convention, the Program signaled a new emphasis upon collective representation and bargaining to achieve economic demands. The evolving attitude of the ANA and its member nurses toward collective bargaining was illustrated in an editorial in the official publication of the ANA, pointing out that "collective bargaining is not to be confused with labor unionism. Collective bargaining is used by many organizations other than labor unions."[127] The ANA was moving toward assuming the responsibility for "advancing the

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[125] Ibid.

[126] Kruger, "Bargaining and the Nursing Profession," p. 700. The implementation of the 1946 Economic Security Program made the ANA the first major professional organization to endorse collective bargaining.

[127] Ibid.

social and economic security of nurses rather than leave it to organizations outside nursing."[128]

An examination of the events preceding the advent of the 1946 ANA Economic Security Program, and the official policy stances subsequently adopted by the organization is important for several reasons. For the first time, the ANA squarely confronted the issue of what approach they, as a "professional association" would take toward collectively negotiating with employers. Prior to this point, the extent of the ANA's policies regarding collective bargaining could be summarized in their position that nurses reject union membership because "professional associations" were more or better able to improve their working and professional lives. While the 1946 Economic Security Program constituted an official reconsideration of the ANA policy regarding collective action with employers, it hardly threw caution to the wind in delving into the brave new world of collective bargaining. The professional movement toward the advocacy of collective action to secure adjustments in economic and working conditions was couched in cautious language. Official ANA publications from 1946 attempted to spell out the differences between collective bargaining and labor unionism, still rejecting the latter in the form being practiced by trade unions, and perceived as a threat by the ANA.

Additions and refinements to the ANA Economic Security Program followed the 1946 convention. In 1948, the ANA advised

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[128] Ibid.

the state affiliates not to undertake economic security programs jointly with state hospital associations.[129] The advisement was based on efforts to encourage "responsible" relationships between employee organizations and employers, avoiding any "collusive relationships with the employer" by nurses or their representatives.[130]

The same year (1948) saw the ANA advise the state associations to avoid becoming party to agreements with employers unless the proper authorization from the nurses involved was obtained. The rationale behind this action was two-fold: such agreements were not likely to be held valid or enforcible if tested, and they were contrary to principles of democratic employee organization and representation before employers.[131]

Although the ANA was showing signs of moving toward a more democratic form of organization with the increasingly important role as the agent for nurses confronting their employers simultaneously evolving, their role as a "labor union," and competition with unions was continually eschewed. The ANA maintained that state associations should discourage nurses' memberships in other organizations whose activities were in direct competition with the Economic Security Program of the state associations.[132]

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[129]Miller, "Development of Bargaining," p. 136.

[130]Kruger, Bargaining and the Nursing Profession," p. 701.

[131]Ibid.

[132]Ibid.

At the 1950 ANA Convention, a "no-strike" policy was adopted. The policy asserted the ANA's belief that striking was contrary to professional nurses' responsibilities to patient care, and that their voluntary relinquishment of the strike as a negotiating tool should increase employers' obligations to recognize and deal justly with nurses regarding their employment conditions.[133] A policy of strike neutrality on the part of nurses regarding the labor-management relations between their employers and non-nurse employees was adopted. In disputes between the employers and non-nursing employees, the position adopted by the ANA defined the nurses' obligations as being limited to carrying out their normal duties "unless a clear and present danger" to the patients existed.[134] Essentially, RNs were not to serve as strike breakers.

The 1960s saw the ANA continue to slowly take on increasing characteristics associated with trade unionism. While they continued to assist local units organizing for collective representation, offered legal counsel, economic and labor-relations advise, and worked for favorable state legislation, the ANA clung to its "doctrine of personal responsibility" that rejected strike activity by their members. However, it was becoming increasingly apparent that the "moral obligations" for the codetermination of nursing wage levels and employment conditions between the nurses and their hospital employers that the ANA had hoped to substitute for strike action in their 1950

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[133]Ibid.

[134]Miller, "Development of Bargaining," p. 136.

no-strike policy was "frequently misunderstood or forgotten."[135] The ANA's belief that hospitals would not vigorously resist codetermination of wages and employment conditions if the nurses assumed a "professional approach" to collective bargaining turned out to be erroneous. Hospital authorities maintained that upward economic adjustments for nurses could not be provided beyond those initiated unilaterally by employers if the hospitals were to perform their primary functions.[136]

From 1960-1965, nurses were reported to have participated in only one work stoppage; in 1966, nurses engaged in six.[137] The 1968 ANA convention, held in May, resulted in a vote to terminate the eighteen year old voluntary no-strike policy.

The Michigan Nurses' Association (MNA) has been the state constituent of the ANA since 1909, but was slow to heed the ANA's enterance into collective bargaining activity (with the 1946 Economic Security Program). A program encompassing the activities of the ANA Economic Security Program was not instituted in Michigan by the MNA until 1954. Collective bargaining was regarded by the MNA as "a last resort to be used 'only where other approaches had failed'" as late as 1962.[138]

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[135]Miller, "Development of Bargaining," p. 222.

[136]Ibid.

[137]Work stoppages in 1966 were reported in San Francisco, Minneapolis, New York, Seattle, Chicago and Richmond, CA. Thomas R. Brooks, Toil and Trouble, A History of American Labor, (New York: Dell Publishing Company, Inc., 1971), p. 315.

[138]Stieber, Public Employee Unionism, p. 125.

The MNA's attitude toward, and policies regarding, collective bargaining activity changed with the advent of the 1965 Michigan Public Employment Relations Act. Following the Act, it became apparent that the nurses would be included in collective bargaining units that included nonprofessional hospital employees unless they acted through their own organization.[139] While the MNA had informally advised and consulted nurses in organizing and bargaining with their employers for approximately five years prior to the Michigan Public Employment Relations Act, they embarked upon formal negotiating activity in 1966, and were "fully committed to collective bargaining" by the end of that year.[140]

The MNA's evolving stance on collective bargaining has undoubtedly been heavily influenced by the increasing numbers of organizations (particularly unions) that have become involved in representing nurses on economic and/or employment matters. With real or perceived competition from outside organizations, and an increasing level of interest by nurses in the representatives available to them, the professional associations that previously steered clear of collective bargaining activity have had to assume roles as effective agents for their members. ANA affiliates in states beside Michigan have undoubtedly faced the same challenges.

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[139] Ibid.

[140] Ibid., and confirmed in a September 11, 1980 telephone conversation with Ms. Joan Guy, Executive Director of the MNA.

The Michigan Licensed Practical Nurses Association is the professional association representing LPNs in the State. The national association to which LPNs may voluntarily belong is the National Federation of Licensed Practical Nurses, Inc. (NFLPN). Many of the Federation's policies regarding collective bargaining are analogus to those previously promulgated by the ANA. They recognize the right of all hospital employees to bargain collectively with their employers through representatives of their own choosing, and take the position that an LPN's "legal right and ethical duty" in a hospital where a labor dispute has arisen is to continue to perform normal and necessary nursing services, but refuse to perform the duties of other employees except those immediately necessary to safeguard the life of patients.[141] Like the previous ANA policies, this essentially constitutes a refusal to serve as strikebreakers.

Like the ANA, the foundation of the NFLPN economic security program is the collective bargaining process, by which the NFLPN (through its state organizations) represents the individual members in securing improved economic conditions. Also like the ANA, the NFLPN views itself and its affiliates as the best representatives of LPNs in hospitals, rather than non-professional associations of hospital employees.[142]

Aside from the professional associations active representing nurses in Michigan hospitals, several nonprofessional

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[141]John M. Boyer, Carl L. Westerhaus, and John H. Coggeshall, Employee Relations and Collective Bargaining in Health Care Facilities, 2nd ed. (St. Louis: C.V. Mosby Co., 1975), p. 241.

[142]Ibid., pp. 242-243.

representatives act as the collective bargaining agents for Michigan RNs, LPNs, and aides. The wide number of organizations active in the field is typical of the national picture. Richard Miller has written that "Few industries reveal a greater number and variety of labor organizations than health care generally, and hospitals in particular."[143] Data from the NLRB on representation elections revealed that between August, 1974, and December, 1977, at least thirty-four different employee organizations participated in organizing activity.[144]

No single union has received a charter from the AFL-CIO to represent hospital workers, and, given the activities of organizations independent of the AFL-CIO, such a charter would be meaningless.[145] Several unions whose membership has historically been outside the health care area have found their way into the hospital industry. The Laborer's International Union of North America (LIUNA), Communication Workers of America (CWA), Hotel, Restaurant Employees and Bartenders International Union (HREBIU), Steelworkers, Paperworkers (UPIU), Meatcutters, and United Food and Commercial Workers International Union (formerly the Retail Clerks International Union), are all actively involved in organizing hospital employees on the national level.[146] The SEIU, District 1199, and AFSCME are the unions "most aggressively

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[143] Miller, "Hospitals," p. 394.

[144] Ibid.

[145] Ibid.

[146] Ibid.

seeking hospital members on the national level."[147] These three unions, along with the ANA, have the bulk of the public or private hospital employees as members, and accounted for nearly 75 percent of all hospital representation elections from the date of the Taft-Hartley amendments through December, 1977.[148]

The SEIU has the longest history among the unions in the hospital industry, organizing its first hospital bargaining unit in the mid-1930s, and is particularly strong in the West Coast and upper Midwest hospitals.[149] Although the SEIU has traditionally concentrated on nonprofessional hospital workers — including aides and orderlies — it is making strides to organize technical and professional employees, including RNs and LPNs.[150] The MSU Survey findings indicated that the SEIU was the second and third largest representative of aides and LPNs, respectively (Table 28). The SEIU-represented nurses included in the MSU Survey were members of the Union's Local 79. This is a "dispersed" local union, covering nursing personnel employed in a large number of facilities and organizations, as contrasted to a plant or local industrial union.[151]

Nationally, AFSCME and the SEIU compete for the leading position in terms of representing the largest absolute number of health care employees.[152] In Michigan, AFSCME holds the edge

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[147] Ibid., p. 395.

[148] Ibid.

[149] Ibid.

[150] Ibid.

[151] Ibid., p. 396.

[152] Ibid., p. 398.

over the SEIU as the largest representative of LPNs and aides. Unlike the SEIU, AFSCME has also been successful in organizing RNs in two of the MSU Survey respondents, accounting for slightly less than one percent of the total number of RN FTE positions reported by MSU Survey respondents.

None of the MSU Survey respondents indicated the other major national labor union representing hospital employees — the National Union of Hospital and Health Care Employees, District 1199 — as the representative for their nurses. District 1199 has its historical origins in New York City hospitals, and is particularly active in New York and along the East Coast states.

The American Federation of Teachers (AFT) has developed a health care division — the Federation of Nurses and Health Professionals (FNHP) — and has launched a national campaign aimed at organizing health care employees with a special emphasis on gaining new units of RNs.[153] Although no FNHP activity was reported by MSU Survey respondents, they have waged successful representation elections among previously nonunion nursing personnel in Colorado, Texas, Oklahoma, Wisconsin and Pennsylvania. RNs in Massachusetts and New York have replaced their states nurses' association (and ANA affiliate) with FNHP representation.[154]

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[153] "Union Zeroes in on Nurses: An Updated Scorecard," RN 42 (October 1979), p. 13.

[154] Ibid.

In another case of Teachers unions entering the nursing field, the Rhode Island State Nurses' Association leadership has suggested that their members merge their collective bargaining units with the Rhode Island State Federation of Teachers (RIFT).[155] Roughly half of the Association's total membership could be involved in the switch; unique due to the Association's initiating the move rather than the RIFT.

The teachers associations and unions have capitalized on two basic strategies to woo nursing personnel from the ranks of the professional association. The AFT and RIFT have hired "top nursing leaders" as well as field representatives from the economic and security programs of the ANA and state associations.[156] In the Rhode Island case, the RIFT is seeking collective bargaining representative status for the state nurses' association members, but is not contesting their continued membership in the association for professional reasons aside from collective bargaining. The unions have also effectively employed the argument that the professional association's commitment to collective bargaining simply has not kept up with their members' demands for strong representation at the bargaining table.[157] In advancing the argument that nurses need full-time professional labor representatives rather than nursing association representatives whose labor

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[155]"'Unionize,' Association Tells Members," RN 42 (November 1979), p. 11.

[156]Ibid.

[157]Cathy Beason, "Nursing's Labor Relations Crisis," RN 42 (February 1979), p. 21.

activities only occupy part (rather than all) of their responsibilities to their constituents, they have achieved increasing success in convincing nurses to resolve their conflicts over professionalism and unionism by "pursuing economic parity with other workers."[158] The professional association's counter-arguments that the unions are not really interested in nurses, but solely out to boost their membership (particularly in the case of teachers' unions, who face an economy demanding fewer teachers) are of little defense in the presence of "outmoded concept(s) of professionalism" that decline increasingly aggressive stances on collective bargaining.[159]

MSU Survey respondents indicating the MNA as the representative for their RNs reported that the MNA had acted as their RN bargaining agent for an average of 7.61 years. The corresponding figure for the labor unions representing RNs was 7.53 years, a difference of less than one-tenth of a year. Aggregate figures for the MLPNA and labor unions representing LPNs indicated that the unions had represented LPNs an average of approximately half a year longer than the MLPNA; 8.45 years to 7.91 years for the MLPNA.

The labor unions representing RNs reportedly have fared better than their MNA counterparts in securing wage advances for their members. Table 36 compares the labor union,

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[158] Ibid., pp. 21-22.

[159] Ibid., p. 22.

professional association and independent organization salaries for Michigan RNs and LPNs.

TABLE 36

MSU SURVEY RESPONDENT RN/LPN WAGE LEVELS BY TYPE OF BARGAINING REPRESENTATIVE, 1979

	Minimum	Maximum	Average
RNs			
MNA	$ 6.47	$ 7.64	$ 7.14
Labor Union	6.78	8.58	7.46
Indep. Org.	6.54	7.41	6.89
Non-union	6.41	7.92	7.35
LPNs			
MLPNA	$ 4.99	$ 5.84	$ 5.65
Labor Union	5.00	6.15	5.53
Indep. Org.	4.97	5.50	5.28
Non-union	4.87	6.09	5.43

SOURCE: MSU Survey Data.

The Table 36 data illustrates the mixed success the various types of collective bargaining representatives have had in Michigan hospitals.

Among RNs, the labor unions have been considerably more successful in obtaining wage advances than the professional MNA or independent organizations. Hospitals responding to the MSU Survey whose RNs were represented by a labor union had aggregate average (RN) salaries that were thirty-two cents per hour more than comparable MNA figures, and fifty-seven cents per hour above independent hourly figures. On a yearly basis, these differentials alone would amount to $665.60 (union versus MNA) and $1,185.60 (union versus independent organization);

certainly not insubstantial amounts. MSU Survey respondents with unions representing their RNs also reported higher hourly maximum and minimum RN wage scales than the comparable MNA and independent organization figures. However, the independent organizations were reported as having slightly higher average minimum salary levels that the MNA RNs.

The MLPNA appears to have had more success relative to the unions representing LPNs than the MNA has had competing with unions to secure wage increases for their respective constituencies. On the aggregate level, LPNs represented by the MLPNA averaged twelve cents per hour ($249.60 per year) more than union-represented LPNs, and thirty-seven cents per hour ($769.60 per year) more than the LPNs represented by independent organizations. Aggregate minimum or entry wage levels did not vary more than three cents per hour between the three bargaining representative types. Union-represented LPNs had the highest aggregate maximum hourly wages, followed by MLPNA-represented LPNs and independent organization members, whose aggregate maximum wages were $1,352.00 per year (excluding premiums and bonuses) below the union figures.

Hospitals indicating the MLPNA as their LPN representative reported average hourly LPN salaries of $5.65 per hour, twelve cents more than the comparable figures arrived at through calculating the average union-represented LPN salary. The unions have managed to negotiate higher maximum salaries, and almost identical minimum salaries to those reportedly being paid to MLPNA-represented LPNs.

Conclusions

MSU Survey results confirmed several commonly accepted beliefs concerning the union movement. In Michigan hospitals, labor unions have been most successful organizing larger hospitals with correspondingly large numbers of nursing personnel. Not surprisingly, hospitals located in relatively large cities also tend to be more highly unionized, while the nursing staffs of hospitals in smaller cities tend to have lower rates of unionism. Further evidence of unions' interests in organizing large facilities with more employees (and potential union members) was provided by MSU Survey respondents, who indicated that almost half the reported unsuccessful organizing drives taking place since 1970 have been directed at 401-plus bed hospitals.

Among the professional associations (the MNA and MLPNA) active in representing nursing personnel in Michigan hospitals, the MNA (representing RNs) appears to have met with considerably more success or acceptance than its LPN counterpart, the MLPNA. Almost one-quarter of the RN FTE positions were represented by the MNA. The MLPNA, while representing the second largest number of LPNs (behind the AFSCME) in Michigan hospitals, only accounted for approximately 10 percent of the LPN FTE positions. Roughly one-quarter of the unionized LPN FTE positions were represented by the MLPNA, while almost three-quarters of the unionized RN FTE positions were represented by the MNA, testament to the success of the MNA relative to the MLPNA.

Locally and federally controlled hospitals had the highest rates of unionism among nursing personnel, while state and religious hospitals exhibited the lowest overall rates of unionism (although LPNs in state hospitals were highly unionized).

If records of work stoppages between hospitals on differing control types are any indication, the legal prohibitions against striking in state and federal facilities have proved to be successful. Of the twenty-eight separate work interruptions reported by MSU Survey respondents, only one took place in a state facility, while none were reported by federal respondents. Work stoppages were most common in non-profit hospitals. If the cronological occurrence of the work stoppages is an appropriate indicator, militancy among nurses regarding their wage levels and employment conditions is on the increase. Almost 80 percent of the reported work stoppages have occurred since 1976.

Two- and three-year collective bargaining agreements were the most common in the profession, accounting for 84.4 percent of the reported agreements.

Perhaps one of the (minor) reasons for the particular success of unionism among aides relative to RNs and LPNs lies in the more extensive experience unions have had representing aides with hospital employers. A related issue partially explaining aides' collective bargaining success could be their ability to resort to firmer measures in dealing with employers

without violating professional ethics or tenets, a historically restraining influence on professional nurses. However, no specific aspects of the MSU Survey were designed to test this theory. Of the three nursing categories, MSU Survey data indicated that aides had been organized for the purposes of collective bargaining an average of slightly more than one year than RNs, and over half a year more than LPNs.

Local and federal hospitals had been organized by their nurses for the longest time periods of different control categories.

CHAPTER VI. COLLECTIVE BARGAINING STRUCTURES

Multiemployer Bargaining

Nationally, multiemployer bargaining across similar occupational groups in health care facilities has become increasingly common. This is particularly true in large cities.[160] Formal multiemployer units are common in San Francisco and in the Kaiser Permanente system in Northern California.[161] Multiemployer negotiating units comprised of RNs, LPNs and operating engineers have recently come into existance in Seattle, although single-hospital contracts for unionized hospital service workers continue in that city.[162] In Minneapolis-St. Paul, hospitals belonged to an association which acted as a bargainer for each facility, and each hospital signed an individual but nearly uniform contract. However, since 1974, their bargaining firm has negotiated a single uniform contract that covers as many as twenty-three hospitals and 5,000 workers.[163]

Multihospital units exist in private and proprietary hospitals in New York City that include as many as fifty-five hospitals.[164] However, collective bargaining between unionized RNs and LPNs and their hospital employers in New York City is still primarily done on a single-hospital unit basis.[165]

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[160]John A. Fossum, Labor Relations (Dallas, TX: Business Publications Inc., 1979), p. 417.

[161]Miller, "Hospitals," p. 411.

[162]Ibid.

[163]Ibid.

[164]Ibid.

[165]Ibid., p. 412.

Bargaining may be concurrent in a number of hospitals even though separate contracts are signed, or highly coordinated but without formal concurrent negotiations, as exists in Chicago. The SEIU and the Teamsters have jointly organized several Chicago hospitals under the umbrella or title of the Health Employee Labor Program. The HELP covers twenty-three Chicago hospitals.[166]

Only three respondents (2.3 percent) to the MSU Survey reported that they were involved in multiemployer bargaining with their nursing personnel. One of these respondents was located in a 50,000-100,000 inhabitant city in southeastern Michigan, but the other two respondents were in rural areas. Two of the multiemployer bargaining facilities were state institutions; the other was a non-profit hospital which reported having been involved in multiemployer bargaining since 1969. The state facilities reported three and "?" years of multiemployer bargaining.

Contrary to reported findings on the national level, none of the hospitals located in the state's ten largest cities responding to the MSU Survey reported any involvement with multiemployer bargaining with their nursing staffs.

A review of the nationally reported instances of multiemployer hospital bargaining suggests several conclusions regarding this practice. The multiemployer bargaining structures tend to evolve in urban areas where unions have

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[166]Ibid., p. 397.

been successful in organizing, and are able to exert significant bargaining power.[167] The key factor associated with multihospital bargaining structures seems to be union power.[168]

Because only three MSU Survey Respondents indicated that they were involved in multiemployer bargaining with their nursing personnel, and only two of those reported the length of time they have been involved in multiemployer bargaining arrangements, it is difficult to draw meaningful comparisons between multiemployer bargaining on the national and state levels. Information contained in the questionnaires indicated that the facilities involved in multiemployer bargaining and responding to the MSU Survey did appear to be exceptions to typical multiemployer bargaining situations. While one respondent's RNs, LPNs and aides had been unionized for ten years, it was located in a rural area. Another respondent's LPNs and aides had been unionized for one year, but the RNs were non-union. Between the three facilities, only one collective bargaining agreement with non-nursing personnel was reported. Hence, the exceptions to normal hospital characteristics associated with multiemployer bargaining: conditions not suggestive of tremendous union power, and facilities in rural or urban fringe areas.

In spite of the MSU Survey's contrasting findings on multiemployer bargaining (as opposed to single employer conditions), it seems logical to conclude that multihospital bargaining will

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[167] Ibid., p. 412.

[168] Ibid.

become increasingly common in the future. Economic pressures to share activities, standardize wages and employment conditions, and consolidate hospital functions across metropolitan areas are all pointing toward continued increases in the degree of integration in hospital management.[169] The MSU Survey and a review of Michigan hospital organizational configurations bear this out. However, until hospitals and nurses' unions are able to generate more power than they currently exercise, it seems doubtful that hospital representatives at the bargaining table will be willing to relinquish their individual discretion in exchange for possible advantageous positions that might accrue from the solidarity of group representation.[170]

Pattern Bargaining

Although only three MSU Survey respondents indicated that they were involved in formal multiemployer bargaining, considerable evidence suggests the existance of a system of de facto multiemployer bargaining. Richard Miller has referred to these arrangements as "orbits of coercive comparison" in which the impact of agreements between actual negotiating units extends to other divisions of the hospital as well as other hospitals.[171] One union's achievements in negotiating a settlement will not go unnoticed by other unions for very long. Nor are Miller's orbits of comparison limited to

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[169] Ibid.

[170] Ibid., p. 413.

[171] Ibid.

unionized employers. Unorganized employees in a partially unionized hospital, or hospitals in which none of the employees are covered by collective bargaining agreements, are also potential satellites in the orbits of comparison.

The spillover effects of union settlements on nonunion employees (particularly within the same hospital) present significant difficulties in arriving at an accurate measurement of the union impact on the industry or profession wage levels. In assessing the union impact on hospital wages, Myron Fottler was careful to note the difficulty in measuring employer wage decisions resulting from spillover effects, or the threat of unionism.[172] To the extent that nonunion employers' reactions to threats of unionism exist and wage increases are used to forestall unionization, comparisons between union and nonunion rates may understate the union impact. However, it is also possible (in theory) for employer resistance to unions to be strong enough to negate any union pay-raising impact. Collective bargaining could exist and lead one to believe that unions had won something. However, the employers might have offered less than they really intended to pay and the union demanded more than that figure, but settled for a somewhat higher amount, seemingly indicative of a union bargaining victory. But the outcome might be equivalent to what the employer would have unilaterally settled upon without a union.[173] Miller speculated that in

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[172]Fottler, "The Union Impact," p. 350.

[173]Mitchell, Unions, Wages and Inflation, p. 77.

pattern bargaining, the most crucial effect of negotiated settlements would be on nonunion hospitals, given their attempts to remain equitable with, or ahead of union-negotiated settlements as a response to the possibility of being unionized themselves. This would be particularly true in metropolitan areas with large numbers of hospitals following a leader in negotiating and responding to "so-called 'threat' effects."[174]

Cartelization is characteristic of the hospital industry. Seventy-five to 80 percent of the hospitals in the United States are affiliated with the American Hospital Association, which is organized into state (and sometimes smaller geographic area) associations. Local AHA affiliates and councils frequently act as focal points for coordinating bargaining and labor relations strategies and exchanging information relevant to organizing drives, contract negotiations and employee actions. The AHAs personnel division, the American Society for Hospital Personnel Administration, is also broken down into state and local groups, and provides further possibilities for exchanging information and coordinating labor relations activities.

The high incidence of hospital employer organization has resulted in combinations with employee organizations that facilitate the linkage of one settlement to another within and between hospitals, and establishes a basis for integrating or applying individual bargaining outcomes to wider settings, including union and nonunion entities.

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[174]Miller, "Hospitals," p. 413.

Conclusions

Although multiemployer bargaining between hospitals and nurses is becoming increasingly common - particularly in major metropolitan areas - little evidence of the practices was uncovered by the MSU Survey. Much to the contrary, of the three reporting facilities indicating some involvement with multiemployer bargaining, two were located in rural areas, further contradicting national trends.

While formal multiemployer bargaining in Michigan hospitals appears to be quite uncommon (based on MSU Survey data), conditions do exist that suggest a more informal type of linkage between the bargaining processes at different facilities. The fact that one union's (or hospital's) success in negotiating a collective bargaining agreement will not go unnoticed by other parties for very long suggests that bargaining outcomes are at least informally linked. The infrastructure of the hospital industry lends itself to the free exchange of data between constituent units (hospital organizations, individual facilities, professional groups, etc.) designed to aid organizations in negotiating favorable bargaining agreements. In the same token, labor or professional associations representing hospital employees may also cooperate in exchanging relevant bargaining information, although their infrastructure may not be organized to facilitate the unimpeded flow of data to the extent that the hospital industry's is.

CHAPTER VIII.
LEGAL ASPECTS OF HOSPITAL-NURSE COLLECTIVE BARGAINING

Hospital Labor Relations Legislation

In 1969, Ann Sommers noted that "hospitals have been historically exempt from most taxes, labor legislation, and other burdens imposed on other enterprises of their size and wealth."[175] When viewed from a historical perspective, this is largely true. However, in the past few decades, the nature of the hospital industry's regulatory exemptions have undergone substantial changes. The very incidence of unionism and its economic power derived through the use of collective bargaining is a "function of the legal framework setting forth employees' rights to organize, bargain, and engage in collective job actions."[176] Given this relationship of economic power among organized labor tied to the prevailing legal framework, the importance of policies and regulations flowing from the legal structure governing the industry becomes obvious. The diversity of political jurisdictions or authorities the hospital industry operates under clearly impacts the legal framework for regulating the industry's and related profession's labor-management relations. Richard Miller has broken the legal framework governing hospital labor relations into three major systems: hospitals under federal public sector law; nonfederal

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[175] Sommers, Hospital Regulations: The Dilemma of Public Policy, ix.

[176] Miller, "Hospitals," p. 380.

government hospitals; and private health care institutions subject to federal regulation through the NLRA since the 1974 health care amendments to the Taft-Hartley Act.

In amending the NLRA in 1974, Congress apparently came "full circle in its regulation of the health care industry."[177] Originally, the 1935 Wagner Act did not specifically exempt nonprofit voluntary hospitals, and when two unions filed petitions to represent employees in a nonprofit Washington, D.C. hospital in 1942, the NLRB and the Federal Court of Appeals ruled that voluntary nonprofit hospitals were within the jurisdiction of the Wagner Act.[178] These cases temporarily resolved any disputes regarding the NLRA coverage of private hospitals attributable to the silence concerning their actual coverage (or exemption) in the original collective bargaining statute (i.e. the 1935 Wagner Act). While the 1942 cases

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[177]Knapp, Labor Relations Law, p. 4.

[178]Central Dispensary and Emergency Hospital, 44 NLRB 533 (1942), enforced, 145 F.2d 852 (E.C. Cir. 1944), cert. denied, 324 U.S. 847 (1945). The hospital argued that they should be excluded from Wagner Act coverage because: they were not engaged in "trade, traffic or commerce" as defined in the legislation; they were nonprofit and the law was aimed at profit-making enterprises, and; hospital activities were semi-public in nature, thus should be treated as a direct arm of government (which was excluded from jurisdiction). The NLRB denied the hospital's petition and ruled that voluntary non-profit hospitals were within the jurisdiction of the Wagner Act. The Board found that the hospital was engaged in interstate commerce and that the Act's intent did not hinge upon the financial motive of the organization, and while the federal government did purchase services from the hospital, such a contract was not indicative of organizational integration.

confirmed the extension of the NLRA's coverage to private nonprofit hospitals, public and legislative sentiment opposing any developments that could increase health care costs or disrupt hospital services was growing.[179] An insight into the legislative logic for excluding nonprofit hospitals from NLRA coverage was provided by Senator Carl Curtis (R-Nebraska from 1939-1978) during debate proposing the extension of minimum wage coverage to nonprofit hospitals: "My purpose is to exempt from the provisions of this law the voluntary hospitals. These are splendid organizations which provide some employment and income for people who would otherwise not have any . . . I think of these charitable, nonprofit hospitals which seek to hold down their labor costs in order that their funds may reach more needy people . . . Many employees serve as a labor of love, as a matter of dedication, yet they must receive and do receive some wages."[180]

The labor relations status of nonprofit hospitals under federal law was effectively reclassified by the 1947 Taft-Hartley Amendment which, in Section 2(2) exempted "any corporation or association operating a hospital, if no part of the net earnings inures to the benefit of any private shareholder

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[179]Joseph J. Bean and Rene Laliberty, Understanding Hospital Labor Relations (Reading, MA: Addison-Wesley Publishing Co., 1977), p. 13.

[180]1199 News, pp. 33-35.

or individual."[181] The justification for the LMRA-granted exemption from NLRA regulatory machinery hinged upon the premise that voluntary or private nonprofit hospitals were "eleemosynary" institutions and, if subjected to federal labor relations law, would experience difficulty in continuing to serve patients who "lacked the means to pay for hospital service."[182] In summary, the 1947 LMRA exclusion of voluntary nonprofit hospitals from federal protection concerning union organizing and collective bargaining was largely based on the hospitals' nonprofit status, the prevailing view of these institutions as charitable service providers motivated by benevolence toward patients and employees alike, and opposition to potentially inflationary influences on health care costs or disruptive influences on hospital services.

The implications of the exclusion were clear. Voluntary or private (as opposed to federal, state and municipal institutions) nonprofit hospitals were no longer obligated to recognize or bargain with their employees on a collective basis. Hospital management could directly halt or limit union activity (e.g., discharging union organizers and/or sympathizers, promoting or offering pay increases to employees

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[181]Labor Management Relations Act, Public Law 101, 80th Congress, 1947. The Section 2(2) exclusion of nonprofit hospitals in the LMRA was actually opposed by the bill's Senate sponser, Senator Taft. A Congressional Record exerpt of the debate over the exemption of nonprofit hospitals is included in the Appendix.

[182]Miller, "Hospitals," p. 383.

unsympathetic to the union cause, etc.). Conversely, unions could coerce employees to join or not join a collective organization, and could engage in actions deemed illegal in the industrial sector (e.g., secondary boycotts, recognitional strikes and jurisdictional work stoppages).

The Taft-Hartley exclusion of nonprofit hospitals from NLRA coverage created a virtual void insofar as the regulation of labor-management relations in that sector were concerned. In thirty-nine states there was no legal framework to turn to, and the legal presumption was that nonprofit hospitals were not required to recognize or bargain collectively with their employees. In Illinois, the state Supreme Court admonished its legislature to respond to a growing epidemic of labor-management conflict arising in the new legal vacuum.[183] State labor legislation in the (voluntary) nonprofit hospital sector provided an "unsystematic array of coverage."[184] By the early 1970s, only twelve states had labor laws covering nonprofit hospitals either through specific citation or court interpretation.[185] Four states — North Dakota, Utah, Vermont and

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[183]The Illinois problems were "exacerbated" by the state's anti-injunction law, which effectively prevented the state courts from interfering in private-sector labor disputes. Miller, Hospitals, p. 383.

[184]Pointer, "Hospital Labor Relations," p. 72.

[185]Connecticut, Idaho, Massachusetts, Michigan, Minnesota, Montana, New Jersey, New York, Oregon, Pennsylvania, Rhode Island and Virginia had statutes or implied coverage of some or all hospital employees. Miller, Hospitals, p. 384.

West Virginia — specifically excluded nonprofit hospitals from coverage, and the remaining jurisdictions demonstrated no particular pattern.[186]

Michigan law covering private sector hospitals and their employees was first enacted in 1939, undoubtedly reducing the labor- management conflict arising from the (1947) Taft-Hartley void concerning nonprofit hospitals. Although Metzger, Pointer, and Miller include descriptions and analyses of the Michigan legal background covering private sector hospitals, citations contained in their research are partially incorrect.[187]

The 1939 Michigan Labor Mediation Act specifically addressed the issue of labor disputes in hospitals.[188] The LMA formally legalized employees' rights to bargain collectively

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[186]For example, a Montana statute included only RNs and LPNs; Virginia's had no labor statute, but prohibited work stoppages by hospital employees. Pointer, "Hospital Labor Relations," p. 72.

[187]In their 1972 publication, Metzger and Pointer included a chapter on the state labor law status of hospitals in which they referred to the (Michigan) "Bonnie-Tripp Act of 1949" as the initial state provision sanctioning voluntary hospital employees' collective bargaining rights. In fact, these employees' collective bargaining rights had been specifically recognized ten years earlier, in the Michigan Labor Mediation Act (Michigan P.A. 1939, No. 176, Sec. 13); and the "Bonnie-Tripp Act of 1949" was an erroneous reference to the 1947 Bonnie-Tripp Act (Michigan P.A. 1947, No. 318, Sec. 13; Michigan Compiled Laws 1970, 423.9 et seq.). In discussing Michigan's private sector legal framework covering hospitals prior to the passage of P.L. 93-360 in 1974, Richard U. Miller in his 1980 "Hospitals" article apparently used the 1972 Metzger and Pointer publication as a reference, repeating that Michigan private sector hospital employees' collective bargaining rights were not covered until 1949.

[188]Michigan Labor Mediation Act, P.A. 1939, No. 176.

with their employers, and in hospital disputes, the following steps were developed:

1. Notice of the dispute had to be filed with the Labor Mediation Board prior to any work interruption.

2. No work interference was allowed for a 30-day period following the notification of the Board. During this time, the governor appointed a 3-person commission to mediate the dispute.

3. The commission reported their findings to the governor.

Failure to give the Board notice of the dispute was a misdemeanor. While the Act required mandatory mediation and a longer 'cooling-off' period than was called for in normal labor-management negotiations (five days), it did not prohibit strikes or lockouts in the event that mediation was unsuccessful.

The 1947 Bonine-Tripp Act amended the earlier 1939 Act, providing for the arbitration as well as mediation of labor disputes.[189] The revised procedures for mediating and arbitrating hospital labor disputes called for:

1. The Board to notify the governor of the dispute, and the failure of mediation efforts.

2. Within 10 days (of no. 1), the disputing parties could agree to voluntary arbitration by a board of their own choosing, or submit the dispute to an arbitration board including a chairman appointed by the presiding circut court judge of the state, and a representative from each disputing party.

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[189] Bonine-Tripp Act, Michigan P.A. 1947, No. 318.

3. Within 30 days, the arbitration board issued a decision.[190]

If a work stoppage, or threatened work stoppage occurred following the arbitration board's decision, the circuit court was permitted to issue injunctive relief.[191]

A further revision of the Act was legislated in 1949.[192] Unlike the previous two acts, the 1949 Act included the goal of settling hospital labor disputes in the title section (of the Act) — perhaps evidence of an increasing awareness of the importance of labor peace in the health care sector. Formally excluded were federal, state or locally controlled hospitals.[193] Also excluded from the "employee" definition were any individuals employed as executives or supervisors.[194]

Section 13 of the Bonine-Tripp Act was held unconstitutional within two years of its passage, thus eliminating the mandatory arbitration requisites for hospital labor disputes.[195] The amended procedure for resolving hospital disputes stipulated the following steps:

1. The Board must be notified of the dispute at least 30 days prior to a strike or lockout. Upon receiving notice, the Board designates at least one member to participate in negotiation and mediation.

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[190]Ibid., Sec 13.

[191]Ibid., Sec. 13a.

[192]Michigan P.A. 1949, No. 230.

[193]Ibid., Sec. 2(f).

[194]Ibid., Sec. 2(e).

[195]Michigan Op. Atty. General 1949-50, No. 847, p. 48.

2. If a collective bargaining agreement with a settlement procedure exists, it is followed; if it does not result in voluntary arbitration or settlement, the Board investigates to determine whether the parties have bargained collectively (the parties are obligated to bargain and mediate in good faith).

3. If the dispute is still at impasse, the Board may urge arbitration. If no settlement has been reached within 30 days of the initial Board notification, the governor may submit it to a special commission.

4. The 5-person commission (3 voting members, and 1 nonvoting member from each disputing party) makes their findings public within 30 days (the findings are not binding on the parties).

While the revised procedures urged settlement through the voluntary submission to arbitration and the appointment of special committees, the power to force a settlement was not incorporated into the settlement process. The 1947 provision offering injunctive relief in the case of a cessation of employment (or threat of same) following the arbitration decision was also repealed.[196] However, hospital work stoppages during the dispute settlement proceedings were deemed unlawful, and the circut court was given the option of issuing injunctive relief in such cases.

The 1959 test of the revised procedure's constitutionality occurred when AFSCME Local No. 1644 began organizing employees at Oakwood Hospital, a nonprofit facility located in Dearborn, Michigan.[197] The Union obtained authorization

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[196]Michigan P.A. 1947, No. 318, Sec. 13a.

[197]Local No. 1644, American Federation of State, County and Municipal Employees, AFL-CIO, et. al., v. Oakwood Hospital Corporation (July 2, 1962), 50 LRRM 2751.

cards from 54.2 percent of the employees in the departments being organized, but Oakwood refused the Union's request for recognition and collective bargaining. The court ruled that Oakwood was legally obligated to recognize and bargain collectively with the Union, and that Oakwood's contention that Section 13 provisions of the Act were unconstitutional — because the relative consequences of labor strife in hospitals was no basis for discrimination (i.e., restrictive regulation limited to hospital and public utility facilities) — had "no real merit," since the Actobviously indicated the health and welfare of the public is "necessarily contingent on their (hospitals) continual operation unaffected by strikes and discord."[198] The purpose of the Michigan Labor Mediation Act — "to promote industrial peace" — permitted the hospital and utility distinction. Oakwood's failure to commense good faith bargaining with Local 1644 would have allowed the Labor Mediation Board to seek injunctive relief on behalf of the employees.[199]

The Michigan Labor Mediation Act included provisions governing the settlement of disputes, and prohibiting slowdowns

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[198]Metzger and Pointer, Labor-Management Relations, p. 67.

[199]Ibid.

during the negotiation period.[200] Strikes or lockouts were only permitted following a (minimum) thirty-day notice filed with the Labor Mediations Board, and (in the event of a strike) a majority vote supporting a strike.[201]

On August 25, 1974, Taft-Hartley was amended by Public Law 93-360 to extend its jurisdiction to all nonpublic health care facilities. Several factors led to the 1974 enactment of PL 93-360.

Unionization in the health care industry had been gradually expanding. Between 1967 and 1973, union recognition in the

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[200]The Act provided two mechanisms for settling disputes in the event of a breakdown in collective bargaining. If an existing contract included a settlement procedure, it had to be followed. If no contract existed, or an existing contract did not contain a settlement procedure, the following five step process was/is invoked:

1. Notice of the dispute must be filed with the MERC at least thirty days before a strike or lockout can be instigated.
2. The MERC investigates the dispute to determine whether the parties have been bargaining collectively. The MERC may recommend arbitration to the parties if settlement through bargaining, mediation and/or conciliation appears unlikely.
3. If the dispute has not been settled within thirty days, it is certified to the governor, who then submits it to a fact-finding commission.
4. The commission holds public and private hearings and within thirty days submits its findings and recommendations to the governor. These findings and recommendations are made public, but are not binding on the parties.
5. In the final stage of the process the parties are required to resume bargaining for at least ten days with the assistance of the MERC. If the dispute still cannot be settled and either party notifies the MERC that negotiations have stalemated, a strike election is conducted. A majority vote must be obtained before a strike can commense.

Metzger and Pointer, Labor-Management Relations, pp. 67-68.

[201]Ibid.

nation's nonprofit hospitals almost doubled.[202] However, the recognition was often accompanied by conflict and disruption, largely attributed by both labor and management to nonexistant or inadequate labor legislation. Government and proprietary hospitals were also falling under thejurisdiction of increasing labor-management regulation. In spite of efforts to limit 1974 amendments to the deletion of Section 2(2) of Taft-Hartley (the nonprofit hospital exclusion), several conditions unique to health-care institutions were promulgated by Congress, including:[203]

1. A 90-day notice is required of parties intending to modify or terminate existing contracts. For parties in other industries,only a 60-day notice is required.

2. The Federal Mediation and Conciliation Service must be notified 60 days in advance in the event of modification or termination of existing agreements. For parties in other industries, the notification period is 30 days.

3. Notice of intent to strike or picket must be made ten days before such action takes place.

4. In the event of a dispute, the parties are required to participate in mediation efforts offered by the FMCS.

5. If, in the opinion of the Director of the FMCS, a strike or lockout will "substantially interrupt the delivery of health care in a locality concerned," a Board of Inquiry may be convened. Fifteen days after its establishment by the Director, the BOI must issue a nonbinding report.

The 1974 amendments attempt to minimize health care delivery disruptions while extending the rights to engage in collective

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[202]Miller, "Hospitals," p. 385.

[203]Ibid., p. 386.

bargaining, strikes, picketing and related forms of concerted action to employees in proprietary and nonprofit hospitals. The extended notification periods were an attempt to increase the opportunity to reach agreements, and give mediation an early start. The mandatory mediation provision and ten-day notice prior to striking or picketing enables hospitals to insure the safety and well-being of their patients.

The "ally doctrine," which normally holds that a previously neutral employer may become a primary employer for dispute purposes if struck work is accepted is not applied to hospitals receiving patients from threatened or struck institutions in the same (normal) manner. In the case of hospitals, the establishment of an ally relationship differs considerably. If a hospital is struck and another facility supplies "an occasional technician" to assist the struck facility, an ally relationship would not be established. However, if the assisting facility provided entire shifts of nurses to a struck facility, they would become allies. The significance or magnitude of the assistance is the key factor.[204]

Another question arises concerning the application of the ally doctrine in health-care situations where the "neutral" is not a health-care institution. For example, a manufacturer making its laboratory facilities available to a health institution during a strike might become an ally of the primary institution far easier than another health-care facility, and

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[204]Fossum, Labor Relations, pp. 420-421.

leave itself open to economic pressure without the ten-day notification called for under Section 8(g) of Taft-Hartley.[205]

The NLRB traditionally declined jurisdiction over proprietary hospitals until 1967, when it departed from this policy in the 'Butte Medical Properties' case.[206] In dealing with privately owned and profit oriented hospitals, the Board asserted jurisdiction over the facilities if their gross revenues equaled or exceeded $250,000 per year. The Board justified its action by noting that state labor relations regulation of privately owned hospitals was limited, and that these (proprietary) facilities had a considerable impact on interstate commerce by nature of their considerable financial arrangements with private and government health insurance programs, and their substantial purchases of supplies and services from out-of-state sources. Although the 'Butte' direct impact upon the hospital population in Michigan was relatively minor due to the small number of proprietary facilities in the state (only 5 of 243 at the time of the MSU Survey), the indirect national impact was considerably more significant. The 1967 change in NLRB jurisdictional policy resulting from 'Butte' placed noncovered employees at a

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[205]"Extension of Taft-Hartley Act to Nonprofit Hospitals Discussed by Nash," White Collar Report, 14 June, 1974, p. A-14.

[206]Butte Medical Properties, d/b/a/ Medical Center Hospital, 168 NLRB 52 (1967); Benjamin J. Taylor and Fred Whitney, Labor Relations Law, 3rd ed. (Englewood Cliffs, NJ; Prentice-Hall, Inc., 1979), p. 257.

distinct bargaining disadvantage. Pressures on nonprofit and public hospitals to essentially conform to the same labor standards imposed by the NLRB upon facilities over which the Board asserted jurisdiction led to considerable conflict and unrest in the industry. The lack of parity arising from the differential federal policy of guaranteeing bargaining rights to some hospital employees while excluding others (in non-profit hospitals) contributed to the pressures on Congress to reevaluate the disparate federal policy created by 'Butte.' Congressional response culminated in the passage of PL 93-360, approximately seven years after 'Butte.'[207]

In the public sector, hospital labor regulations are governed by state statutes or federal Executive Orders applicable to the particular facility.

The six federally controlled hospitals in Michigan employed a total of approximately 4,323 people at the time of the MSU Survey.[208] Prior to 1962, employees in these facilities were without the legal right to unionize and bargain. President Kennedy's Executive Order 10988 in 1962 gave federal employees the legal right to organize and bargain collectively on a limited number of items; because salaries are fixed

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[207]The passage of the 1974 amendment left the NLRB with a problem in applying the new regulation. In 1975, the Board held that it would apply the same dollar jurisdictional standards to nonprofit health care establishments it previously adopted for proprietary facilities (i.e. $250,000-plus in yearly gross revenues). East Oakland Community Allience, 218 NLRB 1270 (1975).

[208]American Hospital Association, American Hospital Association Guide to the Health Care Field, 1978 (Chicago: American Hospital Association, 1978), pp. A-110 - A-118.

through civil service regulation, negotiations dealt with non-economic issues. As advisory grievance arbitration procedure was established that proved to be inadequate, and was revised by President Nixon's 1970 Executive Order 11491. Among other provisions, the new Executive Order created a three-member Federal Labor Relations Council to administer E.O. 11491, placed the authority to handle recognition issues within the U.S. Department of Labor, and established the Federal Service Impasse Panel to settle new contract disputes. Section 305 of E.O. 11491 specifically bans strikes and specifies penalties for violations of the no-strike rule (including a labor organization initiating or condoning federal employee strikes) that include discharge, loss of civil service status and ineligibility for federal government re-employment for three years.

The first bases in any state law (nationally) for non-federal public employees to unionize, bargain, or strike were introduced in Wisconsin in 1959.[209] While federal Executive Orders were recognizing the rights of federal employees to organize and bargain collectively (following 1962), the number of states with some form of legal framework for public employee bargaining increased dramatically - from one in 1959 to a total of thirty-six by the end of 1969.[210]

In Michigan, several factors spurred the enactment of the 1965 Public Employee Relations Act (PERA). Vigorously supported by the state AFL-CIO, AFSCME and International Association of

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[209]Miller, "Hospitals," pp. 381-382.

[210]Ibid., p. 382.

Fire Fighters, PERA authorized public employees to join unions and bargain collectively, but prohibited strikes.[211] Besides the then-recent federal E.O. 10988, the 1964 state reapportionment -- the redrawing of electorial districts to reflect the one man/one vote principle -- acted to promote PERA. The 1964 reapportionment reflected a stronger urban orientation with less hostility to unionization and increasing sympathy in the State legislature toward the idea of granting some form of collective bargaining rights to state and local employees.

While PERA prohibited strikes, it softened the 1947 Hutchinson Act's automatic discharge (for striking) penalty. The Michigan Employment Relations Committee (MERC) -- formerly the Michigan Labor Mediation Board -- has the authority to hold elections and certify bargaining units and agents, and process unfair labor practice charges.[212]

Legislative Impacts on Michigan Hospitals

While Michigan was not the first state to pass legislation protecting public employees' bargaining rights, PERA is among

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[211] PERAs provision making public employee strikes illegal extended the 1947 (Michigan) Hutchinson Act, which had initially prohibited public employee strikes, calling for the automatic discharge of striking employees. McLaughlin, Michigan Labor, p. 418.

[212] The three-member Michigan Labor Mediation Board had originally been established in 1939 to provide fact-finding, mediation and arbitration of labor disputes in the private sector in Michigan with specific reference to hospitals and public utility workers. The 1947 Hutchinson Act added public employee disputes to the Board's duties, although such cases could not go to arbitration.

the strongest of the state acts in terms of the rights it gives to unionized government employees falling under its jurisdiction. Passage of PERA saw an immediate and massive rush of public employees to present representation petitions to the MERC (still called the Labor Mediations Board in 1965). During the first two years following PERAs passage, the MERC received over 8000 certification petitions and approximately 175 unfair labor practice charges. Roughly 1500 labor agreements were signed by parties covered by PERA in those first two years.[213] Jack Stieber has called PERA "the major impetus for change" in the MNA's stance on the use of collective bargaining.[214] By the end of 1966, the MNA was fully committed to collective bargaining; a position they had previously considered as "a last resort to be used 'only when other approaches had failed'."[215] By making state and local government employees eligible for union representation, the MNA was essentially forced to represent members in covered facilities to the fullest extent allowable by PERA, or risk the loss of members in these facilities to unions willing to represent the intents of nurses beyond the MNA's concentration on professional goals and standards. However, PERA was not the first legislative action that provided a breakthrough in the form of collective bargaining rights in the Michigan hospital industry.

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[213] McLaughlin, Michigan Labor, p. 154.

[214] Stieber, Public Employee Unionism, p. 125.

[215] Ibid.

The 1947 Taft-Hartley exclusion covering voluntary nonprofit, state and local government hospitals left individual states and municipalities responsible for labor legislation regulating the labor-management relations in these facilities. In Michigan, the void left by the Taft-Hartley exclusion was not as drastic as that occurring in many other states, primarily because of the relatively comprehensive nature of the State labor laws. The volume of hospital labor unrest that became fairly common-place nationally following Taft-Hartley was offset by the Michigan LMA, which in 1947 mandated binding arbitration in nonpublic hospital disputes, although the binding arbitration was repealed in 1949.

Although nonprofit hospital employees in Michigan have been subject to legal coverage the longest of any of the hospital control-types, MSU Survey data indicated that federal hospital nurses who have elected to unionize have (on the average) been organized longer than their counterparts in other types of hospitals. Table 37 illustrates the length of unionization among nursing personnel according to the type of hospital control.

TABLE 37

YEARS OF UNION REPRESENTATION ACCORDING TO NURSING POSITION AND HOSPITAL CONTROL-TYPE, 1979

Facility Type	(a)	(b)	Responses w/ unionized RN	LPN	aide	$\bar{X}$ years of unionization** RN	LPN	aide	Md. years of unionization** RN	LPN	aide
Federal	6	4	2	4	4	8.0	12.5	12.5	8.0	12.5	12.5
State/Local	67	35	14	18	19	7.4	7.0	8.4	7.4	7.0	9.0
Proprietary	5	1	-	-	-	-	-	-	-	-	-
Nonprofit	165	84	24	28	30	6.6	7.4	8.0	6.5	7.0	8.0
Totals	243	124*	40	50	53	6.9	7.4	8.4	7.0	8.0	9.0

*eight others did not provide acceptable or legitimate control data categories
**from facilities with currently unionized nursing personnel
(a) solicited
(b) responses

SOURCE: MSU Survey Data

The four responding federal hospitals (all of which were unionized by at least two of the three nursing categories) had been unionized the longest. Two of these facilities reported nurses that had been organized since 1964, two years after E.O. 10988. The order apparently did have a direct impact on the growth of unionization in federal hospitals — almost all of the initial years unionization was reported by these facilities took place in the 1960s. The no strike provisions in E.O. 10988 and 11491 also seem to have had some impact on federal hospital labor relations in Michigan; no work stoppages were reported by any of the federal MSU Survey respondents (see Table 34).

Along with PERA, E.O. 10988 eventually affected the balance of negotiating power within the hospital industry by placing federal, state and local (the ladder two covered under PERA) hospital employees under various bodies of labor regulation. Although Michigan already had legislation covering nonprofit hospital employees, the increasingly comprehensive blanket of labor regulation being cast upon the national hospital industry left a disparity in that nonprofit hospital employees were still excluded from national coverage because of the Taft-Hartley exclusion. The disparity undoubtedly acted as another factor in the evolving movement to reevaluate the 1947 Taft-Hartley exclusion. This movement was aided again in 1967 by the NLRB extension of its jurisdiction to proprietary hospitals (in 'Butte'). Although the direct impact on Michigan was slight, considering the limited number of proprietary facilities in the state, 'Butte' was the final major extension of labor regulation to the hospital industry before PL 93-360, the statutory provision extending NLRA coverage to nonprofit hospitals. A summary of the various extensions of labor coverage to hospitals is included in the Appendix.

While the provisions against public employee strikes included in PERA have not totally eliminated work stoppages in covered facilities, the length of the work stoppages by nurses in state and local hospitals has, on the average, been far shorter than interruptions occurring in nonprofit facilities. Table 38 demonstrates the data on nursing work stoppages

obtained through the MSU Survey. The average and median length nursing work stoppage was far shorter in the facilities subject to PERA, although the ratio of incidents to facilities is almost identical between the PERA-covered and nonprofit facilities.[216] In no case did a reported work stoppage in a state or local facility exceed twenty-six days, with the shortest incident reported as one shift. In the nonprofit facilities, the median-length work stoppage lasted approximately one month, with incidents ranging from thirteen days to thirty-three months. All the reported incidents occurred since 1970, and as late as 1979 (the year of the MSU Survey). It should be noted that Table 34 figures are not necessarily absolute in their summary of work stoppage activity, because of their subjectivity to reporting error by administrators who were unaware of earlier incidents, or had simply forgotten some incident.

Briefly summarizing, the increased coverage of the hospital-employee (nurse) relationship by labor statute or judicial decision has affected the collective bargaining status

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[216] Based on Table 34, an equal proportion of work stoppages per facility would be as follows:

facility type	(a)/(b)	equal proportion	actual ratio from Table 34
nonprofit	11x84	11/84	11/84
state/local	.5x35	4.58/35	5/35

(a) work stoppages
(b) responding facilities

in the industry in several ways, limiting the tactics used by employers to respond to unionization drives and protecting employees from threats or coercion in joining or rejecting labor organizations. The rights to strike and/or lockout employees have been clearly delineated, and the entire scope of behavior in the collective bargaining arena has become defined with an eye toward balancing the management rights of hospitals, the rights of employees to engage in collective activity, and the rights of patients to appropriate health care. When a particular group of employees is denied the protection of labor legislation, union recognition and subsequent collective bargaining frequently become practically impossible to achieve.[217] In the absence of relevant regulation, labor and management are able to employ a tactical carte blanche in resisting or promoting unionization. The implications of increasing comprehensive labor relations coverage in the industry point to a moderating or calming influence on collective bargaining.

Appropriate Bargaining Units

Several factors somewhat unique to the health care field and (more specifically) hospitals make the issue of bargaining unit determination a difficult one. The variety of professions employed in hospitals balanced against the

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[217]Metzger and Pointer, Labor-Management Relations, p. 50.

Taft-Hartley prohibitions on the inclusion of professionals in a larger bargaining unit without their bargaining consent, and the NLRB attempt to prevent the proliferation of bargaining units is one perplexing issue in the health care industry. Whether or not some designated supervisory personnel (i.e. head nurses, nursing supervisors) have jobs of a managerial nature, or are primarily responsible for judgements regarding patient care is another potential issue of conflict. Other key factors affecting the choice of a bargaining unit structure includethe community of interest and desires of employees, the history of collective bargaining, the organization, representation and interchangeability of employees.[218] In the establishment of a collective bargaining relationship, "the determination of bargaining units is a precursor to any other negotiations."[219] Besides simply determining who is going to bargain with whom, it substantially affects the entire employment relationship, and once decided, is quite difficult to alter.

Employee organizations, associations and unions typically prefer the establishment of the largest possible units in which they believe they can win representation rights while maintaining the ability to effectively repre-

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[218] Kruger, "The Appropriate Bargaining Unit, " pp. 3-4.

[219] Moore and Chiodini, "Unit Determination Criteria," p. 236.

sent those organized.[220] Employers want units that represent employees in such a manner that legitimate concerns may be addressed and "peaceful and stable employment relations may be promoted."[221] Government employers may desire units that will contribute to their efficiency and effectiveness in delivering the services or products of their departments to constituent populations. The overfragmentation of bargaining units may be antithetical to the desired objectives of all parties, and result in reducing the effectiveness of the bargaining process to all the relevant parties.

Congress, in passing PL 93-360, extending federal labor law coverage to nonprofit hospitals, was particularly mindful of the prevention of the proliferation of bargaining units in the health-care industry.[222] Recognizing the difficulties that could befall health-care institutions if widespread bargaining unit proliferation occurred, forcing hospitals to negotiate contracts with dozens of unions, the NLRB set forth guidelines for appropriate health-care institution bargaining units in 1975. The NLRB unit classification

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[220] Ibid. pp. 236-237.

[221] Ibid. p. 236.

[222] In 1973, Sen. Robert Taft, Jr., R-OH, unsucessfully sponsored a bill to provide for no more that four appropriate bargaining units in the health-care industry; an attempt to avoid the proliferation of bargaining units in the industry. The four units were 1) all professional employees, 2) all technical employees, 3) all clerical employees, and 4) all service and maintenance employees. S2292, 93rd Congress, 1st Session.

framework includes (nursing personnel capitalized for emphasis):

1. REGISTERED NURSES: In granting RNs separate representational status, the NLRB emphasized the 24-hour patient care responsibilities of nurses; the requirements of the Joint Commission on Accreditation of Hospitals (JCAH) for nursing services; the licensing requirements for nurses, and the RN's "singular history of separate representation."[223]

2. Other Professionals: A unit that may or may not include RNs, as the RNs decide appropriate. Such a unit may contain physical therapists, pharmacists and social workers.

3. Technical Employees: Classified on the basis of state licensing, certification or registration; this category includes x-ray technicians, LPNs, state certified technicians and other substantially trained and certified technicians.

4. Business Office Clericals: Including cashiers, billing, admitting and financial clerks, switchboard operators, etc.

5. Service and Maintenance: Includes NURSES AIDES, dietary personnel, maintenance employees, noncertified technicians, medical record and unit clerks, housekeeping and laundry personnel.

6. Guards.

7. Physicians.[224]

Although exemptions may arise, the Board generally does not require the merging of units having a separate bargaining history if the relevant community of interest appears some-

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[223] Pepe, "Appropriate Health Care Bargaining Units," p. 54.

[224] Norman Metzger, The Health Care Supervisor's Handbook (Germantown, MD: Aspen Systems Corporation, 1978).

what distinct.[225] These guidelines are NLRB-formulated and as such, do not necessarily apply to health care institutions outside the Board's jurisdiction.

Following E.O. 10988 in 1962, unit determinations at the federal level were allowed on plant or installation, craft, functional or other bases ensuring a "clear and identifiable community of interest among the employees concerned, but (not) solely on the bases of the extent to which the employees have organized."[226] Responsibility for overseeing unit determination questions was delegated to the individual agencies. In 1969, E.O. 11491 assigned this function to the Assistant Secretary of Labor, and provided new standards to avoid unit proliferation, emphasizing broader-based bargaining units, and denying severance from existing units with histories of fair and effective collective bargaining (unless unusual circumstances intervened).

In Michigan, based on the 1952 Hotel Olds decision, the MERC is required to institute the largest unit appropriate under the circumstances of the particular case.[227] Unlike some other states, Michigan does not require the most appropriate bargaining unit, just the "largest unit appro-

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[225] William J. Abelow and Norman Metzger, "Multiemployer Bargaining for Health Care Institutions," Employee Relations Law Journal, 1 (Winter 1976).

[226] Moore and Chiodini, Unit Determination Criteria, p. 241.

[227] Ibid., p. 242; Hotel Olds v. State Labor Mediation Board, 333 Mich. 382, 53 N.W., 2d. 302, 1952.

priate."[228] Most states only require that a new unit be an appropriate one, versus the most appropriate. The MERC "largest appropriate unit" determination criteria covers local government employees (including police, firefighters and teachers), and uses a departmental interpretation of "community of interest" in bargaining unit determination decision for state employees."[229] However, the state is moving from a departmental structure to statewide occupational units.[230]

Supervisory Personnel in Bargaining Units

Prior to 1947, the NLRA made no distinction between supervisory and nonsupervisory employees. In the absence of such a definition, the NLRB generally acted to exclude supervisory personnel from bargaining units that included employees under their supervision. Section 2(3) of Taft-Hartley addressed the issue, by excluding "supervisors" from the definition of "employees" who are eligible for collective bargaining rights. The Act also (in Section 14(a)) exempted employers from any obligation to consider supervisors as "employees" under any law relating to collective bargaining. Thus, under the NLRA guidelines, the NLRB is without author-

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[228] Ibid.

[229] Ibid., pp. 224, 249.

[230] Ibid., pp. 249-250.

ity to include supervisors in bargaining units with other employees, or to establish separate units compiled entirely of supervisory personnel.[231] However, the Act does not prohibit supervisors from joining labor organizations; it just removes them from the protection accorded to "employees".

The major difficulty in assessing the role of supervisory personnel insofar as their collective bargaining status is concerned revolves around the application of the originally intended definition of a "supervisor" — a definition based on industrial rather than health-care organizational structures — to a nursing staff hierarchy. A February, 1975, AORN Journal editorial addressing the problem stated that "Many nurses are unsure on which side of the table they sit. In some situations, it is not clear whether a nurse is a supervisor."[232] The potential difficulties arising from appropriately assessing the positions of the nursing supervisor in collective bargaining have been described by informed observors as issues that "may ultimately destroy the professional organization (ANA). There may be considerable conflict when head nurses, supervisors and directors are pitted against the staff nurses."[233] The Taft-Hartley

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[231] Emerson, "Appropriate Bargaining Units," p. 12.

[232] Elinor S. Schrader, "Supervisory Nurses Caught in Increasing Tension," AORN Journal, 21 (February 1975), 191.

[233] Cleland, "The Supervisor in Collective Bargaining," p. 33.

Section 2(11) definition of a "supervisor" reads as follows:

> any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibility to direct them or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature but requires the use of independent judgement.[234]

The definition was developed under the assumption that when applied to the prevailing industrial "blue-collar" versus "white-collar" organizational hierarchy, it would be relatively easy to classify supervisory and nonsupervisory personnel.

In determining the individual's employment status with regard to whether they fall into the supervisory exclusion, the employee's function (not title) in relation to the Section 2(11) statutory definition is the principal factor. The ANA position on the issue of the exclusion of supervisors from the bargaining unit was articulated in a 1975 brief before the NLRB:

> RNs at every level, short of the Director and the Director's Assistant are engaged wholly if not primarily in patient care, and such supervision as they exercise is collegial in nature,

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[234]P.L. 80-101, 1947 Section 2(11) 29 USC Section 152 (11). In reviewing the application of this definition, the Sixth Circuit Court ruled that Section 2(11) is to be interpreted in the "disjunctive." Ohio Paper Company v. NLRB, 176 F .2d 385 (C.A. 6, 1949), cert. denied 338 U.S. 899.

> within the control of the parameters set by the profession and the hospital, and an incident solely of patient care and not in the furtherance of any other interest of the employer.[235]

Congressional acceptance of the inherent distinction between those who supervise in the interest of the employer, and those who supervise in a professional capacity in the interest of their professional tasks, was evidenced in a 1974 directive to the NLRB, stating in part:

> . . . existing Board decisions (have) . . . carefully avoided applying the definition of "supervisor" to the health-care professional who gives direction to other employees in the exercise of professional judgement, which direction is incidental to the professional's treatment of patients and thus is not the exercise of supervisory authority in the interest of the employer.[236]

Table 38 lists several disputes regarding the determination of bargaining units in the nursing profession (all but one deal with hospitals). The case results illustrate the differences between states largely attributable to the differing legal regulations the cases were decided under.

The 1966 Michigan case involving the MNA and the City of Detroit municipal hospitals and Public Health Department was decided by the State Labor Mediations Board under PERA and the LMA. Applying the legal guidelines provided in section 9(e) of the 1939 LMA, to wit:

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[235] Emerson, "Appropriate Bargaining Units," p. 13.

[236] Ibid.

> the board shall determine a bargaining unit "as will best secure the employees their right of collective bargaining. The unit shall be . . . employees . . . not holding executive or supervisory positions . . . Provided, however, that if the group of employees involved in the dispute has been recognized or identified by certification, contract or past practice, as a unit for collective bargaining, the board may adopt such unit."[237]

The City wanted nursing supervisors in the municipal hospitals and health department excluded from the bargaining unit representing professional nurses in these facilities, while the MNA sought a single unit including all professional nurses, excluding the Director and Assistant Director of Nursing. The parties agreed to two bargaining units; one for head nurses, supervisors, instructors and (nurse) consultants, and another unit composed of general duty staff and public health nurses. The director and assistant directors were not involved in the classification dispute. Both joint bargaining and separate bargaining was then employed, depending on the applicability of theissue.

The MSU Survey requested whether respondents had any employee organizations composed of supervisors, although the questionnaires did not explicitly request whether such organizations were in their nursing departments. Ten of the 132 usable responses (7.6 percent) indicated that they did have employee organizations composed of supervisors. Table 39 categorizes these affirmative responses according to location, hospital bed size and control-type.

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[237]Kruger, "The Appropriate Bargaining Unit," p. 3.

TABLE 38

NURSING BARGAINING UNIT CASE DETERMINATIONS

Year	State	Disputing Parties	Case Decided By
1962	Oregon	State Nurses Assn.[1] Private Hospital	State Bureau of Labor
1962	New York	State Nurses Assn.[3] Proprietary Hospital	State Labor Relations Board
1965	Mass.	State Nurses Assn.[4] City Hospital	State Labor Relations Committee
1965	New York	State Nurses Assn.[6] Nursing Homes	State Labor Relations Board
1966	Michigan	State Nurses Assn. City of Detroit[7]	State Labor Mediation Board
1974	Michigan	State Nurses Assn. County Hospital[8]	

SOURCE: Daniel H. Kruger, "The Appropriate Bargaining Unit for Professional Nurses," Labor Law Journal 19 (January 1968): 3-11; Virginia S. Cleland, "The Supervisor in Collective Bargaining," Journal of Nursing Administration 6 (September-October 1974): 34.

[1]Oregon State Bureau of Labor, Case No. 1-62; July 5, 1962.

[2]Kruger, "Appropriate Bargaining Units," p. 7.

[3]Square Sanitarium, Inc., v. N.Y. State Nurses Assn., 25 (N.Y.) SLRB No. 117, Case No. SE-35178, November 8, 1962.

TABLE 38 CONTINUED

Bargaining Unit(s)	Comments
1) Head Nurses Asst. Head Nurses Staff Nurses	Unit members considered "a homogeneous group . . . having similar interests, duties, preparations and qualifications;" work assignments between unit members "immediately interchangeable."[2] Nursing hierarchy: Director of Nursing; Supervisory Nurse; Asst. Head Nurse; Staff Nurse.
1) Head Nurses Asst. Head Nurses Staff Nurses	Supervisory employees (1 Director of Nursing and 4 Asst. Directors) excluded from the unit.
1) Supervisors Head Nurses Asst. Head Nurses Staff Nurses School of Nursing Faculty	The Mass. law was "silent on the exclusion of supervisors from the bargaining unit," but protected all public employees — except police — desiring collective bargaining representation. The Commission concluded that nursing supervisors and head nurses did perform a limited administrative function, but did not have the authority to hire, discharge, or effectively recommend the hiring/discharge of employees.[5]
1) Directors of Nursing Supervisors 2) RNs (excluding supervisors)	
1) Head Nurses and Supervisors Instructors and Consultants 2) Staff (RN) Nurses and Public Health Nurses	
1) Directors Asst. Directors 2) Supervisors Head Nurses 3) Staff Nurses	All three bargaining units represented by the State Nurses Assn., each with a separate contract.

[4]Quincy City Hospital, Mass. State LRC Case No. CR 2591, June 9. 1965.

[5]Kruger, "Appropriate Bargaining Units," p. 6.

[6]Metropolitan N.Y. Nursing Home Assn., Inc., v. N.Y. State Nurses Assn., 28 (N.Y.), SLRB No. 81, Case No's. SE-39509 and SE-39510, October 13, 1965.

[7]Municipal Hospital and Health Department.

[8]Wayne County Hospitals, see Cleland, p. 34.

TABLE 39

HOSPITALS WITH SUPERVISOR ORGANIZATIONS, BY CITY SIZE, BED SIZE AND CONTROL TYPE

City Size	(a)	Bed Size	(a)	Control Type	(a)
100,000-plus	1	1-100	6	Non-profit	3
50,000-100,000	1	101-200	1	Local	5
25,000-50,000	1	201-300	-	State	2
10,000-25,000	1	301-400	-		
under 10,000	6	401-plus	3		

SOURCE: MSU Survey Data.

(a) Hospitals with employee organizations composed of supervisory personnel.

Supervisor organizations were most common in relatively small facilities located in the smallest city-size category. No affirmative responses were reported from federal facilities, but the responses were somehwat evenly distributed among the other control categories.

A simple test that may be applied in supervisor questions regarding their bargaining unit status is whether the nursing supervisor has the authority to hire, fire or transfer a nurse without consulting with the director of nursing. A nurse who has this authority to act in the interest of the employer belongs outside of the staff nurse collective bargaining unit.[238] Occupational titles in nursing do not necessarily have the same significance of meaning corresponding titles

[238] Cleland, "The Supervisor in Collective Bargaining," p. 34.

have in business and industry, hence the difficulties in transferring the definition of a "supervisor" from the industrial sector to the nursing field. Based on the case history, NLRB precedents and guidelines, the nursing supervisory hierarchy might generally be expected (for the purposes of bargaining unit determinations) to be divided or considered in the following manner (in descending order).

Directors and Assistant Directors of Nursing: These individuals can generally be considered as "supervisors" within the Taft-Hartley Section 2(11) definition, and as such, the collective bargaining rights extended to "employees" would not apply to them. In the hospital setting, these individuals normally serve as the nursing department's administrative (i.e. employer) representatives, and are not engaged in the same "interchangeable" work assignments performed by staff nurses. An exception might occur in a very small facility lacking an extensive organizational hierarchy. In a facility only employing very few nurses, a director of nursing might also perform regular patient care duties. As previously mentioned, the emphasis would be on function rather than title.

Supervisor and Head Nurses: Different situations might find these nurses included in a unit with staff nurses, or excluded and placed in a separate unit for supervisory personnel. The degree to which they could act in the interests of the employer in authorizing sanctions and other actions applied to staff (subordinate) nurses would be of key importance in determining their unit classification. Once again, their function would be the key issue in determining their eligibility for NLRA or state protected collective bargaining rights, although a finding that they are not eligible for protection would not necessarily preclude them from entering into a collective bargaining contract with their employer.

CHAPTER VIII
BARRIERS TO COLLECTIVE BARGAINING

The MSU Survey did not attempt to solicit data on the barriers to collective bargaining, but the body of literature addressing this issue is substantial. Key issues or subjects that impact the process of initiating and maintaining a collective bargaining relationship include the legal framework governing collective bargaining behavior, the degree of militancy expressed by both employees and employers, peer group pressure and the idealogical orientation toward collective activity. Although not addressed in the MSU Survey, a survey of the pertinent literature provides several perspectives that are both relevant and significant in examining the current state of the art of collective bargaining in the nursing profession.

In the previous chapter addressing the legal framework governing the nursing profession, the legal vacuum that existed in many states concerning hospital labor relations regulation (from Taft-Hartley in 1947 to P.L. 93-360 in 1974) was discussed. The implications of the 'no holds barred' approach to collective bargaining were overwhelmingly negative. However, the barriers to collective bargaining implicit in a nonregulated negotiating environment have not been as important in Michigan as they have in other states where relevant legislative promulgations have been nonexistent, slow in coming, or enfeebled to the point of uselessness. The 1939 LMA's stated policy of promoting permanent indus-

trial peace and eliminating economic waste resulting from labor disputes recognized employees' rights to organize and engage in collective bargaining, and hospital employees' specific collective bargaining rights (with mandatory mediation). Because of the relatively early efforts of the state legislature to address this potential area of conflict, the lack of legal sanctions protecting the rights to collective activity has not been the major problem it has been in other states.

Much of the literature on collective bargaining in nursing points to the idealogical dimension (i.e. professionalism vs. unionism) as the major barrier to collective action. While other occupational groups have made substantial progress in attaining wage increases and improved working conditions by unionizing and confronting employers on these issues, nurses have frequently been reluctant to follow such a course of action.[239] Nurses employed in supervisory capacities have frequently resisted their inclusion in collective bargaining units, finding that they may obtain spillover economic rewards of collective bargaining without paying union dues and losing their "management" status.[240] Some of these nurses have strong antiunion attitudes, identifying themselves with management rather than with staff nurses.[241]

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[239] Grand, "Nursing Idealogies," p. 29.

[240] Cleland, "The Supervisor in Collective Bargaining," p. 33.

[241] Ibid.

The relatively limited number of supervisor organizations reported in Table 39 might bear reference to, or support this theory. The tendency of nurses to equate collective action with unprofessional behavior is one of the "most obvious deterrents to the use of collective bargaining."[242] This dilemma of professionalism raises the question, can a nurse be both a professional and a union member without violating the tenets of either?

Some of the situations that encourage employees to seek union representation have been identified by Metzger and Pointer as the following:

> The presence of a large group of minority workers;
> A difference in fringe benefits between departments across job classifications;
> Inconsistent and indefensible scheduling;
> Uncompetitive wages and benefits;
> Depersonalization and routinization of jobs;
> Gains in negotiated wages and benefits in blue-collar and unionized white-collar situations.[243]

To effectively deal with these conditions, Hopping has developed a sixteen-point concept of unionism, the primary ideological bases including provisions for job security and the establishment of industrial democracy, the elimination of discrimination between workers, a grievance procedure, preference based on seniority and demands for the "whole collective or not at all."[244] However, also included in Hopping's idealogical foundation of unionism is a "present-

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[242]Grand, "Nursing Ideologies," p. 29.

[243]Hopping, "Professionalism and Unionism," p. 374.

[244]Ibid., p. 375.

mindedness rather than future- or goal-mindedness," and the idea that merit pay or advancement plans are "unionbusting disguised."[245] It is here that one of the unionism-professionalism points of conflict appears, for the concept of professionalism, which (for the most part) centers on specialized expertise, autonomy and service, recognizes a reward structure based on work achievement. The professional merit-based structure may dispute an inflexible seniority approach to pay and promotion. Hopping's fundamental difference between professionalism and unionism is the method by which each exerts control — unionism using "coercion" while professionalism uses "humanity."[246] In unionism, security "takes the place of merit; rigidity takes the place of experiment; arm's length attitudes supplant any comraderie between professional and employer."[247] Given this negative (if not uncommon) view of unionism, why abandon the time-honored role of professionalism? Primarily because of professionalism's pitfalls and an increasing recognition on the part of nurses that engaging in collective bargaining does not necessarily render them unprofessional or less dedicated to the service ideal.

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[245] Ibid.

[246] Ibid., p. 378.

[247] Ibid.

In discussing the conflict between collective bargaining and professionalism, Grand examined nurses initial acceptance of unionism in the 1930's, when nursing employment conditions (which had deteriorated rapidly during the depression) failed to improve in any significant measure as the depression lessened. The unfavorable employment conditions led some nurses to seek union representation and pressured the ANA to give increasing attention to its members economic plight.[248] The ANA further responded to the question of unionism versus professionalism by viewing the quality of nursing care as dependent upon nurses' economic status and satisfactory working conditions. This rationale argued that nurses "must broaden their concerns about their work beyond face-to-face relationships with patients."[249] The merging of unionist and professional idealogies allows a strike to be conceived as not being directed against patients (as some 'professional viewpoints' might hold), but as efforts to gain benefits that will enable nurses to provide more and better care in the long run.[250] Although the law does not require employers to bargain on issues beyond wages, terms and conditions of employment; issues of quality care and control of nursing practices have increasingly become part of the bargaining dialogue. In light of professionalism's

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[248]Grand, "Nursing Ideologies," p. 30.

[249]Ibid., p. 31.

[250]Ibid.

concentration on the quality of practice and independence in determining the nursing role, the merging of 'professional issues' into the collective bargaining arena is an encouraging sign of reconciling the two idealogical stands.[251] Several other theories related to the debate over professionalism versus unionism exist that have inhibited collective bargaining.

Employeeism, or paternalism in the nursing field frequently developed in the years during and following the depression of the 1930's. Basically, this belief that employers of nurses have the nurses' best interests in mind in administering and directing health care establishments has proved to be a subtle but effective obstacle to the commencement of a collective bargaining relationship. In the 1930's, it was common for nurses to depend upon the paternalism of their employer. While hospitals offered a livelihood in an extremely depressed job market, long and irregular hours and low pay were common. Although circumstances in the nursing labor market have changed, the dependence continues in an abstract way with many nurses, who find it reassuring to

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[251]A key issue in a 1969 nursing strike in Cleveland centered around the nurses' public assertation of the deteriorating quality of nursing care. While the majority of the striking nurses actually considered the quality of care issue secondary to employment policies, the strikers' public airing of their concerns over care-quality created a stumbling block in negotiations because of the administrator's call for a public retraction of the charges, and the nurses' adamant refusal to retract the statement. Grand, "Nursing Ideologies," pp. 31-32.

believe that their employers are acting to protect their interests. In fact, employers, on the whole, rarely initiate salary and benefit increases, but pay what their employees will accept, or what the labor market conditions command.

In its evolving role as a labor organization, the ANA has generally assumed increasingly militant approaches to collective bargaining when threatened with a potential membership loss. Although it qualifies as a "labor organization" under NLRA guidelines, the ANA has frequently been less than enthusiastic in this role. While the ANA and affiliated state associations "grudgingly concede they are labor organizations," they have (at the same time) tried to persuade members and potential members that they are not 'unions' — an attempt to overcome the unpopular self-concept (that of a union member) common among many professional nurses.[252]

The attitudes of some hospital administrators, who feel that hospitals should "draw the line" on "irresponsible" union demands, and public discomfort (as reflected by Congressional sentiment in the 1947 Taft-Hartley debates) have also been roadblocks to extensive collective bargaining.[253]

Nurses' political apathy has been called "the most widespread threat to the (nursing) profession."[254] Although

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[252]Helen Creighton, "Supervisor Membership in the ANA," Supervisor Nurse 7 (July 1976): 48.

[253]Metzger and Pointer, Labor-Management Relations, pp. 220-1.

[254]John C. Lawrence, "Confronting Nurses' Political Apathy," Nursing Forum 15 (Fall 1976): 363.

nursing has greater numbers than any other health profession, it exerts the least influence on decisions that will affect the future of health care in this country.[255] Some of the reasons for this lack of political involvement include womens' "second-class role" in American society, and nurses' reluctance to be "risk takers" and fight for their personal and professional interests. Lawrence has theorized that the nursing profession has had to line up behind powerful business interests — hospitals, insurance and pharmaceutical companies — to "gain the ear of any legislator in the country."[256] Even peer and professional pressure may inhibit nurses' active participation in collective bargaining. A 1979 survey of doctors found that while they would not object to nurses being given more authority, and that they felt nurses were frequently underpaid, almost ninety percent of the physicians surveyed felt that nurses should not attempt to alter their working environments through union activity.[257] Reasons for this overwhelming resistance to unionization include the (perceived) probable abandonment of patient care, a tendency for (unionized) nurses "to do nothing but what they are forced to do," and the disintegration of "professional" standards and attitudes.[258]

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[255]Ibid., p. 366.

[256]Ibid., p. 367.

[257]Anthony A. Lee, "How Nurses Rate with MDs," RN 42 (July 1979): 27-9.

[258]Ibid., p. 29.

Summarizing, the idealogical conflict of professionalism and unionism seems to have been the greatest single impediment to the spread of collective bargaining. Political apathy and peer and public pressure opposing unionism, an unaccomodating or nonexistent legal framework, and the professional association's grudging acceptance of collective bargaining have all played positions of varying importance in the nursing profession's historically eschewing unionism and collective bargaining.

CHAPTER IX.

CONCLUSIONS

The material that was obtained through surveying the Michigan hospital population and examining the current literature on collective bargaining may be used to support several conclusions or hypotheses. Collective bargaining is a relatively contemporary development in the health care field, unlike the lengthy background of bargaining in industries such as mining, steel or trucking. Unlike some other industries whose history of collective bargaining is extensive, bargaining in the health care profession is still in its formative stages — labor market structures are dynamic, unionization still evolving and bargaining outcomes often uncertain.[260] Because of the important social, political and economic role health care has, the labor-management relations in the industry are correspondingly important.

Within the health care industry, nursing has greater numbers than any other profession, yet exerts a relatively limited influence on decisions that will affect the future of the industry and its role in the delivery of health care services.[261] While nurses have probably not affected their professional environment to the extent they might be capable of, theirs is a profession "caught up in the rapid tempo of

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[260] Miller, "Hospitals," p. 427.

[261] Lawrence, "Nurses' Apathy," p. 366.

economic, institutional and technical changes," and if they have not yet begun to exercise the political and influential clout lying dormant at their fingertips, they have learned that "friendly persuasion" cannot be relied upon to effectively advance their interests and acquire any voice in hospital management.[262]

The importance of examining and understanding labor-management relations in the nursing profession is underscored by the shortage of qualified RNs and LPNs, "even though the government says there isn't (a nursing shortage)."[263] A 1980 hospital survey found that administrators felt there was a shortage of full-time nurses in 96 percent of the Midwest (including Michigan) hospitals surveyed, with a shortage of part-time nurses in 36 percent of the responding facilities.[264] In appraising the shortage in their own institutions, 95 percent of the respondents replied that it was either "somewhat or very" serious.[265] Only 5 percent of the hospitals responding to that survey considered the shortage "minor."[266] While these are ideal labor market conditions for any professional nurse looking for a job or change of employers,

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[262]Miller, "Development of Bargaining," p. 134.

[263]Lynn Donovan, "The Shortage: Good Jobs are Going Begging These Days, So Why Not be Choosy?" RN 43 (June 1980): 21.

[264]Ibid., p. 23.

[265]Ibid.

[266]Ibid.

it raises questions of why so many nurses prematurely leave the profession, and what measures are being taken to alleviate the shortage.

To investigate the current labor market conditions in the Michigan hospital sector, information on nursing wage and benefit levels, educational backgrounds, collective bargaining histories and facility characteristics was solicited from every nonmilitary Michigan hospital. Slightly more than half (54.3 percent) of the surveyed facilities provided usable responses.

The MSU Survey and accompanying research indicated that changing educational trends are taking place among nurses in the Michigan hospital labor force. Although hospital diploma graduates were still the largest group employed in hospitals, associate and baccalaureate degree holders are far more common than was previously the case. Between 1970 and 1974, the number of hospital graduates active in the Michigan nursing labor market was surpassed by associate and baccalaureate degree graduates for the first time. Younger nurses are also turning to jobs with some opportunity to add to their educational background, increasingly emphasizing adequate continuing education and tuition reimbursement benefit programs in potential employers. In Michigan, twenty-one hospital diploma programs were operating in 1965, eight in 1980, and several of those programs are exploring the pos-

sibility of merging with associate or baccalaureate programs.[267] The reasons: policy statements from the professional organizations encouraging bachelor of science nursing programs and the costs of diploma programs to hospitals balanced against the possibility of a hospital losing its diploma graduates to other sources of employment.[268]

Despite the rapid expansion in the hospital industry since the late 1960's, when BLS statistics ranked hospital wage levels next to last in ten major industries, hospital wage and benefit levels have failed to show significant increases.[269] Career earning potential in nursing is also limited. Nurses employed in Michigan hospitals can anticipate their future earning potential to peak at roughly twenty percent above their starting rate if they remain in a direct-patient care setting. The drop out rate of nurses in hosptials is one significant reason for this — many nurses simply do not remain in the employ of a hospital long enough to reach the maximum pay levels.

Nurses leaving the field complain that their earnings potential in non-nursing professions is "two or three times" as high as that in nursing.[270] The high attrition factor

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[267]"Diploma School Programs are Nearly Gone, RN Official Says," Health Care News, pp. 3, 15.

[268]Ibid.

[269]Miller, "Hospitals, " p. 380; "Nurses Turn Away From Hospital Careers," Detroit News, 10 August 1977, Sec. D, p. 7.

[270]Hallas, "Why Nurses are Giving It Up," p. 17.

in nursing generally, and specifically in the hospital sector is one aspect keeping hospital-nursing salaries from reaching higher levels, but other factors related to high turnover rates include competitive labor market conditions, high stress levels (particularly in hospitals) relative to other avenues of employment, and the relative youth of hospital-employed nurses (allowing them to pursue alternate career options). While the MSU Survey found maximum hourly salary rates roughly 20 percent higher than minimum levels, the average rate was roughly 11 percent above the minimum. From this emerges a picture of nursing salary growth potential in Michigan hospitals that is quite limited.

Several factors are tied to salary levels. All the nursing categories included in the MSU Survey (head nurses, RNs, LPNs, and aides) exhibited wage level increases with increases in the bed-size of their hospital employers. The type of hospital control also had some impact on the aggregate wage levels. National data found university-controlled hospitals paying the highest average hourly nursing salaries, followed by non-profit facilities, community, and proprietary facilities (the latter two paying 1.5 and 1.9 percent below the national mean, respectively). The MSU Survey results ranked the average hourly RN salaries paid in state controlled hospitals the highest (at $8.29 per hour), followed by (in descending order) federal, religious, non-profit, proprietary and local government hospitals.

The most crucial observations produced by the MSU Survey concern the impact of unionism on hospital nursing salary levels, and conflict with another recent national survey, which found unionized nurses receiving salaries almost 10 percent higher than nonunion nurses.[271] The same survey indicated that RNs represented by labor unions (as opposed to professional associations) earned 20 percent more than the mean for all full-time general duty RNs, and RNs represented by professional associations reported average earnings of only 3.4 percent above the aggregate mean. In contrast with these national trends, the MSU Survey found nonunion general duty RNs averaging higher salaries than their unionized counterparts, although unionized LPNs and aides had higher average salaries than the corresponding nonunion figures. Unionized facilities paid higher average minimum (starting) salaries to RNs, LPNs, and aides. The data indicates that while unions have been successful in increasing minimum wage levels and bettering wages in general among lower skilled employees in the nursing field (within hospitals), they have not demonstrated widespread effectiveness in securing further increases among higher skill level nursing personnel.

The success unionism has had in the lower skill levels in the nursing hierarchy may not be without costs to the unionized nursing personnel. Increasing the salary com-

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[271] Lucas, "What's Nursing Worth?' p. 37.

pression between skill levels with continually upward adjustments in the lower skill levels is bound to lead to increasing substitution effects favoring more highly skilled personnel. Ironically, the salary gains generated among the lower skill levels in the hierarchy by union representation may be effectively pricing these levels out of the labor market, although the higher skilled nurses (RNs) atop the hierarchy may benefit in terms of spillover effects (salary increases predicated on the basis of maintaining higher salary levels for RNs than LPNs and aides), and increased employment demands in the labor market due to their substitution for increasingly highly paid LPNs and aides.

Comparisons between salaries of nurses represented by professional associations, labor unions and nonunion nurses led to mixed results. Among RNs, the union-represented nurses had the highest mean hourly wages, followed by nonunion and professional association-represented nurses, whose mean wage level was the only one of the three categories falling below the overall average. Among LPNs, professional association members had the highest wages, followed by union and nonunion nurses.

Union representation may be beneficial in securing increased afternoon and night shift differentials among RNs, although no significant difference was reported between union and nonunion hospitals in offering financial incentives tied to educational achievement.

Besides the MNA, the AFGE, AFSCME, Teamsters and Steelworkers were all reported as representative for RNs in MSU Survey respondents. In addition to these organizations (excluding the MNA), the MLPNA, IUOE, OPEIU and SEIU were reported as the representatives for LPN and/or aide groups. The MNA clearly represented the largest number of RNs, while AFSCME was reported as the major representative of LPNs and aides. Independent organizations were also active representing RNs, LPNs and aides. The MNA was the only group representing head nurses, although less than 2 percent of these nurses were organized.

Hospitals in the several largest cities in the state tended to be among the most highly unionized, while nursing staffs in the smallest cities tended to have the lowest rates of unionism, from approximately 4 to 11 percent below the average for the entire state. Hospital bed sizes exhibited little correlation with unionism rates. Federally and locally controlled hospitals had the highest rates of unionism among hospital-control types, while facilities under the control of religious orders or the state had the lowest numbers of nursing staffs represented in collective bargaining agreements.

Besides unions reported as current representatives of nursing personnel, organizations as foreign to the nursing field as the IAM, Hotel, Restaurant and Bartenders Union, and Paperworkers were reported attempting to organize nursing personnel.

If work stoppages are any measure of nursing militancy, the evidence collected in the MSU Survey seems indicative of an increase in militant nursing attitudes in achieving their bargaining goals. Almost 80 percent of the reported work stoppages have occurred since 1976. Work stoppage lengths ranged from one shift, to thirty-three months, although the median length was slightly under one month. Legal prohibitions against striking in public hospitals seem to be relatively effective; no federal hospitals reported work stoppages, and only one state and two local hospitals reported any such activity.

Collective bargaining agreement durations ranged from one to four years, although almost 85 percent of the reported agreements were two or three year contracts, some of which included periodic wage reopeners. Local and federal hospitals reported the longest histories of collective bargaining with their nursing personnel.

Among RNs in the MSU Survey, labor unions have been considerably more successful in obtaining wage increases than the MNA or independent organizations. Although the corresponding figures among LPNs are closer, the trend was different — MLPNA-represented nurses had slightly higher average salaries than nurses represented by labor unions. Nurses represented by independent organizations had average and minimum salary levels below those reported by both professional organizations and labor unions.

While multiemployer bargaining in the health care industry has become increasingly popular nationally, little such activity seems to be taking place in Michigan — only three hospitals responded that they were involved in multiemployer bargaining. However, formal or informal pattern bargaining undoubtedly exists (although the MSU Survey did not solicit specific information on this issue), particularly among nonunion hospitals. Given their attempts to remain competitive with union-negotiated settlements, they are forced to heed the union results or face increasing possibilities of becoming unionized themselves.

Michigan has proved to be one of the few states in which a lack of labor relations legislation has not proved to be an obstacle to collective bargaining. While national coverage of private hospitalswas suspended from 1947 to 1974, coverage of these facilities had been addressed by the LMA since 1939, undoubtedly reducing conflict in the labor-management relations forum. The legal regulation of labor-management relations in the health care industry has been largely responsible for affecting the status of collective bargaining in several ways. The tactics used to organize employees and resist organizing drives, the employees' rights to strike and the entire scope of behavior in collective bargaining are delineated, providing ground rules under which collective bargaining may take place. Without these ground rules, it is questionable whether industrial peace in the health care industry could exist.

Finally, several barrers to collective bargaining were discussed. The 'no holds barred' approach to collective bargaining that can take place in the absence of a regulated environment is only one of several aspects that have negatively impacted collective bargaining in the nursing profession. Because of Michigan's early response to these potential difficulties, problems arising from regulatory inadequacies have not been the perplexing issues they have historically been in other states. However, significant barriers have existed, including the conflict over 'professionalism versus unionism', supervisors' resistance to inclusion in bargaining units because of their pro-management orientation, the professional organization's reluctance to assume the trappings and functions of a labor union, and the unions' historical disinterest in hospitals. While these barriers are largely historical, and in many cases are no longer legitimate impediments to collective bargaining, their legacy has effectively inhibited the acceptance and growth of collective bargaining among nurses, in contrast with other occupations that have employed collective action to the mutual benefit of practitioners and employers. Nurses' willingness to accept employers' paternalism rather than confront them with legitimate employment demands, and peer and public discomfort and disapproval of unionism among nurses has also undoubtedly affected current collective bargaining structures in the nursing profession.

Whether increasing militancy on the part of nurses and the growing acceptance of unionism and collective bargaining will continue to advance nursing's voice in affecting its future in the health care industry remains to be seen, but evidence suggests that the advent of collective bargaining in the profession has, and will continue to play a significant role in impacting the nurse-employer relationship in Michigan hospitals.

APPENDIX

Appendix A

NURSING DATA SHEET - SCHOOL OF LABOR AND INDUSTRIAL RELATIONS
M.S.U.

71% (two-sided) reduction

NURSING DATA SHEET • SCHOOL OF LABOR AND INDUSTRIAL RELATIONS • M.S.U.

1. Is your hospital in a city of:
   ____ 100,000 and over in pop.
   ____ 50,000 up to 100,000
   ____ 25,000 up to 50,000
   ____ 10,000 up to 25,000
   ____ less than 10,000

2. Under what type of control is your hospital? (check all applicable blanks).
   ____ Proprietary
   ____ Non-profit
   ____ Religious
   ____ Federal gov't.
   ____ State gov't.
   ____ Local gov't.

3. How many people does your hospital employ, excluding medical interns, residents, and other trainees (please refer to actual personnel counts)? _____

4. How many beds does your hospital have? _____

5. Do any of your nurses belong to religious orders? ___Yes ___No. If yes, what proportion of your total number of R.N.'s are members of religious orders? _____

6. Nursing Vacancies and Salaries: Please fill in the appropriate numbers for each position. For salaries, indicate the gross monthly salary (before taxes), excluding extra pay for shift differentials, overtime, on-call, etc. Please circle each figure which is an estimate.

	Head Nurses*	General Duty Registered Nurses	L.P.N.'s	Nurse Aides & Assistants
Number of full-time nurses employed as:				
Number of budgeted vacancies now for:				
Minimum salary for:				
Maximum salary for:				
Average salary for:				

7. If an afternoon shift differential is paid, how much more is it than the wage of the day shift? (percentage) _____ (cents/hour) _____
   If a night shift differential is paid, how much more is it than the wage of the day shift? (percentage) _____ (cents/hour) _____

8. Does your hospital grant starting salary incentives to general duty nurses above starting levels for nurses with hospital diplomas when they have: (a) bachelor degrees? ___Yes ___No, (b) associate degrees? ___Yes ___No.

9. Does your hospital give any financial incentives to nursing staff members to increase their education (eg. tuition refunds) while employed? ___Yes ___No. If yes, please comment on the incentives offered: _____

10. What percentage of your hospital's registered nurses:
    (a) have a bachelor's degree, plus at least one year of post-grad. training? _____
    (b) have a bachelor's degree? _____
    (c) have an associate degree? _____
    (d) have graduated from hospital nursing programs? _____

11. (a) Number of regularly employed part-time general duty R.N.'s: _____
    (b) Starting hourly rate for part-time general duty R.N.'s: _____
    (c) Number of regularly employed part-time L.P.N.'s: _____
    (d) Starting hourly rate for part-time L.P.N.'s: _____
    (e) Number of regularly employed Nurse Aides and Assistants: _____

12. (a) Are full-time nursing personnel offered some choice in the selection of their benefit package? ___Yes ___No.
    (b) Are part-time nursing personnel offered some choice in the selection of their benefit package? ___Yes ___No.

* Refers only to nurses with immediate supervisory responsibilities over general duty nurses (they may or may not perform general duty tasks in addition to their first-line supervisory roles).

13. What type of fringe benefits are offered to your part-time nursing staff as compared with your full-time nurses? (please check applicable descriptions).

____ Part-time nursing personnel are not offered a fringe benefit package.
____ Part-time nursing personnel are offered a fringe benefit package prorated according to their amount of hours worked.
____ Part-time nursing personnel are offered a smaller fringe benefit package than full-time nurses, but not calculated on an "hours worked" basis.
____ Part-time nursing personnel are offered a full-time benefit package under the condition they make additional financial contributions.
____ Part-time nursing personnel are offered the full-time benefit package (without having to make additional financial contributions).

Comment:_____

14. Nursing Representation for Collective Bargaining: If your hospital nursing personnel have collective bargaining agreements, please fill in the following table (which requests the names of the organizations representing your nurses, the number of years the organizations have represented your personnel, whether the organizations represent both full- and part-time nursing personnel, the duration and expiration dates of the present agreements).

	REGISTERED NURSES	L.P.N.'S	NURSE AIDES
Bargaining Representative:			
Years of Representation			
Full- and Part Time?*			
Agreement Duration:			
Agreement Expiration:			

15. Have any of your nursing personnel ever been represented for the purposes of negotiation or collective bargaining by an organization other than their current representatives? ____Yes ____No. If yes, please comment, including the name of the organization, and the dates of representation:_____

16. Have there been any formal efforts by a labor organization to organize your nursing personnel for the purposes of securing a collective bargaining agreement since 1970? ____Yes ____No. If yes, what organization was involved, and what date did the effort take place?_____

17. What were the results of the of the organizing efforts (from #16)?_____

18. Is your hospital engaged in collective bargaining agreements with any other division of personnel (besides nurses)? ____Yes ____No. If yes, how many agreements do you currently have?_____

19. Do you have any employee organizations composed of supervisors?_____

20. Are you involved in multiemployer bargaining of any kind with your nursing personnel? ____Yes ____No. If yes, how long have you been involved with multiemployer bargaining?_____

21. If your hospital has experienced any nursing strikes/work stoppages, please complete the following table, including the group involved, date, and number of days involved for each stoppage (please abbreviate head nurses as HN; general duty R.N.'s as GRN; L.P.N.'s; Aides). A sample entry is provided in the first column.
If you have not had any nursing strikes or work stoppages, please check here: ( ).

	(sample)								
Group	GRN								
Date	3/77								
# of Days	10								

* If the bargaining representative represents BOTH full- and part-time personnel, please signify by filling in "Both". If only one group is represented, fill in ONLY that group (eg. "Full-time only").

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Appendix B

EDITED SENATE DEBATE REGARDING THE 1947 LABOR MANAGEMENT RELATIONS ACT, SECTION 2(2) EXCLUSION OF NONPROFIT HOSPITALS

Appendix B

EDITED SENATE DEBATE REGARDING THE 1947 LABOR MANAGEMENT RELATIONS ACT, SECTION 2(2) EXCLUSION OF NONPROFIT HOSPITALS

Mr. MILLARD E. TYDINGS (D-MARYLAND). I ask that the amendment be stated.

The PRESIDING OFFICER. The clerk will state the amendment.

The CHIEF CLERK. . . . (or) any corporation or association operating a hospital, if no part of the net earnings inures to the benefit of any private shareholder or individual.

Mr. TYDINGS. . . . this amendment is designed merely to help a great number of hospitals which are having very difficult times. They are eleemosynary institutions; no profit is involved in their operations, and I understand from the Hospital Association that this amendment would be very helpful in their efforts to serve those who have not the means to pay for hospital service, enable them to keep the doors open and operate the hospitals . . .

The PRESIDING OFFICER. Does the Senator move the adoption of the amendment?

Mr. TYDINGS. I move that the amendment be agreed to . . .

Mr. ROBERT A. TAFT (R-OHIO). The committee considered this, amendment, but did not act on it, because it was felt it was unnecessary. The committee felt that hospitals were not engaged in interstate commerce, and that their business should not be so construed. We rather felt it would open up the question of making other exemptions. This is why the committee did not act upon the amendment as it was proposed.

Mr. TYDINGS. I think we all realize that hospitals that are working on a nonprofit basis are not engaged in interstate commerce, but I know that they are having a hard time to keep going, and I think it would be very helpful if the committee would put the specific language in the bill. They serve all mankind. I move the adoption of the amendment.

Mr. GLENN H. TAYLOR (D-Idaho). What does the amendment do, may I ask the Senator from Maryland? Does it prevent hospital employees, particularly nurses, from organizing? Is that the sense of the amendment?

Mr TYDINGS. It simply makes a hospital not an employer in the commercial sense of the term. It is not a business operating on a profit basis. It is a charitable institution which is kept open, and it is to lift it out of the category of ordinary business, and it is to except such charitable institutions. It is, rather, to relieve them from the pressures thta normally go with business. Such institutions cannot keep open, in certain cases, I may say to the Senator, unless relief is afforded. The people who are affected are the poor people of the country. The amendment affects only charitable institutions, which do not derive a cent of profit, but are maintained by donations almost entirely, except for a small amount of revenue received for services rendered.

Mr TAYLOR. . . . but I wanted to know what would be the effect if nurses in a hospital should decide to organize. Whould it prevent their organization?

Mr. TYDINGS. I do not think it would.

Mr TAYLOR. That is all I wanted to know.

Mr. Tydings. They should not have to come to the National Labor Relations Board, as in the case of ordinary business concerns. They are not in interstate commerce. A hospital is a local institution, quite

often kept up by the donations of benevolent persons. Employees of such a hospital should not have to come to the National Labor Relations Board. A charitable institution is always beyond the scope of labor-management relations in which a profit is involved. No profit is involved in this work.

Mr. TAYLOR. That may be true, but nevertheless I have in mind that nursing is one of the most poorly paid professions in America; outside the profession of school teaching it is perhaps the poorest paid, in proportion to the service rendered to humanity. I do not want to place the nursing profession under any handicap in their efforts to obtain an improved standard of living.

Mr. TYDINGS. I do not think the amendment will affect them in the slightest way as to salaries. I will say to the Senator they can still protest, they can still walkout. The only thing it does is to lift them out of commercial channels of labor-management where a profit is involved.

Mr. TAYLOR. . . . these may not be profit-making institutions, but even so, I feel that, simply because an institution, even one like the Red Cross, is kept up by popular subscription, the professional workers, even employees of the Red Cross, should be permitted a decent living and should not be hamstrung in their efforts to obtain it.

Mr. TYDINGS. I agree with the Senator.

Mr. TAYLOR. With that assurance, I shall not oppose it.

Mr. HARLEY M. KILGORE (D-W. VIRGINIA). . . . is the amendment so worded that it applies only to hospitals not operated for profit?

Mr. TYDINGS. Absolutely.

Mr. KILGORE. There are hospitals that are highly profitable.

Mr. TYDINGS. . . . the amendment applies to completely nonprofit organizations. There is not a penny of profit in it for anybody.

The PRESIDING OFFICER. The question is on agreeing to the amendment offered by the Senator from Maryland.

(the amendment was agreed to)

SOURCE: U.S. Congress, Senate, Debate on S. Bill 1126, 80th Congress, 1st Session, 12 May 1947. Congressional Record 93: 4997.

Appendix L

HOURLY SALARY COMPARISON OF UNIONIZED AND NONUNION FULL-TIME LPNs EMPLOYED IN MSU SURVEY RESPONDENTS BY HOSPITAL BED SIZE, 1979

Appendix C

HOURLY SALARY COMPARISON OF UNIONIZED AND NONUNION FULL-TIME RNs, LPNs, AND AIDES EMPLOYED IN MSU SURVEY RESPONDENTS, 1979*

Nursing Position	Unionized	Nonunion	Differential**	Totals
General Duty RNs				
Average minimum	$6.54 (39)	$6.41 (83)	+13	$6.45 (122)
Average maximum	$7.75 (39)	$7.92 (79)	-17	$7.87 (118)
Average mean	$7.11 (34)	$7.35 (69)	-24	$7.27 (103)
LPNs				
Average minimum	$5.08 (46)	$4.87 (78)	+21	$4.95 (124)
Average maximum	$6.02 (46)	$6.09 (75)	-07	$6.06 (121)
Average mean	$5.58 (36)	$5.43 (67)	+15	$5.48 (103)
Aides				
Average minimum	$4.18 (51)	$3.78 (70)	+40	$3.95 (121)
Average maximum	$4.96 (51)	$4.66 (66)	+30	$4.79 (117)
Average mean	$4.59 (41)	$4.33 (60)	+26	$4.44 (101)

SOURCE: Michigan State University School of Labor and Industrial Relations Nursing Data Sheet, computations from questions six and fourteen.

*Parenthetical numbers in the unionized, nonunion and totals columns indicate the number of observations the averaged figures are based on.

**Column figures indicate the differential in cents between the unionized and nonunion hourly salaries, and are calculated by subtracting the nonunion figures from the union figures in column one. Thus, a +13 indicates that union hourly salaries are an average of thirteen cents per hour greater than nonunion salaries in the same category.

Appendix E - continued

	Unionized[b]	Nonunion[b]
301-400 Beds		
Average minimum	$5.12	$5.30 (+18)
Median minimum	$5.12	$5.47 (+35)
Range	$5.01-5.23	$4.16-6.23
	n=4	n=6
Average maximum	$6.72 (+01)	$6.71
Median maximum	$6.72	$6.91 (+19)
Range	$5.51-7.93	$5.85-7.43
	n=4	n=6
Average average	$5.55	$5.86 (+31)
Median average	$5.55	$6.04 (+49)
Range	$5.26-5.84	$4.68-6.64
	n=4	n=5
401+ Beds		
Average minimum	$5.75 (+45)	$5.30
Median minimum	$5.66 (+23)	$5.43
Range	$4.24-7.17	$4.39-5.95
	n=9	n=12
Average maximum	$7.70 (+125)	$6.45
Median maximum	$7.39 (+88)	$6.51
Range	$5.67-10.72	$5.34-7.23
	n=9	n=12
Average average	$7.02 (+103)	$5.99
Median average	$7.10 (+82)	$6.28
Range	$4.94-8.59	$6.28-5.99
	n=6	n=11

SOURCE: Michigan State University School of Labor and Industrial Relations Nursing Data Sheet, computations from questions four, six and fourteen.

*Figures in each category equaling "n" indicate the number of observations the averages and medians are based on. For the actual number of facilities in each bed size category, see TABLE 1.

[b]Parenthesized figures indicate the difference in cents between unionezed and nonunion hourly salaries (excluding extra pay for shift differentials, on-call, etc.), and are calculated by subtracting the smaller hourly figure from the larger, and parenthetically recording the difference in the column containing the larger figure in each average and madian category.

Appendix F

HOURLY SALARY COMPARISON OF UNIONIZED AND NONUNION FULL-TIME AIDES EMPLOYED IN MSU SURVEY RESPONDENTS BY HOSPITAL BED SIZE, 1979

Appendix D

HOURLY SALARY COMPARISON OF UNIONIZED AND NONUNION FULL-TIME RNs EMPLOYED IN MSU SURVEY RESPONDENTS BY HOSPITAL BED SIZE, 1979*

	Unionized**	Nonunion**
1-100 Beds		
Average minimum	$6.38 (+26)	$6.12
Median minimum	$5.92	$6.11 (+19)
Range	$5.55-8.63	$5.00-12.83
	n=14	n=39
Average maximum	$7.23	$7.41 (+18)
Median maximum	$7.22 (+06)	$7.16
Range	$6.05-8.80	$5.00-13.97
	n=14	n=36
Average mean	$6.82	$6.90 (+08)
Median mean	$6.74 (+06)	$6.68
Range	$6.00-8.07	$5.00-12.98
	n=12	n=31
101-200 Beds		
Average minimum	$6.35 (+12)	$6.23
Median minimum	$6.09	$6.25 (+16)
Range	$5.40-7.83	$2.78-8.20
	n=10	n=13
Average Maximum	$7.41	$7.52 (+11)
Median maximum	$7.51	$7.82 (+31)
Range	$6.53-8.36	$3.45-9.10
	n=9	n=13
Average mean	$6.92	$6.95 (+03)
Median mean	$6.59	$7.18 (+59)
Range	$6.03-8.16	$3.24-8.24
	n=9	n=13
201-300 Beds		
Average minimum	$6.90 (+79)	$6.11
Median minimum	$6.91	$7.25 (+34)
Range	$6.10-8.19	$5.76-7.69
	n=8	n=9
Average maximum	$8.22	$8.37 (+15)
Median maximum	$8.29	$8.45 (+16)
Range	$7.32-9.37	$6.87-9.75
	n=8	n=9

continued on next page

Appendix D - continued

	Unionized**	Nonunion**
Average mean	$7.38	$7.76 (+19)
Median mean	$7.38	$7.92 (+54)
Range	$6.80-8.92	$6.50-8.59
	n=7	n=7
301-400 Beds		
Average minimum	$5.93	$7.14 (+121)
Median minimum	$5.93	$7.38 (+145)
Range	$5.79-6.08	$6.23-8.00
	n=4	n=6
Average maximum	$7.60	$8.71 (+111)
Median maximum	$7.60	$9.00 (+140)
Range	$6.53-8.68	$7.75-9.38
	n=4	n=5
Average mean	$6.42	$8.34 (+192)
Median mean	$6.42	$8.30 (+188)
Range	$6.16-8.68	$7.25-9.40
	n=4	n=5
401+ Beds		
Average minimum	$7.00	$7.15 (+15)
Median minimum	$6.96	$7.40 (+44)
Range	$6.10-8.24	$6.00-8.20
	n=5	n=16
Average maximum	$9.21 (+31)	$8.90
Median maximum	$9.51 (+86)	$8.65
Range	$7.67-10.42	$7.56-12.02
	n=5	n=16
Average mean	$7.92	$8.21 (+29)
Median mean	$8.04	$8.29 (+25)
Range	$7.00-8.58	$7.20-9.76
	n=4	n=13

SOURCE: Michigan State University School of Labor and Industrial Relations Nursing Data Sheet, computations from questions four, six and fourteen.

*"n" figures in each category indicate the number of observations the above figures are based on.

**Parenthesized figures indicate the difference in cents between unionized and nonunion hourly salaries

Appendix F

Hourly salary comparison of unionized and nonunion full-time aides employed in MSU Survey respondents by hospital bed size, 1979*.

	Unionized[b]	Nonunion[b]
1-100 Beds		
Average minimum	$3.87 (+37)	$3.50
Median minimum	$3.70 (+41)	$3.29
Range	$2.92-5.35	$2.90-4.71
	n=17	n=36
Average maximum	$4.44 (+25)	$4.19
Median maximum	$4.16 (+13)	$4.03
Range	$3.68-6.12	$3.20-5.75
	n=17	n=33
Average average	$4.14 (+19)	$3.95
Median average	$4.09 (+28)	$3.81
Range	$3.37-5.61	$3.23-5.20
	n=14	n=29
101-200 Beds		
Average minimum	$3.93 (+10)	$3.83
Median minimum	$3.79 (+03)	$3.76
Range	$2.93-5.08	$1.64-5.35
	n=11	n=12
Average maximum	$4.45	$4.73 (+28)
Median maximum	$4.06	$4.83 (+77)
Range	$3.68-5.98	$2.03-6.51
	n=11	n=12
Average average	$4.21	$4.30 (+09)
Median average	$3.92	$4.28 (+36)
Range	$3.57-5.60	$1.71-5.92
	n=9	n=12
201-300 Beds		
Average minimum	$4.36 (+61)	$3.75
Median minimum	$4.24 (+42)	$3.82
Range	$3.19-6.12	$3.19-4.22
	n=10	n=7
Average maximum	$4.99	$5.01 (+02)
Median maximum	$5.07 (+10)	$4.97
Range	$3.86-6.51	$4.58-5.77
	n=10	n=7
Average average	$4.69 (+16)	$4.53
Median average	$4.50 (+09)	$4.41
Range	$3.86-6.51	$4.30-4.84
	n=4	n=5

continued on next page

Appendix F - continued

	Unionized[b]	Nonunion[b]
301-400 Beds		
Average minimum	$4.55 (+37)	$4.18
Median minimum	$4.55 (+52)	$4.03
Range	$4.22-4.89	$3.83-4.86
	n=4	n=6
Average maximum	$5.87 (+76)	$5.11
Median maximum	$5.87 (+75)	$5.12
Range	$4.63-7.11	$4.78-5.43
	n=4	n=5
Average average	$4.98 (+17)	$4.81
Median average	$4.98 (+20)	$4.52
Range	$4.43-5.54	$4.23-5.77
	n=4	n=5
400+ Beds		
Average minimum	$4.68 (+11)	$4.57
Median minimum	$4.71 (+19)	$4.52
Range	$3.39-6.76	$3.67-5.35
	n=11	n=9
Average maximum	$6.09 (+32)	$5.77
Median maximum	$5.73 (+02)	$5.71
Range	$4.54-9.45	$4.47-7.69
	n=11	n=9
Average average	$5.74 (+52)	$5.22
Median average	$5.21 (+19)	$5.02
Range	$4.04-7.81	$4.25-6.19
	n=7	n=9

SOURCE: Michigan State University School of Labor and Industrial Relations Nursing Data Sheet, computations from questions four, six and fourteen.

*Figures in each category equaling "n" indicate the number of observations the averages and medians are based on. For the actual number of facilities in each bed category, see TABLE 1.

[b]Parenthesized figures indicate the difference in cents between unionized and nonunion hourly salaries (excluding extra pay for shift differentials, on-call, etc.), and are calculated by subtracting the smaller hourly figure from the larger, and parenthetically recording the difference in the column containing the larger figure in each average and median category.

Appendix G

HOURLY EARNINGS OF FULL-TIME NURSING PERSONNEL IN MSU SURVEY RESPONDENTS BY TYPE OF BARGAINING REPRESENTATIVE AND NURSING POSITION

Appendix G

HOURLY EARNINGS OF FULL-TIME NURSING PERSONNEL IN MSU SURVEY RESPONDENTS BY TYPE OF BARGAINING REPRESENTATIVE AND NURSING POSITION

Nursing Position	Nonunion	Professional Assn.	Labor Union	Aggregate
RN				
Minimum	$ 6.41	$ 6.47	$ 6.78	$ 6.45
Maximum	7.92	7.64	8.58	7.87
Average	7.35	7.14	7.46	7.27
LPN				
Minimum	$ 4.87	$ 4.99	$ 5.00	$ 4.95
Maximum	6.09	5.84	6.15	6.06
Average	5.43	5.65	5.53	5.48
Aide				
Minimum	$ 3.78	-	$ 4.21	$ 3.95
Maximum	4.66	-	4.96	4.79
Average	4.33	-	4.63	4.44

Appendix H

NUMBER OF RESPONDENTS PROVIDING SHIFT DIFFERENTIAL INFORMATION, BY CATEGORY AND TYPE OF INFORMATION PROVIDED (supplements Table 21)

Appendix H

NUMBER OF RESPONDENTS PROVIDING SHIFT DIFFERENTIAL INFORMATION, BY CATEGORY AND TYPE OF INFORMATION PROVIDED (supplements Table 21)

Bed Size / Shift	Number of Respondents						Provided Data	Solicited & Percent
	Percentage of Hourly Earnings			Dollars per Hour				
	Union	Nonunion	Total	Union	Nonunion	Total		
1-100	N	N	N	N	N	N		
Afternoon	1	11	12	14	34	48	61 / 99	(61.6%)
Night	1	11	12	14	36	50		
101-200								
Afternoon	1	5	6	9	9	18	23 / 54	(42.6%)
Night	1	5	6	9	10	19		
201-300								
Afternoon	3	4	7	6	8	14	18 / 35	(51.4%)
Night	3	4	7	6	8	14		
301-400								
Afternoon	-	2	2	1	4	5	7 / 17	(41.2%)
Night	-	2	2	1	4	5		
401+								
Afternoon	3	13	16	2	8	10	22 / 38	(57.9%)
Night	3	13	16	2	8	10		
Total								
Afternoon	8	35	43	31	63	95	131 / 243	(53.9%)
Night	8	35	43	31	63	98		

Appendix I

RN SHIFT DIFFERENTIALS REPORTED IN CENTS PER HOUR, BY UNION STATUS AND HOSPITAL BED SIZE

Appendix I

RN SHIFT DIFFERENTIALS REPORTED IN CENTS PER HOUR, BY UNION STATUS AND HOSPITAL BED SIZE

AFTERNOON

Bed Size	Union		Nonunion		Total	
	n	¢	n	¢	n	¢
1-100	15	35	36	25	51	28
101-200	10	43	8	40	18	42
201-300	6	61	8	35	14	46
301-400	1	45	4	64	5	60
401-plus	4	49	4	40	8	44
Total	36	43	60	32	96	36

NIGHT

Bed Size	Union		Nonunion		Total	
	n	¢	n	¢	n	¢
1-100	15	39	36	34	51	35
101-200	10	46	9	41	19	44
201-300	6	70	8	35	14	50
301-400	1	60	4	70	5	68
401-plus	4	52	4	40	8	46
Total	36	48	61	38	97	41

Appendix J

EDUCATIONAL INCENTIVES AND REIMBURSEMENT PROGRAMS REPORTED BY MSU SURVEY RESPONDENTS

Appendix J

EDUCATIONAL INCENTIVES AND REIMBURSEMENT PROGRAMS REPORTED BY MSU SURVEY RESPONDENTS

Per semister/term, or credit hour reimbursement schedules:

$200 maximum
$200 or 75% (whichever is less)
50%
50% plus additional tuition supplements
$350 maximum
two-thirds of tuition
75% for full-time employees; 50% for part-time over 24 hours per week
100% for full-time; prorated for part time
100% for first $250, and 75% of the difference up to $600 per year for full-time; 50% for the first $250 and 37.5% of the difference up to $600 per year for part-time
75% up to 8 cr. hrs. per semister for 32-plus hour per week employees
75% up to $250 per term
50% up to 6 cr. hrs. for full-time; 50% up to 3 cr. hrs. for part-time employees.
75% up to $300 per semister for unionized employees; 50% of this for part-time and nonunion employees
$45 per credit hour (maximum)
$50 per credit hour (maximum)
100% for 9 credit hours per year
100% for up to $50 per credit hour

Per year reimbursement programs:

$100 (maximum)	50% up to $500
$125 (maximum)	$300
$150	$400
$200	$500

Achievement related aid programs:

#1) A=80%
B=70%
C=60%
below C=0%

#2) percentage for A or B

#3) A, B or C reimbursed at 100$ of cost

Othe reimbursement programs:

75% of total costs
100% of total costs
100% of tuition
75% for night shift nurses; 50% for afternoon shift nurses

Appendix K

FTE NURSING POSITIONS BY CITY SIZE
FTE NURSING POSITIONS BY HOSPITAL BED SIZE
FTE NURSING POSITIONS BY TYPE OF HOSPITAL CONTROL

Appendix K

FTE NURSING POSITIONS BY CITY SIZE

City Size	HN	RN	LPN	Aide	Totals	Reporting[1]
100,000+	390	3,508	1,845	2,592	8,335	24/ 59
50,000-100,000	261	2,979	1,327	1,812	6,379	17/ 24
25,000-50,000	117	1,050	561	581	2,309	11/ 27
10,000-25,000	172	770	565	1,439	2,946	18/ 27
under 10,000	306	1,041	911	1,756	4,014	49/106
Totals	1,246	9,348	5,209	8,180	23,983	119/243

FTE NURSING POSITIONS BY HOSPITAL BED SIZE

Bed Size	HN	RN	LPN	Aide	Totals	Reporting
1-100	304	900	710	1,109	3,023	54/ 99
101-200	215	1,050	592	1,023	2,880	22/ 54
201-300	152	1,546	789	1,044	3,531	15/ 35
301-400	152	1,302	787	691	2,932	8/ 17
401+	423	4,550	2,331	4,313	11,617	20/ 38
Totals	1,246	9,348	5,209	8,180	23,983	119/243

FTE NURSING POSITIONS BY TYPE OF HOSPITAL CONTROL

Hospital Control	HN	RN	LPN	Aide	Totals	Reporting
Proprietary	3	2	2	21	28	1/ 5
Non-profit	718	5,070	2,829	3,605	12,222	69/145
Non-profit/Rel.[2]	154	1,552	769	687	3,162	10/ 20
Federal gov't	53	454	179	505	1,191	3/ 6
State gov't	52	258	332	2,146	2,788	7/ 14
Local gov't	225	924	681	1,090	2,920	23/ 53
Other	25	1,061	385	89	1,560	4/ 4
No Info.[3]	16	27	32	37	112	2/ 2
Totals	1,246	9,348	5,209	8,180	23,983	119/243

[1] The first figure indicates the number of hospitals that provided information on FTE nursing positions by the categories listed. The figure in the right hand column indicates the total number of hospitals in each category in the 243-facility effective population.

[2] Abbreviation for Non-profit/religious.

[3] No control type was indicated by these two respondents.

Source: Questions one, two, four and six in the MSU Nursing Data Sheet.

Appendix L

UNSUCCESSFUL/INCOMPLETE FORMAL ORGANIZING EFFORTS REPORTED BY HOSPITALS RESPONDING TO THE MSU NURSING SURVEY (since 1970)

Appendix L

Unsuccessful/Incomplete Formal Organizing Efforts Reported by Hospitals Responding to the MSU Nursing Survey (since 1970)

Labor Organization/Year	Hospital Location (city size)	Type of Hospital Control	Hospital Bed Size	Comments
Teamsters/1976	under 10,000 under 10,000	local gov't.	20	"voted down"
Steelworkers/1979	under 10,000	non-profit	81	in process at time of survey
SEIU/(Feb.) 1978	under 10,000	non-profit	82	"voted down"
SEIU/ ?	under 10,000	non-profit	106	"failed in campaign stage"
United Food & Commericial Workers Intl. Union[1]/?	10,000-25,000	non-profit	174	"Retail Clerks tried twice in the last 6 yrs., & lost both times"
SEIU/1977	25,000-50,000	non-profit	228	"unsuccessful"
Teamsters MNA SEIU AFSCME/1973 — 1977	25,000-50,000	non-profit	253	"union lost elections"
SEUI MLPNA AFSCME Steelworkers — at various times	25,000-50,000	?	328	all rejected by the employees ("RNs currently represented by the MNA)
AFSCME/1978	100 100,000+	religious/ non-profit	423	union lost election (aides represented by AFSCME)
MNA SEIU MLPNA IAM[2] — 1978	50,000-100,000	non-profit	485	"all defeated" (aides represented by the IUOE)

AFSCME/71 SEIU/1972 Hotel, Restaurant Employees & Bartenders Intl. Union/1975 SEIU/1978	100,000+	non-profit	554	"employees rejected unions" (all nursing personnel currently are nonunion)
Indepandent/1979	100,000+	non-profit	597	LPNs & aides were unionized prior to this effort; mgmt. won this RN representation election.
AFSCME/?	under 10,000	state gov't.	800	aides-election results not given. (RNs & LPNs are currently nonunion)
AFSCME/1979	50,000 100,000	non-profit	940	organizing effort being conducted at the time of the survey)

[1]At the time of the organizing drive, the labor organization was referred to as the Retail Clerks international Union.

[2]Abbreviation for the International Association of Machinists and Aerospace Workers.

NOTE: Several of the hospitals returning questionnaires simply answering "numerous", "many", etc., to question number 16. Other hospitals replied that there had been some union activity, but no formal records were kept. of the activity. The only organizing efforts reported in this table were the ones documented in the returned questionnaires.

Source: Information reported in questions one,two, four, fourteen, sixteen and seventeen of the MSU Nursing Survey Data Sheet.

Appendix M

WORK STOPPAGE SUMMARY

Appendix M

WORK STOPPAGE SUMMARY

GROUP	STARTING DATE	LENGTH	BEDS	HOSPITAL TYPE
Aide	3/77	26 Days	21	State
RN	7/78	28 Days	56	Nonprofit
LPN	7/78	28 Days	56	Nonprofit
LPN	11/77	64 Days	93	Nonprofit
Aide	11/77	64 Days	93	Nonprofit
Orderly	11/77	64 Days	93	Nonprofit
LPN	7/79	122 Days	127	Religious
Aide	5/68	35 Days	143	Nonprofit
LPN	7/76	19 Days	145	Nonprofit
Aide	7/76	19 Days	145	Nonprofit
RN	(1971)	14 Days	158	Nonprofit
RN	(1971)	14 Days	158	Nonprofit
RN	3/78	45 Days	199	Nonprofit
LPN	3/78	45 Days	199	Nonprofit
LPN	3/73	30 Days	214	Nonprofit
Aide	3/73	30 Days	214	Nonprofit
Aide	4/75	15 Days	224	Nonprofit
Aide	5/72	1,004 Days	239	Nonprofit
RN	8/77	25 Days	243	Nonprofit
RN	12/77	76 Days	256	Nonprofit
RN	12/78	1 shift	409	Local Gov't.
Aide	2/79	4.5 Days	409	Local Gov't.
LPN	2/79	4.5 Days	409	Local Gov't.
LPN	5/77	13 Days	473	Religious
Aide	5/77	13 Days	473	Religious
RN	3/70	2 Days	524	Local Gov't.
Aide	3/70	2 Days	524	Local Gov't.
LPN	3/70	2 Days	524	Local Gov't.

SOURCE: MSU Survey Data.

Appendix N

LABOR LAW STATUS OF MICHIGAN HOSPITALS

Appendix N

LABOR LAW STATUS OF MICHIGAN HOSPITALS

hospital type	bargaining covered by	rights since	right to strike	right to organize	right to bargain collectively	admin. authority for unit determination
federal	E.O. 10988[2]	1962	no	yes	yes[1]	individual agencies
	E.O. 11491[2]	1970	no	-	-	asst. sec. of labor
state/local	PERA[3]	1947	no	yes	yes[4]	MERC[5]
proprietary[6]	LMA[7]	1939	yes[8]	yes	yes	MI. Labor Med. Board
	NLRA	1967	yes	yes	yes	NLRB
nonprofit	NLRA[9]	1935	yes	yes	yes	NLRB
	LMA	1939[10]	yes[11]	yes	yes	MI. Labor Med. Board
	NLRA	1974[12]	yes[13]	yes	yes	NLRB

1. Negotiations primarily limited to noneconomic matters; salaries fixed through civil service; advisory (nonbinding) grievance arbitration.

2. Created the Federal Labor Relations Council to arbitrate policy questions/disputes and the Federal Service Impasse Panel to settle contract negotiations in the event of a failure in voluntary negotiations.

3. Public Employment Relations Act, Michigan Complied Laws Annotated, Sections 423.201-423.216 (1947), as amended (1965). Authorizes public employees to join labor organizations of their choosing and bargain collectively with their public employers. Does not cover employees in classified state civil service positions because the 1963 Constitution prohibits the state legislature from enacting laws applying to them. However, some of these employees are union members.

4. Political subdivision public employees are granted the right to bargain collectively; state public

employees have the right to meet and confer with the employer regarding terms of employment, although eventual decisions are the responsibility of the employer.

5. Formerly the Michigan Labor Mediation Board.

6. The 1935 Wagner Act (49 U.S. Stat. 449, July 5, 1935) was silent on the coverage of proprietary facilities, but the NLRB declined jurisdiction over these facilities until 1967. The NLRB asserts jurisdiction over proprietary facilities having at least $250,000 gross annual revenue (employers who refuse to supply the Board with appropriate financial data may have Board jurisdiction asserted without the dollar criterion being met). Butte Medical Properties, d/b/a Medical Center Hospital, 168 NLRB 52 (1967).

7. Michigan Labor Mediation Act, Michigan P.A. 1939, No. 176 (June 8, 1939), as amended by P.A. 1947, No. 318 (July 1, 1947), and P.A. 1949, No. 230 (May 31, 1949).

8. From 1947 to 1949, the LMA required binding arbitration in the case of hospital disputes, with injunctive relief available to enforce the arbitration decisions. The arbitration and injunctive relief provisions were repealed in 1949.

9. While the Wagner Act covered nonprofit hospitals, only one case was contested involving the coverage of a nonprofit facility, and the Board and court of appeals sustained jurisdiction. Central Dispensary & Emergency Hospital, 44 NLRB 533 (1942), enforced, 145 F. 2d 852 (D.C. Cir. 1944), cert. denied, 324 U.S. 847 (1945).

10. Constitutionality challenged and upheld in Local No. 1644 American Federation of State, County and Municipal Employees, AFL-CIO, et al. v. Oakwood Hospital Corporation (July 2, 1962), 50 LRRM 2751.

11. Emergency machinery to prevent hospital employee work stoppages, primarily relying on advance notice requirement with the MERC preceding a work stoppage, and recommendations of arbitration to the parties in conflict.

12. P.L. 93-360, 93d Cong. S. 3203, 88 Stat. 395, July 26, 1974. Repealed Taft-Hartley Sec. 2(2) exclusion of nonprofit health care facilities from NLRA coverage.

13. Advance notification required prior to agreement termination (90 days, versus 60 days in other industries), striking and/or piciketing; mandatory mediation by the FMCS.

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