Fall 1988

The management response to union organizing of registered nurses

Jill Kathleen Kriesky
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UMI

THE MANAGEMENT RESPONSE TO UNION ORGANIZING OF REGISTERED NURSES

BY

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DISSERTATION

Submitted to the University of New Hampshire
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the Requirements for the Degree of

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in

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ABSTRACT

THE MANAGEMENT RESPONSE TO UNION ORGANIZING OF REGISTERED NURSES

by

Jill Kriesky
University of New Hampshire, September 1988

In recent decades, employment in the service sector has swelled while the number of jobs in manufacturing has declined. Simultaneously, the percent of the workforce belonging to labor unions has fallen to about seventeen. It is the organization of service industry workers which unions expect to reverse the latter trend. However, a major obstacle facing union organizers of service workers is management's increasing use of labor-management consultants to resist organization.

In a growing, predominantly female, service occupation, registered nurses (RNs) in hospitals represent the type of workers unions must organize to increase membership. While dissatisfaction with job conditions makes nurses ripe for unionization, consultant-inspired management has responded with union election campaign tactics and personnel policies designed to discourage RN interest in unions. This dissertation seeks to determine the effectiveness of these strategies in limiting unionization among hospital RNs.

Based on a review of relevant management, union, and academic literature, employers which have experienced union activity among

workers appear to maintain different personnel policies than those which have not. Further, institutions employing consultants appear to use policies not used by their counterparts without such assistance.

These observations are examined thoroughly in a case study of RN-managment relations at the Portsmouth (N.H.) Hospital from 1979 through 1986. Analysis of a survey of hospital administrators in Maine and New Hampshire also seeks to identify the specific consultant-inspired techniques used to discourage RN organizing.

The research indicates that, despite the consultants' contention that they provide advice on preventive labor relations and on methods to defeat organizing drives, their use in the latter role predominates. Additionally, results found here are consistent with the view that consultant-inspired management changes its communication style and implements new personnel policies in response to perceived organizing threats. The revisions rarely occur in categories which administrators believe substantively affect nurses' job satisfaction. But hospitals appear to make changes in communication programs believing that RNs will perceive them as responsive to their needs. Based on the survey analysis, the tactic appears to have contributed to management success in discouraging unions in Maine and New Hampshire hospitals.

CHAPTER ONE

INTRODUCTION

In recent years, employment in United States manufacturing industries has declined precipitously while the ranks of service occupations have swelled. Service-sector jobs account for nearly ninety percent of all positions created in the 1970s. By the early 1990s, three-fourths of all U.S. jobs may fall into the service classification (AFL-CIO Committee on the Evolution of Work 1985, 8). Labor union membership changes parallel this phenomenon. Auto, steel, and textile workers' unions are shrinking at the same time that teachers, communication workers, and other service workers' organizations expand (U.S. Department of Labor 1980, 661). So far, the expansion has not offset the losses. Union membership, as a proportion of the entire workforce, has fallen from approximately thirty percent to seventeen percent in the last twenty years (Economic Notes 1988, 3).

Apologists for this poor membership record have pointed to a variety of obstacles facing union organizers. But many of their traditional justifications are no longer acceptable. For example, the widespread organization of teachers and government employees in recent years dispels the belief that "white collar" service workers refuse to unionize on professional grounds. Similarly, research denies the commonly accepted theory that women shy away from labor organizations. The University of Michigan's Institute for Social Research reports that forty-one percent of

women not now organized would vote for a union if an election occurred at their workplace (Freeman and Medoff 1984, 29). This is particularly important for unions given that women already hold nearly two-thirds of all service jobs (U.S. Department of Labor 1987, 3). Finally, successful contract negotiations, such as those recently completed by Boston's Local 26 of the Hotel Employees and Restaurant Employees International Union, Yale University clerical workers, and Equitable Life Insurance Company workers (Syracuse, NY), demonstrate that unions can bargain effectively on the nontraditional issues of employee respect, discrimination against women, and office health hazards (Hotel Restaurant, Institutional Employees and Bartenders Union, Local 26, and Member Hotels of the Greater Boston Hotel and Motor Inn Association 1982; Maschinot 1984; The Progressive 1985).

In spite of these improvements in the unionizing climate, a major hurdle for organizers exists. According to a 1985 report published by the American Federation of Labor-Congress of Industrial Organizations (AFL-CIO) Committee on Work:

> A study of organizing campaigns in the private sector shows that 95 percent of employers actively resist unionization, and 75 percent of all employers hire so-called "labor-management consultants" to guide their efforts to avoid unionization at an estimated cost of $100,000,000 annually. (AFL-CIO 1985, 10)

From their consultations, books, articles, and seminars, employers have learned to resist organizing efforts at several stages. For example, company- initiated grievance procedures and discussion groups are two positive labor relations techniques that can help to keep unorganized

workers uninterested in unions. More aggressive union avoidance tactics include firmly worded statements about the company's intention to remain nonunion and preemployment screening of potential union sympathizers. Management actually faced with a certification election has adopted a variety of antiunion methods ranging from legal enforcement of solicitation rules to illegal firing of prounion workers.

In order to explore the impact of employers' resistance on union organizing, this investigation is limited to one representative occupation--registered nursing in hospitals. There are currently nearly 1.6 million working registered nurses in the United States. Two-thirds are employed in hospitals (Fagin 1987, 121). To an even greater extent than most service occupations, women dominate nursing. Over ninety-four percent of nurses are female (U.S. Department of Labor 1987, 3).

Even by service industry standards, expansion in health care over the last two decades has been impressive. The aging of the U.S. population, growth of private and public health insurance coverage (Kahl and Clark 1986,17), rising personal income, and newly researched treatments for previously incurable diseases all contributed to a 5.6-percent annual growth in health care output between 1960 and 1984 (Kahl and Clark 1986, 25). That increase, in turn, increased registered nurses' (RNs) employment in hospitals by sixty percent during the 1970s (Sekscenski 1981, 11).

In 1984, the federal government began phasing in a prospective payment system for medicare reimbursement. The diagnosis-related group (DRG) system ties the reimbursement for services to established rates for 467 DRGs. It has reduced hospital admissions, staffed beds, and length of

stays and motivated administrators to contain costs by reducing employment of licensed practical nurses, nursing aides, clinical laboratory technologists and technicians, and others (Kahl and Clark 1986, 28). While forecasters are uncertain whether output of hospital services will continue to grow through the 1990s (Kahl and Clark 1986,32), they have established that demand for registered nurses will remain strong as they "assume some of the duties previously performed by other health personnel" (Silvestri and Lukasiewicz 1987, 57).

Union Organizing among Registered Nurses in Hospitals

Prior to 1974, the National Labor Relations Act (NLRA) did not protect the collective bargaining rights of nurses and other health care workers in nonprofit hospitals. However, in 1939, health care workers in Wisconsin won legal protection for union activity with the court determination that the state's general labor code did not exclude them. Ten other states--Connecticut, Massachusetts, Michigan, Minnesota, Montana, New York, Oregon, Pennsylvania, Idaho, and New Jersey--also enacted laws providing these workers some collective bargaining rights before 1974 (Miller 1980, 384-5).

Initially, organizing among registered nurses moved slowly for two reasons. The public perception of nursing and values taught to nursing students encouraged their complete dedication to their patients and hospitals:

> As the profession developed in the nineteenth century, nursing came to epitomize the culturally idealized woman in its public image. Unswerving in her devotion to caring for her patients, the nurse carried into the hospital the roles of mother and wife: submissive,

> supportive, obedient, and self-sacrificing. In turn, these roles were reinforced by hospitals which provided the training for young women who sought careers in nursing. Hospital nursing emphasized hierarchical relationships, strongly suggestive of military organizations in which uniforms identified rank; rules, often of a paternalistic nature, strictly governed behavior; and deference and respect for authority were instilled. The nurse's cap symbolized a way of life without whose self-effacing dedication nursing could not be considered a profession. (Miller 1980, 404)

In addition, the RNs' professional organization, the American Nurses Association (ANA), failed to embrace the concept of collective bargaining for many years. In 1938, the ANA's journal argued that "a nurses' union would be almost, if not quite as absurd as a mother's union" (Miller 1980, 404). But during the next decade, nurses, like other workers, observed the effectiveness of unions in addressing unemployment, inflation, and their other concerns. State nurses associations in California and Minnesota began to organize RNs and to secure contracts for them. By 1946, the California Nurses Association had won its first contract. Two years later, the Minnesota Nurses Association had signed contracts in fifty hospitals (Miller 1980, 404).

By the late 1940s, the ANA gradually began to accept and to promote such activity. It adopted the idea of an economic security program "to guarantee reasonable and satisfactory conditions of employment while at the same time assur[ing] the public of professional nursing services of quality and quantity" (Miller 1980, 405). Forty-three state associations established these programs in the following decade. But in 1950, the national organization reiterated both its opposition to strikes by nurses and its insistence on nurse neutrality in disputes of other health care workers. It finally abandoned those policies in 1968, but gave the state associations

the discretion to continue them. Still, observers note that the ANA's limited commitment to the concept of unionization, together with its small contribution of financial and human resources to the cause, has tempered the growth of RN unions throughout their history (Miller 1980, 405-6).

In 1974, Congress passed Public Law 93-360, an amendment to the National Labor Relations Act. It provides protections similar to those in the NLRA for workers in nonprofit hospitals. Rules governing their collective bargaining rights differ slightly from those of other private sector employees.[1] However, the protections and limitations to organizing activities are essentially the same. While the law presented many nurses with their first opportunity to join unions with the protection of the NLRA, observers note that at least three new obstacles arose.

First, hospitals' arguments about the appropriate bargaining unit for nurses has engendered vigorous debate. In accordance with a congressional mandate to avoid an excessive number of bargaining units in health care facilities, the National Labor Relations Board (NLRB) established five basic units--registered nurses, other health care professionals, technical employees, service and maintenance employees, and business office clericals--in 1975 (Miller 1980, 387). But some hospitals have insisted that one professional unit better represents a single community of interest than a separate RN unit. The NLRB and federal courts have produced contradictory rulings on the topic, causing delay and confusion in organizing efforts (Selby 1984, 6). Union proponents believe that management has raised the issue explicitly to postpone elections.

Second, hospital management has contested some elections involving state nurses associations, charging that their inclusion of supervisory nurses

creates a conflict of interest in bargaining. On the one hand, delay and uncertainty in the legal resolution of this issue has resulted in slow progress for organizing and certification by the associations which, so far, have exhibited the most success in organizing this professionally oriented workforce (Selby 1984, 6; Miller 1980, 405). On the other hand, the difficulty has provided opportunities for the American Federation of Teachers (AFT), the International Brotherhood of Teamsters (IBT), the American Federation of State, County, and Municipal Employees (AFSCME), 1199--the National Union of Hospital and Health Care Employees (1199), the Service Employees International Union (SEIU), and as many as fifteen other unions to use their greater experience and financial resources to organize RNs (Miller 1980, 408; Schanie 1984, 70).

Third, health care organizers report that resistance to unionization directed by management consultants has hindered their efforts. They charge that consultants create an atmosphere of antagonism and fear which "almost always works against the Union, rather than against those who are responsible for it" (Daily Labor Report 1981, D-10). They argue that consultants violate both the intent and letter of the NLRA and its amendments.

Still, as the numbers reported above indicate, these obstacles to unionization in health care, and specifically among RNs, have not completely discouraged unionization since 1974. Wage and benefit concerns undoubtedly motivated a substantial number of prounion votes during this time period. In 1987, the average minimum and maximum salaries for staff nurses were $19,676 and $26,362 (Iglehart 1987, 649). However, observers suggest that the following issues were, perhaps, more

influential in election outcomes.

First, some observers argue that the salaries not only fail to provide adequate support for families, they are not commensurate with the responsibility which nurses carry (Iglehart 1987, 646). In addition, over the last several decades there have been intermittent nurse shortages which temporarily increase the workload and, therefore, responsibilities of working RNs (Fagin 1987, 120). These factors have led some RNs to debate whether their professional commitment to nursing requires that they continue to perform to the best of their abilities under adverse conditions or that they consolidate power by organizing and demand changes in working conditions (see Beletz 1980; Colangelo 1980; Flaherty 1980; and Jacox 1980).

Some nurses have also looked to unionization for the answer to problems of occupational definition which plague their field. RNs' responsibilities for patient care are great, but their autonomy is limited by physician's decision making (Iglehart 1987, 646):

> Central to the RN's problems has been nursing's inability to carve out more professional tasks for nurses. Training has been extended and moved out of hospitals and into academies, where it has become more theoretical, less practical and presumably more professional and prestigious; and some routine skills of the RN have been given to others, but few claims to new ground have been staked out. The result for the RN: more years of schooling, an actual shrinkage of her scope of practice (on the lower end), and rising frustration at being overschooled for her job (Sexton 1981, 48).

Two final issues have further complicated this dissatisfaction and motivated nurses to look for solutions through unionization. First, observers admit that hospitals fail to pay serious attention to RN

suggestions on practices and policies despite their direct contact and awareness of problems in servicing patients (Iglehart 1987, 646). Second, with the growing recognition of women's equality in society, some nurses have sought to increase doctors' awareness of their professional status. As one nurse explained, "The relationship of RNs to doctors is a big issue in the hospital. One day the doctor will learn that the nurse is not a maid" (Sexton 1981, 50).

Additional RN Organizing Issues in the 1980s

Hospital administrators and nurse organizers agree that three additional factors have worsened the working conditions of nurses in the 1980s. One is that the demand for nursing services has risen. The nurse-patient ratio grew from fifty nurses per one hundred patients in 1975 to eighty-five RNs per one hundred patients in 1985. Simultaneously, the enrollment in two-year associate degree, three-year diploma, and four-year bachelor's degree nursing programs has declined (Iglehart 1987, 648). The 1986 rate of RN position vacancies--13.6 percent--was twice that of the 1985 figure (Iglehart 1987, 647). That the factors creating this shortage are not likely to change soon suggests that it will continue for several years.

Second, the proprietary hospital chain is increasing its share of the market, although, overall, the portion it represents is small. Between 1978 and 1983, the number of for-profit chain hospitals increased from 437 to 767--an increase of seventy-six percent. During the same time period, proprietary chains also took over ninety-one nonprofit hospitals (Senior Citizens News 1986). Initial reports indicate that the low wages and heavy

patient loads for nurses in these institutions are a growing source of dissatisfaction among RNs (Craypo and Lehman 1986, 39-45; National Council of Senior Citizens 1986, 22-24, Steffens 1984).

Finally, debate has continued for at least two decades regarding the appropriate degree credentials in the nursing profession. Two-thirds of all RNs enter the field with associate degrees or diplomas. But since 1964, the ANA argued that all professional nurses should earn bachelor's degrees. Finally, in 1985, the organization "called for two minimum educational thresholds: a baccalaureate degree for the professional nurse and an associate degree for a worker to be known as a technical nurse" (Iglehart 1987, 649). Other nursing associations--the American Association of Colleges of Nursing and the National League of Nursing--have adopted this position after similarly lengthy discussion. This resolution of the "education debate" suggests that the proportion of RNs holding bachelor degrees will continue to grow. But "remarkably little progress has been made by hospital leaders to improve working conditions for nurses to ensure the future stability of their institutions and the care of the sickest segment of the health care marketplace" (Fagin 1987, 121). Some observers expect the increased preparation to further exacerbate the nurse frustration respecting job autonomy discussed above.

All of these considerations have contributed to the growth of union representation among nurses and other hospital workers in the last two decades. The annual growth rate of union membership in hospitals was 5.6 percent during the 1970s (Becker, Sloan, and Steinwald 1982, 4). By the 1980s, approximately twenty-seven percent of hospitals had at least one contract with employee groups (Richman 1984, 121). Health care experts

have predicted that forty-five to sixty-five percent of hospitals may have at least one organized employee group by 1990 (Richman 1984, 122). These statistics are particularly impressive given the history of limitations to health care employee organization.

A summary of the foregoing discussion establishes four characteristics of registered nurses in hospitals which make it an appropriate occupation for the study of management resistance to union organizing in the service sector. First, experts expect job opportunities in the field to continue to expand. Next, there is evidence that nurses' working conditions have and will continue to move them to seek representation. Likewise, many unions have demonstrated the willingness and ability to organize workers in the rapidly expanding industry. Finally, health care organizers have identified the use of management consultants as a serious obstacle to the success of their campaigns.

Contents of the Dissertation

The central purpose of this dissertation is to determine the effectiveness of consultant-inspired avoidance tactics used by management in response to the threat of union organizing among registered nurses. To do so, the following three steps are taken. First, the management, union, and academic literature describing strategies recommended by management consultants regarding how to resist unions is reviewed. This review identifies both personnel policy responses and election campaign methods which consultants may advise hospital administrators to use to prevent organization among registered nurses. It also reports on the current quantitative assessment of consultants' impact on workers' decision to

organize. Finally, the review points out "continuing" forms of resistance to unionization--those that may appear during collective bargaining with an established local.

Based on the literature review, it appears that hospitals which have experienced union activity among their registered nurses maintain different personnel policies than those which have not. Similarly, institutions employing management consultants have established personnel policies which their counterparts without such assistance do not use. These two observations comprise the major hypothesis examined in the following two parts of this dissertation.

A case study of the role of management consultants provides a thorough examination of the types of obstacles to unionization which they may recommend. Following the advice of consultants, the hospital administration of the Portsmouth (New Hampshire) Hospital attempted to dissuade the nurses from pursuing union representation before, during, and after a 1978 certification election. The case study of this nurses' bargaining unit outlines the history of RN-management relations, focusing on management efforts to resist the union using many of the methods described in the literature review. The study examines both the administration's and union's views of union avoidance strategies over a ten-year period.

The final and most important part of the dissertation is an analysis of a survey which attempts to identify the specific consultant-inspired union avoidance techniques employed by hospital personnel directors in Maine and New Hampshire. In the summer of 1986, personnel administrators in these two states completed a mail survey describing their personnel

policies, consultant use, union activity in their own and neighboring hospitals, and union certification election campaign methods. A quantitative study of the relationships between policy variables and consultant advice is undertaken. The goal is to identify the importance of various policies to RN job satisfaction, and to determine which of these policies consultants recommend implementing and changing in response to union activity.

The dissertation's concluding chapter assesses the validity of the main hypothesis based on the case study and survey analysis. It establishes the contribution made by this research to the current understanding of consultants' influence in shaping hospital management opposition to unionization. Also included in the final chapter are suggested directions for future research which emerge from the study undertaken here.

CHAPTER NOTES

[1]Parties intending to modify or terminate contracts must notify their adversaries and the Federal Mediation and Conciliation Service (FMCS) thirty days earlier than in other industrial settings. Unions must provide ten days' notice of their intent to picket or strike a health care facility, and parties must participate in mediation offered by the FMCS. The FMCS director may require a Board of Inquiry (BOI) study of outstanding issues if a strike or lockout appears likely to interrupt health care delivery. The BOI issues its nonbinding report within fifteen days of its establishment (Miller 1980, 386).

CHAPTER TWO

A REVIEW OF MANAGEMENT, UNION, AND ACADEMIC LITERATURE ADDRESSING EMPLOYERS' RESISTANCE TO UNION ORGANIZING

An accurate assessment of the academic literature on management resistance to the union organizing of registered nurses requires a review of the management and union practitioners' views. This isolates the factors which each side believes are central to the effort to defeat unions. In the following pages, examples of information disseminated by a variety of management sources to limit unionization before, during, and after an organizing campaign are first presented. The evaluations and responses to management's actions made by union sources then follow. Once the relevant variables in employers' campaigns to defeat RN unions are established, the academic literature addressing the topic is examined.

The Management Consultants' Message

Types of Consultants Assisting Management

There are four major sources of management advice on handling the threat of union organizing. Several employer organizations have departments which specialize in providing members with information on how to avoid unionization. The most nationally prominent among these is the Council on a Union-free Environment (CUE)--a subsidiary of the National Association of Manufacturers. Member hospitals concerned

with organizing by their employees depend on the American Hospital Association (AHA) for such assistance (McDonald and Wilson 1979, 4). A second group spreading the nonunion message is the management consulting firm. While more than 1,000 of these operate in all parts of the country (U.S. Congress 1979a, 410), the best known and the most active in the health care industry is the Chicago-based firm Modern Management, Inc. Individual labor relations attorneys represent a third source of information on union avoidance. There may be more than 1,500 of them advising managment clients. Based on their own admissions at congressional hearings in 1979, there numbers increased tenfold between 1969 and 1979 (U.S. Congress 1980a, 112). Finally, many large corporations maintain in-house staffs to address labor relations problems within their plants and offices nationwide. International Business Machines and Texas Instruments are, perhaps, the most widely publicized examples in this category. At least one major proprietary hospital chain--Hospital Corporation of America--appears to develop labor relations policies centrally for its institutions (Craypo and Lehman 1986, 51-56).

Through publications, films, seminars, and individual consultations these carriers provide management three types of assistance. First, they alert employers to sources of workplace dissension and advocate preventive labor relations policies designed to keep the dissatisfaction from growing into a demand for union representation. Second, consultants may inform management of the the legal restraints placed on them during a union election campaign and how to respond to them. Finally, if the above methods fail, they may continue to assist

management in contract negotiations and in decertification campaigns. Their performance in each of these roles is considered below.

Sources of Dissatisfaction and Preventive Policies

Consultants frequently view their role as that of "marriage counselors" encouraging improvements in the relationship between employers and employees. Consultant Fred Long of West Coast Industrial Relations Association describes his job in the following way:

> . . . the role of labor-relations consultants is not to block union representation, but rather to help employers willingly provide a safe and financially secure work place for their employees. When employers make a conscientious effort toward that goal, there simply is no need for unionization and employer, employees, and productivity all benefit. (Lagerfeld 1981b, 16)

Communications Virtually all consultants' advice on sources of worker dissatisfaction stresses the importance of communication. Representative of the communications programs consultants the CUE's outline of the "six C's of employee communications" found in its guide, Communications and Climate Building in the Union-free Environment (Council on Union-free Environment 1979, 6-9):

1. Customers--Management must explain to employees who their customers are and what "the impact of their day-to-day efforts on sales and employment [are] so they will put forth their best efforts to satisfy customers."

2. Competition--Workers must understand that the company's ability to attract business insures steady employment. Management

should communicate both what it has done and what the employees must do "to keep ahead in the competitive struggle."

3. Costs--Employers must "get all employees involved in the sharing of cost problems because everyone can exercise some control over costs." In turn, cost reductions allow for a more competitive price for whatever is produced.

4. Change--Employees need to be told about changes in organization, equipment, facilities, and procedures and "convinced that it is in their best interest to cooperate with management's efforts in making these changes." Even if the new ways are unpopular, workers will accept them more readily if management has not instituted them unannounced.

5. Compensation--Fairness and equity are essential in the determination of workers' wages and benefits. In addition, employees want to know how their pay compares with similar workers in the community.

6. Concern--"Management's honest concern for people, when successfully conveyed to employees through both actions and communication,, can help in the development of a work force that is, in turn, involved in the company concerns." To this end, managers must address problems, answer questions, and provide individual help and encouragement.

Employee input programs. Foremost among the specific actions advocated by consultants to address these six topics are a variety of employee participation programs. Members of the Jackson, Lewis, Schnitzler and Krupman consulting firm note that "unions are attempting to entice health care professionals . . . by focusing on issues of specific

concern to them, such as greater input in decisions affecting patient care, and more respect for their professional judgment by the hospital administration" (Vaccaro and Saletsky 1982, 5). They warn administrators that "the channels of both upward and downward communication must be opened (Vaccaro and Saletsky 1982, 6)." Typical of many consultants, the Jackson firm encourages small and large group meetings conducted by personnel department staff and one-on-one conversations either in formal interviews or informal conversations (Vaccaro and Saletsky 1982, 6-7). Many consultants also suggest using regularly administered employee surveys.

Management-RN relations. Concern for employees' input is but one aspect of hospital activity which requires communications. Management must also convey important information on business aspects of the company (customers, competition, costs, and competitive wages). Recognizing that shift work and changes in scheduling in hospitals can make meetings covering all these topics hard to arrange, consultants to the health care industry advocate a variety of other methods to address them. (Management in all industries receive similar instructions.)

Specifically, they warn hospitals that "good supervisors are the cornerstone upon which a dynamic, effective hospital personnel program is built" (Bannon 1974, 4). Thus supervisors must learn to listen to employees and involve them in daily decision making. They need to spend time with their workers, both listening and responding to their concerns with explanations of why management is attacking a problem in a given way (U.S. Congress 1980a, 75-76). One hospital consultant sums up the message as follows: "The point is to care enough to know your

employees. If you don't, the union will" (Chaney and Beech 1976, 118). In congressional testimony, representatives of two consulting firms--Modern Management and West Coast Industrial Relations Association--testified that a majority of their efforts focus on training supervisors to communicate with workers (U.S. Congress 1980a, 75, 265)

Hospital consultants Vacarro, Saletsky, and Bannon emphasize that perceived inequities in wages, benefits, and work assignments create dissatisfaction which, again, can be dispelled with communication. Consultants advise managers to start explaining the rationale of their personnel policies at an orientation session where they can discuss "such matters as management's attitude toward union organization, the community rate practice, your determination to conduct a successful business, etc." (Council on Union-free Environment 1979, 11). An employee handbook serves as "an easily accessible reference for employees with questions about policies, procedures, or benefits, as well as a reminder of the many advantages of working for the hospital" (Vaccaro and Saletsky 1982, 7). In-house newsletters are useful in explaining changes in policies and procedures in addition to providing information about business and professional developments (Vaccaro and Saletsky 1982, 7). The CUE suggests using bulletin board campaigning to diffuse issues which might lead to interest in unionization (Council on Union-free Environment 1983, 5).

Nearly every consultant who identifies sources of worker dissatisfaction with management includes the mounting of unresolved grievances. Again, the awareness and responsiveness of supervisors is essential to avoiding employee unrest. Consultants also encourage "open

door" policies which provide workers with answers to their complaints (see Schicker and D'Andrea 1981, 16). But in recent years, increasing unionization among health care workers has led many hospital consultants to the same conclusion as their colleague, Norman Metzger:

> The road to unionization is paved with the cadavers of supervisors who were responsible for unattended accumulation of minor irritations and aggravations, which finally exploded into an organizational drive by a union. It is, therefore, essential that in a nonunion environment a formal grievance procedure be available to employees. (Metzger 1982, 92)

Finally, Schanie identifies exit interviews as a source of "upward communication" from workers to top management regarding unresolved workplace problems (Schanie 1984, 77).

Wage-benefits package. In addition to the need for better communications on workplace issues, consultants uniformly advise management to review their wage-benefits package to assure that it is both equitable and competitive with neighboring employers. They frequently suggest polling area businesses with similar workers to determine the prevailing wage rate and benefits. Administrators then must develop complete job descriptions for all positions in their institution. Using a job evaluation method to determine the relative ranking of each position, administrators can then determine the appropriate grade and steps available to employees in each job classification (Boyer, Westerhaus, and Coggeshall 1975, 66-71).

Likewise, consultants expect that employers who want to retain a union-free environment will maintain a variety of benefit programs.

Health care advisors regularly suggest paid holidays, vacation days, sick leave, life insurance, disability insurance, medical and hospitalization plans, pension plans, provision of uniforms, tuition refund plans, and drug discounts (Boyer, Westerhaus, and Coggeshall 1975, 72).

Advancement-transfer. Among the questions that consultant Woodruff Imberman claims will uncover "why some employees become angry with their company and . . . fall prey to the blandishments of union organizers" are the following:

> Where does seniority figure in the nonunion company policies? How are promotions, shift transfers or job transfers handled, particularly as regards minorities? Is there any truth to the charge that foremen often sabotage promotions of good employees from one department to another? (Imberman 1980, 282)

Thus, protection against unionization lies in preparation and enforcement of clear promotion and transfer policies. Consultants regularly recommend these measures to health care administrators because they "win the loyalty of [hospital] employees" (Chaney and Beech 1976, 125).

Scheduling. Because staffing appears to be a chronic problem for many hospital nursing directors, policies affecting how the workload is distributed among existing staff members--overtime, shift preference, and flextime--represent an importance source of dissatisfaction for registered nurses. One labor relations attorney warns that "although there is usually nothing that a union can do to solve the staffing problem, sometimes any port in a storm looks good" (Elliot 1981, 18).

Women's issues. Consultants to the health care industry advise that special considerations apply to their clients since an overwhelming majority of their workers are women. Vaccaro and Saletsky warn that workers will be receptive to unions' promises to negotiate on issues such as comparable worth, day care, maternity benefits, and sexual harassment if management does not address them (Vaccaro and Saletsky 1982, 5-6).

Tactical Advice during the Union Campaign

Consultants admit that management frequently does not ask for their help until interest in unionization has already surfaced. Services that consultants provide at that time fall into three categories--explaining to supervisors their roles in the campaign, providing information and guidance on the preparation of written communications, and advising management on the laws governing NLRB elections.

In addressing the supervisors' job in an election campaign, consultants again stress the importance of communication and the central role of the first-line supervisor. Modern Management explained to a congressional hearing committee that

> the law gives employees the right to be for or against a union. The basic premise of the law is that employees should have freedom of choice. Face-to-face communication between management and employees is essential. It is important to provide an opportunity for employers and employees to discuss the union issues so that an informed choice may be made by the employees. (U.S. Congress 1980a, 77)

More specifically, consultants advise managers to determine which employees are for, against, and neutral about union representation. One consultant promises seminar participants that he can train supervisors to classify employees as red (union sympathizers), yellow (undecided votes), and green (promanagement). Efforts to persuade the undecided votes can then be targeted more effectively (Abbott 1985).

In addition, consultants encourage top managers to conduct meetings with the employee group in which they can clearly establish the reasons for their opposition to the union. In The Union Epidemic, Chaney and Beech give management an example of an address given to workers whom the Teamsters intended to organize. They claim that the speech outlining the criminal acts of top Teamster leaders was well received by the audience (Chaney and Beech 1976, 72-73).

Consultants have insisted that they do not author the letters which management writes to employees during a campaign. They acknowledge, however, that both the content and form have become standardized as a result of their advice (U.S. Congress 1980a, 77). The AFL-CIO's compilation of letters sent by companies counselled by Modern Management identifies eight topics regularly addressed in campaigns (AFL-CIO 1984a):

1. Strikes--Loss of wages, benefits, and even employment are possible if the union authorizes a strike. The strike record and violence that have occurred in strikes by the relevant union are often reported.

2. Guarantees--A union can only guarantee that it will try to negotiate a contract with management. Current wages, benefits, and

working conditions can be lost if the union's negotiations are unsuccessful.

3. Constitutions--The content of the constitution on the union seeking to represent the employees is outlined. Particular emphasis is put on the dues collected, fines that can be assessed, and language establishing the control of the national or international leadership over the affairs of the local, including the decision to strike.

4. Not perfect--Personnel directors or other administrators acknowledge that problems exist in the institution. They state their willingness to continue to address these weaknesses, but note that if a union is elected, workers will lose their right to have individual voices in making further changes.

5. Third party--The company and its employees do not need a third party to negotiate for them. It will "interfere and change the positive management-employee relationships established with you over the years" (AFL-CIO 1984a, 11,16).

6. Management rights--The employer has exclusive rights to direct and determine work assignments, hiring, firing, and discipline. The management rights clauses of union contracts are reproduced to verify for workers that management maintains its control over the company despite a union's presence.

7. Harassment--Management documents cases in which union members or supporters have harassed workers who have chosen either not to vote for the union or not to support strikes and other job actions.

8. Dues--The amount and use to which union dues are put is published. The letter explains that unions can ask management to terminate employees who fail to pay their dues.

Consultant-directed managers of registered nurses frequently raise an additional issue--"professionalism"--during their organizing campaigns. One nurse administrator argued in a professional publication, "most nurses realize that in joining a union they are apt to lose something they cherish very much. They must feel in their bones that their professionalism will be questioned" (Rotkovitch 1980, 17). Management also points out that the traditional union goal of "wage equality" denies incentives and rewards for excellence. Further seniority systems and job security provisions in contracts threaten professional standards by allowing for the layoff of less senior but more capable RNs and for the continued employment of incompetent workers (Rotkovitch 1980, 17).

Consultants also advise their clients on the legal limits of their activities. New England consultant Ralph Abbott teaches supervisors to avoid "T.I.P.S."--threats, interrogation, promises, and spying--in order to stay within the boundaries of the NLRA. His partner in seminar presentations, John Glenn, advocates refusing to agree to a consent agreement which would allow for an election within weeks. Instead, management should challenge the bargaining unit to delay the election until the employees have had a chance to consider both the pros and cons of unionization. It is a suggestion made by nearly every consultant in the business (Abbott 1985; Glenn 1985).

Herbert Melnick, in his final remarks to the congressional Subcommittee on Labor-Management Relations, provided a clear self-assessment of the management consultant industry:

> Some managements, particularly in industries like hospitals and health care, desperately require [our advice and consultation] because of their inexperience and lack of knowledge of the rules governing employer conduct during an organizing drive . . . . We believe that if employees are given knowledge of the facts both from management's viewpoint and from the viewpoint of the union organizers, they can make an intelligent choice as to whether they do or do not want to be represented by the union. (U.S. Congress 1980a, 77-78)

When the union prevails in an election, the consultant may serve management in a third capacity. Because many employers have little experience in collective bargaining, they frequently hire consultants to serve as their chief advisors or spokespersons in contract negotiations. In this role, it is the consultant's job to limit union influence on wages, benefits, and work rule decisions previously made by management alone. As the authors of a health care administrator's guide to the NLRA explain, "If a labor organization is successful in organization, management will be required to adopt a new perspective towards unions and their their participation in the health care facility" (Pointer and Metzger 1975, 6). However, they make it equally clear that "it is not suggested that administrators stop viewing the union as a threat to management--especially management prerogatives" (Pointer and Metzger 1975, 6-7).

Consultants generally acknowledge their role in negotiating favorable contract language on union security, management rights,

grievance procedures, advancement and transfer, and other negotiable issues (Boyer, Westerhaus, and Coggeshall 1975, 110-24). In addition, consultants have assisted management in establishing either the aggressively adversarial or conciliatory atmosphere in which contract bargaining occurs (see, for example, AFL-CIO Report on Union Busters 1981, 4). Some consultants have also advised management on the use of strike preparations, a strike, or a lockout to attain its bargaining goals (AFL-CIO Report on Union Busters 1979c, 1-3).

Finally, consultants may counsel management on using the divergence between contractually mandated wages, benefits, and working conditions and employer-initiated changes to encourage a decertification campaign (Yanish 1985, 60). One high profile labor attorney, Alfred DeMaria, has taught seminars and written a manual on methods of identifying and fostering worker dissatisfaction with unions. Once employees have filed a decertification petition, he instructs management in aggressive campaign tactics in favor of it, noting that "the same law that gives employees the right to bring in a union gives you the right to get rid of [it]" (Poe 1983, 23).

The Union Perception of Consultant Activity

The unions' interpretation of the management consultants' motives and messages sharply diverge from the above description. In the late 1970s, in response to the growth of the consultant industry, the AFL-CIO, national union organizing staffs, prolabor journalists and legislators began to condemn both the "marriage counselor" and legal advisor roles of consultants. In newsletters, journals, and congressional testimony,

these prounion sources have described the consultants' tactics and supported changes in labor law and organizing strategies to combat them.

Analysis of Preventive Policies

The House Labor Subcommittee on Labor-Management Relations reflected the union view of consultant activity in its report on the 1979-1980 "Pressures in Today's Workplace" hearings:

> It is true that some consultants mention in passing the need for long-term "constructive" labor-management policies as the best antidote to unionization. Some refer to their function as promoting "preventive labor relations." In spite of these claims, however, the fact remains they are most often hired for a particular campaign, not for long-term personnel policy development. They are hired to win an election. (Daily Labor Report 1981, D-8)

In cases where the consultant is hired before union activity arises, union supporters argue that often they advise management on how to choose employees who will not develop an interest in unions. AFL-CIO representatives claim that consultants recommend hiring only as many blacks or Hispanics as is necessary. They also counsel employers to avoid employing the youngest child of a family, people with marital problems, or workers sympathetic to the "underdog" (Dollars and Sense 1983a, 9).

Phillis Payne, a Laborers' International Union attorney, is particularly critical of the consultant's role in the union-free workplace. Her study charges that some labor relations specialists teach management "thought control" methods which turn workers away from unions without an explicit anti-union campaign (Payne 1977, 26). She warns that the "labor consultant will analyze a particular company to determine the

underlying value systems of the employees and identify both the psychological and economic needs which, if satisfied, will cause workers to 'identify' themselves with management rather than with a union" (Payne 1977, 24).

In addition, Payne argues that the communications systems set up by management are largely information collecting schemes. She points to consultant James Dougherty's Union Free Supervisor, which instructs supervisors on how to elicit complaints from workers and to use some employees as "roving listening-posts" to support her contention. In turn, Payne suggests that consultants teach management to spend the interval between the recognition of worker unrest and the union's filing of an NLRB petition to its advantage. During that period, employers can make "unilateral changes in wages and working conditions and 'prun[e]' the workforce of union adherents" without fear of unfair labor practice charges (Payne 1977, 26).

Organized labor is also critical of the other positive labor relations schemes instituted by management. They point to consultants like John Glenn who instruct their clients to implement grievance procedures, seniority layoff systems, and sexual harassment policies to blunt union criticism of working conditions (Glenn 1985). Further, organizers note that the ultimate goal of positive labor relations schemes is often better productivity and profitability. Even though the goals are not mutually exclusive, unions warn that "it is very likely that the final emphasis will be on improving productivity and profitability at the expense of the workers" unless the union acts as the workers' advocate (AFL-CIO Report on Union Busters 1980c, 5-6).

The Advisory Role in the Union Election Campaign

The union assessment of management consultants tactics in organizing campaigns also stands in stark contrast to the view presented above. Again the comments of the Labor-Relations Subcommittee draw from the experiences of the union organizers and representatives who testified before it:

> The characteristics that the consultant-led campaigns seem to have in common are: (1) an extensive and critical role played by "front line" supervisors in providing information about employee sentiments and in communicating and implementing the management campaign, (2) utilization of modern persuasive techniques including the domination of employee access to information, (3) legal tactics that emphasize delay and manipulation of the procedures of the law, sometimes to the extent of advising its violation. (Daily Labor Report 1981, D-9)

Union supporters claim that consultants depend heavily on the supervisors in anti-union campaigns for two reasons. First, because they have no protection under the NLRA, management can require that supervisors participate in legal antiunion activity and not join or support the local union. Supervisors choosing not to follow these orders may be terminated (U.S. Congress 1979a, 416). In addition, by sending their messages through supervisors and not engaging directly in "persuader activity," consultants avoid the reporting requirements of the Landrum-Griffin Act (Daily Labor Report 1981, D-13). Consultant Alfred DeMaria explains the advantage of this method: "I don't want the union to have the political advantage. They will tell the workers, 'Look, the

company hired this guy from New York City.' I try not to let the union take that potshot at me" (AFL-CIO News 1982a, 2).

Unionists condemn the consultant-directed efforts of supervisors starting with their efforts to identify promanagement and prounion workers. A nurse involved in a consultant-run campaign described her supervisors' behavior to the Subcommittee on Labor-Management relations:

> The supervisors have lost sight of their patient care responsibilities and are focusing their efforts on eliciting information, distributing information, and surveillance. This has been detrimental to the quality of patient care (U.S. Congress 1980a, 9).

Once supervisors have classified employees by their attitudes toward the organizing campaign, union organizers claim that the consultants direct them to use intense psychological pressure and information control to cultivate anti-union votes. Through captive audience speeches, one-on-one conversations, and the barrage of letters critical of the union, supervisors send the message that a unionized workplace will be an unpleasant one. AFL-CIO Director of Organization and Field Services Alan Kistler summarized the experiences of workers organized by member unions to the House Subcommittee: "Day after day pressure is difficult to withstand by yourself . . . . The message is carried by someone who clearly has the ability to make the employee's job relatively pleasant or miserable" (U.S. Congress 1979a, 29).

In addition, consultants teach managers to limit the prounion messages which reach the undecided workers (Daily Labor Report 1981, D-10). In a much-noted case, management instructed a union activist to

sweep an eight-square-foot patch of floor in a remote area until the paint on it disappeared (Dunbar and Hall 1980, 28). More commonly reported are transfers of union supporters to departments where she/he can only communicate with like-minded employees (Daily Labor Report 1981, D-10).

In registered nurses campaigns, organizers find that the management appeals to "professionalism" are particularly convincing. Nurses' training impresses upon RNs the tradition of their work as established by founder Florence Nightingale. It is this which largely defines their role.

> To the doctor, she brought the wifely virtue of absolute obedience; to the patient, she brought the selfless devotion of a mother; to the lower-level hospital employees she brought the firm but kindly discipline of a household manager, accustomed to handling servants. (Ehrenreich and Ehrenreich 1973, 22)

Appealing to the "selfless devotion" of "professional" nurses, hospital consultants, through management, warn that should RNs strike, "patient care will suffer, and the individual could suffer greatly" (Chaney and Beech 1976, 17). An organizer noted, "RNs are among the toughest people to organize. I've organized engineers and other professionals so I have some experience. The RNs have ideas about 'professionalism,' so they hold themselves above the other workers. . . [It] is like a lead weight around their necks" (Sexton 1981, 103).

But organizers level their most angry condemnations at management's efforts to create fear that translates into antiunion votes. Concentrating on "union violence" and "union strikes," management

employ a "'saturation technique' or 'buzz effect' designed to make employees believe something they know is contrary to the reality of their own situation and the character of their fellow workers" (U.S. Congress 1979a, 619). Observer Roberta Lynch finds that the predominantly female workforces in health care and white collar businesses are severely affected by this tactic. She notes that "fear is particularly paralyzing for women who have been trained since girlhood not to fight" (Lynch 1979, 29).

One final issue of particular importance to nurses and other health care providers centers on tactics used by hospital chains to avoid or to rid themselves of unions. Both SEIU and 1199 have produced literature for their members and organizers describing the policies used by the Hospital Corporation of America, the Beverly Enterprises, and other proprietary chains to keep unions out. For example, 1199 claims that in response to union activity, "chains can afford to shut down one and lose money for a while--the others will continue to profit . . .Unless workers throughout the chains organize, they will remain isolated victims of these giant corporations" (Steffens 1984, 5-6).

Consultants' Legal Advice

When consultants advise their clients on how to use existing legislation to their advantage in election campaigns, unions find that both the spirit and letter of the law are violated. Consultants admit that the delaying tactics they recommend work against organizers who then must find a way to sustain interest in the campaign. New England consultant Ralph Abbott has proudly explained to seminar participants that he has

filed frivolous charges to delay elections until holiday periods (when people are generally "feeling good"), vacation time (if union supporters are out of town), or after an annual pay raise (Abbott 1985).

Furthermore, union representatives argue that consultants subtly point out to employers that breaking the law may be an acceptable option in a campaign for two reasons. First, it is likely that the violation will remain undetected. Second, the cost of negotiating with a union far outweighs any penalty imposed if wrongdoing is uncovered. For example, union supporters point out that consultant Fred Long subtly advised management to fire or otherwise harass union supporters if the election is close--a clear violation of the law. He did this by explaining to participants of an antiunion seminar that among employers found illegally firing, threatening, isolating, or spying on workers, ninety-six percent won the NLRB-ordered rerun election (Lagerfeld 1981a, 11). Again, both delay and the fear cultivated by the firings work in management's favor.

Another illegal practice which unions believe the consultants encourage entails providing "Vote No" committees with advice and funds for their activities. One AFL-CIO Report on Union-Busters (RUB Sheet) describes how a "Vote No" committee, allegedly formed with the help of Modern Management during a "white collar" unit election, dissuaded workers from unionizing. It continually circulated lists of employees who had signed a pledge against unionization. Undecided workers, believing that not appearing on the list indicated union sympathies, soon signed the list. Eventually the "bandwagon" effect defeated the union (AFL-CIO Report on Union Busters 1979a, 3-4). The

RUB Sheet reports that consultant Woodruff Imberman suggests that participants at his seminars help finance the "Vote No" committee. "Slipping $20 bills in their lockers or pay envelopes" for expenses and assuming their charges for printing and supplies successfully fosters procompany committee operations (AFL-CIO Report on Union Busters 1979b, 6).

Unions assess similarly the consultants' role as management advisor during contract negotiations. They believe that consultants may try to foment worker dissatisfaction with the union's performance in a variety of ways. Once a union has won the right to represent employees, consultants may attempt to break the union by bargaining to impasse and forcing a strike. Replacing the participants of the allegedly "economic" strike with antiunion workers, management prepares for certain victory in a decertification election held one year after the union election (see, for example, AFL-CIO Report on Union-Busters 1980b, 1-4).

Union officials attribute other preparations for a decertification election to consultants as well. Hiring a new legal counsel (who may be a "union-buster"), change in personel directors and foremen, new ownership, and stalled grievances and arbitrations are but a few of the "warning signs" of consultant-inspired efforts to increase dissatisfaction among union members. The dissatisfaction, in turn, encourages employees to ask for a decertification election and allows management to launch an attack on the union's existence (AFL-CIO Report on Union Busters 1980b, 6-7).

In short, the union assessment of consultants' activities contrasts sharply with the image the latter promotes. Instead, union supporters agree that:

> the use of outsiders to assist in the development of more effective management and personnel practices, who have as their objective the development of a better management-employee relationship, is desirable. Such outsiders are like marriage counselors who work with one or both parties to help them better understand themselves and their relationship. But using outsiders to give advice about how to thwart the other partner's goals and desires not only destroys the foundation of trust on which the original relationship may have been based, but also sets one side against the other like implacable enemies, each pur-suing its own interests with little regard for the other. (Poe 1983, 29)

Union Response to Consultant Tactics

The union response to consultant activity has three dimensions. First, the AFL-CIO has produced monthly RUB Sheets and Statisticaland Tactical Information Reports (STIRs) to inform organizers of the existence and practices of attorneys, firms, and companies engaged in antiunion campaigns nationwide. SEIU, 1199, and other national unions have prepared similar materials tailored to the needs of their organizers. These publications, in turn, provide organizers with information for the employees engaged in campaigns. By warning them of management tactics in advance, unions hope to lessen the impact of the unrelenting antiunion campaign. The third response by unions is to expose the training sessions run by the consultants. For example, the Nevada State Federation organized a 5,000-member protest on the site of a consultant seminar, which forced its cancellation (Poe 1983, 29).

Still, unions admit that exposing the consultants has not necessarily reduced their influence. As SEIU organizing director David Cromer pointed out, the upheaval that consultants cause in the workplace can instill fear in employees even if they are warned in advance (Cromer 1984). A health care organizer's testimony sums up the continuing problem:

> Ironically, this transformation of the hospital into an armed camp almost always works against the Union rather than against those who are responsible for it . . . . It is very easy to associate the transformation of one's workplace into a nightmare with the existence of the union drive. After all, it was never like this before all this union talk started. With any luck, things will go back to normal after the Union's gone.(U.S. Congress 1979a, 102-3)

Relevant Academic Literature

In considering the foregoing views of the consultant's role in union organizing campaigns, an obstacle to academic analysis of the issue emerges. Practitioners insist that variables such as job satisfaction, trust, fear, and violation of the intent of the law are relevant to campaign outcomes. But these are difficult to measure. In turn, the consultant impact is difficult to assess in quantitative terms. Still, research in several academic disciplines has examined resistence to union organizing among registered nurses. The contributions that the industrial relations, health care administration, and nursing literature make to a fuller understanding of the topic appears below.

Industrial Relations Research

Antiunion campaign tactics. Existing academic research on employer opposition to union organizing appears in both qualitative and quantitative analyses. Recent qualitative publications, summarizing the tactics advocated by management consultants reach two substantially different conclusions. In Union Organizing and Staying Organized, Gagala finds that employers who use the "short-term" tactics advocated by consultants for elections cannot succeed. "If employer strategies are limited, then they are predictable. If they are predictable, unions can enhance their organizing strength by anticipating the employer's campaign and neutralizing its impact . . ." (Gagala 1983, 92-93). Both Gagala and Imberman assert that the high success rate on NLRB second elections (sixty-one percent) are proof of the consultant's inability to stave off elections permanently (Gagala 1983; Imberman 1980). On the other hand, Weiler based his views on the growing percentage of unfair labor practices filed against employers and the long delays between the commitment and remedy of unfair labor practices. He concludes that coercive and illegal tactics contribute heavily to the decline in union organizing successes (Weiler 1983).

Both the Industrial and Labor Relations Review and Industrial Relations have reviewed quantitative research on union organizing (Fiorito and Greer 1982; Heneman and Sandver 1983). Most of these analyses employ statistical methods to explain election outcomes as dependent upon a number of economic, industrial, political, and/or personal variables. Only a handful of the nearly fifty articles reviewed

or since published include indicators of employer resistance as explanatory variables.

Several studies use a single variable to account for union opposition. The most commonly used measure of employers' antiunion sentiments is the existence of "Right-to-Work" legislation. However, studies using this indicator have shed little light on the importance of this form of resistance. Becker and Miller (1981), Delaney (1981), Cooke (1983), and Seeber and Cooke (1983) find no statistically significant effect for this variable on election outcomes. Greer and Shearer (1981) establish a positive relation between "Right-to-Work" legislation and union election victories. Hirsch (1980) and Moore and Newman (1975) report that the relationship is a negative one. Again, however, the variable's coefficient is insignificant in some equations.

Although the "Right-to-Work" variable may capture the generally resistant atmosphere in which elections occur, it does not reflect management's antiunion tactics. Researchers have attempted to quantify these techniques in several ways. For example, consultants often advise management to delay voting by opting for the stipulated election rather than the relatively quick consent election. Thus, the proportion of annual elections entered into under consent agreements serves as a direct, inverse measure of management resistance. Seeber and Cooke (1983) and Cooke (1983) have produced statistically significant, positive relationships between union election victories and this variable. Employing a similar argument, Prosten (1979), Block and Roomkin (1981), and Cooke (1983; 1985a; 1985b; 1985c) establish significant negative associations between

successful union elections and the length of delays between petitioning and election dates.

Recently, researchers have attempted to account for consultant influence directly by measuring the impact on election outcomes of both consultant use and the specific tactics they advocate. Again the studies have produced conflicting results, possibly due to the difficulty of measuring consultant activity in campaigns. In an early statistical study, Brotslaw (1967) examined the perceived effectiveness of management's antiunion letters and conversations by questioning individuals involved in a single department store union election. His data show that the employers' antiunion campaign had little effect on those employees who were aware of it. However, Brotslaw used a "retrospective" interview design which allows for inaccurate responses due to both the lapse in time between the election and interview and the "decision bolstering" phenomenon whereby subjects answer attitudinal questions in a manner consistent with their votes (Heneman and Sandver 1983, 554).

Getman, Goldberg, and Herman's 1976 study is frequently cited as pathbreaking research on employers' opposition tactics. The authors calculated the correlation coefficients between voters' exposure to and familiarity with the company's campaign methods (both legal and illegal), their intended votes prior to the election, and their actual votes. The actual votes of eighty percent of the workers interviewed were compatible with their stated precampaign intentions. Further, the study shows that these initial thoughts on unionization would have accurately predicted the outcomes of twenty-nine of the thirty-one elections examined. Getman, Goldberg, and Herman therefore conclude that

"there are not likely to be many cases in which the number of votes affected by employer campaigning will be sufficient to deprive the union of victory it would have gained under existing law" (Getman, Goldberg, and Herman 1976, 159).

Finally, in 1982-83, the AFL-CIO studied the large organizing campaigns (fifty or more workers) of its top fifteen affiliates. Based on organizers' reports on consultant involvement, the study found that consultants were used in eighty-one percent of the 224 contests surveyed. While unions won forty-two percent of the campaigns in which consultants operated, the percentage was only slightly greater--forty-four percent--when management advisors were not involved. Furthermore, in health care and service elections, unions won a larger percentage of elections in which management used consultants (fifty-five percent) than when they did not (fifty percent) (AFL-CIO 1984b, 4).

Equally convincing evidence supports the conflicting view that the consultant's impact on election outcomes is substantial. Again, difficulties with measuring consultant influence arise. Freeman and Medoff's study based on comparisons of union successes over time, across states, and within states over time finds that unfair practices are responsible for one-quarter to one-half of the decline in union election wins. (Freeman and Medoff 1984, 237). They note that they had to narrow their focus to illegal opposition because of the availability of data. "As legal and illegal opposition have presumably grown together, we interpret the analysis as showing the effect of 'total' management opposition on union success, not of illegal opposition only" (Freeman and Medoff 1984, 237-38).

Lawler's econometric study of the impact of consultant use on election outcomes finds that antiunion advisors reduce the odds for prounion voting slightly. However, the author uses the number of reports of consultant activity--LM-20s and LM-21s--filed by consultants under the Landrum-Griffin Act as a dependent variable. He cautions that this consultant use measure is biased by the severe underreporting of persuader activity. In turn, its impact on election outcomes is likely to be understated (Lawler 1982, 377).

A recent reanalysis of the data collected by Getman, Goldberg, and Herman using probit estimation finds that employers' threats, captive audience speeches, and written communications caused a small but statistically significant reduction in prounion votes (Dickens 1983, 574). Weiler emphasizes that the percentage of initially prounion and undecided votes which eventually turned against the union was higher in illegal campaigns than clean ones in the Getman data. He criticizes the Getman, Goldberg, and Herman conclusion that, because the differences in percentages were not statistically significant at the ninety-nine percent level, a certain relationship between illegal campaigns and negative votes could be established (Weiler 1983, 1783).

Additionally, Dickens and Weiler argue that employers concentrate their efforts on undecided votes in close elections. The number of election outcomes in the Getman,Goldberg, and Herman study altered by antiunion messages thus depends on both the number of votes affected in all campaigns and the distribution of affected voters among elections. Weiler cites data indicating that "a shift of only 2% of the total votes cast in the thirty-one elections, if those 2% had been carefully allocated,

would have been sufficient to provide . . . eight additional victories" in the Getman sample (Weiler 1983, 1785).

Three other studies using alternative data sets report that antiunion campaigns have a significant impact on election outcomes. Murrmann and Porter surveyed 113 employers involved in elections in the 1980-82 time period and measured correlations between their campaign tactics and election outcome. Their data indicates that "the employer's campaign was more effective if it was managed through the combined efforts of an inside general management official and an outside consultant" (Murrman and Porter 1984, 69). Both limiting solicitation and communicating the management position correlate significantly with the union's election loss. They caution that, "because of the potentially sensitive and confidential nature of the information collected, some degree of response bias must be expected to exist in the data" (Murrman and Porter 1984, 72).

Cooke (1985c) measures the impact of previous and current discriminatory actions towards union activists, election delay, changes in the orginally requested bargaining unit, and employers' victories in previous campaigns upon election outcomes. His data suggest that discrimination in violation of Section 8 (a)(3) of the NLRA reduces the probability of a union victory by approximately seventeen percent (Cooke 1985c, 437). Further, Cooke notes that "nonmeritorious" claims of discrimination have a significantly negative effect on union victories. He believes that this result implies that employers are finding successful ways of masking their discrimination against unions (Cooke 1985c, 440).

However, using data similar to that analyzed by the AFL-CIO--organizer reports filed with the AFL-CIO Organizing Department

between 1975 and 1982--Lawler and West reached a different conclusion. Their regression analysis measures the impact of antiunion tactics--captive audience speeches, literature distribution, and unfair labor practices--on the proportion of employees voting for collective bargaining in each election. It indicates that the strategies have a significant, cumulative, negative effect. The use of consultants also appears to have a large negative effect of election outcomes. Still, the authors conclude that "better data . . . would certainly contribute to more reliable parameter estimates" and that the role of consultants needs more detailed scrutiny (Lawler and West 1985, 419).

Despite these several quantitative investigations of management election campaign activities, academic research on such antiunion behavior in bargaining after a union election victory is limited to Cooke's quantitative assessment of factors reducing the probability that a newly elected union will secure a first contract. He found that NLRB delays in resolving employer objections and challenges to election results, charges of managment's refusal to bargain, and discrimination against union activists all significantly reduce the union's ability to obtain a contract (Cooke 1985a; Cooke 1985b). While unions charge that consultants advocate these types of activity, it must be noted that the survey data which Cooke uses in his study do not indicate whether consultants were involved in the contract talks.

Finally, industrial relations experts provide qualitative data on labor law developments and the organizing history of the hospital industry useful in projecting the future of unionization in health care. The history of RN bargaining both prior to and after the passage of PL 93-360

describes the extent of unionization, the location of significant organizing activity, and the particular unions involved. It also identifies some of the sources of resistance to RN organizing. For example, Miller points out that "with many of the larger, urban [and most vulnerable] hospitals of the Northeast and Pacific regions already organized labor groups have had to turn increasingly to hospitals in areas more hostile to union--the South and Southeast, or the suburban and nonmetropolitan areas" (Miller 1980, 393).

He also documents the timidity and lack of experience with which the American Nurses Association entered the organizing and collective bargaining arenas. Prior to 1968, the association operated under a national no strike policy and the budget for collective bargaining programs is small relative to expenditures of similar-sized organizations (Miller 1980, 405-6). This discussion contributes to an understanding of why well-counseled management can defeat some union drives among nurses, who generally prefer representation by their professional associations (Feldbaum 1981, 151).

Likewise, descriptions of the NLRB policy relating to proliferation of units in hospitals refer to the types of units to be organized (Tanner, Weinstein, and Ahmuty 1980; Miller 1980; Maxey 1981; Richman 1984). The first ruling regarding the proliferation of bargaining units in hospitals suggested that unless a community of interest with licensed practical nurses or other professionals could be established, registered nurses should constitute a separate bargaining unit (Fossum 198, 452). Labor relations specialists note that more a recent NLRB decision calling

for larger units may further increase the difficulty of organizing hospital RNs.[1]

A third topic recently examined is the growth of proprietary hospitals and hospital chains. The preliminary research by Craypo and Lehman provides case studies of proprietary hospitals in which organized health care workers met with determined efforts by management to limit or to eliminate collective bargaining rights. Together with statistics of low levels of unionization which they uncovered in proprietary hospitals, Craypo and Lehman's study concludes that the hospital chains' own personnel departments employ union resistance techniques which present serious obstacles to union organizers in the future (Craypo and Lehman 1986).

Preventive labor relations techniques. While there has been relatively little research on the impact of consultant-inspired preventive labor relations programs, researchers are far more unified in both their qualitative and quantitative conclusions than they are on the effect of consultant tactics in union elections. After summarizing successful preventive programs, Gagala observes that "the union avoidance consultants are right; matching and surpassing the provisions in union contracts removes the incentive for workers in the United States in the 1980s to organize" (Gagala 1983, 92). Quantitative studies by Fiorito, Lowman, and Nelson (1987), Kochan, McKersie, and Chalykoff (1986), and Cappelli and Chalykoff (1986) all support these qualitative observations.

Using Conference Board survey data of management practices, the Cappelli and Chalykoff study shows that unionization in firms practicing

preventive labor relations dropped approximately five percent. Firms focusing on securing a favorable collective bargaining agreement experienced a three-percent decline (Cappelli and Chalykoff 1986, 176). In turn, the authors believe that the priority given to union avoidance strategies by management is a contributor to the decline in union coverage in firms which are partially unionized.

A second investigation using the Conference Board data is that of Kochan, McKersie, and Chalykoff. They examine use of "innovative" management techniques--formal grievance procedures, employee participation programs, profit sharing, work sharing, flexible work schedules, pay for knowledge, autonomous work teams, and information sharing--in unionized and nonunionized settings. Their results indicate that both "management innovations and union avoidance strategies substantially reduce the probability of organization of new plants" (Kochan, McKersie, and Chalykoff 1986, 496-97). The Fiorito, Lowman, and Nelson research (again using Conference Board data) examines the importance of individual preventive policies on election results. It identifies participation, communications, grievance procedures, "pay-for-knowledge" schemes, and open discussions of production as policies which negatively affect unions' attempts to win recognition. This result confirms "'old news' to employers who engage in such programs and to unions attempting to organize employees subject to them" (Fiorito, Lowman, and Nelson 1987, 124). After a review of each of the studies described here, Lawler concludes that the union avoidance tactics "appear in almost all studies to exert strong effects on

employee preferences and behaviours independently of tactics and/or the use of 'union busters'" (Lawler 1986, 229).

Unionization by sex. Since difficulties of organizing both women workers and professionals are relevant to union activity among RNs, the research on this topic is also explored. Some of the qualitative work addressing the issue simply asserts that professionals and women are difficult to organize despite their apparent willingness recorded in recent surveys (Roomkin and Juris 1979; Fiorito and Greer 1986). Fiorito and Greer acknowledge that some researchers find that "embryonic" organizations for working women are not unions and have not encouraged collective bargaining to improve wages and working conditions. They note that others suggest that women do not believe unions address their needs (Fiorito and Greer 1986).

Empirical research on this topic is quite limited. Kochan examined the importance of perceptions of the workplace, influence perceptions, beliefs about unions and demographics in males' and females' interest in unionizing. He concludes that "women [are] at least as willing as men" to join unions (Kochan 1979, 27). A 1980 study which attempts to explain the male-female unionization differential (Antos, Chandler, and Mellow 1980) finds that occupational and industrial status, not the role played by management, are significant factors. Likewise, after undertaking multivariate analysis of 1977 Quality of Employment Survey and General Social Survey data, Fiorito and Greer conclude that

> explanations for gender-related variation in unionism measures can be found in terms of labor force attachment, industrial and occupational distributions, exposure to or experiences with unions,

different levels of satisfaction with similar factors that may vary with gender. (Fiorito and Greer 1986, 162-3)

Finally, the completed studies which incorporate sex as an explanatory measure find that women are not associated with organizing successes (Moore and Newman 1975; Hirsch 1980), although the relationship is sometimes statistically weak (Lawler and Hundley 1983).

Health Care Administration Literature

Concern for good health and the growing availability of medical insurance have made health care a boom industry since the 1970s. Health care expenditures represented less than eight percent of gross national product in 1970, nine percent in 1979, and may rise to twelve percent in 1990 (Sekscenski 1981, 10; Sample 1985). Also, hospital RN employment increased by about sixty percent in the 1970s (Sekscenski 1981, 11) and may increase another fifty percent by 1990 (Carey 1981, 10).

Since the literature in the health administration discipline analyzes the problems that accompany this growth, it has generated research on past and future unionization in hospitals. Until recently, researchers focused largely on unions' effect on hospital wages (see, for example, Fottler 1977; Feldman and Scheffler 1982; Sloan and Adamache 1984). While this wage impact on the hospital may affect nurses' decisions to unionize and hospital managements' desire to resist, they are not central to the present research. More relevant are the studies isolating factors which have contributed to hospital organizing in the past and those which will affect unions' success in the future.

For example, Robbins and Rakich have reviewed the approaches to labor relations taken by management over the past decades. They first consider economic factors of the late 1960s and 1970s, including increasing demand for health services, minimum wage laws, the equal employment requirements of the 1964 Civil Rights Act, Occupational Safety and Health Administration legislation, and RN and technologist shortages. Together with the expansion in organizing rights for health care workers, these factors produced a "perceived threat of unionization of hospitals or its actuality [which] permeated the era." At this time, "the underlying theme was conflict and confrontation" (Robbins and Rakich 1986, 22). More recently (1975-1985), however, management has been subject to further cost pressures, including federal intervention to contain health care costs. This has moved management to use its staff more effectively by identifying their needs and attitudes and implementing quality-of-work programs.

In the early 1980s, McKibbin and Robertson assessed the personnel policies of hospitals. They reached virtually the same conclusions as the management consultants regarding the forces moving hospital workers to organize:

> Several management deficiencies may place a health facility in a vulnerable position . . These include irregular and poorly-conceived performance appraisal systems; no policy on seniority; lack of uniformity among departments in the application of hospital policy; grievance procedures that favor management; absence of opportunities for promotion, transfer, and training and development; and wage and salary plans that do not establish appropriate relationships among the many jobs in the hospital. Another poor practice that creates ill feelings among employees in inequitable

rotation for weekend, evening, and night shift employees. (McKibbin and Robertson 1981, 184)

Some authors have noted overt resistance to organizing efforts. Richman examined the increasing efforts of industrial unions and the ANA to organize nurses and other hospital workers despite the "shamelessly pro-management" NLRB (Richman 1984, 121-22). Fottler recognizes the increased management resistance to collective bargaining in the 1980s (Fottler 1987, 33). McKibbin and Robertson's work closely examines the role of management consultants in hospital elections. Their discussion of employer opposition addresses management efforts to limit campaign literature distribution and solicitation It also uncovers strong antiunion sentiments among administrators who have not worked with unions relative to those which have. They conclude that hospital management "needs to review and modify antiquated attitudes .... [L]abor relations and personnel administration programs will also probably need to be developed or reexamined" (McKibbin and Robertson 1981, 193).

A few studies have sought to explore unionization in the health care industry in quantitative terms. In analyzing hospital industry election success rates, studies by Delaney (1981), Becker and Miller(1981), and Freeman and Kirkman-Liff (1984) are relevant. Delaney and Becker and Miller use hospital bargaining climate characteristics as variables explaining the outcome of representation elections. Delaney establishes a positive relation between an employee association variable and union victories. Becker and Miller find that professionals have the highest probability of union victory among hospital occupations. Since nurses

are identified by both membership in an employee association (ANA) and professional occupational status, these results suggest that RN unit campaigns are positively related to union victory.

Both articles report that dummy variables indicating the existence of "Right-to-Work" laws were insignificant. Insofar as these represent the only measures of management resistance used, one cannot attribute any statistical importance to it in the hospital industry. These studies and similar work by Dworkin, Extejt, and Demming (1980) indicate that other factors may increase the probability of union success. They include legislation allowing hospital employee organization prior to the 1974 amendment, the hospital's lack of church affiliation, low election turnout, large number of employees, white collar unit designation, small election unit, and previous elections in the unit.

The Freeman and Kirkman-Liff study examines many of the same variables as Becker, Delaney, and Dworkin, Extejt, and Demming with more current data. Although most of the relevant results agree with already published outcomes, two new sources of resistance to unions are noted. The authors uncover a marked decrease in the percentage of union victories in proprietary hospitals, from 59.7 percent in the 1974-1978 period to 17.4 percent in 1979-1980. Additionally, Freeman and Kirkman-Liff show that union victories in church-affiliated hospitals fell from 53.3 percent to 39.5 percent between 1974-1978 and 1979-1980 (Freeman and Kirkman-Liff 1984, 107).

Only one study appears to address specifically the antiunion tactics employed by hospital administrators when workers seek unionization. Rosmann investigates union organizing activity and management's

response to it during the first year of hospital coverage under the NLRA. He determines that "employees chose unions in only thirty-five percent of those elections in which management campaigned aggressively" (Rosmann 1975, 66). Further, he finds that management won sixty-seven percent of the elections in which consultants assisted them (Rosman 1975, 66).

In addition to exploring the variables which have affected health care union elections in the past, health administrators have made qualitative assessments of the factors that may influence future organizing efforts. Schanie asserts that, because the decline of blue collar unionism has moved labor organizations to turn to professional and service employees for new members, unionization of health care workers will grow. He also expects that "it is unlikely . . . that professional/white-collar values will be a protection [against union activity] in the future," given hospital workers' growing concerns about pay, job security, equitable treatment, and greater workplace participation (Schanie 1984, 70). Becker, Sloan, and Steinwald identify the aggressiveness of unions in pursuing hospital workers as a relevant factor as well. They note, however, that the "easy" units in the Northeast and on the West coast have been organized, leaving the difficult targets in the "Right-to-Work" states (Becker, Sloan, and Steinwald 1982, 11).

Robbins and Rakich warn that, in the future, hospitals must address "risk-survival issues." They predict that administrators will build on cooperation developed with employees over the last decade. They will

institute participation policies for workers, but will focus primarily on their institution's competitiveness:

> Employees will have opportunities to participate in organizational and work systems design, to the extent that results lead to productivity improvement; they will participate in the fruits of such efforts, perhaps through incentive programs. Concurrently employees will also be at risk in terms of employment security as hospitals alter the character to cope with competition. (Robbins and Rakich 1986, 28-29)

Further, they assert that "unions have become less and less of a factor and will continue to diminish in importance" (Robbins and Rakich 1986, 32). Established unions will only survive by joining in the fight for cost and market competitiveness.

Fottler provides the most detailed description of the factors affecting future hospital unionization. The expected increase in state regulation of hospital rates and greater federal intervention "should facilitate collective bargaining activity since research indicates that hospitals in more heavily regulated environments tend to adopt collective bargaining in order to acquire social legitimacy" (Fottler 1987, 42). Likewise, improved techniques by unions to coordinate and effectively target organizing efforts against chains or regions improve chances for heavier unionization. Even the possible election of a Democratic president in 1988 promises to help the union organizing attempts (Fottler 1987, 43).

On the other hand, numerous factors militate against growing organizational efforts. Among them are increasing competition in the health care field brought on by deregulation of advertising, the NLRB

decision which will require the organization of more diverse employees in a single bargaining unit, organizational complexity of hospitals, and "the degree of goal differentiation between for-profit and non-profit health facilities" (Fottler 1987, 43). Further, cost containment, through prospective payment plans and other schemes, reduce "organizational slack" and, therefore, increase resistance to organizing. But Fottler recognizes that management resistance has been considerable since the beginning of the decade. He expects that "further intensification of such resistance is unlikely. Consequently, changes in management resistance will neither help nor hinder future collective bargaining"(Fottler 1987, 43).

Studies in the health administration journals have addressed the future importance of proprietary hospital chains referred to by Fottler. Experts predict that they are growing at an annual rate of about fifteen percent and will control twenty percent of all hospitals by 1990 (Southby and Greenberg 1986, 3). Lewin, Derzon, and Margulies (1981) and Pattison and Katz (1983) have analyzed the operating costs of these organizations and conclude that proprietary hospitals maintain profitability largely by pricing ancillary services considerably higher than do nonprofit hospitals. However, the Booz-Allen and Hamilton study of sixty-five for-profit and seventy-three nonprofit hospitals in Tennessee finds that in addition to higher charges for some services, proprietary hospitals enhanced their profitability by reducing hospital staff. "With one exception, the non-profit hospitals provide more fully trained employees per occupied hospital bed than the for-profits" (National Council of Senior Citizens 1986, p.36). Likewise,

investigating the Habersham County (Georgia) Hospital in 1982, the Joint Commission on Accreditation of Hospitals criticized the HCA-managed hospital "for insufficient staffing of registered nurses, especially during the night shift" (National Council of Senior Citizens 1986, 23). Yet beyond the statistical measurement of resistance to organizing and Craypo and Lehman's case studies discussed above, research focusing on personnel practices and union activity in proprietary hospitals does not exist.

Analyses of RN Organizing in Hospitals

Finally, several studies in a variety of disciplines have focused specifically upon factors affecting RN organizing in hospitals. In their own professional journals, nurses and nurse supervisors have debated RNs' decisions to organize. As discussed earlier, administrators encourage the nurses' view of themselves as professionals with responsibilities to patients which will override interest in organizing. On the other hand, nurses who see efforts to administer "quality" care frustrated by staffing shortages, work rules, and scheduling changes try to preserve their professionalism by unionizing (see Flaherty 1980; Jacox 1980; Rotkovitch 1980; Beletz 1980; Colangelo 1980).

Feldbaum's 1981 article specifically addresses factors influencing nurses' organizing efforts. She finds that the most important among them are ANA support for collective bargaining, the 1974 changes in the NLRA, the women's movement, and the growing number of baccalaureate degree nurses who desire "meaningful and participant roles within the health sector" (Feldbaum 1981, 149).

Ehrenreich and Ehrenreich (1973), Sexton (1981), the Boston Nurses Group (1978), and other academics have developed a class analysis of the hospital hierarchy. They conclude that the segmentation of the workforce is an intentional effort by management to keep nurses from uniting with fellow workers. Instead, as professionals, they turn to other members of the occupation and rely on the professional organization to suggest to hospitals the appropriate improvements. The authors also note that the women's movement has helped to awaken RNs to the economic advantages of worker organization.

Three empirical studies of nurses have shown the importance of "white collar" and professional attitudes regarding union issues. Two of these works indicate that RNs (both organized and unorganized) express concern for non-traditional or professional topics. Their priorities include patient care, staffing, working conditions, and in-service education above traditional money and benefit issues (Ponak 1981; Feldbaum 1981). Feldbaum reached these conclusions after analyzing 5300 responses from RNs to questions about their feelings towards RN unions and strikes in 1977-78. Only 37.2 percent of those questioned thought that nurses should be represented by a union. However, 49.3 percent and 40.6percent, respectively, approved of strikes to improve patient care and working conditions. One-third agreed that strike action to reduce staff workloads is appropriate (Feldbaum 1981,155). Additionally, nurses who "favored unionization were more material, advancement, and expanded role aspiring than were nonsupporters" (Feldbaum 1981, 165). Ponak's results depend on survey responses of unionized nurses. They show that approximately one-half of their

bargaining objectives reflect professional concerns; the other half are traditional wage and benefit goals.

The third study finds that nurses are less militant than another predominantly female, professional group--teachers (Alutto and Belasco 1974). None of these surveys establishes a causal link between RNs' professional concerns and the success of union organizing. However, they do suggest that unions' ability to demonstrate that they can secure improvements in hospital working conditions without resorting to strikes can greatly influence their success.

One final piece of research is directed specifically towards nurses' attitudes in relation to union campaigns. LeLouran measures job-related stress, management styles, and the perceived ability of unions to satisfy job-related needs (union instrumentality) (LeLouran 1980). He determines that union instrumentality, psychological stress and role ambiguity on the job, and age serve as significant predictors of the actual election votes of the RNs surveyed.

Conclusions

Union and management observers have asserted that organizing attempts among RNs will continue to increase throughout the 1980s. Both union and nursing association officials note that prospective pricing systems which exacerbate their staffing and job security concerns may foster interest in union protection (Richman 1984,125; McCormick 1986, 73). They also recognize that consultants are likely to be involved in management efforts to defeat such organizing drives.

In spite of these expectations for future organizing, none of the academic studies investigating consultant involvement in elections isolate and measure their effects on RN campaigns alone. To determine whether consultant influence over management-RN relations in hospitals is similar to that generally described above, further investigation is needed in several areas. One needs to examine the consultant's role in personnel policy making both prior to and during a formal union campaign and in negotiating collective bargaining agreements with RN locals. Additional consideration of the strategies used by for-profit hospital corporations' personnnel advisors in addressing labor relations is also required, given the current and predicted growth in proprietary hospitalchains.

The case study presented in the next chapter highlights the experiences of the Portsmouth (N.H.) Hospital administration and its nursing staff on each of these subjects. It is followed by a survey analysis whose primary focus is one of these issues not thoroughly explored in previous research--the personnel policy changes advocated by consultants who assist hopsitals in avoiding unionization among registered nurses.

Because nurses are predominantly women and viewed as professionals, management's resistance and the unions' responses to it described in these chapters may be indicative of conflicts that will arise in future service industry and white collar campaigns. Morever, as management admits that "they are powerful, because they make such a large contribution to patient care" (Richman 1984, 125), these

administration reactions to hospital nurses' attempts to organize may foreshadow resistance that other hospital units may face.

CHAPTER NOTES

[1]A U.S. Court of Appeals overturned the NLRB decision in March 1984 (Richman 1984, 122).

CHAPTER THREE

CASE STUDY OF NURSE-MANAGEMENT RELATIONS AT THE PORTSMOUTH (NEW HAMPSHIRE) HOSPITAL

The History of RN-Management Labor Relations at Portsmouth Hospital

In the late 1970s, Portsmouth, New Hampshire, was a growing community of nearly 30,000 people. At that time, Portsmouth Hospital, a 150-bed, private, nonprofit, acute-care facility met the primary health care needs of the local residents. Approximately the same size as neighboring hospitals--Wentworth-Douglass, Exeter, Frisbie Memorial, and York (Maine)--it offered a typical range of acute care services. And like the other hospitals, Portsmouth faced changes in area health care needs, government funding, and employee dissatisfaction typical in area hospitals at that time.

But the situation at Portsmouth Hospital differed from its neighbors. A strained relationship between the administration and registered nurses, which began in the mid-1970s, erupted into an enduring management-labor battle. At first, the RNs complained among themselves, to their professional association, and to union organizers about the need for improved working conditions and wages at the hospital. When management resisted their demands, the nurses at Portsmouth Hospital voted for union representation by 1199--the New England Health Care Employees Union (1199). At its inception in August 1979, the local was unique. It was the first union of nurses in New Hampshire, and the first

unit in northern New England to be unionized by an organization other than a professional nurses association.

Throughout its history, the bargaining relationship between the hospital and union was troubled. It included several of consultant-inspired union avoidance strategies described in the literature review. Prior to the union election and in first contract negotiations in 1979, management employed attorneys who were well recognized for the tactics they used to defeat unions. After protracted bargaining to establish a contract, the nurses struck the hospital for three weeks. Although the opposing sides finally reached an agreement, the administration and nurses' relationship remained aggressively adversarial over the course of the 1982 and 1984 contracts. During that time, the hospital continued to depend on consultants for assistance in bargaining.

In 1985, the situation at Portsmouth Hospital became unique nationwide. To alleviate mounting financial troubles, the Portsmouth Hospital trustees sold the hospital to the investor-owned Hospital Corporation of America. The nurses' local thereby became the only such organization in an HCA-owned facility. The collective bargaining that occurred then reflected the proprietary management-labor relationships reported above. The hospital administration, backed by corporate officials who preferred not to negotiate with unions, continued to resist 1199. In the 1986 contract negotiations, it used new tactics fostered by HCA's financial and personnel resources to produced a stunning contract victory over the local.

In short, two aspects of the Portsmouth Hospital administration-RN bargaining relationship recommend its analysis as a case study of union

resistance to the organization of registered nurses. First, management employed a wide variety of union resistance techniques at each stage of the relationship in order to defeat the union. Second, the change in ownership status from private, nonprofit to proprietary provides insight into the direction management-labor relations in hospitals may take in the future if both unionization among health care workers and proprietary hospital corporations continue to grow at their current rates.

The First Wave of Dissatisfaction Among the Registered Nurses

In the early 1970s, the administration of Portsmouth Hospital's employee relations policies was informal. Practices were infrequently developed according to stated hospital personnel objectives or even written down. The telephone switchboard operator stationed near the hospital entrance provided prospective employees with job applications. The nursing director handled RN employment and personnel matters alone. She sometimes administered RN interviews after hiring the employees (Clarke 1982).

By 1976, some Portsmouth Hospital nurses had become dissatisfied with their pay, health insurance coverage, and inconsistently administered maternity and sick leave policies (Clarke 1982). They approached the New Hampshire Nurses Association for guidance. The association recognized that they had legitimate concerns, but it had no experience in organizing bargaining units. According to nurse Pamela Clarke, "They told us our situation was deplorable and we should do something about it" (Vital Signs 1979, 1). The nurses met with representatives of 1199, the New England Health Care Employees Union to discuss the possibility of

organizing a local at Portsmouth Hospital (Estes and Goodman 1986, 249).

The hospital administration responded quickly to the RNs' dissatisfaction by hiring labor relations lawyer Christopher Gallager. He convinced the nurses to give the hospital a chance to make improvements before they voted for unionization. Moreover, he convinced management to develop the type of positive labor relations policies, described in the literature review, which can discourage organizing. Through the newly-developed communications procedure known as "Why?" nurses could submit written requests for explanations of specific hospital policies or procedures. In a forum called "We Hear You," they could voice opinions and suggestions. Finally, RNs received a small pay increase which set their starting wages at $4.50 per hour, and increased maximum vacation time of three weeks for some nurses. The administration also promised to implement a pension plan (New England Hospital and Health Care Employees Union 1981).

The Second Wave of RN Dissatisfaction

Unhappiness with hospital policies again surfaced three years later. In mid-1979, the starting pay for a staff nurse at Portsmouth Hospital was still only $4.96 per hour. It was reportedly among the lowest of the five hospitals in commuting distance from Portsmouth and well below the national average starting wage of more than $6 per hour (Portsmouth [N.H.]Herald 1979b, 1; American Nurses' Association 1985, 186). Further, with a difference of only fifteen percent between the highest and lowest pay for nurses, there was little chance for financial advancement

(Mayer 1986). The hospital had neither a pension system nor disability benefits for the nursing staff. Permanent part-time RNs received no benefits at all (Portsmouth Herald 1979b, 1).

Nor had working conditions improved significantly, despite the implementation of communications programs. Nurses believed that the administration was unreceptive to their concerns about working conditions (Clarke 1982). The current Human Resources Director, Donald Mayer, has acknowledged that nurse supervisors, responsible for administering personnel decisions in individual units, had little input into formulating such policies. Indeed, hospital administrators did not recognize them as managers (Mayer 1986).

Again the nurses considered requesting changes by top administrators (Clarke 1986). But instead, in late spring, a group of RNs and LPNs contacted 1199. Within months, they had signed cards and filed a request for an election with the National Labor Relations Board. (Estes and Goodman 1986, 250)

1979 Union Organizing Campaign and Election

A new personnel director, Donald Mayer, was hired on June 4, 1979, only hours before 1199 petitioned for a representation election (Mayer 1986). The hospital also contracted with Modern Management Methods, a consulting firm with an aggressively antiunion reputation, to advise it in the campaign. To assist its consultants, the hospital also hired a Massachusetts labor law firm, Skoler, Abbot, Hayes, and Presser (Mirabito 1982a). Based on managment, union, and academic descriptions of antiunion campaigns, the hospital's immediate response to

the organizing campaign clearly indicated its intention to resist union representation of its staff.

At the time Portsmouth Hospital hired Modern Management Methods, union organizers across the country recognized the firm as the most successful of the "union-busting" consultants employed by management to avoid unionization. Robert Muelenkamp, Executive Vice President and Director of Organizing for 1199, testified at congressional hearings in 1980 that the firm had continuously violated the rights of unions and workers:

> I can say, without qualification, that there has not ever been a fair, legal first election which a Union lost in a hospital in the United States where 3M [Modern Management Methods] was an agent for management. Every single election either has been or could have been ruled illegal by the NLRB. 3M advises management not to worry about breaking the law--the Union has even less chance in a re-run election, where management wins 94% of the time.(U.S. Congress 1980a, 159)

In western Massachusetts where Skoler, Abbott, Hayes, and Presser's offices are located, a labor relations student made a similar assessment:

> There is nothing innovative in the Skoler and Abbott strategy. In fact, the pattern is so standardized that most area unions can predict each step. Their anti-union campaign uses intimidation, propaganda, and obstruction.(AFL-CIO Report on Union Busters 1981, 1)

The hospital used many campaign strategies typically suggested by management consultants. For example, it appealed to the regional office

of the NLRB for a ruling to establish the appropriate bargaining unit. Mayer has admitted that the delay caused by this move was useful to managment in in its effort to defeat the union (Mayer 1986). The RN-LPN unit originally proposed by 1199 was denied. Instead the NLRB accepted the hospital administration's request for separate elections for RNs and for a LPN-technical staff unit. The latter body combined part of the nursing staff with x-ray, EKG, and other technicians (Drexler 1982).

During the course of the campaign, the hospital forbade nurses to remain in the hospital when not on duty. Head nurses distributed management's antiunion letters and sometimes discussed the information with individuals in their units. RNs received such letters, either at work or home, almost daily in the month prior to the union election. All nurses attended mandatory "captive audience" speeches in which management outlined the negative characteristics of unions and its opposition to them (Clarke 1982). Management reported that its intention was to expose 1199's "format of outrageous demands with the threat to strike" (Portsmouth Herald 1979a, 1) and the negative effect unionization would have on the nurses' professionalism (Ferriter 1980, 16).

Likewise the union campaigned vigorously for election votes and against Modern Management Method's tactics with strategies predictable from the literature review. Union representative Rick Mirabito explained that 1199 blunted the consultants' impact by describing to the nurses the tactics which the firm was likely to use before the actions were taken (Mirabito 1982a). A union official reported to the press that

"management has tried to convince the nurses the union will indulge in everything from car bombing to Communism" (Portsmouth Herald 1979b, 1).

On August 10, 1979, the RNs voted sixty-four to forty-five in favor of representation by 1199. The union lost its bid to represent the LPN-technical unit by a vote of fourteen to twenty-eight (Portsmouth Herald 1979c, 1).

The 1979-1980 Contract Negotiations

Initial discussions. Negotiations over the nurses unit's first contract began in the fall of 1979. Conflicts ensued immediately over virtually ever aspect of bargaining style and contract language. Guided by its consultant, Martin Skoler--the senior partner of the Skoler, Abbott, Hayes, and Presser law firm--the administration vigorously opposed the union's bargaining format and contract proposals. Initially the union suggested "fish bowl" bargaining sessions which representatives of the press and general public could attend. Management denied the request (Portsmouth Herald 1979d, 1). Additionally, 1199 reported its position and progress in the talks to the news media on a regular basis. Characterizing the talks as "private" and "confidential," administration representatives limited their contact with the press (Portsmouth Herald 1979d, 1).

At the second bargaining session, in October 1979, management negotiator Skoler insisted on one-on-one negotiations with a single nurse representative (Portsmouth Herald 1979e, 1). Jerome Brown, the regional 1199 vice president, and organizer Robert Warfield demanded

that the entire eighteen-member RN bargaining team be allowed to attend all sessions (Portsmouth Herald 1979e, 1). A federal mediator was selected after the second negotiating session to help determine the bargaining format. Skoler dropped the demand shortly before the mediator held his initial meeting (Foster's [Dover, N.H.] Daily Democrat 1979,1). Thus, after a month-long delay, the talks proceeded with the union's original committee intact.

Conflict abounded on basic contract language as well. Throughout negotiations, the hospital remained firmly opposed to any type of union security clause other than an open shop. Further, the administration spokesman revealed its intentions to oppose dues checkoff or union meetings on the hospital grounds. The union sought primarily to win an agency shop, dues checkoff, and free access of its representatives to the hospital (Roberts 1980a).

Major disagreement also surfaced on several management rights issues. The union attempted to gain input into RN staffing decisions, overtime assignments, and shift rotation schedules. It also demanded a strong grievance procedure for the nurses (Clarke 1982; Roberts 1980a, 1). Given the consultant's determination to limit such encroachments on employers' right to manage described in the previous chapter, it is not surprising that the Portsmouth administration opposed these proposals. Instead, management sought to maintain the right "promote the BEST QUALIFIED professionals," assign overtime, and rotate shifts in order to "provide the best possible patient care" (Portsmouth Herald 1980d, 1). It argued that, to retain an "atmosphere of cooperation" in resolving grievances, union representatives should not attend the initial meetings on

RN complaints (Roberts 1980a, 1).

Finally, the negotiating teams presented vastly different proposals on wage rates and benefit packages. Early in negotiations the union proposed that nurses receive a wage increase five percent above the inflation rate (Kincaide 1980, 3). The hospital originally offered a total of ten percent over the course of the contract (Portsmouth Herald 1980a). Although management was amenable to the request for a pension plan, it at first refused the union proposal for a fully vested pension for RNs who had already completed ten years of servic (Roberts 19801, 1).

Board of inquiry findings and strike preparations. In February 1980, 1199 requested that a Board of Inquiry be set up by the Federal Mediation and Conciliation Service to study the opposing sides' proposals. Federal mediator William MacWilliams filed his recommendations on twenty-eight disputed points on March 4. Among his many recommendations, MacWilliams suggested a limited union security clause under which newly hired RNs would be required to join the union, but current staff could decline. He also proposed a system of limited shift rotation, and a management-RN committee to study staffing levels and related problems. His wage recommendation included a fourteen percent wage increase to be implemented in three steps (Roberts 1980b, 1).

The union claimed to accept twenty-two of the twenty-eight proposals MacWilliams made. However, it noted that the report did not adequately address the RNs opposition to shift rotation, health benefits, or the need for larger pay increases to match inflation (Roberts 1980c, 1; Portsmouth Herald 1980a, 1). The hospital negotiators denied most of the study's major points, rejecting the union security and modified

rotation provisions outright. Mayer initially reported that the suggested management rights clause seemed sound, but he later told the press that it made too many concessions (Roberts 1980b, 1; Portsmouth Herald 1980a,1). While the mediator's findings provided a point of departure for bargaining, no settlement was immediately forthcoming. Thus on March 13, the RNs voted seventy-six to twenty-eight to send a ten-day strike notice to the hospital in accordance with the 1974 amendment to the National Labor Relations Act. Only eleven nurses failed to vote. Twelve more nurses voted for the strike notification than the sixty-four who voted for the union in the August 1979 election. Twenty-eight RNs voted against the measure--seventeen fewer than voted against the union (Portsmouth Herald 1980b, 1).

The union coupled the strike vote with a request for intensive bargaining and intervention by MacWilliams (Portsmouth Herald 1980c, 1). It promised to hold public forums and asked the administration to participate (Portsmouth Herald 1980b, 1). Further, 1199 filed unfair labor practice charges with the NLRB alleging that the hospital had failed to bargain in good faith. The union also charged that nurses had been hired on the basis of their attitudes towards unions (Roberts 1980d, 1).

With the strike deadline approaching and no progress evident, Portsmouth Mayor John Wholey offered to serve as a mediator in the discussions (Portsmouth Herald 1980d, 1). The union suggested binding arbitration. Management rejected both offers, saying that the issues were too complex for an outside observer to decide (Roberts 1980d, 1). The nurses granted a request by the mayor for a two-week postponement of the strike on the evening prior to the scheduled deadline (Roberts 1980f,

1). Still the two sides failed to reach a settlement. Union security, wage increases, shift differentials, staff rotation, and the grievance procedure remained as points of contention (Roberts 1980h, 1).

On April 8, one day before their second strike deadline, the nurses' bargaining team offered to drop its demand for a union security clause in exchange for higher wages. The City Council unanimously requested that the Board of Trustees resolve the conflict. The Board, however, backed management's efforts to win a more favorable contract (Roberts 1980i, 1). On April 9, the nurses voted seventy-six to thirty to strike, the first strike in Portsmouth Hospital history. Approximately 90 of the 115 bargaining unit members refused to report to work (Roberts 1980j, 1).

The strike. During the course of the strike, the union representatives continued to report movements in contract talks to the press. They also denounced the role of the consultants in the stymied negotiations. Robert Warfield, an 1199 negotiator, charged that the management consultants had attempted to dictate the terms of the agreement. He reported that hospitals in Boston had paid them "exorbitant fees" in similar cases (Roberts 1980l, 1). Adding fuel to the controversy over the hospital's bargaining stance was Mayor John Wholey. After his attempts to facilitate negotiations between the two camps failed, he publicly condemned Mayer and Skoler's "nineteenth century bargaining position" (Roberts 1980m, 1).

Administrators, too, increased their communication with the news media. In response to public concern and press questions regarding the resolution of management-union differences, hospital spokesmen pointed out how the union's approach to bargaining militated against a settlement.

For example, Mayer explained that in the final bargaining sessions, the RNs' negotiators chose to focus on minor issues rather than addressing the major stumbling block, union securit (Portsmouth Herald 1980h, 1) He also characterized 1199's seemingly dramatic offer to give up its demand for union security language just prior to the strike deadline as "a sham . . . an attempt to justify a strike." The concession, Mayer noted, was coupled with a significantly increased wage demand (Roberts 1980j, 1).

Throughout the strike, reports of the level of activity in the hospital varied. The nurses claimed that, with supervisory staff and head nurses working twelve-hour shifts, the quantity and quality of patient care had declined. They requested that Governor Hugh Gallen order the transfer of patients from the hospital. The governor forwarded the RNs' request to the Commissioner of Health and Welfare who promised to evaluate the quality of care provided (Roberts 1980k, 1).

On the other hand, the administration at first claimed that, with supervisory staff, some forty RNs, and volunteers working, the intensive care unit, emergency room, and medical surgery service all operated with full staff (Roberts 1980j, 1). Human Resources Director Mayer announced that, with a higher patient-RN ratio, the hospital continued to function and even reduced its cost (Portsmouth Herald 1980j,.1). When the strike moved into a second week, the hospital placed advertisements in local newspapers to fill vacant RN positions necessary for continued services (Roberts 1980n, 1).

In spite of inconveniences or curtailment of services caused by the strike, support for the union nurses mounted in the community.

Prominent Portsmouth politicians established a "Help the Nurses Fund" (Whiteman 1980, 1). Pledges of support poured in from the local teachers association, the city employees union, the state nurses association, women's organizations and unions across the state. Governor Gallen attended a rally held by the nurses even though the state had no authority to intervene in negotiations (Roberts 1980m, 1).

Resumed negotiations and settlement. Movement towards the resolution of the deadlock began as the strike continued into a third week. City councilman Peter Weeks charged that the hospital representatives "were not negotiating in good faith . . . They were waiting out the situation hoping that it would go away" (Estes and Goodman 1986, 254). Since he also served as a hospital incorporator (a member of the body of Portsmouth business and civic leaders which operated as the nonprofit Portsmouth Hospital Corporation), Weeks met with administrators. He convinced them to open financial records to the union (Roberts 1980s, 1). On April 25, Donald Mayer released the information to the union bargaining team, and the administration permitted Weeks to attend bargaining sessions in which it was discussed (Roberts 1980q, 1; Estes and Goodman 1986, 254). Talks then focused on economic differences, union security, and shift rotation. Within a week, the two sides had resolved eleven outstanding issues and had exchanged proposals on the remaining fifteen (Roberts 1980r, 1). In the final days of negotiations, neither side discussed developments with the press (Estes and Goodman 1986, 253-54). The negotiations reached a conclusion early in the morning of May 3, 1980.

The settlement included an open shop clause, a dues checkoff

provision, and a seventeen percent increase in wages over two years. There were no benefits negotiated for most of the part-time staff. The language on union access to the hospital, seniority, the grievance procedure, the pension plan, and medical insurance all reflected the RNs' position. A committee of RNs and nurse supervisors would determine the specific terms of the limited shift rotation, but senior nurses would be favored in its assignments. Both sides claimed publicly to be satisfied with the arrangements. However, the union qualified its support with reservations about the union security clause and lack of benefits for part-time RNs. The hospital administration stated that the contract would be a financial burden (Roberts 1980s, 1).

Administration of the First Contract

During the course of the first contract, numerous personnel changes occurred at Portsmouth Hospital. Cecile Kidder, the Director of Nursing for twenty years, resigned before the strike ended (Mayer 1987a). Several head nurses retired shortly after the strike. They were not replaced by senior staff nurses as had been the practice in the past. Instead, nurses with advanced degrees and management training were hired from outside the hospital (Clarke 1982; Drexler 1982).

Staffing changes occurred at higher levels as well. Hospital president Vernon Ballard "stepped down to become, instead, planning associate to the chairman of the Trustees" (Estes and Goodman 1986, 254). The public relations staff had grown steadily from one part-time staffer to five full-time members over the four years since the 1976 organizing attempt (Clarke 1982; Drexler 1982).

Measures were also taken to address the nursing department staffing issue. The administration commissioned a time-motion study of nursing care upon which it built a point-based staffing procedure. Simultaneously, the contractually mandated Professional Staff Committee composed of RNs and supervisors began meeting to discuss RN problems, including workload concerns. Nurses also participated on the RN Advisory Council, a committee set up independently by the hospital, to consider staffing and equipment problems in various departments. (Drexler 1982; Clarke 1982; Plodzik 1982).

In addition to personnel changes, the settlement of the new contract brought financial changes. The hospital's estimated budget deficit increased from $200,000 prior to the new wage settlement to $223,000 for the following fiscal year (Portsmouth Herald 1980f, 1; Estes and Goodman 1986, 254). Administrators attributed the growth, in part, to the unbudgeted increases in wages and benefits. Moreover, approximately one hundred elective operations which were postponed during the strike never occurred, thereby decreasing the hospital's income (Estes and Goodman 1986, 254). In January 1982, these and other financial problems forced the hospital trustees to publish its first annual report in forty years, "to quash rumors that the hospital was 'going under'" (Estes and Goodman 1986, 312).

1982 Contract Negotiations

In 1982, the opposing sides again met to negotiate a contract. Jerome Brown and another organizer, Rick Mirabito, led the twelve-member RN bargaining team (Cote 1982, 1). Martin Skoler no longer

negotiated for the administration. But a junior member of his firm, John Glenn, joined Mayer in leading the administration bargaining team in the new round of contracts talk (Clarke 1982).

As was the case in previous negotiations, management opposed union-proposed arbitration of outstanding issues in order to avoid a strike (Freel 1982b, 3). But again it allowed Mayor Peter Weeks to attend negotiations in the final days. Both the union and administration spoke regularly to the news media. In general, "press statements made by both sides appeared to be more flexible than those made two years ago prior to a breakdown in negotiations" (Foster's Daily Democrat 1982b, 3).

Management again denied union proposals for a stronger form of union security in the contract. Hospital negotiators additionally made a proposal curtailing the relatively free access provisions negotiated in the first contract. They requested that the union representative be restricted to a few areas of the facility after giving the hospital substantial notice of his arrival (Foster's Daily Democrat 1982a,.3). Initially the administration offered a five percent wage increase in each year (Freel 1982d, 3).

The nurses again repeated their demand for a union security clause in the contract. In another attempt to contractually establish RN participation in workplace policies and procedures, the union proposed a management-labor safety committee to develop policy on staffing and use of equipment. It suggested that an outside arbitrator render binding resolutions of the body's internal disputes (Foster's Daily Democrat 1982b, 1). Finally, the nurses wanted fifteen percent wage increases in each of the two years of the new contract (Freel 1982d, 3). Even with

the sizable wage increases won in the first contract, they charged that experienced RNs at Portsmouth Hospital earned the same pay as entry level staff members at nearby Wentworth-Douglass Hospital (Roberts 1982a, 1).

Once more negotiations stalled, and the RNs prepared for a possible stalemate by filing a ten-day strike notice. The hospital claimed to take the threat "very seriously" (Freel 1982a, 3). It responded by announcing its intention to hire permanent replacements for union nurses in the event of a work stoppage (Freel 1982c, 10).

But reports on the eve of the contract expiration indicated some progress at the bargaining table. Management offered to meet as long as the union desired to reach a settlement (Foster's Daily Democrat 1982b, 3). The union had given up its demand for union security. It accepted the original open shop language in exchange for management's acceptance union representative access to all parts of the hospital after two hours of prior notification (Roberts 1982b, 2). But important issues remained unsettled. While agreeing to the establishment of a safety committee, the hospital still refused to allow its disputes to be settled by outside binding arbitratio (Roberts 1982c, 1). Neither was there evidence of movement on the divergent wage proposals (Roberts 1982b, 2).

On May 1, the nurses met to consider the final offer before them. It included the previously settled union security and representative access language. It called for a safety committee to address staff and equipment problems. Internal disputes would be solved by binding decisions made by representatives from staff and management. Management also offered approximately nine percent wage increases in each of two years of the

contract raising the average wage to $6.90 per hour. Other improvements included new dental insurance, larger shift differentials and tuition reimbursement for RNs enrolled in higher education courses, price reductions for staff using the hospital's emergency services, additional vacation time for some RNs, and more benefits for part-time nurses (Cote 1982, 1).

Still unhappy with the lack of union security language, the nurses considered the final offer. On a vote of thirty-eight to thirty-one (twenty-seven union members not voting), they signalled the administration that they would strike on the following Monday, May 3. But on May 2, the bargaining team reconsidered its recommendation to reject the contract. Acknowledging the significant improvements in benefits it offered and realizing that the only alternative was to strike, it reversed its opposition to the offer. In turn, the unit accepted the contract, with a seventy-six - to-four vote. (Sixteen union members did not vote.) (Cote 1982, 1).

Changing Health Care Conditions and the Proposed Sale of the Hospital

Along with changes in the collective bargaining relationship, Portsmouth Hospital was experiencing changes in its overall financial condition in the early 1980s. Local competitive pressures meant large investments in new and expensive medical equipment (Ferriter 1980; Ghioto 1985, 6). In October 1983, the federal government instituted the Diagnosis Related Groups (DRG) system which bases Medicare reimbursement upon fixed rates for 467 treatment categories to replace its practice of paying for patients' full hospital costs. Hospitals were suddenly faced with the fact that, if circumstances pushed the cost of a

patient's treatment above the government's fixed price, the institution bore a financial loss (Ghioto 1985, 7).

While the reverse situation (in which treatment below the prescribed government cost produces net income for the hospital) might also occur, Portsmouth and other New Hampshire hospitals were faced with another complicating factor. Hospital occupancy rates fell statewide from 71.7 percent to 60 percent between 1980 and 1985 due to the increased use of outpatient facilities and the apparent improved health of residents (Ghioto 1985, 7). At the end of fiscal year 1983, Portsmouth Hospital's occupancy rate stood at 65.85 percent (Ghioto 1985, 9). Because major costs of running a hospital are fixed, lower levels of reimbursement resulting from the smaller patient loads exacerbated the hospital's financial crisis (Estes and Goodman 1986, 312-13; O'Neil 1986, 12).

When the Board of Trustees realized that a new building was needed to replace the current ones, it authorized a study to determine how the hospital should meet both its financial and operating needs. Proposals included partial renovation of existing buildings and a merger with either of two neighboring hospitals, Exeter or Wentworth-Douglass (Estes and Goodman 1986, 312-13). But in the fall of 1983, the Board of Trustees announced their intentions to pursue a third option. It decided to sell the Portsmouth Hospital operating franchise to the Hospital Corporation of America for $6.5 million (McLaughlin 1983, 1).

To the hospital incorporators and trustees, the plan seemed optimal. A $3 billion-a-year corporation and the largest for-profit hospital chain in the country, Hospital Corporation of America (HCA) had the resources

to finance both a new 144-bed acute care hospital and the first psychiatric hospital in the New Hampshire seacoast region (Pokorny 1983, 83,86). Although the trustees would hand over the operating franchise to HCA, the Portsmouth Hospital buildings would still belong to the Portsmouth Hospital Foundation. It could sell the facilities or use them to promote health care in the community (Berg 1985b, 1; Richard 1984, 2).

Local leaders worried that the community would lose control over its health care policy. Reports of the failures of HCA hospitals to care for the indigent surfaced. Community officials called for negotiated assurances of full care for patients regardless of their ability to pay in the purchase and sale agreement (Pokorny 1983, 83, 86).

As Portsmouth Hospital and HCA sought to clear the bureaucratic hurdles necessary to construct a new building and transfer management rights, the debate was aired in several community meetings. But within weeks of the announcing the proposed sale and before opposition formally organized, Portsmouth Hospital quietly signed a contract providing for HCA management of the hospital. It began in December 1983 (McLauglin 1984a, 1, 20).

1984 Contract Negotiations

Preliminary talks. William Ford, an Atlanta-based attorney who had handled contract talks for HCA in other locations, arrived to represent Portsmouth Hospital in the 1984 negotiations. The ten-member union committee and the new 1199 staff representative, Alan Saffron, immediately raised concerns about which entity--the Portsmouth Hospital administration or HCA--Ford represented. After some delay,

the hospital and HCA agreed that Ford would bargain for both. Thus, when the anticipated change in hospital ownership occurred, new contract negotiations would not be required (Berg 1984,.1).

Further, nurses became concerned about the hospital's willingness to bargain after hospital spokesman Charles Noon made an oblique reference to the ability of HCA to replace striking nurses. He announced to the press, "The hospital does have a plan for maintaining all hospital services in the event of a labor dispute" (Cote 1984b, 1). The hospital also placed advertisements in local papers announcing positions that would be available in the event of a work stoppage by the RNs (Hart 1984b, 4).

The nurses repeated their charges that the hospital was failing to bargain with them fairly throughout the negotiations (see, for example, Berg 1984, 1; McLaughlin 1984a, 1; Hart 1984b, 4). Without responding to the nurses' charge, management stated to the press that "the union is presenting a very distorted view of the negotiations. However, the hospital does not believe the negotiations are well-served by debating over differences in public rather than at the bargaining table" (Cote 1984c, 16).

The nurses' contract demands also reflected their worries about the expected takeover by HCA. They related to the press their concern over the "operational issues" of what "their status and responsibilities [would be] . . . once the sale of Portsmouth Hospital to HCA . . . [was] complete" (Cote 1984a, 1). Additionally, the union asked for wage and benefit increases. It sought twelve percent more pay in each of two years of the contract and full health benefits for employees' family members

(McLaughlin 1984d, 16).

Ford originally proposed a freeze on wage and benefit levels and no change in the existing union security provision. He also asked that stricter union representative access rules be established. Finally, he suggested abolishing the committee on day care and the dues checkoff provisions instituted in the first contract (Berg 1984,.1).

With essentially no progress made on major issues and the old contract due to expire on April 30, the union requested that a mediator from the Federal Mediation and Conciliation Service attend bargaining sessions (Berg 1984, 20). For the third time in as many contract negotiations, the nurses also voted to file a ten-day notice of their intention to strike on May 9 (Hart 1984a, 4).

In spite of the mediator's presence, there was little movement in the meetings during most of the crucial ten-day period. New disagreement arose over the bargaining format. Ford insisted upon meeting with only one union negotiator in the final days before the strike deadline. The nurses insisted that their entire committee be present (McLaughlin 1984c, 16).

Community intervention. Before a confrontation could erupt between the union and management, the city politicians intervened with their own controversy. City Councilman Rick Newman had opposed the HCA takeover plan since its inception. He requested in early May that the Council pass a motion opposing the hospital's sale. Instead, the body tabled the motion on a narrow, five-to-four vote a few days before the strike deadline (McLaughlin 1984c, 1). On another front, prominent Democrats, including gubernatorial and Senate candidates, state senators,

and city council members, attended an 1199 news conference to speak in defense of the RNs' position. According to one news reporter, the message to HCA was clear:

> Perhaps the most significant comments made at the press conference...were those that suggested HCA might risk negative comments on its plans for building and operating a new $29 million hospital in Portsmouth when those plans are the subject of a state certification and need hearing June 1 in Newington.(McLaughlin 1984b, 1,12)

One day before the strike deadline, the city's delegation to the state legislature requested that the parties submit their differences to binding arbitration. The administration had repeatedly balked at this proposal. The RNs always endorsed it enthusiastically (McLaughlin 1984c, 1).

The opposing teams bargained through the night and reached a settlement within an hour of the scheduled strike deadline. The negotiations ended with five percent annual wage increases, continued access for the union representative, dues deductions, and operation of the day care committee. The hospital retained the former union security language and did not increase health care coverage. The new contract provided slightly more management control over RN scheduling, increased employer contributions for nurses' continuing education, and increased pay for weekend work (McLaughlin 1984d,.1). The nurses ratified the contract by a vote of seventy-one to eleven (twenty union members not voting) (Cote 1984e, 1).

The Sale of Portsmouth Hospital Completed

On June 1, the state certificate of need meeting was held. HCA treatment of the nursing union was not an issue. The question of how much indigent care the new owners would provide arose again. But HCA discarded its former plan to maintain care for the poor at its current level. It offered to use a ratio of the dollar value of indigent care to the gross cost of patient care in determining the future amount of assistance. This calmed the fears of leading opponents to the sale and the certificate of need for a new hospital building was approved (McLaughlin 1984f, 1, 14).

Eight more months elapsed before all of the appropriate state and local administrative bodies approved the HCA building and ownership plan. When HCA finally assumed ownership on February 19, 1985, it already had in place a new hospital administrator, William Schuler. He arrived in Portsmouth the previous summer from the Parkland Medical Center, a smaller HCA-managed acute-care facility in Derry, New Hampshire. In January, Schuler announced his intentions of reducing staff where appropriate (Berg 1985a, 1). By June, the number of full time equivalents working in the hospital had fallen from 418 to 350 (Berg 1985c, 3).

1986 Contract Negotiations

The nurses' bargaining team and its union staff representatives, Kevin Doyle and Rachel Donovan, requested that talks for a new contract begin in December 1985. Indicative of its reputed unwillingness to cooperate with organized labor, HCA declined (Portsmouth Herald

1986b, 1). Bargaining began in early February 1986, with the 1199 local presenting demands in four areas. It asked for increased wages, additional vacation days for nurses with ten or more years of service at the hospital, disability and dental insurance plans, and additional paid holidays (Cote 1986a, 1).

The hospital chose not to contest the wage and benefit demands. Early in the negotiations HCA agreed to a generous increase, roughly seventeen percent over two years. The night, weekend and holiday shift differentials were increased, and the improved dental care plan requested by the union was granted (Cote 1986b, 1).

In return for the generous financial settlement, hospital negotiator William Ford proposed abolition of the dues checkoff provision. Curbed access for the union representative and reductions in the number of allowable leave of absence days from 180 to 90 per year were also part of HCA's plan. Finally, management asked for a change in the hospital grievance procedure which prohibited nurses from grieving new or altered work rules on the reasonableness criteria previously available (Healy 1986a, 1).

The nurses' traditional political allies--the mayor, Democratic candidates, and local union officials--again called for fair bargaining at a public rally. Portsmouth Mayor Mary Keenan charged that management negotiators "are not bargaining in good faith." Gubernatorial hopeful and Portsmouth politician Paul McEachern called the nurses' predicament "a fight against corporate colonialism" (Healy 1986d, 15).

At first management reacted to the publicity with its usual comment that "it is too early to discuss publicly what has transpired in the

negotiation sessions." (Healy 1986b,.6). Later it noted that it had made "every effort to be as reasonable as possible on the economic issues, but there [were] a number of issues on the non-economic side that are very important to the hospital" (Healy 1986c, 17). Finally, as the strike deadline neared, the hospital took out a full-page advertisement in several area newspapers. It assured hospital patrons of continued services in the case of a work stoppage and acquainted them with management's views of the HCA proposals. It also urged union members to reconsider its offer (Portsmouth Herald 1986c, 7).

The union responded to management's publicity with door-to-door leafletting and discussions on local radio talk shows (Ghioto 1986, 3). It also notified the member unions of the Portsmouth Labor Council, who offered financial and picket support in case of a strike (Cote 1986c, 1). On May 1, the day after the 1984 contract expired, the nurses filed the ten-day notice of intent to strike (Hart 1986a, 3).

The administration had already started preparing for a possible work stoppage. It published a strike contingency plan in April which described staff and administrative functions under strike conditions. Four days before the May 13 deadline, HCA flew twenty-five nurses from their hospitals across the country to Portsmouth. Management integrated them into the hospital routine with the negotiating nurses (Mayer 1986; Hart 1986a, 3).

Bargaining continued until the strike deadline. In the last negotiating session, the RNs proposed binding arbitration of the unsettled noneconomic issues. Management refused and stood by its previous demands (Healy 1986e, 11).

The RNs accepted their union representatives' recommendation not to strike. In a fifty-eight-to-ten vote (seventeen union members not voting), they approved a contract. The union had lost the right to a dues checkoff clause in the contract and the right to grieve new work rules on their reasonableness. Once the hospital moved to its new location, the union representative would be restricted to one room in the facility. He or she could only visit the premises after giving the administration twenty-four hours advance notice (Cote 1986c, 1,6).

At the conclusion of negotiations and six years of collective bargaining, the union members and administration held vastly different views of their relationship. RN Dee Hebert complained that the current agreement "is not a good contract but it was in our best interest to sign it .... HCA intended to push a strike and break the union" (Cote 1986c, 6). Hospital representative Charles Noon's assessment was far more optimistic: "It is obvious to us that a vast majority of our employees feel that the hospital is an excellent place to work and that our position in these negotiations is very fair" (Cote 1986c, 1,6).

Analysis of the Management Position

After negotiating the 1984 contract, Human Resources Director Donald Mayer admitted, "it is no secret that no management anywhere prefers to deal with its employees through a third party" (McLaughlin 1984d, 16). Both before and after the nurses unionized, management sought to implement measures which would realize that preference. The Portsmouth Hospital administration consistently attempted to secure contract provisions on five topics--union security, dues checkoff, union

representative access, RN input into decision-making, and wages and benefits. By prevailing on these issues, management would avoid the entrenchment of the union and its impact on the hospital's procedures and budget.

In pursuit of its goal, management regularly employed four bargaining tools in negotiations with the nurses' union. It used the advice and assistance of antiunion labor relations consultants, the avoidance of publicity, the refusal of outsiders' intervention in settling the contract, and the development of a strike contingency plan. The success of these methods varied over contracts depending upon both the effectiveness of the RNs' bargaining strategies and the financial resources available to the hospital.

The following synopses review the hospital's bargaining tactics and positions on each of the contract language areas. The obstacles posed by union tactics and hospital financial constraints in each round of negotiations are then explored.

Contract Issues

Union security. In all four rounds of talks, the administration bargainers firmly opposed the inclusion of union security language in the contract. A statement issued to the press during the first round of negotiations clearly establishes the administration's public position:

> The hospital sincerely believes that employees should retain freedom of choice . . . . that each registered nurse should have the right to work unencumbered by a superimposed requirement of mandatory membership in a labor organization as a condition of continued employment.(Portsmouth Herald 1980i, 20)

However, labor relations experts assert that unions win strong security provisions, such as agency shops, where "an employer accepts unionism and collective bargaining and acknowledges that members of a bargaining unit have an obligation to support the union financially" (Scheuch 1981, 539). It is, therefore, likely that the administration refused to negotiate union security in order to resist the establishment of the local.

Dues checkoff. Over the course of the bargaining history, four reasons for opposing dues checkoff emerged. First, Human Resources Director Mayer argued that contributions to such organizations should be voluntary. "Chip [Charles Noon] and I pay dues to the Rotary. No one makes us do it. If an organization is valuable, people will pay without automatic deductions" (Mayer 1986). Second, the hospital claimed that administering the provision expended valuable management time on a union duty. When HCA entered negotiations, a third explanation appeared. Management stated that "no other hospital in the HCA system has negotiated union dues checkoff, and Portsmouth Hospital does not want to agree to provisions in its union contract which will foreclose other HCA facilities from their right to make their own decision on this issue" (Portsmouth Herald 1986c, 7). A final important but unspoken reason is that the willingness to collect money for an organization implies acceptance of its existence. Thus, agreement to dues checkoff ran counter to the administrations desire to operate without a union. Donald Mayer admitted that throughout the bargaining relationship, the hospital preferred to operate without a dues checkoff

clause in the contract. It was simply unable to prevail on the issue in early negotiations (Mayer 1986).

Union representative access. The administration continuously sought to limit union representative access to all public areas of the hospital without prior notification. The position represents a third dimension of its effort to minimize the union's impact on the hospital. Administrators frequently argued that it was "no secret that 1199 would like to expand its base in Portsmouth Hospital" (Roberts 1980a,.3). In each round of talks, they expressed concern that the union representative's contact with LPNs, technicians, or the housekeeping staff would encourage their unionization (Foster's Daily Democrat 1982a, 3; Berg 1984, 1; Mayer 1986).

RN input into policy making. Hospital administrators understood early on that "the heart of the issue . . . is the desire by nurses to be treated better and to receive the respect and dignity that their professional status deserves" (Roberts 1980l, 1). But they also resisted the RNs' attempt to exercise their professionalism by demanding union intervention into managerial decisions. The administration stated that it shouldered the responsibility "for [maintaining] quality and continuity of care on a 24-hour basis" and for "promot[ing] the BEST QUALIFIED professionals in order to provide the best possible patient care." This assignment required that managerial rights remain intact (Portsmouth Hospital 1980d, 1). To that end, management attempted to weaken RN proposals to limit its decision making on shift rotation and arbitration of Safety Committee disputes by a neutral third party. In later years, it also sought to limit grievances of work rules based upon their

reasonableness.

Wages and benefits. The adjustment of wages and benefits in negotiations was the final exercise of union power which management tried to temper. In the first three rounds of contract talks, the administration initially refused to acknowledge the need for substantial pay increase (Portsmouth Hospital 1980d, 1,3; Freel 1982d, 3; Berg 1984, 1). The pension plan, medical benefits, and dental benefits also emerged as points of contention (Portsmouth Hospital 1980d, 1,3; Roberts 1982r, 1;. Berg 1984, 1). The hospital's intransigence on these issues may have emerged, in part, as posturing which typically occurs early in negotiations. But the financial difficulties which plagued the institution in later years suggest that administrators felt that they needed to limit the local's impact on the hospital budget. Only in the 1986 contract talks did the hospital quickly agree to wage and benefit improvements. Management admitted that it did so then because there were "a number of issues on the non-economic side that [were] very important to the hospital" (Healy 1986c, 17).

Bargaining Tactics

Use of management consultants. The use of the Modern Management Methods and Skoler, Abbott, Hayes, and Presser consultants clearly indicated the hospital's determination to resist the establishment of a union. Both the consultants' antiunion reputations and the consultant-inspired bargaining tactics employed by the Portsmouth Hospital negotiating team conveyed their unwillingness to provide job improvements through contract talks with the local. Management

negotiators appear to have considered the consultants' advice indispensable. In all but the final round of negotiations, the union questioned the usefulness of the attorneys in facilitating administration-RN relations. But management avoided either defending their use of the consultants or dismissing the advisors in response to the union's pressure (Portsmouth Herald 1979c, 1; Roberts 1980l, 1; Cote 1982, 1; Berg 1984, 1,20).

Publicity and community support. At the start of the first contract negotiation, management did not comment publicly on the talks. It insisted that it was more appropriate "to negotiate at the bargaining table, not in public via votes and news releases" (Portsmouth Herald 1980d, 1). This tactic allowed hospital administrators to limit both public assessment of their demands and pressure for change in those positions. Most frequently the strategy emerged in management's refusal to talk with the press (Portsmouth Herald 1980b, 1; Cote 1982, 1; Healy 1986b, 6). During only one round of talks, in 1982, did administrators speak regularly to reporters. Then their comments focused on the hospital's willingness to compromise with the union. They still did not discuss specific proposals.

Attendance and intervention by outsiders. Management's view on reliance on outside parties to help settle contract disagreements was similar to its policy on publicity. It resisted observation of bargaining by community representatives. Administrators believed that the hospital trustees, to whom they reported regularly on negotiations, were appropriate representatives of the public interest (Portsmouth Herald 1980g, 1).

Further, the hospital denied union and public requests for binding arbitration of outstanding issues as the strike deadline approached. The "official" position held that negotiations were "too complex" for outside arbitrators "not involved in the health care field" (Roberts 1980d, 1; Freel 1982b, 3; Cote 1984e, 1). However, arbitrators are hired by both the union and management to serve as a neutral party. They undoubtedly treat both the employer and union as legitimate entities. As stated above, this view runs counter to Portsmouth Hospital's determination to resist the union's establishment.

The strike contingency plan. At the onset of the strike in 1980, hospital president Vernon Ballard issued an explanation of the hospital's strike preparation. The following excerpt generally describes the administration's intentions in all succeeding years:

> Should a strike occur, the hospital will implement a carefully prepared strike contingency plan, the intent of which is to maintain all services at a level as near normalcy as possible. The plan relies on a variety of approaches, which combine the utilization of registered nurses who refuse to strike, supervisory personnel, community volunteers, personnel from other institutions, with possible reductions in non-essential services if necessary. The hospital will not compromise the quality of patient care . . . (Portsmouth Herald 1980i, 20)

When talks snagged, management supplemented this general policy with announcements of various plans for replacing union nurses in the event of a strike.(Roberts 1980n, 1; Freel 1983c, 10; McLaughlin 1984a, 1; Cote 1986c, 6). These hospital actions signalled its intention to continue resisting RNs' demands despite their threats to disrupt service.

Management's Success in Achieving Its Goals

Management's position prior to the first contract negotiation. When the nurses first brought their concerns about wages and working conditions to management, its response rested on two of its three main approaches to resisting the union's impact on hospital activity. The hospital tried to minimize publicity about the unrest. It also sought the advice of a management consultant. Despite the historic importance of a union election among RNs, the administration's comments to the press were limited. Neither the RNs' meeting with hospital trustees nor the implementation of consultant Gallagher's advice attracted much public notice or debate. And the union threat quickly subsided (Paul 1980b, 15).

But management's apparent achievement of its goal of protecting itself from RN-union impact was constrained in two ways. First, in extracting trustee response to their grievances, the nurses succeeded in their initial use of collective action to influence wages and working conditions. While management undoubtedly acted as it did to avoid unionization, its reaction to group demands was one that the nurses sought to repeat in future years.

Second, current administrators have admitted that the hospital president, Vernon Ballard, remained unwilling to implement further financial changes once the union threat subsided. Promises of increased wages and a pension plan were never fully realized. Neither Ballard nor the long-time nursing director, Cecile Kidder, pursued proper administration of the communications programs (Mayer 1987a). Their

lack of attention to changes instituted in 1976 fomented further dissatisfaction among the nurses.

When the nurses' frustrations again surfaced in 1979, the hospital intensified its efforts to defeat the establishment of a union. This time, it depended primarily upon the advice of antiunion consultants. Mayer explained the hiring of the Modern Management firm in the following way: "They were costly, but you knew that by using them you 'bought' the defeat of the union" (Mayer 1986).

Despite the hospital's use of many usually successful consultant tactics, the obstacles to overcoming the organizing drive were too numerous. First, the nurses had developed an effective strategy for building support. They pointed out to undecided workers that the hospital had reneged on its 1976 promises of better wages and working conditions. Already familiar with Modern Management Methods's involvement in campaigns, the 1199 representatives warned the nurses in advance of antiunion arguments the hospital was likely to use.(Mirabito 1982a)

Management has admitted that its own failures in dealing with the nurses contributed heavily to the union's election, too (Mayer 1986). Its avoidance of public debate with the nurses on undeniably bad working conditions was not complete. Remarks made by Trustee Arthur Brady in a July incorporators' meeting denouncing both 1199's strike activity and the nurses' demands did not provoke community reaction. But they fueled the RNs' anger with the hospital (Portsmouth Herald 1979a, 1; Clark 1982). Moreover, long-term neglect of labor relations deprived the hospital of the head nurses' enthusiastic assistance. Mayer noted that

"many of the supervisors didn't support us. If midlevel managers aren't with you, you're sunk. They are the key to productivity and management" (Mayer 1986).

The consultants' inability to defeat both the RN and LPN-technician units did not diminish the hospital's evaluation of them. Mayer reported, "We tried our best to change things, block the union, but it didn't work. As far as having Modern Management work with us, I think it's fair to say they didn't lose us any votes" (Paul 1980b, 15)

The 1979-1980 contract negotiations. Neither the goals pursued by management nor the means it used to achieve them changed with the establishment of the union. The administrators' determination to limit the union's presence appeared in their insistence on open shop language and objections to dues checkoff and union representative access to RNs in the hospital. The hospital tried to curb the nurses' impact on managerial and financial decision making by resisting their demands for participation schemes and wage/benefit improvements. It frequently sought to secure these measures by avoiding media attention and community involvement in the bargaining process. Further, the hospital showed its unwillingness to concede on important issues by preparing to use strike contingency plans. Finally, all management's interactions with the union occurred with the assistance of management consultants.

In the first round of contract talks, consultant Martin Skoler led the hospital bargaining team. Beginning with the first meeting, management's bargaining style was clearly aggressive. As noted above, it refused to allow community observers and proposed bargaining with

only one nurse representative. The hospital attempted to limit the union's success at building public pressure for a contract settlement by refusing to participate in media debates of the issues. Likewise, the administration initially resisted intervention by neutrals beyond that required by law.

The most important aspect of the hospital's antiunion strategy was its successful use of its strike plan. As explained in the literature review, union observers believe that consultants advocate provoking a strike to cripple or destroy the resolve of union members. Such action additionally raises the possibility of a union decertification election in the following year. It is plausible that the Portsmouth hospital administrators intentionally encouraged a strike to rid itself of the 1199 local. However, it is equally likely that management believed its announced willingness to continue operating the hospital during a work stoppage would stop the RNs from carrying out their strike threat. Under the latter assumption, the administration could secure more favorable contract terms by continuing its tough bargaining style.

Despite this aggressive strategy, the hospital faced substantial obstacles to achieving the goal of managing the hospital without union interference. The first barrier was the strength of the bargaining unit. The increase in RN support for the union between its election in August 1979 and the contract settlement confirms that the nurses' resolve was strong. It withstood both Skoler's angry words and actions at the negotiating table and a lengthy, acrimonious strike.

Further, the strong union support in the community forced the administration to retreat from its initial avoidance of press coverage.

The hospital attempted to assure the public of a quick return to normal activity in the hospital (see, for example, Portsmouth Herald 1980i,.20). Likewise, management finally acceded to the nurses' persistent requests for outside intervention by allowing Peter Weeks to participate in talks. (Estes and Goodman 1986,.254).

The second barrier to the success of the hospital's plan was its own financial insecurity. Its decision to hire management consultants to conduct protracted negotiations represented a large (but undisclosed) financial commitment to resisting the union's establishment. Together with the cost of the strike, the effect on the hospital budget threatened to be devastating. For even if the hospital did not suffer financially during the stoppage, as Personnel Director Mayer claimed, (Portsmouth Herald 1980j, 1) patient census remained low. The negative publicity undoubtedly worsened its competitive position in attracting new patients.[1]

These tactical and financial constraints finally forced the hospital to accept dues checkoff and union representative access provisions which provided 1199 the chance to build a strong union. They also moved management to agree to wages and working conditions that bolstered the union's reputation among the RNs and eased its task of attracting new members. Still, the hospital's aggressive strategy succeeded in keeping the union from firmly establishing itself by avoiding essential union security language.

The 1982 contract negotiations. Although management's tactics appeared more conciliatory in 1982 than in the first contract negotiation, most methods for fighting the union's impact remained intact. Again the

hospital depended on a Skoler, Abbott, Hayes, and Presser attorney, John Glenn, to lead the bargaining team. Under his direction, the administration used confrontational tactics. It emphasized the importance of the union representative access issue in order to keep the open shop language previously negotiated. Management also took a tough stand in the last session prior to the strike by simply repeating its previous offer rather than bargaining over issues (Cote 1982, 1). The hospital strengthened its stand on strike preparation by announcing its intention to hire permanent replacements for union RNs in the case of a work stoppage.(Freel 1982c,.10)

Other tactics were altered in 1982 in response to the 1980 experience. The hospital continued to resist resolution of the contract dispute by outside arbitrators. However, before a lengthy stalemate began, it again allowed Peter Weeks to attend meetings. Management's final strategy for limiting the union's success--its avoidance of public debate with the nurses--also reappeared in a revised form. Instead of refusing to respond to press questions, management focused its discussions with reporters on the issues the two sides had settled and the hospital's willingness to meet with the union. (See Portsmouth Herald and Foster's Daily Democrat reports in April and May 1982.)

But even having changed some of its strategies, the hospital faced constraints upon their use. The union had not developed extensive support in the community as it had in 1980. Still, there was interest in their cause. Mayer has admitted that the hospital lacked the clout to prevail on issues such as dues checkoff and union representative access (Mayer 1986).

More importantly, management found itself in a financial position which required a settlement without a strike. It feared that another strike would bring bad publicity and loss of elective surgeries as it did in 1980. Thus management bargainers agreed to a wide range of improved wage, health, tuition, and vacation benefits to avoid another such confrontation.(Mayer 1986). The hospital also consented to expanded participation by the RNs in determining safety procedures. These concessions to the union were expensive. And, they demonstrated to the RNs and other hospital employees the local's bargaining strength. But the administration expressed satisfaction that "the management philosophy of Portsmouth Hospital has changed in a most progressive way." It still denied the contractual guarantee for union security, but avoided a financially devastating strike (Cote 1982,.1).

The 1984 contract negotiations. Again in 1984, management tried to use the tactics that it had previously found effective in weakening the union's impact on the hospital. Labor attorney William Ford became its chief negotiator. His experience in negotiations at HCA-managed facilities introduced the Portsmouth Hospital bargaining team to the contract terms preferred by the corporation and its bargaining style (Berg 1984, 20). Ford's bargaining tactics recalled the adversarial posture of management in the 1979-1980 negotiations. He sought one-on-one bargaining between himself and one nurse representative. Initially he proposed concessions on all five of the important contract language issues (Berg 1984, 1, 20; McLaughlin 1984c, 1).

Furthermore, the administration avoided speaking with the press, hoping to ward off "inappropriate" publicity surrounding the talks. It

denied arbitration of disputed issues as well (McLaughlin 1984d, 16). When rumors of the possible replacement of striking nurses by HCA employees from other locations emerged, the hospital failed to deny or confirm this new twist to the strike plan (McLaughlin 1984a, 1, 20).

But in 1984, constraints on management were too severe to allow full implementation of all of its tactics. The hospital's financial condition had deteriorated. The administration and trustees believed that the hospital's sale to HCA was necessary for its survival (Pokorny 1983, 83,86). Although the Portsmouth City Council's approval was not required for the sale, management believed that passage of a council resolution against it could jeopardize the transaction (Mayer, 1987b).

Since local politicians had taken up the nurses' cause, management conceded its demands for one-on-one bargaining. While the administration still refused arbitration, it replaced its suggestion of a strengthened strike plan with a final all-night bargaining session before the strike deadline. Finally, the hospital gave in to demands for public participation in permitting Councilman Newman to attend some sessions (Donovan 1986a).

RN objections limited administrators' bargaining efforts even before the politicians influenced the contract settlement. Consultant William Ford originally intended only to bargain for Portsmouth Hospital. The local's objections forced him to represent both the hospital and prospective owners (Berg 1984, 20). The move forestalled any administration's attempt to negotiate new, more favorable contract terms once ownership of the hospital shifted to HCA.

Unable to execute many of its most effective bargaining strategies,

management could not achieve the contract provisions it desired. The single issue upon which it prevailed was the continuation of the open shop. The hospital did not win abolishment of dues checkoff, limits to union representative access, or wage and benefits freezes. Neither was it able to curb union participation in decision making on day care. Coupled with the open shop, these new concessions would have diminished the union's power and usefulness to its members. But personnel director Mayer explained that the bargaining team expected to prevail on very few of these demands. He described their efforts as a trial run which the administration used to observe the RNs' reaction to concession demands. The hospital was "preparing for 1986 when the reaction of the city council wouldn't be so important to us" (Mayer 1986).

The 1986 contract negotiations. In 1986, management again employed William Ford as its attorney for the contract negotiations. He repeated his demands for no dues checkoff, restricted union access, and new limitations on grievances (Healy 1986a, 1, 15). The administration did not respond to the nurses' charges of union-busting which appeared regularly in newspaper interviews. It also refused outside observation of the contract talks for this study (see appendix A) and a union request for arbitration of noneconomic issues (Hart 1986b, 3). Most importantly, a rumored plan to bring HCA nurses from other hospitals to Portsmouth in the event of a strike became a reality. Their arrival at the hospital prior to the strike vote told the nurses that management was "serious about keeping the hospital operating" (Mayer 1986).

At first glance, it appears that management did not employ all of its

tactics for ridding itself of union influence. Neither did it seem to win all of the contract provisions needed to secure that goal. However, a closer analysis shows that HCA's tactical moves were well planned, and their contract concessions were minor. For example, HCA did respond publicly to the nurses contract demands and charges of union-busting shortly before the strike deadline. But the full-page newspaper advertisements run throughout the seacoast region were completely designed by management. "The best way for us to get our message across was to buy space .... We could send a press release, but we couldn't guarantee it would be used or edited" (Ghioto 1986, 3). Similarly, management conceded pay raises and improved dental benefits to "show that we weren't just going to take but to give something, too" (Mayer 1986).

The hospital attributed the ease with which it weakened the union's influence on hospital decision making to the lack of constraints in the 1986 negotiations. The nurses had not taken any visible efforts to channel community sympathy for them into organized opposition. Despite supportive statements by city officials at an 1199 rally, Mayer reported that there was no pressure from the city council during these negotiations (Mayer 1986).

More importantly, the financial barriers to full implementation of the policy present in all past negotiations had disappeared. Mayer commented that "we could have spent a lot of money on a strike. With HCA, the resources come from Nashville, and the checks don't bounce."(Mayer 1986). HCA and the Portsmouth Hospital managers successfully used those resources to warn the RNs of administration

intentions to dictate the contract terms. Mayer's assessment of the negotiations was that "we got everything we wanted this time around" (Mayer 1986). That included continuation of the open shop, limitations on the union representative's access to all parts of the hospital, and abolishment of the dues checkoff provision. They also won a reduction in the RNs' role in policy determination with the elimination of work rule grievances based on the reasonableness criteria.

Conclusion

Management's ultimate success in bargaining stemmed from its clear strategy for resisting the union's firm establishment, its ability to adjust its bargaining tactics, and the financial and human resources available to it. Although the 1980 strike required concessions to end it, management held on to its demand for an open shop. The measure denied the union's contractual entrenchment. In 1986, when it finally possessed the resources to impose its will, management chose to prevail on dues checkoff, union representative access, and RN input into decision making--the other issues affecting the union's security. Thus, the union currently faces increasing difficulty in maintaining membership. And the administration anticipates that it may no longer have to bargain with the local over the final contract issues--a few policies providing RN input into decision making and wages and benefits (Mayer 1987a).

Pursuing this specific strategy occasionally required adjustment of tactics. After the unsuccessful attempt to avoid public relations in 1980, the hospital was available for comment to reporters in 1982.

Recognizing the potential negative public relations impact, administrators avoided involvement in a strike in 1984. And management skillfully conveyed HCA's position to the community in 1986 when it sought to curb the union's rights. Additionally, management allowed selected city officials to attend bargaining after the 1980 talks rather than appear completely uncooperative.

Finally, one cannot overestimate the importance to management's success in bargaining of the financial and personnel resources of HCA. However, a clear understanding of the contract concessions necessary to weaken the union, and the appropriate publicity and strike preparations to back those demands were essential. Without them, the nurses might have forced a long, bitter strike. In that case, HCA's resources might still have allowed it to prevail. But both the hospital's reputation and income could have suffered. Instead, the skillful use of resources has essentially achieved management's original goals. Mayer reports a higher than anticipated occupancy rate in an environment where management hardly notices the union's presence (Mayer 1987b).

Analysis of the Union Position

From the time the registered nurses at Portsmouth Hospital decided to organize a union local, they pursued two goals. First, they sought to contractually insure the existence of their organization. Second, they attempted to use the local's bargaining power to improve their working conditions and wages. To achieve these two objectives, the RN local bargained for favorable contract language on five issues. Union security, dues collection, union representative access to the hospital, RN

input into decision making, and wages and benefits were all important issues for them. To secure agreement in these areas, the union regularly used three tactics--cultivation of public awareness and support, intervention by neutral parties, and the strike threat.

But an attempt to negotiate in a particular style does not guarantee that management will agree to desirable contract language. The analysis of the Portsmouth nurses' negotiations given below reveals that in each round of talks, both management resistance and the union's internal limitations hampered bargainers in prevailing on contract issues. A review of each of the contract issues and bargaining tactics based on the Portsmouth Hospital history is first presented. Discussion of the obstacles to the union bargaining committee's negotiating style, and the effect of these constraints on eventual contract settlements then follows.

Contract Issues

Union security. The registered nurses and their union representatives feared that without a union security provision, they could never achieve their goal of firmly establishing the Portsmouth local. Further, the high turnover of the staff coupled with management's ability to selectively hire antiunion nurses lay open the possibility of the decertification of 1199 as the union representative (Portsmouth Herald 1980g, 1). Based on these considerations, the union bargainers made union security a priority in the 1979-1980 and 1982 negotiations (Portsmouth Herald 1980e, 1; Freel 1982a, 3). In later years, the issue subsided as bargaining focused on the concessions which management demanded of the union.

Dues checkoff. In addition to the union security requirement, 1199 believed that the contract needed a dues checkoff provision to firmly establish the union in Portsmouth Hospital (Roberts 1980a, 1). As 1199 representative Rachel Donovan pointed out, the task of collecting dues becomes virtually a full-time job for union officials if the money is not deducted from RN paychecks (Healy 1986a, 1). The union characterized management intransigence on this issue as "an attack on our organization" (Portsmouth Herald 1986b, 4).

Union representative access. The final condition which the RNs viewed as essential for the security of their organization was free access of their representative to all public areas of the hospital. Nurses argued,"If we're too busy to talk to [the union representative], we know enough to tell him that. It's unprofessional of them (management) to assume that we can't handle something like that" (Foster's Daily Democrat 1982a, 3). Together with the original union security language, the local characterized resistance to union representative access as "the administration . . . trying to subvert the union's role in the hospital" (Freel 1982c, 10).

RN input into decision making. In order to achieve their second goal--better working conditions and wages--the nurses attempted to secure greater RN input into decision making. Even before establishing the union, the nurses prompted management to implement "Why?" and "We Hear You"--two employee involvement programs. In its first contract, 1199 sought a strong grievance procedure. Without such protection, nurses complained that "it was the same old story--if you don't like it you can leave" (Roberts 1980a, 1). Additionally, the

bargaining committees sought to contractually establish professional staff, safety, and day care committees over the course of the bargaining relationship. Again, they expected these groups would allow RN input into policies affecting their working conditions.

Wages and benefits. From their first confrontation with management in 1976 through the 1986 contract negotiations, the nurses demanded wage increases to make their pay competitive with that of neighboring hospitals. Other wage and benefit issues addressed in bargaining included higher overtime pay and shift differentials, institution of a pension plan, improved vacation policy, and upgrading of medical and dental benefits.

Bargaining Tactics

Cultivation of public awareness and support. During negotiations, the union informed the public about its position in a variety of ways. In each round of talks it regularly reported both areas of agreement and stalemates to the news media. Public question and answer sessions, rallies attended by sympathetic politicians and union leaders, informational leafletting, and letters to the editors of local newspapers were other methods of communication used by the nurses. The union also called for negotiating sessions which representatives of the public could attend. This, they believed, would "alleviate area fears that . . . [union] demands were irresponsible or exorbitant" (Portsmouth Herald 1979d, 1).

Intervention by neutral parties. As previously noted, in each of the four contract negotiations, 1199 requested intervention by a mediator in

accordance with the 1974 amendment to the National Labor Relations Act. But because a mediator is not specifically directed to suggest terms for a contract settlement, the nurses frequently requested the assistance of other neutrals. In each round of talks, the union proposed submitting unresolved issues to binding arbitration. At various times the union also suggested participation by the Portsmouth mayor, city councilman Peter Weeks, or other representatives of the public interest.

The strike threat. Federal law requires that health care unions notify their employers ten days in advance of an intended strike deadline. The Portsmouth local voted for notification prior to every contract settlement. The nurses sometimes fortified the legal notice by publicizing the hospital's actions which compelled them to strike.

The Union's Success in Achieving Its Goals

Early attempts to secure workplace improvements. When Portsmouth nurses approached hospital administrators in 1976 and 1979, they focused on securing improvements in their wages and working conditions, rather than seeking union representation. But they employed some of the tactics used in later negotiations to win their demands. For example, in 1976, the RNs met with hospital trustees in order to publicize their complaints. They threatened to vote for union representation (though not a strike) to gain attention for their concerns. The nurses did not request outside intervention, but their organized appeal moved the administration to hire labor lawyer Gallagher. By accepting his advice to institute wage and communications policies, the hospital seemed to demonstrate its responsiveness to the nurses (Paul

1980b, 15).

But the RNs soon encountered obstacles to the implementation of these programs. They claim that hospital administrators resisted using the question and answer procedure, "Why?". Management did not respond to queries unless thirty percent of the nursing staff was affected by a policy questioned by an individual. Nurses also report that managers conducting the "We Hear You" sessions tried to intimidate RNs who asked difficult questions (Clarke 1982; Gardner 1982). Finally, management failed to pursue regular wage increases or the promised study of a pension plan (Mayer 1986).

The difficulties brought on by hospital resistance to improved working conditions, in turn, uncover a second constraint. The nurses retained no organization of their own either to monitor management's progress in implementing change or to discuss additional RN proposals for job improvement. Thus, they were unable to initiate collective demands for better working conditions as they had in 1976.

In 1979, the nurses revised their strategies, and the RNs again sought workplace improvements. Once more they presented their demands to the trustees. They also aired their concerns in a meeting with reporters at the Portsmouth Herald offices (Estes and Goodman 1986, 250-1). Finally, when negotiations with the trustees broke down, the nurses followed through on their threat to organize.

Despite their success in the RN unit election, the nurses did not overcome all obstacles to establishing the union. The consultants hired by management this time did not support staff demands. Instead, Modern Management Methods recommended tactics designed to intimidate nurses

and to delay the election. Their suggestions both succeeded in removing the prounion licensed practical nurses (LPNs) from the nurses' bargaining unit and contributed to the LPN-technician unit defeat (Mayer 1986). The nurses and 1199 representatives also found that their own "lack of organization" hindered their campaign to win the LPN-technician unit election (Portsmouth Herald 1979d, 1).

The 1979-1980 contract negotiations. In its first attempt to negotiate a contract with Portsmouth Hospital, the 1199 nurses tried to win favorable language in all five of the categories listed above. To do so, they employed all three of the bargaining strategies discussed above. In daily reports on the negotiations' progress, the nurses portrayed management as an uncompromising employer willing to provoke a strike. When the work stoppage began, the union members held a seminar on the negotiations at which "most of the audience appeared to be supporters of the RNs' union" (Roberts 1980e, 1).

Their educational efforts paid off as local residents and politicians provided financial support and encouragement which strengthened the resolve of the strikers. The union bargaining committee's persistence in calling for outside help to end the conflict was also rewarded. The administration finally agreed to allow city councilman and Incorporator Peter Weeks into negotiations to facilitate discussions on wages and benefits.

Most importantly, the nurses succeeded in exercising the strike option. After having twice notified management of their intention to stop working, the bargaining unit members finally walked out and remained on the picket line for three weeks. Hospital spokesmen argued

that the facility continued to function well with even lower costs than under normal conditions. But the loss of potential patients to other area hospitals and the postponement and cancellation of elective surgeries created financial pressures which forced management to bargain seriously.

However, other efforts to strengthen their negotiating position met stiff management opposition. The hospital clearly signalled its determination to resist union proposals by retaining as its chief negotiator the antiunion attorney, Martin Skoler. Led by Skoler, the hospital bargainers refused to open bargaining sessions to the public as 1199 requested. They studied and rejected the suggestions of the Board of Inquiry, most of which the nurses favored. Even after protracted negotiations, management did not to agree to a contract. When the talks appeared to be failing, management denied both arbitration of outstanding issues and intervention by Mayor John Wholey. The significant personnel and financial commitment to defeating the union which these actions represent provided a major challenge to RN bargaining efforts.

The second obstacle facing the union was the cost of its own strike option. The RNs' strike benefits were less than their pay, and there were no guarantees that the conflict would end with management's capitulation. One union representative suspects that if the strike had lasted another week, some of the nurses would have returned to work. In short, the tactic was effective, but the union realized that it could not use it indefinitely (Mirabito 1982).

This potential bargaining strategy weakness and management's

resistance to other tactics led the union to agree to contract terms which did not achieve its main goals. It failed to gain union security language. However, the 1199 representative noted, "Our members feel there will be no problem in maintaining a majority because the attitude of the hospital management is so antinurse" (Roberts 1980c, 1). Moreover, union success in securing favorable language on both dues checkoff and union access provided the 1199 representative the opportunity to concentrate on addressing the RNs' concerns. Those efforts could contribute to building membership.

Neither did the above difficulties block the nurses from realizing some progress towards their second goal--the improvement of working conditions and wages. Upon the settlement of the strike, the union claimed that because it had won the shift rotation policy based on both seniority and RN input, it "got the best of both worlds" (Roberts 1980s, 1). The nurses were also pleased that the hospital had agreed to the safety committee which they had proposed (Roberts 1980o, 3). Finally, the RNs expressed satisfaction with the wage increase, improved health benefits, and new pension program which they had won.

As the 1982 negotiations approached, the nursing staff recognized that the language designed to increase staff input was ineffective. Union members claimed that management subverted the contract, in part, by creating a Nursing Advisory Council. The supervisor, RN, LPN, and nurses' assistant representatives in that body provided what little input management allowed on patient care policy. The contractually mandated Professional Staff Committee rarely met and rarely agreed on substantive proposals (Drexler 1982; Clark 1982). In short, the RNs had

forced the establishment of the means by which they could air their concerns. But management's determination to minimize the union's impact moved the local to consider new contractual measures to improve the committees' decision making capability.

The 1982 contract negotiations. After the difficult, but ultimately successful 1980 negotiations, the nurses looked forward to making additional improvements in contract talks. In 1982, they hoped to gain union security language and the establishment of a safety committee where nurses could participate in binding decision making on staffing and equipment issues (Freel 1982b, 3). Again the local sought to use both union and public pressure to attain its goals. It produced regular reports to the press on the progress of negotiations. Once more the nurses filed a ten-day strike notice. In doing so they noted that the national nursing shortage would impede management attempts to hire replacements. Another tactic--repeated offers to submit unresolved issues to binding arbitration--failed. But the union won some public intervention when the hospital agreed to participation by Mayor Peter Weeks in the final bargaining sessions.

On the other hand, management's resistance to the union and 1199's preparation for negotiations limited its success in attaining its goals. The administration revealed its continued intention to block the firm establishment of the union despite its announced willingness to compromise on disputed issues. The hospital's bargaining team offered to meet as often as necessary to settle the contract. It also agreed to an attractive wage increase, larger shift differentials, and expanded vacation, educational, and health benefits (Cote 1982, 1). Its usual

intransigence, though, became apparent in three important areas. The hospital bargained aggressively on the representative access question. It did not address the unit's demand for union security or RN participation in decision making.

Management's offers and tactics exacerbated the union's second obstacle--its own failure to assess the relative importance of each contract goal. By accepting essentially the same open shop and union representative access language as was already in place, the union indicated its willingness to settle for less than its initial demands. Such movement from an initial bargaining position is typical in negotiations. But the representative and nurses complained bitterly about the hospital's deception in "creat[ing] an issue over access, only to turn around and offer to trade it for something else" (Freel 1982d, 3). Their complaints suggest that the union negotiators failed to deny management charges of improper behavior by the union representative. More importantly, they apparently failed to take an appropriate, tough stand consistent with their bargaining goal on union security.

Two final issues in the 1982 negotiations point out the union's failure to set and to pursue priorities among its bargaining goals. The tactic which proved successful in the first contract settlement--building community support--received little attention in the second round of contract talks. In addition, the local's sudden reversal on the final strike vote further hints at its lack of preparation for implementing this strategy. Although these obstacles slowed union progress towards its goal of firmly establishing itself at Portsmouth Hospital, the union still secured improvement in working conditions through better benefits.

The 1984 contract negotiations. In 1984, 1199 again used the press to expose the "complete failure by the hospital to deal fairly with the nurses." It openly attacked management's demanded give backs to provoke community awareness of negotiations (Berg 1984, 1). The nurses initiated efforts to cultivate support for their cause among Portsmouth residents by organizing a public press conference. Local politicians were on hand to announce their support for the union. The nurses criticized the administration for its newspaper advertisements for replacement nurses. Believing it was "preparing not for negotiations but for a strike" the local responded by filing a ten-day strike notice (McLaughlin 1984b, 12).

Insofar as HCA was "forced to recognize [1199's] existence and recognize us as a force to be bargained with," this strategy produced acceptable results (Cote 1984e, 1). But the combination of tactics did not yield significant gains in either the establishment of the union or the improvement of wages and working conditions. Again, the union's own preparation for negotiations and the resistance offered by management prevented further advancement towards those two goals.

There is little evidence of union research into HCA's employee relations during either initial discussions about the hospital's purchase or the 1199 contract negotiations. Information available to 1199 during contract talks reveal a troubling record of negotiations prior to 1984:

> In 1983 [HCA] reported no collective bargaining agreements in its hospitals and subsidiaries. During 1973-83, HCA had union contracts or negotiations in progress in seven locations, but no union had survived in an HCA facility longer than five years. Either it was decertified or HCA sold the hospital.(Craypo and

Lehman 1986, 53)

Descriptions of 1981 and 1982 contract negotiations in two West Coast hospitals owned by HCA are equally troubling from the union perspective. HCA made noneconomic demands similar to those made in Portsmouth in bargaining with technical, clerical, service, and maintenance locals. Union media campaigns which exposed HCA's personnel and business practices elicited strong public support. Locals struck the HCA hospitals to settle the contract. But none of the tactics were successful. The unions were decertified within a little more than a year (Craypo and Lehman 1986, 53-55). During negotiations with a nurses' local in one of these hospitals, HCA flew RNs who could serve as replacements in the event of a strike. The move forced the nurses to surrender the contract's union security language (Craypo and Lehman 1986, 55-56).

One cannot know with certainty how the community would have responded to an RN campaign against these HCA bargaining tactics based on this information. But the citizens had supported RNs' concerns in 1980. They also fought for, and eventually secured, changes in the sale agreement insuring corporate responsibility for indigent patient care. Both suggest that the nurses might have cultivated sizable local support for HCA assurances that the hospital would bargain fairly on union security, wages, and working conditions in this and future negotiations.

Instead, the union won an acceptable contract by exploiting management's inability to actively resist a settlement in the immediate situation. The nurses recognized that the hospital could not afford the

bad publicity created by a strike as the Certificate of Need meeting approached (McLaughlin 1984d, 16). As it had in the past, the hospital refused to submit the contract issues to binding arbitration. But their political needs moved the administrators to temper their resistance to union goals and to reach an agreement before the strike deadline.

The 1986 contract negotiations. In 1986, 1199 continued to inform the public of union proposals and progress in the talks through press coverage. As it had in the past, the union assembled local politicians and labor leaders at a daytime rally. They urged the hospital to bargain on the changes in representative access, dues checkoff, and the grievance procedure rather than simply demanding union concessions. Again the nurses signalled their intention to strike within ten days, hoping to move the administration to better offers. They argued, "If HCA felt their proposals were fair and just, they would have no problem with [the union-proposed] binding arbitration" (Hart 1986c, 39).

But, the availability of both HCA's financial and personnel resources made the hospital unreceptive to such demands in the 1986 negotiations. Access to the the corporation's financial resources allowed the hospital negotiators to offer wage increases and better dental benefits which the union quickly accepted. Ultimately, these improvements were sufficient to prevent RN dissatisfaction with other contract language from erupting into unified opposition to management.

Even more effective in convincing the RNs to settle was the arrival at Portsmouth Hospital of twenty-five nurses from HCA facilities across the country. Working aside these potential replacements intimidated union nurses by raising their fears that they would lose their jobs. The

action was key in forcing the surrender of dues checkoff, union representative access, and grievance language won in earlier contracts (Cote 1986c, 6).

But weaknesses in union preparations for the negotiations also contributed to the retreat from its goals relating to the union's existence. The local made little effort to involve the community in its struggle beyond the single, sparsely attended public rally. Further, union representative Rachel Donovan estimated that to overcome management's contract demands and strike plan might have required a six- to eight-week strike by the local membership. Her relatively recent (December 1986) arrival in Portsmouth as the union representative had not allowed her to prepare the unit for a commitment of that duration (Donovan 1986b).

Conclusion

After the 1986 settlement, Donovan noted that 1199 would explore the possibility of forming a coalition of area unions, progressive political organizations, and health care advocates in preparation for future negotiations. It planned to explore methods of publicizing HCA's unwillingness to bargain fairly with its nurses including a highly visible education campaign and boycott of the hospital. Given HCA's considerable financial resources, it is unclear whether such efforts would be sufficient to win a better contract. Donovan believed that they represented the minimum required to exploit vulnerability of the hospital chain--its need to attract clients to its hospital and auxiliary facilities (Donovan 1986).

The timing of Donovan's comments points out another weakness in union strategy. After 1980, the nurses and the 1199 staff failed either to prepare thoroughly or to follow a coherent plan to realize union security. One cannot know retrospectively if the union would have succeeded in bargaining more aggressively on union security language in 1982, 1984, or 1986. Especially because the HCA administration was ready to defend itself with its own publicity, mobilization of financial and moral support of local residents may not have produced the desired results in 1986. But without such an effort, continuous attacks on the union's existence by the antiunion Portsmouth administration and HCA were inevitable.

Insights into the union's failure to establish itself in the hospital emerged both from the history 1199's activity in Portsmouth and from Donovan's comments after the 1986 settlement. First, management has increasingly turned to part-time nurses to fill vacancies since the negotiation of the first contract. According to Donovan, the difficulties of organizing employees who both spend less time in the hospital and receive less (if any) of the union benefits has consumed much of the union representatives' time and effort (Donovan 1986b).

This problem is further exacerbated by the frequent change in union representatives servicing the Portsmouth local. Since 1979, at least six 1199 staff members have served as the RNs' contact. Donovan acknowledged that the short period of time each representative has spent working with union officers has limited the amount of leadership and steward training they have received. In turn, neither the representatives nor local officers have focused on long-term planning and preparation

for contract negotiations (Donovan 1986).

Finally, New Hampshire remains an environment unfriendly to labor unions. During the course of its history, 1199 appeared hesitant to build a community alliance around bargaining issues. Possibly the union believed that if the effort failed, the isolation already experienced by this unique nurses' local would increase. However, after the unsuccessful 1986 negotiations, local community groups contacted the local to offer their support in improving conditions in the HCA facility (Donovan 1986). Whether or not it was feasible in the past, 1199 must now seriously entertain the possibility of constructing a coalition to pressure management.

Despite the many, usually successful union avoidance strategies employed by managment before the 1986 negotiations, the 1199 local achieved moderate success in pursing a firmly established bargaining unit and better wages and working conditions for its members. But to achieve future victories over its newest obstacle--the HCA-financed attempt to limit union influence--the nurses must use the tools that produced success for management in 1986. They need to develop clear goals for contract negotiations, a strategy for their implementation, and financial and personnel resources to achieve them.

The union has not publicly announced whether it has the resources or inclination to pursue this path in 1988. But a failure to make such a commitment at Portsmouth or another HCA hospital may result in serious consequences for the organization of registered nurses. It will expose unions' unwillingness and inability to thwart a significant, new form of management resistance in today's fast-growing health care industry.

CHAPTER NOTES

[1]In a 1986 interview, Mayer confirmed that the hospital's reputation was severely damaged by the strike.

CHAPTER FOUR

SURVEY DESIGN AND RESPONSE

The foregoing review of the literature indicates that hospital administrations, their management consultants, and union organizers agree that opposition to unionization occurs both prior to and during election campaigns. Management may seek to limit employees' initial interest in organizing by using union avoidance techniques. It is a generally accepted maxim of consultants that "[f]rom the point of view of an individual worker, it is essentially irrelevant whether his or her needs are met and questions answered either by a labor union or by management" (Lagerfeld 1981). Further, as consultant John Glenn has noted repeatedly, "no company has ever lost an election that wasn't held" (Glenn 1985). These statements indicate that consultant recommended programs are most effective in those situations not frequently considered in previous studies--work environments in which no union election occurs.

When faced with a NLRB-ordered election, employers may additionally turn to the more aggressive antiunion letters, one-on-one conversations, and captive-audience speeches advocated by consultants. In accounting for union resistance, nearly all of the statistical and econometric studies discussed above focus on the election situation and use the employees' votes or the outcome of an election as dependent variables explained by consultant intervention and other factors.

Thus, the initial intention of survey research undertaken for this dissertation was to evaluate hospitals' use of two types of consultant tactics described in the literature review and case study. First, differences between personnel policies in hospitals employing consultants and those which did not would be analyzed to determine if consultant-directed management implemented unique personnel measures likely to discourage unionization. Second, a comparison of the use and success of campaign tactics employed by administrators relying on consultant assistance and those who did not would be completed to examine consultants' influence on union card campaigns.

It was not feasible to pattern a study after earlier employee-level studies. At the outset of this study, union organizers in Northern New England did not anticipate any RN organizing drives resulting in a NLRB election within the following year. This made it impossible to pursue the research method of Getman et. al. (1976) for monitoring employees' voting intentions. Neither had there been organizing activity recently enough to expect that an unbiased sample of RNs from a hospital in which an election was held could be located and interviewed "retrospectively" according to the methodology used by Brotslaw (1967). Instead, this study is based on a unit level survey in which the relations between the occurrence of union activity and hospital labor relations policies are explored. Both the characteristics of the hospitals participating in the study and the content of the survey are described more fully below.

Characteristics of Survey Population

Hospitals chosen for this study meet several requirements developed after interviews with the executive director of the New Hampshire Nurses Association, 1199 organizers previously involved in organizing northern New England healthcare workers, area nurses, and hospital personnel directors. All hospitals included are community hospitals--private nonprofit, church-affiliated, city, or hospital district institutions--serving patients with short-term, acute-care needs. Since a 1974 amendment to the National Labor Relations Act insured union organizing rights to private nonprofit hospitals, this study is restricted to private nonprofit hospitals which maintained nonprofit status from 1974 through 1985. Hospitals with less than fifty beds designated for acute care patients were omitted in order to allow for the assumption that administrators at the chosen institutions consciously formulate labor relations policies rather than addressing all concerns of employees on an informal, individual basis.

In all, sixty-one hospitals--thirty in Maine, eighteen in New Hampshire, and thirteen in Vermont--meet these requirements. Inquiries to the New Hampshire and Maine State Nurses Associations (MSNA) and regional representatives of the Service Employees International Union (SEIU), American Federation of Teachers (AFT), International Brotherhood of Teamsters (IBT), 1199 - New England Hospital and Health Care Employees Union revealed that some union activity had occurred in approximately forty percent of these hospitals. Due to the small size of the population and the expected difficulties in

obtaining data on the sensitive issue of union organizing, information was solicited from all eligible hospitals.

Survey Design

A mail survey soliciting details on implementation and the perceived importance of labor relations policies which management-consultants might influence was constructed (Appendix B). Hospital personnel directors were asked to identify individual policies from each of the six personnel policy categories described in the literature review--employee input programs, management/RN relations, wage/benefits package, advancement/transfer, scheduling, and women's issues--in use at their institution. They were also asked if their hospitals had experienced informational meetings and picketing, literature dissemination, or card campaigns sponsored by a union or nurses' association. Hospitals in which unions had launched card campaigns were asked additional questions regarding consultant-suggested anti-union strategies employed to defeat the organizing drive. Finally, questions designed to elicit information about the hospital environment, including the form of patient care delivery, scheduling and staffing levels of RNs and LPNs, and changes in the hospital management structure as they related to union activity, also appear in the survey. The questionnaire was pretested by Mr. Donald Kassilke, the personnel director of St. John's Hospital in Lowell, Massachusetts, a hospital similar to those in the survey population. It was also reviewed by the executive director of the New Hampshire Nurses Association.

It was recognized that, in addition to personnel policy, hospital demographic factors might also influence union organizing efforts in the institutions surveyed. However, to avoid extending the length and difficulty of the survey, data on bed capacity, patient census, and staffing levels covering respondent hospitals were purchased from the American Hospital Association (1979-86a). Readily accessible data were available for the years 1978 through 1985.

The individual functioning as the hospital's personnel or human resources director was chosen to complete the survey for several reasons. First, the personnel director's communication with the directors of each department including nursing implies familiarity with RNs' most important concerns. Second, this administrator is usually instrumental in developing labor relations policies (although a board of trustees may determine broad policy direction and approve specifics of a policy). Personnel directors are also likely to participate in a regional professional association which keeps personnel administrators attuned to other local labor market conditions, union activity, and management responses. Third, the personnel director administers employees' wage and benefit programs. He or she therefore knows which policies affect nurses and how frequently they are used--information useful in assessing the importance of such programs to RNs. Finally, a personnel director typically has the authority to complete personnel surveys on behalf of the hospital administration, although he or she may choose to obtain the chief executive's permission to divulge policy information relating to union organizing in the hospital.

Fashioned after the Total Design Method developed by Dillman (1978), three mailings were made regarding the survey. A copy of the survey and an explanatory letter were mailed on May 1, 1986 (Appendix C). One week later, a postcard reminding the personnel directors of the request was sent to all who had not yet either returned the form or indicated that they would not participate.

The first mailing and postcard resulted in responses from fifteen Maine hospitals, seven New Hampshire hospitals, and two Vermont hospitals. Because of the small number of returns from New Hampshire and Vermont ,and because several personnel directors had inquired and/or voiced concern about the confidentiality of their responses, efforts were made to secure statements from the presidents of the three states' hospital associations confirming the guarantee of anonymity of respondents and their hospitals (Appendix D).

In an ensuing telephone conversation with Ms. Allyson Spring, Program Manager of the Maine Hospital Association, the request to that state hospital association was denied. Ms. Spring indicated that the organization does not review or endorse surveys produced by anyone other than allied hospital or health care associations or the federal government.

The requests made of the New Hampshire and Vermont presidents were passed on to the Vice Presidents, Irene Peters and Duncan Brines, respectively, for further consideration. Their responses (Appendices E and F) show an unexpected degree of resistance to the project.[1] Mr. Brines mailed his statement independently to all Vermont hospitals. Ms. Peters sent her statement to me. Her comment that "[t]he NHHA

assumes that Ms. Kriesky will hold responses to this survey in confidence, but has insufficient information to verify the legitimacy of her research" seemed likely to raise concern about the survey rather than to encourage responses. The letter, therefore, was not included in the follow-up mailing. Instead, a statement outlining the University procedures assuring subject confidentiality in survey research signed by dissertation committee members was sent with the letter and questionnaire to nonrespondents in all three states on May 24 (Appendix G).

Few personnel directors responded to this second survey mailing. Three Maine hospitals sent letters declining participation as did one New Hampshire hospital. A second indicated that, due to a vacancy in the personnel director position, participation was not possible at that time. Two New Hampshire hospitals returned completed forms. Four letters of refusal came from Vermont including two that cited Mr. Brines' memo in justifying their decision. No completed surveys were received. Given the chilling effect that the Vermont Hospital Association memo apparently evoked statewide, Vermont hospitals were dropped from the study.

The low return to the May 24 mailing suggested that a third mailing--a measure advocated by Dillman--was unlikely to bring further responses. Instead, a follow-up telephone call was placed to each nonrespondent between July 7 and July 25, 1986. An additional three Maine hospitals returned their surveys after receiving the calls. One participant, too busy to write his responses, answered the survey questions over the telephone. Two personnel directors refused to

participate. Six, each of whom received three telephone messages, neither returned the calls nor completed the questionnaire.

In New Hampshire, the telephone follow-up verified that an additional three hospitals refused to fill out the questionnaire. Four personnel directors returned surveys after the telephone contact. When the telephone follow-up was completed, all New Hampshire hospitals either sent in their surveys or indicated that they would not participate in the study.

Final Survey Response Rate

The final response rates among hospitals in the population are given in Table 1. Only seventeen hospitals are recorded in the New Hampshire population although surveys were sent to eighteen. Upon inspection of the hospital size, measured by the average number of beds set up and staffed per year between 1978 and 1985, one hospital was found to be below the fifty-bed minimum specified in the population definition. Its results were subsequently removed from the study.

Representativeness of the Sample Survey

To assure that relevant characteristics of hospitals answering the survey approximated those of the population, several comparisons were made between population and sample statistics. Based on the available

Table 1.--Hospitals included in survey

	Population	Responses	Percent Responding
Maine	30	19	63.33
N.H.	17	12	70.59
Total	47	31	65.96

information for population and sample, the characteristics of the responding hospitals reflect those of the population in five pertinent areas. Table 2 summarizes the comparisons of the two groups on five key characteristics.

Hospital Size

A comparison of the size of the population and sample hospitals is necessary to assure that neither large or small hospitals are overrepresented in the sample. As is the case in most industries, larger hospitals are likely to have more established personnel policies (which can be bureaucratically administered) and more union organizing activity than small ones. Thus, overrepresentation of either large or small hospitals in the sample would bias responses to many survey questions.

Hospital size is measured by the average of the number of beds set up and staffed as reported by the American Hospital Association (1979-86b) between 1978 and 1985. The two-tailed t-test produces the

reported p-value, which does not support the null hypothesis that the sample mean is equal to the population mean at the ten percent significance level. However, the small size of the sample increases the difficulty of producing highly significant results. Further, the similarities of the minima, maxima, ranges, and standard deviations of the two groups, shown in Table 3, support the argument that the sample is, at worst, slightly biased in favor of large hospitals.

Table 2.--Characteristics of hospitals included in survey

Hospital characteristic	Population	Sample	Test Statistic
Average number of beds set up and staffed (1978-1987)	144.5	147.3	p value = 0.858 (two-tailed test)
Average population of city/town in which hospital is located (1980 census)	22,747.9	23,088.7	p value = 0.992 (two-tailed test)
State in which hospital is located			
Maine	30/47 (63.8%)	19/31 (61.3%)	$\chi^2 = 0.085$*
N.H.	17/47 (36.2%)	12/31 (38.7%)	

Table 2.--continued

Hospital characteristic	Population	Sample	Test Statistic
Geographic isolation of hospital			
Hospitals located 35 miles from nearest neighboring hospital	4/47 (8.5%)	2/31 (6.5%)	$\chi^2 = 0.167$*
Proportion of hospitals experiencing union activity			
Maine	12/30 (40%)	8/17 (47.1%)	$\chi^2 = 0.353$*
N.H.	9/17 (52.9%)	5/12 (41.7%)	$\chi^2 = 0.610$*
Total	21/47 (44.7%)	13/29 (44.8%)	$\chi^2 = 0.00002$*

*Based on the chi square test statistics reported here, the null hypothesis that the sample and population characteristics are the same cannot be rejected at the 5 percent level of significance.

Table 3.--Size of hospitals included in survey

	Minimum	Maximum	Range	Standard Deviation
Population	50.0	531.9	481.9	103.9
Sample	51.5	531.9	480.4	111.4

Population of Town or City in which Hospital is Located

The population of the city or town in which a hospital is located can indirectly affect survey results in two ways. First, one must consider that a town or city's size, in part, determines the supply of RNs available to the local hospital. To the extent that the size of that labor pool affects a hospital administration's responsiveness to RNs' concerns, it is important that the town/city size of the sample approximate that of the population. Second, because union organization typically occurs more frequently in more densely populated areas than less populous ones, overrepresentation of hospitals in either large or small communities would bias survey results on union activity.

City and town populations based on the 1980 U.S. census were used to determine if a the sample mean differed significantly from that of the population (U.S. Department of Commerce 1981a, 1981b). Again the p-value produced by the two-tailed t-test indicates that this is not the case. Additional descriptive statistics given in Table 4 also suggest that the sample is representative.

Table 4.--Populations of cities and towns containing hospitals included in survey

	Minimum	Maximum	Range	Standard Deviation
Population	1,000	90,936	89,936	23,552.2
Sample	1,000	90,936	89,936	26,452.9

State in Which the Hospital is Located

Differences in the receptiveness to unionization in Maine and New Hampshire which may cause responses to vary by state are discussed in detail in Chapter 9. It suffices here to note that, should the proportion of hospitals reporting from either state exceed the proportion in which it is represented in the population, the survey results may be biased. The null hypothesis for the goodness-of-fit test is that each state is represented in the sample in the same proportion that it appears in the population. As reported in Table 2, the null hypothesis cannot be rejected at standard significance levels. Bias from this source is, therefore, unlikely.

Geographic Isolation of Hospitals

The above consideration of city/town population as an indicator of the size of the RN labor pool ignores the possibility that RNs from one city or town might travel to another to work. Further, despite the size of the city/town, it is less likely that a union would send an organizer to a remote community. Resources are more effectively used when the organizers can be in contact with nurses from several potential units simultaneously. If underreporting by remote hospitals occurs, the sample results could suggest a higher level of union activity in the population than actually occurred in the two-state region.

To determine whether population or sample hospitals are isolated, all short-term acute care facilities in both states were located. A hospital located more that thirty-five miles from the nearest neighboring institution was labeled "isolated." As reported in Table 2, four of the population fit into this category. Again, the chi-square goodness-of-fit

test statistic supports the null hypothesis that the proportion of isolated hospitals in the sample is not statistically different from that of the population.

Union Activity Among Registered Nurses in Hospitals

The final and perhaps most important indication of the representative nature of the sample is the determination that a similar proportion of hospitals in the sample experienced union activity as did hospitals in the entire population. That hospital personnel directors find organizing efforts among their employees and their responses to them to be a sensitive subject on which they might refuse to report was evident from the responses of the Vermont Hospital Association and several individual directors who explained why they declined to participate in the study.

Without responses from each of the hospitals in the survey it was possible only to estimate the number of institutions experiencing some union activity. The estimates of union activity in the above table is based on interviews with representatives of the Maine State Nurses Association, Service Employees International Union, New England Health Care and Hospital Employees Union--1199, and the International Brotherhood of Teamsters--all of the organizations involved in organizing in the two-state region. Hospitals were counted as experiencing union activity if a union organizer indicated that he/she recalled informational meetings or leafletting or if the RNs established an organizing committee in preparation for a NLRB election, whether or not it actually occurred. As recorded in Table 2, this measure

indicates that the population and sample are similar in the proportion exposed to unionization efforts.

Despite the high response rate and the apparent respresentativeness of the survey sample, the data collected required revision of the initially posed hypotheses. Only eleven hospitals answering the survey indicated that organizing efforts had advanced as far as a card campaign. Given the difficulty of producing statistically significant analyses with so few responses, the decision was made to test only one hypothesis--that hospitals which have either experienced union activity or relied on consultant advice to discourage organizing activity among RNs maintain different personnnel policies than those found in the other hospitals surveyed.

CHAPTER NOTES

[1]This reaction is noteworthy in that both Ms. Peters and Mr. Brines were aware of the project before this request was made. I had discussed it with Peters in an attempt to determine if I could obtain other information for the project from her. I had mentioned it to Brines some months earlier in the telephone conversation in which I requested a list of Vermont hospital personnel directors to whom I intended to send the survey. Mr. Brines sent me that list.

CHAPTER FIVE

SURVEY RESULTS ON PERSONNEL POLICIES USED

The survey results in this and the next two chapters indicate that several hospital administrators in Maine and New Hampshire have faced the threat of RN unionization and have implemented many of the programs advocated by union avoidance consultants. The analysis is presented in three parts to highlight the areas in which the experiences in the survey hospitals parallel and differ from those described in the literature review. This chapter identifies policies that hospital administrators think are important to nurses' job satisfaction and those they have implemented in their institutions. It also explores the relationships between these two sets of policies. The following chapter outlines the union activity that hospital administrators have faced and the extent to which they used consultants to address these problems. It then examines the nature of the relation between policy variables, union activity, and consultant use. The third data analysis chapter considers the hospital-specific and demographic variables which may affect unionization among RNs and, again, how they relate to policy measures.

As mentioned above, this survey does not permit a determination of causality of the relationship between between union activity and the existence of a particular personnel policy or a change in it. Thus, in the case of hospitals in which the nurses have organized, it is impossible to

distinguish policies originated with the hospitals' efforts to avoid unions from those which resulted from the union's collective bargaining agenda. For this reason, three hospitals which report having collective bargaining with RNs are not included in the discussion of results below except as noted.

The Significance of Policy Categories to RN Satisfaction

The significance ratings given by respondents for each of the six policy categories were compiled in frequency tables. (Some respondents rated each individual policy from one through five. In those cases, the mean score for all entries is used for the category.) A summary of those responses appear in Table 5.

The importance of these results is twofold. First, they support the nurses' contention, identified in the literature review, that the primary concerns of RNs are staffing and the way management treats them, although wage and benefit issues remain important (Sexton 1981; Iglehart 1987). The category of policies which most closely addresses the issue of staffing from the perspective of an individual nurse is "Scheduling." More personnel directors rated this topic as significant (four to five) to nurses' job satisfaction than any other category. Nearly as many respondents evaluated "Management-RN relations"--policies related to RNs' treatment in the workplace--as a significant ingredient to their job satisfaction. Finally, the above figures show that there is general agreement among personnel officers that wages and benefits and the chance for advancement and transfer remain as important concerns for their nursing staffs.

Table 5.--Hospital personnel directors' ratings of the significance of policy categories (nonunion hospitals only)

	Percentage of Respondents Rating Policy:		
	Significant	Average	Insignificant*
Work schedules	64.3	28.6	6.1
Management-RNrelations	60.7	28.6	10.7
Advancement-transfer	50.0	35.7	14.3
Wage-benefitpackage	46.4	42.9	10.7
Participation in policy making	42.9	25.0	32.1
Women's issues	35.7	32.1	32.1

* Categories were rated on a scale of 1 to 5. Ratings of 4-5 were considered significant; a rating of 3 was considered average; ratings of 1-2 were considered insignificant.

The second general conclusion that one draws from the above table is that personnel officers hold widely divergent views of the importance of participation in policy making and women's issues to RNs' job satisfaction. While a role in policy making recorded only slightly fewer significant responses than wage-benefit and advancement-transfer policies, a considerably smaller number of administrators classified these policies as average (three) in importance, and many characterized them as unimportant to the RNs.

Since participation in policy making provides RNs with the "involvement in hospital management decisions regarding standards of practice and support services" (Iglehart 1987, 646) and/or "autonomy and control over work" (Sexton 1981, 188), which observers find is central to RNs' job satisfaction, this result appears to contradict conclusions from the literature addressing RN concerns described in Chapter Two. However, there are three explanations which resolve the conflict. First, hospital administrators completed the survey, and thus the finding may reflect their own desire not to surrender policy making authority to the nursing staff. Second, the personnel directors may be recording the actual responses of RNs who, in theory, want to participate in decision making, but who, in practice, find that the suggestion boxes, interviews, and/or committees through which they can act do not empower them to make significant changes in hospital policy. Third, the registered nurses in Maine and New Hampshire may have less interest in participation in policy making than those in prior studies. However, the reason for this difference is not readily apparent.

Opinions on the significance of policies addressing women's issues were evenly divided between the three categories. Because approximately ninety-five percent of RNs are women, one might expect policies specific to their situation to be more significant in determining job satisfaction. However, Sexton, whose survey findings among women hospital workers were similar, provides the following reasoning. Nurses report the occurrence of unwanted advances of doctors. But since hospital workers' direct supervisors are frequently women, "sexual harassment may be less pervasive in hospitals than in offices and more integrated work settings"

(Sexton 1981, 122). The day care problem for nurses is, in part, solved by the existence of shift work in hospitals which allows RNs to work in the evening and night when other adult family members can care for children (Sexton 1981, 137). Finally, an inadequate but workable solution for poor maternity leave policies exists. RNs have resigned their positions to give birth and recover from delivery, later returning to hospital work where vacancies persist.

Inclusion of the three hospitals which conduct contract negotiations alter the results only slightly, as seen in Table 6.

Table 6.--Hospital personnel directors' ratings of the significance of policy categories (unionized hospitals included)

	Percentage of Respondents Rating Policy:		
	Significant	Average	Insignificant*
Management-RNrelations	60.0	30.0	10.0
RN wage-benefit package	48.4	41.9	9.7
RNadvancement-transfer	48.4	38.7	12.9
RN participation in policy making	43.3	23.3	33.3
Women's issues	32.3	32.3	35.5

* Categories were rated on a scale of 1 to 5. Ratings of 4 or 5 were considered "significant"; a rating of 3 was considered "average"; ratings of 1 or 2 were considered "insignificant."

Individual Personnel Policies Used by Respondents

Contingency table analysis of the relation between the significance personnel directors assigned to a policy category and the number of individual policies implemented in the policy category produced only one significant chi square statistic, as indicated in Table 7.[1]

Table 7.--Relation between significance assigned to policy categories and number of policies implemented within categories

	Chi Square Statistic	p Value
RN wage-benefits package	.16	$.50 < p \leq .70$
RN work schedules	1.87	$.10 < p \leq .20$
RN advancement-transfer	.37	$.50 < p \leq .70$
Women's issues	.24	$.50 < p \leq .70$
Management-RN relations	1.35	$.20 < p \leq .30$
RN participation in policy making	.41	$.50 < p \leq .70$

However, a closer look at the specific individual policies in each category which personnel directors report using reveals that some types of programs are more frequently implemented than others and, therefore, appear to be significant to RNs in the estimation of administrators. Both the number of policies and particular policies used are examined below in the order established by the significance rating in Table 7.

Scheduling

"Work schedule policies" is the single category for which dependence between the number of policies and their significance is established statistically. Moreover, the individual policies most often implemented are again consistent with the RNs' concerns about staffing. For example, seventy-five percent of the personnel administrators reported that their hospitals maintained both overtime and shift preference policies.[2]

The use of alternative scheduling policies is less clear from survey results. Thirteen hospitals--less than half of the respondents--reported implementing flextime. Seven hospitals, including two which offer flextime, also named other staffing practices, such as four ten-hour days followed by three days off. These findings suggest two alternative interpretations. First, the hospitals that report use of flextime may allow nurses to start to work perhaps an hour earlier or later to accommodate family needs. Insofar as flextime "does not begin to address the serious issues of hours, scheduling, and time-off confronted by hospital workers" (Sexton 1981, 140), this interpretation suggests that hospital management has not attacked the staffing problems. Only those seven which mention specific scheduling plans have abandoned the traditional 7 A.M.-3 P.M., 3 P.M -11 P.M., and 11 P.M.-7 A.M. shifts.

A second view is that the personnel directors reporting use of flextime (excepting those who indicate otherwise) have interpreted the term as any alternative staffing policy. To the extent that innovative scheduling arrangements encourage nonpracticing RNs to return to hospital nursing, about two-thirds (eighteen of twenty-eight) of the

hospitals have attempted to alleviate staffing shortages. Without further information on the programs in place at responding hospitals, one cannot determine if the particular programs address RNs' concerns about scheduling.

Whether by their own choice or due to contract negotiations with their RNs' unions, the organized hospitals in the sample appear slightly more attuned to the scheduling needs of their nursing staffs than their nonunion colleagues. All three rated the category as greater than average in significance. In general, these hospitals maintain overtime, shift preference, and layoff-recall policies. However, only one reported using flextime.

Management-RN Relations

Although more than half of the personnel directors answering the survey characterized management-RN relations as significant policies, there is less agreement on which of the given individual policies are necessary. While seventy-one percent of the respondents maintain the three basic policies providing for communication between the administration and nurses--planned orientation for new hires, an employee handbook, and a procedure whereby complaints are handled complaints through direct supervisors--only half of the hospitals had all ten of the policies listed on the survey.

This is, in part, explicable by the fact that some individual policies overlap. In keeping with consultant advice, the hospitals have developed channels of communications with their employees. However, a hospital which handles complaints through supervisors may find an "open door"

policy redundant. On the other hand, one can instead draw the conclusion that hospitals rely most heavily upon those labor relations programs which are "top-down"--programs in which management communicates its policies to the workers. Ninety percent or more of all respondent hospitals have orientations for new hires, in-house newsletters (typically written and edited by management), employee handbooks, and exit interviews. Eighty-two percent of sample hospitals use bulletin boards to carry administration messages.[3]

One possible exception to the frequent reliance on "top-down" policies is the establishment of a formal grievance procedure. All respondents indicated that they had such an apparatus in place. Again, without knowing more about the specifics of each of these programs, one cannot determine the type of management style that they reflect. If a grievance procedure provides an appeal process for employees who feel that they have been treated unfairly, it allows for two-way communication between management and nurses. On the other hand, if the procedure is simply the codification of the number of warnings and/or reprimands an employee receives prior to termination, it is again characteristic of "top-down" management.

Another "top-down" measure--speeches by top management--occurred in only sixty-one percent of the hospitals. This may reflect the fact that such talks are frequently "captive audience" speeches used to convey management's position on a particular issue arising in a union campaign. Since less than half of the respondents have experienced an organizing drive, they are likely to have limited need for these speeches.

Policies which could allow workers to voice their opinions are in place in slightly fewer reporting hospitals. Approximately eighty percent provide for channeling of complaints through supervisors and open door policies. Seventy-five percent encourage head nurses to spend extra time on their floors with their staffs, presumably to allow a greater exchange of ideas between them.

Only two of the three unionized hospitals evaluated the significance of the management-RN relations category to RN satisfaction. Both believe that it is of greater than average significance. All three reported having most of the individual policies with the exception of some of the "top-down" measures discussed above. Two hospitals do not use speeches by top management, again hinting that their major role is in union elections. In addition, one of those administrations did not use the open-door policy or encourage head nurses to spend extra time on their floors, presumably because problems are now resolved in the grievance proceess.

Wage-BenefitsPackage

Although personnel directors are less unified in their belief that wage-benefit policies are significant to RN satisfaction, there is somewhat more agreement that all of the policies listed were necessary than is the case with management-RN relations policies. Sixty percent of the respondents had uniform wage rates for specific job titles, wage grade/step structures, vacation policy, retirement benefits, medical insurance coverage, in-house health services, discount services, and reimbursement for college courses--all eight of the individual policies named. Even more hospitals, 67.9 percent, reported maintaining basic

wage-benefit programs including uniform wage rates, wage grade-step structure, vacation, retirement, and medical coverage.

Among the eight individual policies, wage-related policies were less frequently established than most. It is notable that the benefit most directly related to the RNs' job performance--college course reimbursement plans--have been adopted by virtually all reporting hospitals (96.8 percent). Hospitals also reported using vacation, retirement, and medical benefits more frequently than wage grade/step structures or uniform wage rates.

The organized hospitals ranked the significance of the wages-benefits category only slightly higher than nonunion respondents (median rankings of 4.25 and 3.78 respectively). However, collective bargaining appears to have forced them to implement many more policies. With the exception of one unionized institutions which lacks in-house health services, all three have each of the eight policies named.

Advancement-Transfer

Although only half of the personnel directors in the sample thought that the importance of these policies to RN satisfaction was great, 85.7 percent of them have promotion, transfer, and continuing education policies. That the hospitals use such policies regularly, despite their belief that their contribution to RN satisfaction is limited, may reflect several factors. First, since the average size of the sample hospitals (ninety-seven beds) and RN staff (seventy-seven) is small, the opportunity for advancement and transfer are limited. But when the chance for such movement arises, it is important to the RNs, the hospital, or both that

changes are made according to established policy. In addition, as the complexity of health care delivery increases, nurses' concern with the difficulty of "floating" or lateral transfers between departments may move personnel directors to provide policy direction on this topic (Sexton 1981, 183).

Second, even if opportunities for promotion, transfer, and continuing education exist, the career ladder in nursing is short (Sexton 1981, 179; Iglehart 1987, 648). Thus, the importance of advancement to the nurses, both in terms of wages or increased responsibility, is limited.

Two of three unionized hospitals ranked advancement-transfer as average in importance to nurses. Yet all three maintain the three policies listed. Since promotion and transfer policies are normally part of union contracts, an additional reason for divergence between management's significance rating and number of policies in these cases is that the union believes that the issues are important and demands negotiations on them.

RN Participation in Policy Making

Only 32.1 percent of the respondents use a combination of all three participation programs--a suggestion box for anonymous comments, periodic individual interviews with management, and periodic meetings between RN committees and management. However, administrators may believe that the named policies overlap since all are designed to elicit RN input. All but one hospital responding to the question have at least one of the three programs. Thus, a high degree of usage exists given that a third of the hospitals thought such programs were of little or no importance to RNsatisfaction.

The most frequently employed method of involving nurses in decision making is through their participation in periodic RN committee meetings. Twenty-one of twenty-eight hospitals reported using them. An additional three hospitals noted that nurses participated in other types of committees including topic-oriented groups with representatives of other hospital employee groups. The relatively infrequent use of individual interviews with RNs (sixteen of twenty-eight) suggests that the large expenditure of management resources which they require is viewed as a less useful investment than other policies.

The two responding hospitals with active RN locals were split in their evaluation of the importance of participation programs. One rated them below average in significance, the other above. Still, all three organized hospitals conduct meetings with RN committees and individuals, and two had suggestion boxes. As the case study points out, unions do try to negotiate RN participation in policy making. Hence it is plausible that the frequent use of these programs is due to union presence.

Women's Issues

Although there is nearly even division on the evaluation of the programs' significance to RN job satisfaction, 80.6 percent have sexual harassment policies and maternity leave--two of the three named policies. Half have day care policies or child care referral services available to the RNs, indicating that hospitals have begun to address this need of their predominantly female staffs.

The administrator of one organized hospital reported using only one women's issues policy--maternity leave--and ranked the policy

category as insignificant. The other two respondents maintain all three of the policies named. However, only one of the two ranked the policy category above average in significance to RN job satisfaction.

Changes in Personnel Policies

In question five, fewer than one-third of all personnel directors reported making changes in individual policies in all but one category of entries (RN wage-benefit package). Those who made changes typically attributed them to factors other than union activity among their RNs or any other employee group. On three of four surveys where personnel directors explained what the "other factors" were, competition among hospitals was cited as important in shaping policy. The summary of the results to survey question five is given in Appendix H, Table 28.

Complicating interpretation of the surveys, the answers to questions five and six are inconsistent. Individual respondents frequently report the effectiveness of changes in policy categories in question six (see Table 8) despite the fact that, in question five, they noted that no changes were made in any individual policies under the category heading. Since this occurred on approximately one quarter or more of the surveys under each policy category, no part of question five is consistent with question six. Both because personnel directors are more likely to have accurate recollection of policy changes in a general category over a decade than in an individual policy or program, and because the relationship between category changes and significance ratings are directly measurable, the responses to question six are examined more fully below.

In all policy categories except for wage-benefit classification, half or more of the hospitals again report, as they did in question five, that no changes occurred. That a large number of hospitals recorded changes in the wage-benefit category may reflect increases in wage levels that hospitals enacted over the years. Although respondents were not asked which individual policy changed, it is reasonable to believe that pay increases bear the responsibility for effective changes in nearly all cases.

Table 8.--Hospital personnel directors' evaluation of the effectiveness of policy changes

	Percentage of Respondents Rating Policy:			
	Effective	Average	Ineffective	No Change*
Wage-benefitpackage	50.0	13.6	0	36.4
Work schedules	28.6	14.5	0	57.1
Advancement-transfer	9.5	19.1	0	71.4
Women's issues	4.8	9.5	23.7	61.9
Management-RN relations	18.3	22.7	0	59.1
Participation in policy making	27.3	18.2	4.6	50.0

* Responses of 4 or 5 were classified as "effective"; 3 was classified as "average"; 1 or 2 was classified as "ineffective"; 0 was classified as "no change."

The category with the second largest number of changes was "participation in policy making." Since only forty-three percent of personnel directors noted that participation was a significant factor in RN job satisfaction, the relatively frequent changes in this category are unexpected. Three possible explanations exist. First, hospitals may recognize that RNs want to participate in decision making, but are dissatisfied with the existing opportunities for input. Thus, personnel directors are experimenting with new forms of participation, but have not found a program that improve nurses' satisfaction with their jobs. Second, as suggested by the union evaluation of such positive labor relations schemes, hospitals may seek new ways to gather the input of all employees in an effort to improve service and productivity in an increasingly competitive environment of health care delivery. Third, hospital administrators may institute participative policies as a union avoidance tool when interest in union activity arises. Once the RNs become convinced that their participation in hospital policy making--not the establishment of a union--will improve working conditions, management may let the programs atrophy until another union threat emerges.

In the three policy categories--schedules, management-RN relations, and participation--approximately forty percent of respondents reported making changes of average or better effectiveness. Since more personnel directors chose scheduling and management-RN relations above the other categories as policies significant to RN job satisfaction, the relatively large number of successful changes in these areas suggest that, in general, hospitals are attempting to address staff concerns. However,

the results of chi square tests of dependence between policy change and policy importance reported above are not statistically significant in these or any other cases, as indicated in Table 9.

Table 9.--Relation between change in policy category and significance of policy category

	Chi Square Statistic	p Value
Wage-benefitpackage	1.47	$.20 < p \leq .30$
Work schedules	.30	$.50 < p \leq .70$
Advancement-transfer	.02	$.80 < p \leq .90$
Women's issues	.53	$.30 < p \leq .50$
Management-RNrelations	.08	$.70 < p \leq .80$
Participation in policy making	0	$p>.95$

Very little change was recorded in advancement and transfer policies. Since eight-five percent of the hospitals reported having all three individual programs named--promotion, transfer, and continuing education--and since, as discussed above, the opportunities for promotion and transfer are limited, such policy changes occur infrequently. Although they may result from experimentation with a new approach to any of the three programs named, only two of the surveyed hospitals reported such innovations.

Similarly, only 38.1 percent of hospitals changed their policies on women's issues. Again, if the maternity leave and sexual harassment

policies reported by eighty percent of the respondents have been in place since 1974, the possibility for change is virtually limited to the implementation of day care or a new program addressing women's issues. Despite current interest among some hospital workers in women's issues, such as comparable worth and the virtual exclusion of women from the higher-paying hospital jobs including pharmacist, physician's assistant, maintenance worker, and administrator, no survey hospital reported implementing policies addressing these or any other women's issue not listed.

Finally, as shown above, a higher percentage of personnel directors registered dissatisfaction with changes made in the "Women's issues" category than in any other area. Although it appears plausible that a negative experience with instituting new policies may have contributed to the low significance rating given to women's issues policies generally, the contingency analysis above does not support this contention.

Information from the unionized hospitals varied slightly from their unorganized counterparts. Two of the three hospitals reported changing the wages-benefits category in question six. In question five, they attributed changes in both individual wage and benefit policies to union activity (presumably collective bargaining) among their own RNs. Changes in management-RN relations programs (acknowledged in both questions five and six) appear to be due, in part, to the nurses' organizing efforts and, in part, to other factors. For the third category in which two unionized hospitals reported change in question six--participation in policy making--few changes appear in question five. One individual change was attributed to union activity and two occurred for other

reasons. Again, some responses to questions five and six were inconsistent. Although no unionized hospital indicated in question six that changes were made in the schedule, advancement-transfer, or women's issues categories, they admitted some individual policy changes because of their RNs' union activities in question five.

Summary

The importance which hospital administrators attach to the six policy categories and the pattern of policy use that emerges from the survey appear consistent with several observations made in the introduction and literature review. Most importantly, hospital administrators in New Hampshire and Maine recognize what the RN unionization debate has uncovered--that schedules and management-RN relations are central to nurses' job satisfaction. The issues which usually hold top priority for organized workers--wages and benefits and advancement and transfer policies--are slightly less important to nurses.

The policy categories which personnel directors characterized as relatively less important to nurses are women's issues and participation in policy making. The former result agrees with observations made in some of the literature reviewed. However, since studies cited in the literature review suggest that RNs are quite concerned about their input into patient care issues, the latter result is surprising. It may stem from the fact that personnel directors who may be required to share policy-making responsibilities with RNs are less enthusiastic about such policies than the nurses surveyed in other studies.

An examination of the individual policies implemented in each category reveals substantial use of items listed on the survey, although some potential sources of RN dissatisfaction are evident. For example, among scheduling policies, relatively few hospitals maintain flextime--a policy that could help to alleviate staff shortages and the workload problems they create. Additionally, with the possible exception of grievance procedure use, administrators appear to favor slightly "top-down" management-RN relations policies over those which encourage RNs to initiate change. Finally, potential sources of dissatisfaction in the wage-benefit category related to wage administration measures. Use of wage grade-step structures and uniform wage rates, which normally assure equitable pay for all employees, were among the least frequently implemented policies under this heading.

In the two policy categories with the lowest importance ratings--women's issues and participation in policy making--an overwhelming majority of personnel directors reported some use of individual policies. Since one expects hospitals to abandon personnel programs they consider unimportant to their employees, this relationship requires further examination in the following chapter.

Answers to the survey questions explaining the reasons for changes made in the six policy categories produced two important results. First, the decision to make changes in a policy does not depend on the category's importance to RN job satisfaction. Management implemented the most changes in wages and benefits, which nearly all respondents think are somewhat important to nurses. But administrators also altered participation policies, even though one-third of the respondents rate them

as unimportant in determining job satisfaction. This outcome also deserves additional consideration in the following discussion of union and consultant activity.

Second, hospitals in which the RNs are represented by a union acknowledged that some policies changed because of union activity. Hospitals without unions attributed almost all changes to "other" causes and few to unions' actions. On one hand, this result may reflect an unwillingness to acknowledge the effectiveness of unions in promoting change. On the other, it is consistent with the view that conditions in the RN labor market strongly influenced their personnel policies. Particularly in larger cities, nurses have access to several hospitals. When hospitals are experiencing RN shortages, they compete for the existing job candidates with generous wages and benefits and progressive labor relations policies. Additional comments of several respondents indicate that the present shortage has produced this type of competition. Both explanations will be considered more fully in the following two chapters.

CHAPTER NOTES

[1] Chi square statistics for which $.10 < p \leq .20$ are considered statistically significant in the text.

[2] Fewer hospitals, 67.9 percent, maintained layoff-recall policies useful in periods of excess hospital service capacity suggesting that an RN surplus is a less important issue for administrators.

[3] Recall that consultants advocate use of bulletin boards to advertise management's determination to maintain a union-free environment. However, one consulting firm active in hospitals in northern New England advises against using this "top-down" measure. In his seminar presentation, Ralph Abbott, of Skoler, Abbott, Hayes, and Presser argues that since equal access requirements could force management to allow prounion employees to use the boards during an organizing campaign, its use should be limited (Abbott 1985).

CHAPTER SIX

UNION ACTIVITY, CONSULTANT USE, AND THEIR RELATIONSHIPS WITH PERSONNEL POLICY VARIABLES

In this chapter, survey responses describing the types of union activity experienced, use of consultants, and expectations about future organizing efforts are first reported. This establishes the extent to which unionization is a concern to hospitals in Maine and New Hampshire. The relationship between these variables and the policies described in the previous chapter are then reported. Using these results, the central hypothesis of the study--that hospitals which employ consultants or experience union activity implement personnel policies that are significantly different from those of their counterparts without such activities--is explored.

Union Activity among RNs

As reported above, fourteen of twenty-nine respondents have encountered some form of union activity among their RNs between 1974 and 1984. Three hospitals currently have union representation and, therefore, are removed from the sample unless otherwise noted. Thus, of the twenty-six hospitals remaining in the sample, eleven have experienced some form of union activity.

The most commonly encountered activity was informational meetings and leafletting by unions seeking to represent the RNs. Eight of

twenty-six responding hospitals reported such activity. A total of eight hospitals experienced more intense union activities, in the form of a union organizing committee (five) or independent RN committees (three). In one additional hospital, a union undertook a card campaign without forming a committee of RNs. Four other card campaigns were launched by these committees. Only two campaigns led to elections.

Although nine hospitals saw the most intensive union activity, ten hired management consultants. One hospital with no activity employed outside assistance; nine other institutions used consultants, including eight which faced intense organizing efforts and one where only leafletting by a union occurred (see Appendix I, Table 29). The three hospitals in which collective bargaining with a nurses union exists experienced virtually every form of union activity listed on the questionnaire. All reported using consultants throughout the union campaigns.

Chi square tests reveal a strong dependence between the use of a consultant and existence of any activity or the eight specific forms--informational meetings, leafletting, and picketing, establishment of an independent or union-sponsored RN organizing committee, distribution of union authorization cards, an NLRB- conducted representation election, and collective bargaining. The chi square statistics and p values are given in Table 10. (Unionized hospitals are included in these tests. See Appendix I, Table 30.)

Activity among Other Hospital Employees

All health care workers' union organizing activity has been protected by the NLRA since 1974. But in the sample, including hospitals with RN unions, such attempts among other workers has been

Table 10.--Relation between consultant use and union activity

	Chi Square Statistic	p Value
Existence of any activity*	18.3	$p \leq .001$
Union informational meetings	9.8	$.001 < p \leq .01$
Union informational leafletting	9.8	$.001 < p \leq .01$
Union informational picketing	4.1	$.02 < p \leq .05$
Union organizing committee established	8.1	$.001 < p \leq .01$
Independent RN committee established	4.1	$.02 < p \leq .05$
Union card campaign	13.6	$p \leq .001$
NLRB-sponsored election	7.4	$.001 < p <= .01$
Collective bargaining	4.1	$.02 < p \leq .05$
Other activity	1.3	$.20 < p \leq .30$

*Existence of union activity is a variable constructed by summing the responses to survey question #2. Values range from 0 (no activity) to 9 (all activities). For the purposes of analysis throughout this section, responses were grouped into two categories: 0 = no activity; 1-9 = activity.

lower than among nurses. Six of twenty-nine reporting hospitals recalled union informational meetings, leafletting and/or picketing, but only one had a NLRB election. Management prevailed in that election,

so none of the responding hospitals bargain collectively with their other employees (see Appendix I, Table 31). None of the hospitals in which RN collective bargaining unit are currently established have experienced any union-related activities among their other employees.

Five hospitals reported using consultants in addressing activity among other employees in their hospitals. Again, there is a statistically significant association between the use of consultants and activity as reported below (also see Appendix I, Table 32).

Table 11.--Relation between consultant use and certain forms of union activity

	Chi Square Statistic	p Value
Informational meetings, leafletting,and/or picketing	16.0	$p < .001$
NLRB election	4.8	$.02 < p \leq .05$

Activity among RNs in Neighboring Hospitals

Awareness of union activity among nurses in other hospitals was very high among all responding hospitals. Sixty-one percent knew of unions' informational meetings, leafletting, and/or picketing in other area hospitals. Even more--seventy-one percent of respondents--identified organizing campaigns and elections. The same percentage was aware of collective bargaining among RNs in other area hospitals. Six

identified other union activities such as the strike activity of an RN local and organizing efforts in a nearby nursing home. Nineteen of twenty-eight responding hospitals correctly named one or more of the hospitals in which union organizing activity occurred. Nearly as many survey participants, seventeen, were aware that those hospitals faced with the possibility of unionization had hired a management consultant. Although one of the three unionized hospitals did not know of either informational activity or formal organizing campaigns in neighboring hospitals, all were aware of the other area hospitals in which nurses bargain collectively with management.

Tables 12 and 13 show that personnel directors knowledgeable about informational activity and organizing campaigns in other institutions are likely both to have experienced union actions in their own hospitals and to have used a consultant. These results reveal that communication between hospitals about the potential "union threat" is well-established and that consultants may be the carriers of that information. On the other hand, both internal union activity and consultant use are independent of the respondents' knowledge of collective bargaining in other hospitals, suggesting that administrators and consultants focus their attention on their neighbors who produce the outcome which they seek (also see Appendix I, Table 33).

Since eleven of the twenty-six reporting nonunionized hospitals have already experienced some form of union activity, it is not surprising that eight of them admitted that the chances for an organizing drive are even or better. Eighteen hospitals evaluated the possibility that an organizing drive will take hold as unlikely or very unlikely. Again,

the significant chi square statistics given in Table 14 and reported fully in Appendix I, Table 34 suggest that both prior union activity and consultant use are strongly related to the belief that the union may launch an organizing drive.

Table 12.--Relation between organizing activity in neighboring hospitals and internal organizing activity

	Chi Square Statistic	p Value
Informational meetings, leafletting, and/or picketing by a union in another hospital	8.4	$.001 < p \leq .01$
Organizing campaign and NLRB election in another hospital	3.3	$.10 < p \leq .20$

Table 13.--Relation between organizing activity in neighboring hospitals and consultant use

	Chi Square Statistic	p Value
Informational meetings, leafletting, and/or picketing by a union in another hospital	5.2	$.02 < p \leq .05$
Organizing campaign and NLRB election in another hospital	1.7	$.10 < p \leq .20$

Further, even though every hospital used a consultant when it faced union activity among its RNs, a majority (53.8%) claim that they are not likely to do so in the future. The chi square test, reported in Appendix I, Table 34, indicates that a hospital's decision on future use of consultants is not

Table 14.--Relation between expectation of future organizing drive among RNs and past activity and consultant use

	Chi Square Statistic	p Value
Union activity in own hospital	5.1	$.02 < p \leq .05$
Consultant use in own hospital	2.8	$.05 < p \leq .10$

dependent upon their previous use. This finding suggests either that administrators are divided on the perceived usefulness of the consultant in avoiding unionization or that some personnel directors believe that having already learned the fundamentals from consultants, they are ready to handle the campaign alone.

Finally, whether or not they expect the problem to arise and regardless of how they intend to meet it, no hospital gives the union better than an even chance of succeeding. Only two of twenty-seven hospitals responding think that chances are even. It is not surprising, therefore, that chi square tests show that administrators' views of union

success is independent of either previous union activity or consultant use. The unanimity of hospitals' position on this topic suggests that their confidence in their ability to control activity in the hospital is solid.

Dependence between the Unionization Threat and Hospital Personnel Policies

If hospital administrations adjust personnel policies to avoid unionization of their RN staffs, the survey data should reveal that one or both of the following situations exist:

1. Hospitals which have experienced no union activity among RNs have implemented a range of policies which provide them with considerable job satisfaction.

2. Hospitals which have experienced union activity among RNs maintain personnel policies to avoid the possibility that nurses will try again to unionize and succeed.

For the chi square tests of Table 15, the null hypothesis tested is that the variables measuring union activity are independent of those used for policy variables. Depending upon the nature of the relationship observed, one of the above arguments provides the explanation of those cases in which the alternative hypothesis of dependence cannot be rejected.

Four different comparisons are used to determine whether union activity and policy variables are independent. First, the dependence of the existence of union activity upon significance of the six policy categories is measured. The strongest relationship exists between the significance of women's issues and union activity (chi square = 2.4; .10

$< p \leq .20$) where hospitals with no union activity rated the importance of the policy higher than those which unions have tried to organize. This admittedly limited evidence supports the view that,by acknowledging the significance of a policy prior to union activity, hospitals may be able to avoid interest in organizing completely. However, with respect to all other policy categories, the null hypothesis of independence between union activity and the significance of a policy category to RNs cannot be rejected at any standard level of significance (see Appendix I, Table 35).

If hospitals operate under the assumption that a large number of individual policies addressing a given topic increases RNs' job satisfaction, then dependence between the number of individual policies in a category and union activity corresponds to one of the two arguments given above. For five policy categories--wage-benefit package, schedules, advancement-transfer, women's issues, and participation in policy making--chi square tests do not produce evidence of statistically significant dependence (see Appendix I, Table 36). Only the chi square value measuring the dependence between the number of management-RN relations policies and union activity (2.7) is significant at the 10 percent level. The contingency table shows that hospitals which have had no union activity report relatively few labor relations policies in comparison with hospitals which have experienced some activity. This result again supports the hypothesis that hospitals implement a variety of policies to improve job satisfaction after interest in unionization appears.

A third approach to determining if union activity and hospital policy are independent examines the relationship between the establishment of individual policies and union activity. The results of

these chi square tests are given below. Statistics for all other chi square tests were insignificant and are reported in Appendix I, 37.

The pattern of dependence in all of the contingency tables for which results are reported again suggests that having encountered union activity, hospitals have instituted a variety of policies relevant to RN job

Table 15.--Relation between existence of union activity and individual policy variables

	Chi Square Statistic	p Value
Work schedules		
Other policies	7.4	.001< p ≤ .01
RNadvancement-transfer		
Other policies	3.0	.05 < p ≤ .01
Women's issues		
Day care	2.4	.10 < p ≤ .20
Management-RNrelations		
Head nurses encouraged to spend extra time on their floors	2.1	.10 < p ≤ .20
Bulletin boards	3.5	.05 < p ≤ .10
RN participation in policy making		
Periodic individual interviews	1.8	.10 < p ≤ .20
Other policies	1.9	.10 < p ≤ .20

satisfaction. That the "other" entry in three of the six categories produced the most significant results in support of this argument implies that hospitals that have experienced union activities may attempt to use

alternatives to the commonly employed methods of addressing work schedules, advancement-transfer and participation issues named in the survey.

That hospitals experiencing organizing activities have implemented the policies of interviewing individual RNs and of instructing head nurses to spend extra time on their floors suggests that administrators are listening to the concerns of the staff, but hope to encourage individual rather than collective communication. Similarly, the provision of day care by hospitals that have faced the possibility of unionization may represent an effort by hospitals to initiate a change that union representatives promise to negotiate if elected to act as a bargaining agent.

Finally, an explanation of the dependence between the use of bulletin boards to carry management's messages and RNs' interest in unionizing may relate to management consultant advice. As noted above, all of the hospitals in which union activity occurred hired consultants. Since labor relations specialists regularly instruct administrators on the effective use of bulletin boards to convey messages when organizing activity occurs, their influence is apparently noticeable in these results. (The following discussion of the contingency tables for individual personnel policies vs. consultant use--especially the chi square test for dependence between use of consultants and bulletin boards shown in Table 16--strengthens the argument made here.)

A fourth test of the above hypotheses explores the dependence between union activity and policy change as measured in question 6. (Recall that there is too little variation in the question 5 responses to

produce results.) The results, reported in Appendix I, Table 38, reveal that evidence of policy change is independent of union activity in all six categories. (Note, however, that the number of administrators responding to these questions fell to twenty, making it difficult to achieve statistically significant results.)

Dependence between Use of Consultant and Personnel Policy Measures

Whether hospital management employs consultants to develop policies which will prevent nurses from becoming interested in union activity or to combat union activity after it starts, contingency table analysis should establish statistically significant relationships between consultant use and policy measures. The dependence found between consultant use and four policy variables--significance of the category, number of policies, individual policies, and changes in policy category--appears below.

Use of a management consultant is independent of the administrators' perceptions of policy categories' significance ratings at standard levels of significance (see Appendix I, Table 39). When the number of individual policies implemented by hospitals serves as the measure of the hospitals' attempt to meet the nurses' job needs, only one policy category--work schedules--yields a chi square value (3.9) significant at the 5-percent level (see Appendix I, Table 40). The table indicates that hospitals using consultants have a relatively large number of work schedule policies while those without consultants have few, in accordance with the pattern predicted above.

To determine if consultants encourage hospitals to implement particular policies designed to discourage unionization, chi square statistics were calculated for contingency tables of consultant use and the individual policies in each category. Again, as Table 16 shows, only a few chi square statistics were significant. Appendix I, Table 41 contains complete results.

Table 16.--Relation between consultant use and individual policy variables

	Chi Square Statistic	p Value
Wage-benefitpackage		
Reimbursement for college courses	1.66	$.10 < p \leq .20$
Work schedules		
Overtime work	2.12	$.10 < p \leq .20$
Other policies	4.40	$.02 < p \leq .05$
Advancement-transfer		
Transfer	1.66	$.10 < p \leq .20$
Management-RNrelations		
Exit interviews	1.66	$.10 < p \leq .20$
Bulletin boards	2.96	$.05 < p \leq .10$
Other policies	1.66	$.05 < p \leq .10$

Programs in the two policy categories--work schedules and management-RN relations--have a statistically significant relationship with consultant use. One program in the wages-benefits category is also

statistically significant. Broadly interpreted, these results suggest that consultants persuade their clients to establish policies in the categories which are most important to RN job satisfaction. Again, use of "other policies" indicates that hospitals will attempt to use new approaches to these two policy categories when advised by a consultant to do so.

The contingency tables relating consultant use to transfer programs and to exit interviews are identical. They are the only cases in which the hospitals without union activity have comparatively more policies than those where activity has occurred. However, the tables show that, while all hospitals without consultants have exit interviews and transfer policies, all but one of the hospitals using consultants follow the practices as well. In short, the behavior among hospitals with and without consultants is virtually the same.

Other work schedule policies and the use of bulletin boards are two policies for which significant dependence exists with both union activity and use of consultant. The former addresses the critical RN issue of workload, and the latter is an important part of the consultants' instructions on how to control interest in the union. Thus, both lend support to the contention that the consultant attempts to defeat unions with both preventive personnel policies and aggressive antiunion information campaigns.

The reasons are less clear why no other chi square tests of dependence between individual policies and consultant use or union activity show significant results. One explanation is that most types of policies named in the survey were in place prior to the hiring of a consultant. If consultants only advocate change in existing policies, the

above results would not be affected. The contingency tables of policy change versus consultant use provide some evidence for this explanation. The significant chi square statistics appear in Table 17 (also see Appendix I, Table 42).

It is interesting to note, however, that in four categories--wage-benefits, scheduling, advancement-transfer, and management-RN relations--all respondents rated the effectiveness of changes as average or

Table 17.--Relation between consultant use and policy changes

	Chi Square Statistic	p Value
Work schedule change	2.57	$.10 < p \leq .20$
Women's issues change	1.96	$.10 < p \leq .20$
Participation programs change	1.99	$.10 < p \leq .20$

better. For changes in women's issues and participation policies, the effectiveness ratings were independent of consultant use or union activity at statistically significant levels. These results suggest that neither consultant use nor prior experience with union activity influenced the perceived effectiveness of any policy changes made (see Appendix I, Table 43).

A second explanation of why neither union activity nor use of consultant are dependent upon policy variables at standard significance levels is that administrators use early indicators of the union threat to shape personnel policy. The relationship of the policy variables to such measures of interest in unions is explored below.

Dependence between Indicators of Nurse Unrest and Personnel Policies

Management may institute or change policies either in response to signs of unrest among any local RN staffs or based upon their own perceptions of their nursing staff's potential for unionization. Questions 3a and 12 on the survey directly solicit information from personnel directors about their awareness of union activity among nurses in their regions and their assessment of their RNs' interest in unions and ability to organize. Statistically significant dependence between these variables and three policy measures--category significance, number of policies in a category, and changes in policy categories--is recorded in Tables 18 and 19. The results of all contingency table analyses appear in Appendix I, Tables 44 through 46.

Because awareness of activity among RNs in neighboring hospitals is more closely related to policy measures than the other two variables, it was used to construct contingency tables with individual policy variables in each of the six categories. Statistically significant results appear in Table 20 (also see Appendix I, Table 47).

Table 18.--Relation between awareness of organizing activity elsewhere and policy significance, number of policies and policy changes

	Chi Square Statistic	p Value
Significance of policies		
Work schedules	3.14	$.05 < p \leq .10$
Women's issues	4.40	$.02 < p \leq .05$
Management-RNrelations	2.43	$.10 < p \leq .20$
Number of policies		
Women's issues	2.70	$.10 < p \leq .20$
Changes in policies		
Work schedules	2.59	$.10 < p \leq .20$
Women's issues	2.08	$.10 < p \leq .20$

Table 19.--Relation between expectations for future internal organizing and policy significance and policy changes

	Chi square statistic	p value
Likelihood that RNs will try to organize		
Significance of management-RN relations policies	3.37	$.05 < p \leq .10$
Change in management-RN relations policies	3.01	$.05 < p \leq .10$
Likelihood that RNs will succeed in organizing		
Change in work schedule policies	1.82	$.10 < p \leq .20$

These results confirm that administrators who are aware of unions' organizing attempts in their area and and those who believe that RNs in their hospitals may organize also recognize the significance of the issues which move nurses to organize--scheduling and employee relations. They have addressed those issues more frequently than their counterparts with shift preference, flextime, additional work schedule policies, increased communication between nurses and their supervisors, and bulletin boards carrying management's messages.

In addition, even though hospital administrators overall did not rate women's issues significant to RN satisfaction, those who think their staffs may try to organize have both found the category to be important and have implemented several policies to address the issue. Insofar as women's issues policy changes and consultant use are dependent (see Table 17), this outcome implies that hospital directors concerned with activities in the surrounding area are heeding the advice of consultants, at least in a limited way.

Table 20.--Relation between knowledge of organizing activity in neighboring hospitals and individual policies

	Chi Square Statistic	p Value
Wage-benefitpackage		
In-house health services	1.8	$.10 < p \leq .20$
Discount services	1.9	$.10 < p \leq .20$

Table 20.--continued

	Chi Square Statistic	p Value
Work schedules		
Shift preference	4.1	.02 < p ≤ .05
Flextime	1.8	.10 < p ≤ .20
Other	1.8	.10 < p ≤ .20
Advancement-transfer		
Continuingeducation	1.9	.10 < p ≤ .20
Women's issues		
Sexualharassment	2.7	.10 < p ≤ .20
Management-RNrelations		
Head nurses encouraged to spend extra time on floor with staff	5.2	.02 < p ≤ .05
Bulletin boards	2.7	.10 < p ≤ .20
Participation in policy making		
Periodic meetings with RN committees	1.9	.10 < p ≤ .20

Summary

From the foregoing analysis, several conclusions about consultant use in RN organizing campaigns emerge. Foremost among these is a result that confirms both the consultants' and unions' assessment of when these outside advisors are used. There is a strong association between nurses' union activity and administrators' decision to employ a management consultant. Further, hospitals witnessing union campaigns among their RNs are keenly aware of both organizing activity and consultant use in neighboring institutions. Together these two results suggest that a strong link exists between union activity and consultant-

inspired personnel policies. For even if a hospital does not hire its own consultant to address union sentiments, it is likely to be familiar with the policies promoted by these advisors in area hospitals.

While the above analysis cannot establish a causal relation between personnel policies and consultant use or union activity, its results are consistent with the following interpretation. The hospitals which attempted to remain union-free have responded to interest in organizing with four general strategies, all of which reflect consultant influence. First, they have instituted a relatively large number of policies in the management-RN relations and work schedule policy categories. It is notable that this proliferation of policies occurs in the two areas which personnel directors identify as most important to RN job satisfaction. Consistent with the consultant advice described in the literature, hospital administrations appear responsive to worker concerns by listening and reacting to them.

Second, the programs established in four categories important to RN satisfaction focus on methods of addressing job concerns beyond those which are traditionally used. In the areas of work schedules, advancement-transfer, management-RN relations, and participation in policy making, management reported using unspecified "other" policies. Indeed, it appears that, because commonly used policies have failed to discourage unionization of RNs, management is searching for other solutions to existing workplace problems. Since consultants view such policy development as their area of expertise, they undoubtedly assist hospitals in this undertaking.

The consultant-inspired theme of communications as the key ingredient to a union-free environment is evident in the third management response to union organizing in hospitals. Head nurses are encouraged to spend more time on their floors, serving the dual purpose of explaining management's opposition to unionization and giving staff RNs the opportunity to express their concerns directly to management. Likewise, the individual interviews that hospital administrators conduct with the nurses fulfill a similar dual purpose. Even the use of bulletin boards, which only generate "top-down" communication, indicates to employees that management wants to keep them informed. All of these communications strategies are evident where hospitals face union organizing campaigns.

Finally, consultants advise employers to make changes in specific policy topics. A notable difference appears between the policy categories which are not altered in response to union campaigns and those which are. The three areas in which consultant use is not associated with change are wages-benefits, advancement-transfer, and management-RNrelations.[1] According to the personnel directors' assessment, they are three of the four most important factors contributing to RN job satisfaction. They also represent areas where policy change could threaten management's control over personnel and financial decision making. On the other hand, two areas where change occurs--women's issues and participation--are ranked as the least important in influencing RN satisfaction.

The third category in which consultant use is associated with policy revision--scheduling--received high marks for importance. It is

possible that consultants have recommended these changes to improve the RNs' job environment. However, it is also evident that management uses scheduling policies to address the current nursing shortage. The staff's increased satisfaction with their jobs may simply be a by-product of the hospital response to market conditions. In short, consultants recognize the need for improvements in response to RN union activity. But since changing most of the topics important to the nurses' job satisfaction might infringe upon managerial decision making, consultants advocate responding to less salient issues.

Despite consultants' influence on these four dimensions of hospital policy making, the survey results imply that their suggestions do not produce unique results. The reliance on a consultant did not affect management's perceptions of their employees' needs. The importance hospitals attached to the six policy categories did not vary with consultant use. Neither did administrators assisted by consultants rate the effectiveness of the changes made in women's issues, participation in policy making, or scheduling any higher than those who implemented revised policies on their own.

Based on the overall picture presented here, the survey analysis appears consistent with previous research which finds that consultants' advice is instrumental in hospital administrations' campaigns against unions. Hospitals have adopted the policies consultants advocate, and they have worked effectively. In fact, fourteen hospitals faced organizing attempts and employed the consultants' methods. But the nurses organized in only three of them. In spite of this impressive record, many hospitals have reached a curious conclusion regarding

consultant use. Half of the respondents report that they do not plan to use consultants in any future nurses' organizing campaign. They appear to recognize that a flurry of activity surrounding personnel policies, rather than substantive revisions, are key to defeating organizing campaigns. Having learned and successfully implemented the strategies suggested by consultants, hospital administrators in Maine and New Hampshire are ready to fight unionization on their own.

The interpretation of results presented here addresses the hypothesis that survey hospitals with union activity and consultant advice use personnel policies which differ from the remaining institutions. It is also possible, however, that the findings are consistent with hospital concerns other than the threat of unionization. For example, hospitals might also use the new and revised policies reported by surveyed hospitals to attract additional nurses to their staffs during a shortage. Since vacant positions for registered nurses nationwide "reached levels of the last national nursing shortage" (Aiken 1982, 641) by December 1986, its influence on administrations' decision making must be acknowledged by this study. Similarly, hospitals whose size dictates a bureaucratic approach to personnel administration and/or makes it an attractive target to union organizers might implement such policies. It is a consideration examined in further detail in the following chapter.

CHAPTER NOTES

[1] It is interesting to note that personnel directors employing consultants report using a relatively large number of individual management-RN relations policies, but indicate no change in the policy category. This serves to strengthen the conclusion above that hospitals seem to proliferate policies to appear responsive to employees needs.

CHAPTER SEVEN

OTHER VARIABLES AFFECTING UNIONIZATION POTENTIAL

Parts of the literature review, case study, and survey analysis presented so far attribute the use of a variety of personnnel policies which discourage unionization to consultant advice and/or union activity. But management aware of the history of unionization is likely to realize that the workload, size, and location of the institution may make it susceptible to an organizing drive. It may use these characteristics as a measure of potential union activity and react by implementing policies that will improve RN job satisfaction. Thus, even though the foregoing interpretation of survey data supports the hypothesis that consultant-inspired hospital administrators establish personnel policies to avoid unionization among RNs, alternative interpretations must also be considered. The analysis below determines whether variables other than actual union activity are associated with labor policies that stave off interest in unionization.

Relation Between Workload and Personnel Policy Variables

Because RNs' workloads are a major source of dissatisfaction and are measurable using either mean beds/full-time equivalent (FTE) RNs or mean occupancy rate, the relationship between these variables and the three indicators of hospitals' responsiveness to nurses' job satisfaction

were calculated. Again, the reasoning behind this analysis is to determine if heavy workloads, a frequently-cited cause RN dissatisfaction, is related to the policies which hospital administrators implement. Significant chi square statistics and p values are reported in Table 21 (also see Appendix J, Table 48).

Table 21.--Relation of policy variables to RN workload measures

Policy Category	Beds/FTE RN	OccupancyRate
Significance of wage-benefit policies	2.29 $.10 < p \leq .20$	2.29 $.10 < p \leq .20$
Significance of advancement-transfer policies	2.29 $.10 < p \leq .20$	2.29 $.10 < p \leq .20$
Significance of women's issues	2.29 $.10 < p \leq .20$	
Significance of management-RN relations policies	3.74 $.05 < p \leq .10$	
Significance of participation policies	4.09 $.02 < p \leq .05$	
No. of wage-benefits policies		4.09 $.02 < p \leq .05$
No. of participation policies	2.19 $.10 < p \leq .20$	2.29 $.10 < p \leq .20$
Changes in work schedule policies	2.30 $.10 < p \leq .20$	
Changes in participation in policy making	2.90 $.05 < p \leq .10$	

Following the methodology used in the previous chapter, the

workload variable most closely related to the policy category measures--beds/full time equivalent RN--was used to determine if hospital with heavier RN workloads implemented particular individual policies more regularly than hospitals with lighter caseloads. Statistically significant results are given in Table 22. (All chi square statistics and p values appear in Appendix J, Table 49.)

Table 22.--Relation of policy variables to number of beds per FTE nurse

	Chi Square Value	p Value
Wage-benefitspackage		
Other policies	3.59	$.05 < p \leq .10$
RN work schedules		
Layoff-recall	4.09	$.02 < p \leq .05$
Flextime	3.59	$.05 < p \leq .10$
Other	9.33	$.001 < p \leq .01$
Advancement-transfer		
Continuingeducation	2.15	$.10 < p \leq .20$
Women's issues		
Day care	2.33	$.10 < p \leq .20$
Management-RNrelations		
Head RNs encouraged to spend extra time on their floors	1.71	$.10 < p \leq .20$
Employee handbook	2.15	$.10 < p \leq .20$
Participation in policy making		
Other policies	3.39	$.05 < p \leq .10$

The strong relation between policy variables and both patient-

nurse ratios and occupancy rates suggests that workload is a measure of RN dissatisfaction to which management responds. Contingency table analysis using workload variables show that hospitals in which RNs experience heavy workloads are aware of RNs concerns in five of six categories named. They have responded to those concerns in two categories by implementing a number of individual policies greater than the median in two categories and by changing existing policies in two categories. It is particularly noteworthy that management has increased nurses' voice in solving hospital problems--RN participation in policy making--in those hospitals with heavy workloads, since personnel directors generally gave this policy category a relatively low rating.

Following the same line of reasoning, hospitals with heavy RN workloads should be sensitive to scheduling--the work-related variable which the responding personnel directors found most important to nurses satisfaction and which relates most directly to workload problems. Although both the significance and number of "RN work schedules" are independent of the work load variables, beds/FTE nurse is dependent upon flextime and other scheduling policies which might address work overload.

Relationship Between Hospital Size And Personnel Policy Variables

A second measure used in contingency table analysis is hospital size. Larger hospitals may be more careful to meet RN concerns over wages and benefits, advancement-transfer, and management-RN relations since unions frequently to choose to launch organizing campaigns in bigger units by addressing these issues. In addition, the implementation

of policies varies between small hospitals, where management contact with the entire staff is easy, and large hospitals which require bureaucratic decision making. Thus larger hospitals may establish policies on more issues than smaller hospitals which handle situations on a case-by-case basis. The number of beds set up and staffed and number of FTE RNs provide measures of size in the contingency tables. Results of statistically-significant contingency table analyses of both variables and policy category measures are shown in Table 23 (also see Appendix J, Table 50).

Table 23.--Relation of policy variables to hospital size measures

	No. of hospital beds	No. of FTE RNs
Significance of advancement-transfer policies	5.14 $.02 < p \leq .05$	5.14 $.02 < p \leq .05$
No. of wage-benefit policies	8.02 $.001 < p \leq .01$	8.02 $.001 < p \leq .01$
No. of management-RN relations policies	5.14 $.02 < p \leq .05$	5.14 $.02 < p \leq .05$
No. of RN participation in policy making policies	2.19 $.10 < p \leq .20$	2.19 $.10 < p \leq .20$
Change in work schedules	2.29 $.10 < p \leq .20$	2.29 $.10 < p \leq .20$

Since the two size variables gave virtually identical results for each contingency table, either could have been used for the contingency

table analysis of individual policy variables. The hospital bed measure was chosen; significant results are shown in Table 24 (also see Appendix J, Table 51).

Table 24.--Relation of policy variables to number of hospital beds

	Chi square Statistic	p Value
Wage-benefitspackage		
Wage grade-step structure	4.66	$.02 < p \leq .05$
Retirement benefits	2.15	$.10 < p \leq .20$
In-house health services	7.64	$.001 < p \leq .01$
Discount services	2.15	$.10 < p \leq .20$
Work schedules		
Flextime	3.59	$.05 < p \leq .10$
Other policies	4.76	$.02 < p \leq .05$
Advancement-transfer		
Continuingeducation	2.15	$.10 < p \leq .20$
Other policies	2.15	$.10 < p < .20$
Women's issues		
Day care	2.33	$.10 < p \leq .20$
Management-RNrelations		
Complaints handled through RN's direct supervisor	7.64	$.001 < p \leq .01$
Participation policies		
Other policies	3.39	$.05 < p \leq .10$

Results for the tests of independence between hospital size and policy variables substantiate the hypothesis that larger hospitals administer more policies than smaller ones, either because of their

bureaucratic style of operation or because they fear becoming a target of a union organizing campaign. Individual wage-benefit, management-RN relations, and participation policies are more prevalent in larger than smaller hospitals. The number of individual policies showing significant dependence on hospital size is greater than all other variables tested.[1] Hospitals in these locations wishing to avoid unionization might offer improved wages and benefits, attractive scheduling, advancement and transfer policies, similar to those in place in unionized settings, to deflect interest in organizing. Although the number of advancement-transfer policies is independent of hospital size, personnel directors in large hospitals are more likely to think the category is important to RN satisfaction than those in smaller institutions. This possibly reflects the greater opportunity for promotion and movement in a hospital with more beds and possibly more departments.

Relation Between City Size and Personnel Policy Variables

Another measure which might lead hospital directors to defend against unions in their policy making is the size of the city in which the hospital is located. Since unionized workplaces are more frequently found in larger cities rather than rural areas, administrators and nurses working in larger cities might be familiar with the gains that unions can achieve for their members.

However, two additional factors not directly related to union activity might also cause hospitals to establish these labor policies. First, during nurse shortages, hospitals in large cities which compete for RNs may advertise such an employment package to attract job candidates to

their institutions. Second, the size of the hospital depends largely on the size of the city, and as already discussed, the responsiveness of large hospital administrations differs from smaller hospitals for both union-related and bureaucratic reasons. Thus, the presence of a strong relationship between the hospital's city size and policy variables cannot be attributed strictly to union avoidance practices. In this analysis, cities with populations below the sample median were classified as small. All others were considered large. Significant results are given in Table 25 (also see Appendix J, Table 52).

Table 25.--Relation of policy variables to city/town size

	Chi square Statistic	p Value
Significance of advancement-transfer policies	2.86	$.10 < p \leq .20$
No. of wage-benefit policies	4.09	$.02 < p \leq .05$
No. of work schedule policies	1.71	$.10 < p \leq .20$
No. of advancement-transfer policies	3.36	$.05 < p \leq .10$
No. of participation policies	2.19	$.10 < p \leq .20$
Change in wage-benefit policies	3.14	$.05 < p \leq .10$
Change in work schedule policies	10.75	$.001 < p \leq .01$
Change in advancement -transfer policies	4.30	$.02 < p \leq .05$
Change in women's issues	3.88	$.02 < p \leq .05$
Change in management-RN relations policies	6.42	$.01 < p \leq .02$
Change in RN participation in policy making	6.60	$.01 < p \leq .02$

As expected, responsiveness to RNs' concerns varies considerably with city size. Hospital personnel directors in smaller cities characterized advancement and transfer policies as significant less frequently than those in larger cities. Hospitals in smaller cities also reported use of fewer wage-benefit package, advancement-transfer, and participation policies than their large city counterparts. Most significantly, changes in every policy category occurred more frequently in hospitals in median-sized and larger cities than in smaller ones. This outcome may reflect management's interest in maintaining policies competitive with other hospitals or similar to local unionized workplaces as discussed above.

The statistical significance of relationships found in this analysis led to the examination of individual policies dependent on city size reported in Table 26 (significant results only) and in Appendix J, Table 53. Although this contingency table analysis does not indicate which policies were changed, it indicates what issues have been important to larger city management in the past. As expected, most of the individual policies exhibiting the greatest dependence on city size are issues normally addressed in union contracts. The two policies that do not fit that characterization--bulletin board use and handling complaints through direct supervisors--are methods use by management to establish its antiunion position.

Relationship Between State and Personnel Policy Variables

Because the labor relations climates in Maine and New Hampshire

vary in two important ways, the hypothesis that hospital administrators in the two states might implement different policies to avoid union activity was tested. First, several unions, including the SEIU, 1199, and the IBT, have undertaken organizing efforts in New Hampshire. There has been only one organizing drive by the Maine State Nurses Association in New Hampshire. On the other hand, the MSNA has

Table 26.--Relation of individual policies to city/town size

	Chi square Statistic	p Value
Wage-benefitpackage		
Retirement benefits	2.15	$.10 < p \leq .20$
In-house health services	3.39	$.05 < p \leq .10$
Discount services	2.15	$.10 < p \leq .20$
Work schedules		
Shift preference	4.67	$.02 < p \leq .05$
Other	1.71	$.10 < p \leq .20$
Advancement-transfer		
Promotion	3.36	$.05 < p \leq .10$
Women's issues		
Day care	2.33	$.10 < p \leq .20$
Management-RNrelations		
Bulletin board use	2.19	$.10 < p \leq .20$
Complaints handled through direct supervisor	3.39	$.05 < p \leq .10$
Participation in policy making		
Periodic meetings with RN committees	1.71	$.10 < p \leq .20$

sponsored almost all the campaigns to unionize Maine nurses. To the extent that management shows more concern for a unionization threat by the "professional" MSNA than by other unions, survey answers may differ by state.

Second, Maine is generally perceived to be a climate more favorable to unionization than New Hampshire. The percentage of employed persons belonging to labor organizations grew in Maine from 22.0 to 24.1 between 1970 and 1980. In New Hampshire, that figure fell from 21.2 to 15.8 during the same time period (U.S. Department of Commerce 1984, 440). Additionally, interest in unionization among RNs in Maine is likely to be higher than in New Hampshire. Five RN locals are currently represented in collective bargaining in Maine by the MSNA. RNs were successful in organizing in only one New Hampshire hospital. Insofar as the environment for nurses' unionization appears more favorable in Maine than New Hampshire, Maine hospital administrators may exhibit more sensitivity to RNs' job satisfaction than their neighbors do. Table 27 shows the significant results of this analysis (also see Appendix J, Table 54).

Answers from personnel directors in the two states differed significantly in only one category--number of wage-benefit policies (chi square statistic = 4.4; $.02 < p \leq .05$). However, since wages and benefits are the primary focus of most union contracts, the result suggests that the explanation based on a more favorable union environment in Maine given above is plausible.

Table 27.--Relation of policy variables to state

	Chi Square Statistic	p Value
Significance of advancement-transfer policies	2.3	$.10 < p \leq .20$
No. of wage-benefit policies	4.4	$.02 < p \leq .05$

Summary

The contingency table analyses using workload, hospital size, city size, and state variables are consistent with the view that hospitals with characteristics making them susceptible to unionization are aware of RNs' job concerns. These institutions appear to implement or to adjust policies important to nurses' satisfaction at work. With the exception of the state analyses, all predictors of union activity are related to several of the policy categories. In particular, workload, hospital size, and city size measures relate to three important topics--wage and benefits, scheduling, and management-RN relations policy variables. Furthermore, hospitals which are "union-prone" according to the above explanations maintain several individual policies which hospitals less likely to experience union activity do not use. Among the most notable individual policies are "other" scheduling and participation policies, day care, and flextime--all of which might reduce nurses' interest in organizing.

While these results appear to offer an alternative explanation to

the original hypothesis that RN organizing activity and consultant advice lead to personnel policy changes in hospitals, they must be tempered by several considerations. First, some policy measures which are significantly related to workload, hospital size, and city size are also closely associated with union activity and/or consultant use. For example, dependence exists between changes in scheduling policies and both hospital size and consultant use. The use of "other" participation policies relates to union activity and workload.

Second, it is significant that, in addition to their awareness and use of a variety of RN-oriented policies, larger hospitals and those with heavy workloads have also experienced more union activity than their counterparts (see Appendix J, Table 55). In these cases, one cannot be sure whether the hospitals instituted policies to prevent union activity or in response to it since personnel directors did not specify the timing of policy implementation in their survey responses. These limitations, along with RN labor market considerations raised in the chapter, suggest the need for further analysis of the role of workload, hospital, and city size variables in policy making.

CHAPTER NOTES

[1] An equal number of individual policies have a statistically significant dependence on city size which, in turn, is closely related to hospital size.

CHAPTER EIGHT

CONCLUSIONS

From the survey analysis and case study, two general conclusions emerge. This final chapter first presents these findings. Their practical implications for both labor organizers and hospital management then follow. Suggestions of research which will further improve our understanding of management consultant activity in organizing campaigns conclude the chapter.

General Findings

First, despite the consultants' contention that they provide advice on both preventive labor relations and methods of defeating organizing, the research here indicates that their use in the latter role is far more frequent in organizing drive involving RNs. The survey analysis reveals that in virtually every hospital employing them, consultant use is closely related to all forms of union activity. Observations made in the Portsmouth Hospital case study are also consistent with this conclusion.

Second, and more importantly, the analysis identifies specific personnel policy advice associated with consultant use and union activity. The results provided here are consistent with the view that, in response to consultants' suggestions, hospital management changes its communication style and implements a variety of new personnel policies.

These personnel policy revisions rarely occur in categories which personnel directors believe substantively affect nurses' job satisfaction. Hospitals appear to make changes believing that RNs will perceive them as responsive to their job dissatisfaction. The Portsmouth Hospital case study provides an example of this management strategy.

As explained in previous chapters, these general conclusions must be qualified by the following two considerations. First, both the new and revised policies used by the surveyed institutions might also serve to attract nurses to staff vacancies. Since hospital officials note that a nurse shortage has existed at least since late 1986, its influence on administrative actions cannot be dismissed in this study. Second, large hospitals typically require bureaucratic administration of personnel policies and frequently appear as attractive targets to unions hoping to increase their memberships significantly. Thus, large institutions might use the types of policies described above to improve administration or to protect against dissatisfaction which would attract union organizers to them. In short, this study acknowledges that the survey results may be consistent with a variety of hospital administration concerns.

Finally, the thorough examination of consultant-inspired responses to union organizing at Portsmouth Hospital produced conclusions beyond those established by the survey results. The interactions of a single hospital administration and nursing staff are an inadequate basis upon which to analyze or predict the behavior of others. But the case study's consistency with previous research regarding hospital reactions to financial constraints and the role of proprietary hospitals in the health care industry is noteworthy.

The 1985 sale of the Portsmouth Hospital to the Hospital Corporation of American was, in part, motivated by financial difficulties created by the DRG cost containment program and market competition. Both the initial management of the hospital by HCA and its eventual sale reflect the rise of proprietary hospital corporations in the U.S. in recent years. Furthermore, the experiences of Portsmouth Hospital's RN union are consistent with reports that the well financed resistance mounted by the proprietary chain is more difficult to overcome than that of the independent community hospital.

Implications for Unions and Management

Unions

To the extent that they have prepared potential RN bargaining unit members for the consultant-inspired actions against representation, organizers have focused on the antiunion tactics used during election campaigns. Results here suggest that while there is a need for such education, unions should not depend on it exclusively. They should recognize that RNs' hesitance to join unions makes them particularly susceptible to personnel policy changes which appear to respond to job dissatisfaction. Union representatives should explain to RNs involved in organizing campaigns that hospitals are likely to proliferate a large number of new policies and policy changes in response to staff interest in unionization. They should counsel nurses to compare the substance of communications and other new programs sponsored by management to the contract language which they could secure with union representation.

The case study analysis provides RN unions with valuable suggestions about negotiating tactics after winning representation elections. Current economic conditions in the health care industry require careful planning for contract negotiations for RN locals in hospitals. Unions need to explore ways of working with management to improve wages and working conditions within the constraints brought on by competition in health care, cost containment, and the nursing shortage. Otherwise nurses' locals must be prepared to withstand active resistance by hospital management adjusting to these financial difficulties. Since an increasing number of hospitals are turning to proprietary chains for relief from these difficulties, unions determined to win elections and negotiate strong contracts must develop strategies to counter the antiunion tactics described in the case study.

Management

The most cogent conclusion for management emerging from this study is that the consultant-inspired strategy already used by hospitals facing union activity is a successful one. Changes emphasizing the number and form, rather than the substance, of personnel policies appear to have quieted RNs' interest in unionism in Maine and New Hampshire. Management's confidence in its ability to defeat nurses' organizing efforts should, therefore, be strong.

However, even with their success in resisting RN organization, the case study provides some warnings for hospital administrators. They must recognize that financial exigencies which strengthen hospitals' resolve to manage without unions may also create more stressful

working conditions for nurses. In turn, union representation may become an increasingly attractive option to RNs.

Moreover, hospital management needs to understand that the consultant advice used by virtually all Maine and New Hampshire hospitals in facing their first union campaign may not prove effective in a second one. The case study demonstrates that once RNs recognize that personnel policy changes are ineffective, they may be more skeptical if they encounter the strategy again. Thus, hospital administrators may need to address repeated organizing efforts with different, more substantive improvements to convince the RNs of the sincerity of their efforts.

Directions for Future Research

Future research on RN organizing can confirm and expand upon this study both by using different methodology and by exploring issues other than management's personnel policy responses. For example, a slight alteration in methodology -- increasing the size of the sample -- might produce stronger statistical results for some of the relationships examined in the present study. Further, surveying nurses who work at the hospitals represented here would verify both the policy categories which are most important to RN job satisfaction and the effectiveness of policy moves taken in response to union activity. Finally, similar studies in different regions of the country and urban areas are necessary to determine if the conclusions drawn here apply to nurses other than those in northern New England.

But to fully understand the management resistance to union organizing, future research must address additional issues. First, a more complete understanding is needed of how dissatisfaction with existing wages and benefits affects RNs' decision to seek union representation. If the improved wage/benefit packages offered by management in response to the current nurse shortage assuage a major source of job discontent, registered nurses' interest in joining a union may diminish without implementing consultant-inspired policy changes.

Additionally, more investigation of factors touched upon in this study--work load, hospital size, city size, and state--is necessary. The above survey analysis of these characteristics suggests that the data is also consistent with the view that hospitals implement and improve personnel policies if size variables or RN workloads are large and likely to engender dissatisfaction. Identifying the relative importance of these factors in policy making is essential to understanding the consultant's role.

Third, the effectiveness of the consultant's legal advice upon the outcome of union elections requires examination. Employers frequently cite their ignorance of the rights and restrictions which apply to them as their reason for hiring consultants. Empirical research has already established that delaying elections, redefining the proposed bargaining unit, and launching vigorous antiunion campaigns hinder union organizing efforts. Thus, to understand their full impact on RN union campaigns, future research must assess the consultants' role in promoting such measures.

Fourth, this study reports on one case of proprietary hospitals' aggressive opposition to union activity. However, drawing general conclusions from this isolated case is inappropriate. The forecasted growth of proprietary health care requires that researchers examine resistance to organizing in a representative sample of for-profit hospitals.

Finally, all of the foregoing assumes that management resistance alone creates obstacles to union organizing. In fact, unions have used a variety of successful and unsuccessful strategies in their attempts to organize nurses. A comprehensive study of their methods is needed before we can correctly identify all factors contributing to these union election outcomes.

This study has focused on the character of the personnel policy advice which consultants give to management faced with a union organizing drive among RNs. The results offer important information regarding the role of management consultants in resisting the unionization of the RN workforce. These findings in the hospital industry may well apply to other industries, where the character of consultants' recommendations has not previously been examined.

APPENDIX A

CORRESPONDENCE FROM CHARLES A. NOON, DIRECTOR OF MARKETING, PORTSMOUTH HOSPITAL

Portsmouth
Hospital

One Junkins Avenue
Portsmouth, New Hampshire 03801
Tel. (603) 436-5110

April 9, 1986

Jill Kriesky
Whittemore School of Business & Economics
University of New Hampshire
Durham, New Hampshire 03824

Dear Ms. Kriesky:

Thank you for your interest in observing our negotiating session with Local 1199. Unfortunately, we will not be able to allow you to attend the session. You are correct in stating that sensitive issues are often addressed and for that reason we have, since 1980, never allowed observers in the negotiating sessions. We do not question your ability to be a neutral observer, nor do we have any worries that you would publish or comment publicly on the progress of the negotiating session. My denial of your request is based on past history and desire not to create a precedent in any negotiation that Portsmouth Hospital engages in.

I can tell you that I will be happy to discuss with you privately what went on at the negotiating sessions after they are completed. Don Mayer, Director of Human Resources has also agreed to talk with you after the sessions are completed.

I can talk to you now about negotiations in general, but I will not be able to be specific about current Portsmouth Hospital negotiations. I realize that this puts you at some disadvantage in writing your dissertation and I apologize for that. I hope you understand our position. I will be happy to talk to you about it at anytime.

Sincerely,

Charles A. Noon III
Director of Marketing

CN:djs

cc: D. Mayer

APPENDIX B

SURVEY SENT TO HOSPITAL PERSONNEL DIRECTORS IN MAINE, NEW HAMPSHIRE, AND VERMONT

This questionnaire is designed so that it can be completed in a short time. Most questions require only a circle or checkmark in the appropriate place. Where explanations are requested, short answers are generally sufficient, but feel free to respond with as much detail as you wish. If clarification is needed you may be contacted for a brief follow-up interview.

Please remember that most of these questions address hospital actions as best you can recall them as opposed to hospital intentions.

1. Listed below are six major categories in which hospitals generally establish personnel policies. Please give your perception of the impact that your hospital's policies in each of these categories has on the registered nurses' job satisfaction. Check each item under the six main headings for which your hospital presently has an established policy for its registered nurses.

	POLICIES ARE very significant 5 4 3 2 1 insignificant
RN WAGE/BENEFITS PACKAGE	
___uniform wage rates for specific job titles	
___wage grade/step structure	
___vacation policy	
___retirement benefits	
___medical insurance coverage	
___in-house health services	
___discount services	
___reimbursement for college courses	
___other (specify) _____	

	POLICIES ARE very significant 5 4 3 2 1 insignificant
RN WORK SCHEDULES	
___overtime work	
___shift preference	
___layoff/recall	
___flextime	
___other (specify) _____	

	POLICIES ARE very significant 5 4 3 2 1 insignificant
RN ADVANCEMENT/TRANSFER	
___promotion	
___transfer	
___continuing education	
___other (specify) _____	

	POLICIES ARE very significant 5 4 3 2 1 insignificant
WOMEN'S ISSUES	
___sexual harassment	
___day care	
___maternity leave	
___other (specify) _____	

	POLICIES ARE very significant				insignificant
MANAGEMENT/RN RELATIONS	5	4	3	2	1

___planned orientation for new RNs
___exit interviews with RNs leaving the hospital
___head nurses encouraged to spend additional time on their "floors" with their staffs
___bulletin boards carrying management's messages
___speeches by top management
___an employee handbook
___in-house newspaper or newsletter
___an "open door" policy giving the RN a chance to take complaints to top management
___complaints handled through the RN's direct supervisor
___formal grievance procedure
___other (specify) _____

	POLICIES ARE very significant				insignificant
RN PARTICIPATION IN POLICYMAKING	5	4	3	2	1

___a suggestion box for anonymous comments
___periodic individual interviews with RNs allowing them to express job concerns or offer suggestions
___periodic meetings with RN committees allowing them to express job concerns or offer suggestions
___other (specify) _____

2. a)If any of the union-related activities listed below have occurred among RNs in your hospital between 1974 and 1984, indicate the union involved and the approximate date of the activity.

ACTIVITY	UNION	DATE
informational meeting(s) for RNs sponsored by a union	_____	_____
informational leafletting of RNs by a union	_____	_____
informational picketing by a union seeking to represent RNs	_____	_____
establishment of an RN organizing committee sponsored by a union	_____	_____
establishment of an RN committee (independent of the hospital or the union) to present grievances	_____	_____
distribution of union authorization cards among RNs	_____	_____
NLRB-conducted representation election for an RN unit	_____	_____
collective bargaining with a union representing RNs	_____	_____
other (specify) _____	_____	_____

b)Did the hospital hire a management consultant or labor lawyer to advise it during any of these activities?

___no
___yes: Which activities? _____ Who was the consultant? _____

_____ _____

3. a)If any of the union-related activities listed below have occurred among workers in your hospital other than RNs between 1974 and 1984, indicate the employee group and the approximate date of the activity.

ACTIVITY	EMPLOYEE GROUP	DATE
informational meetings, leafletting, and/or picketing by a union seeking to represent an employee group		
a formal union organizing campaign culminating in a NLRB-supervised election for an employee group		
collective bargaining with a union which represents an employee group		
other (specify) _____		

b)Did the hospital hire a management consultant or labor lawyer to advise it during any of these activities?

___no

___yes: Which activities? _____ Who was the consultant? _____

_____ _____

_____ _____

c)Have any of the policies advocated by the consultant(s) during these campaigns been applied to RN relations?

___no

___yes: Which ones? _____

_____

_____

4. a)If you are aware of union activity among RNs in your state or region between 1974 and 1984, please give the name of the hospital(s) in which the activity occurred and the approximate date. If you are aware of such activities in several hospitals, please list the two whose developments you followed most closely.

ACTIVITY	HOSPITAL	DATE
informational meetings, leafletting, and/or picketing by a union seeking to represent RNs		
a formal union organizing campaign culminating in an NLRB-supervised election for an RN unit		
collective bargaining with a union which represents an RN group		
other (specify) _____		

b)Are you aware of any of these hospitals' use of management consultants or labor lawyers during the period of union activity?

___no

___yes: Which hospitals? _____ Who was the consultant? _____

_____ _____

_____ _____

5. Sometimes union activity at one's own hospital or at a neighbor's is a signal to hospital administrators of RN job dissatisfaction. If your hospital made major changes in any of the individual policies given below, indicate the reasons for the changes. Check all of the individual policies under the main heading that you recall being changed.

	REASON FOR POLICY CHANGE WAS				
	union activity among our RN staff	union activity among our other employees	union activity among RNs at other hospitals	other	no policy change
RN WAGE/BENEFIT PACKAGE					
uniform wage rates for specific job titles	____	____	____	____	____
wage grade/step structure	____	____	____	____	____
vacation policy	____	____	____	____	____
retirement benefits	____	____	____	____	____
medical insurance coverage	____	____	____	____	____
in-house health services	____	____	____	____	____
discount services	____	____	____	____	____
reimbursement for college courses	____	____	____	____	____
other (specify) _____	____	____	____	____	____

	REASON FOR POLICY CHANGE WAS				
	union activity among our RN staff	union activity among our other employees	union activity among RNs at other hospitals	other	no policy change
RN WORK SCHEDULES					
overtime work	____	____	____	____	____
shift preference	____	____	____	____	____
layoff/recall	____	____	____	____	____
flextime	____	____	____	____	____
other (specify) _____	____	____	____	____	____

	REASON FOR POLICY CHANGE WAS				
	union activity among our RN staff	union activity among our other employees	union activity among RNs at other hospitals	other	no policy change
RN ADVANCEMENT/TRANSFER					
promotion	____	____	____	____	____
transfer	____	____	____	____	____
continuing education	____	____	____	____	____
other (specify) _____	____	____	____	____	____

	REASON FOR POLICY CHANGE WAS				
	union activity among our RN staff	union activity among our other employees	union activity among RNs at other hospitals	other	no policy change
WOMEN'S ISSUES					
sexual harassment	____	____	____	____	____
day care	____	____	____	____	____
maternity leave	____	____	____	____	____
other (specify) _____	____	____	____	____	____

	REASON FOR POLICY CHANGE WAS				
	union activity among our RN staff	union activity among other employees	union activity among RNs at other hospitals	other	no policy change
MANAGEMENT/RN RELATIONS					
planned orientation for new RNs	____	____	____	____	____
exit interviews with RNs leaving the hospital	____	____	____	____	____
head nurses encouraged to spend additional time on their "floors" with their staffs	____	____	____	____	____
bulletin boards carrying management's messages	____	____	____	____	____
speeches by top management	____	____	____	____	____
an employee handbook	____	____	____	____	____
in-house newspaper or newsletter	____	____	____	____	____
an "open door" policy giving the RN a chance to take complaints to top management	____	____	____	____	____
complaints handled through the RN's direct supervisor	____	____	____	____	____
formal grievance procedure	____	____	____	____	____
other (specify) _____	____	____	____	____	____

	REASON FOR POLICY CHANGE WAS				
	union activity among our RN staff	union activity among other employees	union activity among RNs at other hospitals	other	no policy change
RN PARTICIPATION IN POLICYMAKING					
a suggestion box for anonymous comments	____	____	____	____	____
periodic individual interviews with RNs allowing them to express job concerns	____	____	____	____	____
periodic meetings with RN committees allowing them to express job concerns	____	____	____	____	____
other (specify) _____	____	____	____	____	____

6. Evaluate the effectiveness of the policy changes made in each major category on RNs' job satisfaction.

	POLICY CHANGE WAS					
	very effective				very ineffective	no policy change
RN WAGE/BENEFITS PACKAGE	5	4	3	2	1	0
RN WORK SCHEDULES	5	4	3	2	1	0
RN ADVANCEMENT/TRANSFER	5	4	3	2	1	0
WOMEN'S ISSUES	5	4	3	2	1	0
MANAGEMENT/RN RELATIONS	5	4	3	2	1	0
RN PARTICIPATION IN POLICYMAKING	5	4	3	2	1	0

7. a)Did the form of nursing care delivery most widely used at the hospital change in response to union activity?

___no

___yes: FORM OF NURSING CARE DELIVERY: (primary, total/comprehensive, team, functional care, or other)
prior to union activity _____
after union activity _____

b)Which group of employees undertook union activity which prompted this change? _____
(our RN staff, our other employees, RNs at other hospitals, etc.)

8. a)Did the approximate number of overtime hours worked by the RN staff each year change in response to union activity?

___no

___yes: APPROXIMATE NUMBER OF OVERTIME HOURS WORKED BY THE RN STAFF PER YEAR:
prior to union activity _____
after union activity _____

b)Which group of employees undertook union activity which prompted this change? _____
(our RN staff, our other employees, RNs at other hospitals, etc.)

9. a)Did the percentage of RNs on your nursing staff change in response to union activity?

___no

___yes: The percentages of RNs ____ increased

____ decreased

b)Which group of employees undertook union activity which promoted this change? _____
(our RN staff, our other employees, RNs at other hospitals, etc.)

10. a)Did any of the following positions change hands within a period of six months before or after any union activity? (Check all that apply)

CHANGED HANDS WITHIN A PERIOD OF SIX MONTHS		
before union activity	after union activity	
___	___	chief exective officer
___	___	chief operating officer
___	___	director of personnel/human resources
___	___	director of nursing
___	___	other (specify) _____

b)Which group(s) of employees undertook union activity around the time of the administration change(s)? (our RN staff, our other employees, RNs at other hospitals, etc.) _____

11. Please provide the minimum, maximum, and weighted average salaries for a general duty staff RN at your hospital.

	MINIMUM	MAXIMUM	WEIGHTED AVERAGE		MINIMUM	MAXIMUM	WEIGHTED AVERAGE
1974	_____	_____	_____	1980	_____	_____	_____
1975	_____	_____	_____	1981	_____	_____	_____
1976	_____	_____	_____	1982	_____	_____	_____
1977	_____	_____	_____	1983	_____	_____	_____
1978	_____	_____	_____	1984	_____	_____	_____
1979	_____	_____	_____				

12. How likely do you find the following scenarios?

	very likely				very unlikely
The RNs in your hospital will attempt to unionize within the next two years.	5	4	3	2	1
The hospital will hire a management consultant in response to a unionization effort.	5	4	3	2	1
The RNs will succeed in forming a union at the hospital within the next two years.	5	4	3	2	1

IF THE RNs IN YOUR HOSPITAL HAVE EVER PARTICIPATED IN A FORMAL UNION ORGANIZING CAMPAIGN, PLEASE ANSWER THE FOLLOWING QUESTIONS. IF NOT, PLEASE SIGN THE CONSENT STATEMENT AT THE BOTTOM OF THE NEXT PAGE.

1. a)When did union card campaign(s) occur among RNs in your hospital? _____

b)Which union sponsored the campaign? _____American Federation of Teachers

_____State Nurses' Association

_____1199, New England Health Care Employees Union

_____Other (specify) _____

2. a)Who directed the hospital's response to the campaign? (check all that apply)

___in-house legal staff
___in-house management committee
___in-house labor relations specialist
___hospital administrator or chief executive officer
___trustee committee
___outside attorney with specialized labor practice
___outside attorney with general practice
___outside management consultant
___other (specify) _____

Who is the attorney or consultant? _____

For how long was he/she employed? _____

Is the attorney/consultant's clientele local or national? _____

b)Check all of the other sources upon which you rely to formulate employee relations policy:

___consultant seminars
___consultant newsletters or journals
___hospital association literature
___trustees' expertise
___other (specify) _____

3. Which of the following policies were altered or instituted on the recommendation of one or more of these sources? (check all that apply)

___RN WAGE/BENEFITS PACKAGE
___RN WORK SCHEDULES
___RN ADVANCEMENT/TRANSFER
___WOMEN'S ISSUES
___MANAGEMENT/RN EMPLOYEE RELATIONS
___RN PARTICIPATION IN POLICYMAKING

Answer the following two questions only if you relied on an attorney/consultant and/or their literature during the union organizing campaign.

4. Which of the following actions were taken in response to the union campaign upon the advice of the attorney/consultant and/or their literature? (check all that apply)

___employee meetings to discuss work conditions and/or the card campaign
___one-on-one meetings between supervisors and individual RNs
___literature about unionization sent to RNs' homes
___reclassification of RN positions and/or reorganization of RN duties
___enforcement of hospital no solicitation rules
___replacement of supervisory and/or human resource department personnel
___other (specify) _____

5. How do you rate the effectiveness of the attorney/consultant methods which you employed?

very effective very detrimental

5 4 3 2 1

Please sign the following informed consent statement identifying yourself and your hospital. This information will be removed from the survey form prior to the analysis of the data.

I agree to participate in this survey of RN personnel policy in northern New England hospitals. I understand that my participation is voluntary and that my responses are confidential.

_____
name

_____
hospital

APPENDIX C

LETTER SENT WITH SURVEY TO MAINE, NEW HAMSPHIRE, AND VERMONT HOSPITAL PERSONNEL DIRECTORS

UNIVERSITY OF NEW HAMPSHIRE

The Whittemore School of Business and Economics
McConnell Hall
Durham, New Hampshire 03824
(603) 862-2771

May 1, 1986

&fname& &lname&
&address1&
&address2&
&address3/o&
&address4/o&
&address5/o&

Dear &title& &lname&:

Registered nurses are a vital part of any hospital staff. They are also a large group of professional, predominantly women employees who for many years remained unrepresented by unions. But recently, organized labor has committed itself to unionizing workers with precisely these characteristics. They are, therefore, an excellent focus for the study of management efforts to provide working conditions which reduce the desire for unions.

As a Ph.D. student in economics at the University of New Hampshire, my dissertation undertakes such research for sixty community hospitals similar to yours in New Hampshire, Maine, and Vermont. Because my sample is small, your response is critical to my analysis even if your RNs have not been involved in any union activity. I know that you are busy, so I have limited my questions to those that identify personnel policy changes made to meet both the needs of your RNs and the rise of union activity in hospitals. Throughout the survey, you only need to note the approximate dates of the events in question -- whatever you can remember or find easily in your files.

All hospital-specific information which you supply will remain confidential. I ask that you identify yourself and your hospital at the end of the survey only to verify that you participated voluntarily. It will be removed from the survey form. A summary of the research results will be sent to all participants upon its completion. It is the first survey to document the steps taken by hospitals in northern New England to alleviate the desire for unionization among RNs. It should reveal which actions have been successful, and also those that have not. Thus, I emphasize again that your participation in the survey is vital.

I appreciate you taking the approximately thirty minutes needed to answer these questions. I look forward to receiving your survey soon. If you have any questions, please feel free to call me at 603-862-3329.

Sincerely,

Jill Kriesky
Ph.D. Candidate

APPENDIX D

LETTER SENT TO PRESIDENTS OF MAINE, NEW HAMPSHIRE, AND VERMONT HOSPITAL ASSOCIATIONS

UNIVERSITY OF NEW HAMPSHIRE

The Whittemore School of Business and Economics
McConnell Hall
Durham, New Hampshire 03824
(603) 862-2771

May 9, 1986

&first name& &last name&
President
&state& Hospital Association
&address 1&
&address 2&

Dear Mr. &last name&,

I am presently in the process of surveying &number& hospital personnel directors in your state regarding union organizing activity among registered nurses and their hospitals' responses to it. This study is part of the research I am conducting as a Ph.D. candidate in the Economics Program at the University of New Hampshire. I hope to find out which policies and/or policy changes create the type of working environment that reduce RNs' desire for unions. I have enclosed copies of the survey and the letter which I have sent to the &number& hospitals in your state that I have identified as community, acute care hospitals with fifty or more beds. Surveys were sent to similar hospitals in &state 1& and &state 2& as well.

Although many questionnaires from personnel directors in your state have been returned, several have not. A few have indicated to me their initial hesitance to answer the sensitive questions asked without assurances from the hospital association that the survey is legitimate and answers confidential. I am asking that you review the content and speak to my advisors, if necessary, to confirm the legitimacy of the study. With your approval, I would like to include in a follow-up mailing of the survey to non-respondents, a statement declaring that the &state& Hospital Association has verified the legitimacy of my research.

I will call you in a few days to speak with you further on this issue. If you would like to contact my advisors, please call:

Professor Richard Hurd
Whittemore School of Business and Economics
University of New Hampshire
603-862-3374

Professor John Seavey
Health Administration and Planning Program
University of New Hampshire
603-862-2731

I can be reached at 603-862-3329 if you have further questions for me. If you are satisfied with the survey and are willing to attest to its legitimacy, please sign the enclosed statement. I will copy it and include it in the mailing I plan to make on May 22. Thank you for your assistance.

Sincerely,

Jill Kriesky
Ph.D. Candidate

The _____ Hospital Association has reviewed this survey and has verified that it is legitimate university dissertation research. I have been assured that your responses will be confidential.

_____
Signature and title

APPENDIX E

CORRESPONDENCE FROM IRENE PETERS, VICE PRESIDENT, NEW HAMPSHIRE HOSPITAL ASSOCIATION

New Hampshire Hospital Association

May 20, 1986

Jill Kriesky
Ph.D. Candidate
The Whittemor School of Business and Economics
University of New Hampshire
McConnel Hall
Durham, New Hampshire 03824

Dear Jill:

Please excuse my delay in responding to your letter of May 9, 1986 regarding your survey among hospital Directors of Personnel. I would like to explain to you why, based upon the information available, we are unable to do what you have asked.

You have asked, Jill, that the NHHA assure that the survey is legitimate and that answers will be held confidential. Because I do know Professor Seavey who has given me your name as a doctoral candidate, I would be willing to assume that you would hold response information in confidence. To "confirm the legitimacy of the study" or "declare that the New Hampshire Hospital Association has verified the legitimacy of (your) research," however, would require knowledge we do not have about the basic assumptions from which you proceed. We could, perhaps, guess about the degree to which the perceptions of hospital Directors of Personnel affirm registered nurses' reasons for organizing behavior, but dare not speculate. We cannot verify, for example, that this survey among Directors of Personnel could or should be considered a justifiable hospital response to the perceived job satisfaction of its nurses. From my painfully small knowledge base of what you have stated as your purpose, it would be easier to accept an effort to establish a direct relationship between observable evidence of nurses' organizing behavior and hospitals' observable response to it (We have two hospitals in New Hampshire which should be able to document that data as relates to organizing experiences in 1986). Hospital and union attorneys would seem to be another source of direct information.

Forgive my apparent intrusion into what I'm sure is already a very complex experience for you, Jill. I have tried to explain why NHHA cannot verify the legitimacy of your research without further information. If the attached statement, modified according to this letter, is helpful to you, please feel free to use it.

Sincerely,

Irene Peters

H. Irene Peters
Vice President

HIP/al

Encl.

125 AIRPORT ROAD/CONCORD, NEW HAMPSHIRE 03301/(603) 225-0900

New Hampshire Hospital ssociation

May 9, 1986
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New Hampshire Hospital Association

May 20, 1986

The New Hampshire Hospital Association has verified with Professor John Seavey, Program in Health Administration and Planning, School of Health Studies, University of New Hampshire, that Jill Kriesky is a Ph.D. candidate at the University of New Hampshire. The NHHA assumes that Ms. Kriesky will hold responses to this survey in confidence, but has insufficient information to verify the legitimacy of her research.

by H. Irene Peters

H. Irene Peters
Vice President
NEW HAMPSHIRE HOSPITAL
ASSOCIATION

125 AIRPORT ROAD/CONCORD, NEW HAMPSHIRE 03301/(603) 225-0900

APPENDIX F

CORRESPONDENCE FROM DUNCAN BRINES, VICE PRESIDENT, VERMONT HOSPITAL ASSOCIATION

VERMONT HOSPITAL ASSOCIATION
148 MAIN STREET, MONTPELIER, VERMONT 05602 • 802/223-3461

May 22, 1986

Ms. Jill Kriesky
Ph.D. Candidate
The Whittemore School of
Business and Economics
University of New Hampshire
McConnell Hall
Durham, NH 03824

Dear Ms. Kriesky:

Enclosed is a copy of the memo which I have sent to Vermont hospitals regarding your proposed survey. I did have the opportunity of talking with Professor Richard Hurd regarding your dissertation prior to mailing out this memo. As you can see from the memo, I still have some concerns regarding the sensitive nature of the information involved with the survey.

In addition to talking with Professor Hurd, I also took the time to talk with Bob O'Donnell who is the personnel director at the Central Vermont Medical Center. He shared my concerns regarding some of the questions in the survey. He also suggested that the survey may be an appropriate discussion item for the next meeting of the Vermont Hospital Personnel Association. I take the liberty of suggesting that you might want to call Mr. O'Donnell at (802) 229-9121 to discuss this possibility. As I had discussed with Professor Hurd, I think that a successful survey will require a certain selling effort on your part. Given a clear understanding of the nature of your research work, perhaps hospital personnel directors will be favorably inclined regarding the survey.

I am sure from your perspective the memo which I have sent to Vermont hospitals appears somewhat negative. At the same time, I think the opportunity exists for you to make your case with the hospital personnel directors, and I encourage you to do so.

Please give me a call if you have any questions.

Sincerely,

Duncan S. Brines
Vice President

DSB/et

Enclosure

cc: Robert O'Donnell

VERMONT HOSPITAL ASSOCIATION
148 MAIN STREET, MONTPELIER, VERMONT 05602 • 802/223-3461

To: Chief Executive Officers
Personnel Directors

From: Duncan S. Brines, Vice President DSB

Date: May 22, 1986

Re: Survey Regarding Union Organizing Activity

Enclosed is a letter which was sent to Norm Wright by a Ph.D. candidate at the University of New Hampshire named Jill Kriesky. This letter served as a cover letter to a survey which Ms. Kriesky had previously sent to hospitals in Vermont, New Hampshire and Maine. As you can see, she targeted her survey to hospitals with more than 50 beds. VHA staff have reviewed the survey document and have concluded that the survey would contain sensitive information were it to be completed. VHA cannot endorse this survey.

Concerns regarding the Kriesky survey center around two areas. The survey document does call for hospital identification. Although Ms. Kriesky states that hospital-specific information will remain confidential, there does not appear to be any special mechanism to ensure that this takes place. Secondly, much of the information on the survey involves sensitive issues for hospitals. The release of this data to third parties could, at the very least, cause public relations problems for hospitals in general. This isn't to say that Ms. Kriesky would purposefully release the data but does suggest that upon completion the dissertation will be a public document.

Ms. Kriesky has asked the Vermont Hospital Association to verify the legitimacy of her research. VHA has discussed this situation with Ms. Kriesky and has verified that she is indeed a student. Such verification should not be construed as an endorsement of the survey. VHA suggests that if individual hospitals are interested in participating in the survey, they may wish to obtain some kind of assurance regarding confidentiality. I have also suggested to Ms. Kriesky that she may want to contact the Vermont Hospital Personnel Association regarding the relative merits of the survey.

If you have any questions regarding this survey, please give me a call. Chief Executive Officers may also want to talk to their personnel directors regarding the survey.

/et

Enclosure

APPENDIX G

CONFIDENTIALITY STATEMENT SENT TO SURVEY HOSPITALS

UNIVERSITY OF NEW HAMPSHIRE

The Whittemore School of Business and Economics
McConnell Hall
Durham, New Hampshire 03824
(603) 862-2771

We have reviewed Ms. Kriesky's questionnaire to hospital human resource directors. This questionnaire is part of her dissertation necessary for the fulfillment of the requirements for a Ph.D. in Economics from the Whittemore School of Business and Economics. The survey has been approved by the University's Institutional Research Board for assurances of participant confidentiality and protection of human subjects. She is the only individual who will have a record of responses in order to resolve statistical sampling problems as well as to resolve any discrepancies or inconsistencies in the responses. All data will be aggregated so as to avoid the identification of any respondent or institution.

Professor Richard Hurd
Whittemore School of Business
and Economics

Professor John Seavey
School of Health Studies

APPENDIX H

SUPPLEMENTARY TABLE--CHAPTER FIVE

Table 28 --Reasons for policy changes in hospitals without RN unions

Policy Category Individual policy	Union Activity Influencing Change	No. of Hospitals Naming Factor
Wage-benefits package		
Wage grade/step structure	RN activity in other hospitals	1
Advancement-transfer		
Transfer	Activity among own RNs	1
Continuing education	Activity among own RNs	1
Participation in policy making		
Periodic meetings with RN committees	Activity among own RNs	1
Management-RN relations		
"Open door" policy	RN activity in other hospitals	1
Grievance procedure	RN activity in other hospitals	1
	Activity among own RNs	1

APPENDIX I

SUPPLEMENTARY TABLES--CHAPTER SIX

Table 29.--Frequency tables of union activity in nonunionized hospitals

Type of Union Activity	No. Reporting Activity	Percent Reporting Activity
Informational meeting(s) for RNs sponsored by a union	8	30.77
Informational leafletting of RNs by a union	8	30.77
Informational picketing by a union seeking to represent RNs	2	7.69
Establishment of an RN organizing committee sponsored by a union	5	19.23
Establishment of an independent RN committee to present grievances	3	11.54
Distribution of union authorization cards among RNs	5	19.23
NLRB-conducted representation election for an RN unit	2	7.69
Collective bargaining with a union representing RNs	0	0.00
Other activity	1	3.85
Report of any type of union activity among RNs	11	42.31
Management consultant or labor lawyer hired by hospital	10	38.46

Table 30.--Relationship between RN union activity and consultant use

Type of Union Activity	Chi Square Statistic	p Value
Report of any type of union activity among RNs	18.30	$p \leq .001$
Informational meeting(s) for RNs sponsored by a union	9.81	$.001 < p \leq .01$
Informational leafletting of RNs by a union	9.81	$.001 < p \leq .01$
Informational picketing by a union seeking to represent RNs	4.12	$.02 < p \leq .05$
Establishment of an RN organizing committee sponsored by a union	8.13	$.001 < p \leq .01$
Establishment of an independent RN committee to present grievances	4.12	$.02 < p.05$
Distribution of union authorization cards among RNs	13.60	$p \leq .001$
NLRB-conducted representation election for an RN unit	7.44	$.001 < p \leq .01$
Collective bargaining with a union representing RNs	4.12	$.02 < p \leq .05$
Other activity	1.28	$.20 < p \leq .30$*

*Iman and Conover (1983, 318) note that the chi-square distribution is a good approximation of the distribution of T if expected values (E_{ij}) are large. Where $E_{ij} < .5$, they recommend combining rows or columns to raise these low values. Since the following contingency tables are 2x2, such combinations were not possible. Thus, where $E_{ij} < .5$, asterisks indicate that conclusions drawn from these results should be qualified.

Table 31.--Awareness of union activity among a hospital's other workers

Type of Union Activity	No. Reporting Activity	Percent Reporting Activity
Informational meetings, leafletting, and/or picketing by a union seeking to represent other hospital workers	6	20.69
A formal union organizing campaign culminating in a NLRB-supervised election for other hospital workers	1	3.57
Collective bargaining with a union representing other hospital workers	0	0
Other	0	0
Use of management consultant or labor lawyer for the activity	5	17.86

Table 32.--Relationship between consultant use and union activity among a hospital's other workers

Type of Union Activity	Chi Square Statistic	p Value
Informational meetings, leafletting, and/or picketing by a union seeking to represent an employee group	16.00	$p < .001$
A formal union organizing campaign culminating in an NLRB-supervised election for an employee group	4.77	$.20 < p \leq .05$*
Collective bargaining with a union which represents an employee group	*	*
Other	*	*

* No hospitals report collective bargaining or other activity with employee groups other than nurses.

Table 33.--Relationship between union activity among RNs in other area hospitals, internal organizing activity, and consultant use

Type of Union Activity among RNs in Other Area Hospitals	Chi Square Statistic	p Value
Versus internal union activity		
Informational meetings, leafletting, and/or picketing by a union seeking to represent RNs	8.43	$.001 < p \leq .01$
A formal union organizing campaign culminating in a NLRB-supervised election for RNs	3.28	$.05 < p \leq .10$
Collective bargaining with a union representing RNs	.94	$.30 < p \leq .50$
Versus consultant use		
Informational meetings, leafletting, and/or picketing by a union seeking to represent RNs	5.19	$.02 < p \leq .05$
A formal union organizing campaign culminating in a NLRB-supervised election for RNs	1.74	$.10 < p \leq .20$
Collective bargaining with a union representing RNs	.22	$.50 < p \leq .70$

Table 34.--Relationship between past union activity, past consultant use, and evaluation of the likelihood of future union activity

Evaluation of Future Activity vs.:	Past Union Activity Chi Square p Value	PastConsultant Use Chi Square p Value
Likelihood that one's RNs will attempt to organize in next 2 years	5.06 $.02 < p \leq .05$	2.82 $.05 < p \leq .10$
Likelihood that the hospital will hire a consultant in response to a unionization effort	2.59 $.10 < p \leq .20$	.55 $.30 < p \leq .50$
Likelihood that the RNs will succeed in forming a union at one's hospital in the next 2 years	.03 $.80 < p \leq .90$	.09 $.70 < p \leq .80$

Table 35.--Relationship between union activity and significance of policy category to RN satisfaction

Policy Category	Chi Square Statistic	p Value
Wage-benefits package	.16	$.50 < p \leq .70$
Work schedules	.04	$.80 < p \leq .90$
Advancement-transfer	.004	$p > .95$
Women's issues	2.37	$.10 < p \leq .20$
Management-RN relations	.04	$.80 < p \leq .90$
Participation in policy making	.28	$.50 < p \leq .70$

Table 36.--Relationship between union activity and the number of individual policies in a policy category

Policy category	Chi Square Statistic	p Value
Wage-benefits package	.74	$.30 < p \leq .50$
Work schedules	.01	$.90 < p \leq .95$
Advancement-transfer	.05	$.80 < p \leq .90$
Women's issues	1.26	$.20 < p \leq .30$
Management-RN relations	2.74	$.05 < p \leq .10$
Participation in policy making	1.26	$.20 < p \leq .30$

Table 37.--Relation between use of individual policies and union activity

	Chi Square Statistic	p Value
RN wage-benefits package		
Uniform wage rates for specific job titles	.16	.70 < p ≤ .80
Wage grade/step structure	.11	.70 < p ≤ .80
Vacation policy	.76	.30 < p ≤ .50
Retirement benefits	.76	.30 < p ≤ .50
Medical insurance cover	*	
In-house health services	.01	.90 < p ≤ .95
Discount services	1.59	.20 < p ≤ .30
Reimbursement for college courses	1.42	.20 < p ≤ .30
Other	1.42	.20 < p ≤ .30
RN work schedules		
Overtime work	.82	.30 < p ≤ .50
Shift preference	.11	.70 < p ≤ .80
Layoff/recall	.03	.80 < p ≤ .90
Flextime	.16	.50 < p ≤ .70
Other	7.39	.001 < p ≤ .01
RN advancement-transfer		
Promotion	.05	.80 < p ≤ .90
Transfer	1.42	.20 < p ≤ .30
Continuing education	.05	.80 < p ≤ .90
Other	2.96	.05 < p ≤ .10
Women's issues		
Sexual harassment	.01	.90 < p ≤ .95
Day care	2.34	.10 < p ≤ .20
Maternity leave	.76	.30 < p ≤ .50
Other	.76	.30 < p ≤ .50

Table 37.--Continued

	Chi Square Statistic	p Value
Management-RN relations		
Planned orientation for new RNs	*	
Exit interviews with departing RNs	1.42	$.20 < p \leq .30$
Head nurses encouraged to spend additional time on their floors	2.1	$.10 < p \leq .20$
Bulletin boards carrying management's messages	3.5	$.05 < p \leq .10$
Speeches by top management	1.01	$.30 < p \leq .50$
An employee handbook	1.59	$.20 < p \leq .30$
In-house newspaper or newsletter	.76	$.30 < p \leq .50$
An "open door" policy giving RN a chance to take complaints to top management	.01	$.90 < p \leq .95$
Complaints handled through the RN's direct supervisor	.58	$.30 < p \leq .50$
Formal grievance procedure	*	
Other	1.42	$.20 < p \leq .30$
RN participation in policymaking		
A suggestion box for anonymous comments	.45	$.50 < p \leq .70$
Periodic individual interviews with RNs allowing them to express job concerns	1.77	$.10 < p \leq .20$
Periodic meetings with RN committees allowing them to express job concerns	.26	$.50 < p \leq .70$
Other	1.90	$.10 < p \leq .20$

*All respondents report use of this individual policy.

Table 38.--Relationship between union activity and occurrence of change in policy category

Policy category	Chi Square Statistic	p Value
Wage-benefits package	.04	$.80 < p \leq .90$
Work schedule	1.26	$.20 < p \leq .30$
Advancement-transfer	.28	$.50 < p \leq .70$
Women's issues	1.03	$.30 < p \leq .50$
Management-RN relations	.04	$.80 < p \leq .90$
Participation in policy making	.83	$.30 < p \leq .50$

Table 39.--Relationship between consultant use and significance of policy category to RN satisfaction

Policy category	Chi Square Statistic	p Value
Wage-benefits package	0	$p > .95$
Work schedules	.02	$.80 < p \leq .90$
Advancement-transfer	.25	$.50 < p \leq .70$
Women's issues	.10	$.70 < p \leq .80$
Management-RN relations	.02	$.80 < p \leq .90$
Participation in policy making	.65	$.70 < p \leq .80$

Table 40.--Relationship between consultant use and number of individual policies in a policy category

Policy category	Chi Square Statistic	p Value
Wage-benefits package	.40	$.50 < p \leq .70$
Work schedules	3.87	$.02 < p \leq .05$
Advancement-transfer	.12	$.70 < p \leq .80$
Women's issues	.89	$.30 < p \leq .50$
Management-RN relations	.25	$.50 < p \leq .70$
Participation in policy making	.01	$.90 < p \leq .95$

Table 41.--Relation between use of individual policies and consultant use

	Chi Square Statistic	p Value
RN wage-benefits package		
Uniform wage rates for specific job titles	.26	$.50 < p \leq .70$
Wage grade/step structure	.04	$.50 < p \leq .70$
Vacation policy	.65	$.30 < p \leq .50$
Retirement benefits	.65	$.30 < p \leq .50$
Medical insurance cover	*	
In-house health services	.006	$.90 < p \leq .95$
Discount services	1.35	$.20 < p \leq .30$
Reimbursement for college courses	1.66	$.10 < p \leq .20$
Other	0	$p > .95$
RN work schedules		
Overtime work	2.12	$.10 < p \leq .20$
Shift preference	.04	$.80 < p \leq .90$
Layoff/recall	1.53	$.20 < p \leq .30$
Flextime	.65	$.30 < p \leq .50$
Other	4.40	$.02 < p \leq .05$
RN advancement-transfer		
Promotion	.12	$.70 < p \leq .80$
Transfer	1.66	$.10 < p \leq .20$
Continuing education	.12	$.70 < p \leq .80$
Other	.12	$.70 < p \leq .80$
Women's issues		
Sexual harassment	.89	$.30 < p \leq .50$
Day care	1.25	$.20 < p \leq .30$
Maternity leave	.65	$.30 < p \leq .50$
Other	.65	$.30 < p \leq .50$

Table 41.--Continued

	Chi Square Statistic	p Value
Management-RN relations		
Planned orientation for new RNs	*	
Exit interviews with departing RNs	1.66	.10 < p ≤ .20
Head nurses encouraged to spend additional time on their floors	1.57	.20 < p ≤ .30
Bulletin boards carrying management's messages	2.96	.05 < p ≤ .10
Speeches by top management	.02	.80 < p ≤ .90
An employee handbook	1.35	.20 < p ≤ .30
In-house newspaper or newsletter	.65	.30 < p ≤ .50
An "open door" policy giving RN a chance to take complaints to top management	.006	.90 < p ≤ .95
Complaints handled through the RN's direct supervisor	.36	.50 < p ≤ .70
Formal grievance procedure	*	
Other	1.66	.10 < p ≤ .20
RN participation in policymaking		
A suggestion box for anonymous comments	.15	.50 < p ≤ .70
Periodic individual interviews with RNs allowing them to express job concerns	.04	.80 < p ≤ .90
Periodic meetings with RN committees allowing them to express job concerns	.09	.70 < p ≤ .80
Other	.44	.50 < p ≤ .70

*All respondents report use of this individual policy.

Table 42.--Relationship between consultant use and occurrence of change in a policy category

Policy category	Chi Square Statistic	p Value
Wage-benefits package	.20	$.50 < p \leq .70$
Work schedules	2.57	$.10 < p \leq .20$
Advancement-transfer	.65	$.30 < p \leq .50$
Women's issues	1.96	$.10 < p \leq .20$
Management-RN relations	.04	$.80 < p \leq .90$
Participation in policy making	1.99	$.10 < p \leq .20$

Table 43.--Consultant use, union activity and the perceived effectiveness of change in policy categories

	Ineffective*	Effective*
Consultant Use		
Wage-benefits package		
Hospitals not using consultants	0	8
Hospitals using consultants	0	5
Work schedules		
Hospitals not using consultants	0	4
Hospitals using consultants	0	5
Advancement-transfer		
Hospitals not using consultants	0	3
Hospitals using consultants	0	3
Women's issues		
Hospitals not using consultants	2	1
Hospitals using consultants	2	2
	(Chi Square = .19; .50 < p ≤ .70)	
Management-RN relations		
Hospitals not using consultants	0	5
Hospitals using consultants	0	3
Participation in policy making		
Hospitals not using consultants	1	4
Hospitals using consultants	0	5
	(Chi Square = 1.1; .20 < p ≤ .30)	
Union Activity		
Wage-benefits package		
Hospitals without union activity	0	8
Hospitals with union activity	0	5
Work schedules		
Hospitals not using consultants	0	4
Hospitals using consultants	0	5
Advancement-transfer		
Hospitals not using consultants	0	4
Hospitals using consultants	0	2
Women's issues		
Hospitals not using consultants	1	2
Hospitals using consultants	3	1

Table 43.--Continued

	Ineffective*	Effective*
Hospitals not using consultants	0	5
Hospitals using consultants	0	3
Participation in policy making		
Hospitals not using consultants	1	4
Hospitals using consultants	0	5
(Chi Square = 1.1; .20 < p ≤ .30)		

* Ratings of 1 or 2 were classed as ineffective; ratings of 3, 4, or 5 were classed as effective.

Table 44.--Relation between awareness of union activity in other hospitals and policy variables

	Chi Square Statistic	p Value
Significance of Policy Category to RN Job Satisfaction		
Wage-benefits package	1.01	.30 < p ≤ .50
Work schedules	3.14	.05 < p ≤ .10
Advancement-transfer	1.39	.20 < p ≤ .30
Women's issues	4.40	.02 < p ≤ .05
Management-RN relations	2.43	.10 < p ≤ .20
Participation in policy making	.71	.30 < p ≤ .50
Number of Policies in a Category		
Wage-benefits package	.71	.70 < p ≤ .80
Work schedules	.003	p > .95
Advancement-transfer	.76	.30 < p ≤ .50*
Women's issues	2.70	.10 < p ≤ .20
Management-RN relations	1.39	.20 < p ≤ .30
Participation in policy making	.29	.50 < p ≤ .70
Change Made in Policy Category		
Wage-benefits package	.004	.90 < p ≤ .95
Work schedules	2.59	.10 < p ≤ .20
Advancement-transfer	1.27	.20 < p ≤ .30
Women's issues	2.08	.10 < p ≤ .20
Management-RN relations	.21	.50 < p ≤ .70
Participation in policy making	1.25	.20 < p ≤ .30

Table 45.--Relation between evaluation of nurses' propensity to attempt organizing within two years and policy variables

	Chi Square Statistic	p Value
Significance of Policy Category to RN Job Satisfaction		
Wage-benefits package	.70	$.30 < p \leq .50$
Work schedules	.02	$.90 < p \leq .95$
Advancement-transfer	0	$p > .95$
Women's issues	.70	$.30 < p \leq .50$
Management-RN relations	3.37	$.05 < p \leq .10$
Participation in policy making	.26	$.50 < p \leq .70$
Number of Policies in a Category		
Wage-benefits package	.26	$.50 < p \leq .70$
Work schedules	.93	$.30 < p \leq .50$
Advancement-transfer	1.34	$.20 < p \leq .30$
Women's issues	.22	$.50 < p \leq .70$
Management-RN relations	0	$p > .95$
Participation in policy making	.39	$.50 < p \leq .70$
Change Made in Policy Category		
Wage-benefits package	.19	$.50 < p \leq .70$
Work schedules	.88	$.30 < p \leq .50$
Advancement-transfer	0	$p > .95$
Women's issues	.40	$.50 < p \leq .70$
Management-RN relations	3.01	$.05 < p \leq .10$
Participation in policy making	.21	$.50 < p \leq .70$

Table 46.--Relation between evaluation of nurses' propensity to organize successfully and policy variables

	Chi Square Statistic	p Value
Significance of Policy Category to RN Job Satisfaction vs.		
Wage-benefits package	.003	$p > .95$
Work schedules	1.27	$.20 < p \leq .30$
Advancement-transfer	.003	$p > .95$
Women's issues	.003	$p > .95$
Management-RN relations	1.27	$.20 < p \leq .30$
Participation in policy making	1.08	$.20 < p < .30$
Number of Policies in a Category		
Wage-benefits package	.91	$.30 < p \leq .50$
Work schedules	.76	$.30 < p \leq .50$
Advancement-transfer	.27	$.50 < p \leq .70$*
Women's issues	.49	$.30 < p \leq .50$*
Management-RN relations	.003	$p > .95$
Participation in policy making	1.42	$.20 < p \leq .30$*
Change Made in Policy Category		
Wage-benefits package	.13	$.70 < p < .80$
Work schedules	1.82	$.10 < p \leq .20$
Advancement-transfer	.95	$.30 < p \leq .50$
Women's issues	.09	$.70 < p \leq .80$
Management-RN relations	1.36	$.20 < p \leq .30$
Participation in policy making	.005	$.90 < p \leq .95$

Table 47.--Relationship between use of individual policies and awareness of organizing activity in other hospitals

	Chi Square Statistic	p Value
RN Wage-benefits package		
Uniform wage rates for specific job titles	1.19	.20 < p ≤ .30
Wage grade/step structure	.29	.50 < p ≤ .70
Vacation policy	.20	.50 < p ≤ .70
Retirement benefits	.20	.50 < p ≤ .70
Medical insurance cover	*	
In-house health services	1.77	.10 < p ≤ .20
Discount services	1.87	.10 < p ≤ .20
Reimbursement for college courses	.20	.50 < p ≤ .70
Other	.008	.90 < p ≤ .95
RN Work Schedules		
Overtime work	.76	.30 < p ≤ .50
Shift preference	4.10	.02 < p ≤ .05
Layoff/recall	.25	.50 < p ≤ .70
Flextime	1.86	.10 < p ≤ .20
Other	1.85	.10 < p ≤ .20
RN Advancement-transfer		
Promotion	.76	.30 < p ≤ .50
Transfer	.20	.50 < p ≤ .70
Continuing education	1.87	.10 < p ≤ .20
Other	.41	.50 < p ≤ .70
Women's Issues		
Sexual harassment	2.68	.10 < p ≤ .20
Day care	.008	.90 < p ≤ .95
Maternity leave	.20	.50 < p ≤ .70
Other	*	

Table 47.--Continued

	Chi Square Statistic	p Value
Management-RN relations		
Planned orientation for new RNs	*	
Exit interviews with departing RNs	.41	.50 < p ≤ .70
Head nurses encouraged to spend additional time on their floors	5.22	.02 < p ≤ .05
Bulletin boards carrying management's messages	2.68	.10 < p ≤ .20
Speeches by top management	.41	.50 < p ≤ .70
An employee handbook	.41	.50 < p ≤ .70
In-house newspaper or newsletter	.20	.50 < p ≤ .70
An "open door" policy for RN to take complaints to top management	.003	p > .95
Complaints handled through the RN's direct supervisor	.07	.70 < p ≤ .80
Formal grievance procedure	*	
Other	.20	.50 < p ≤ .70
RN Participation in Policymaking		
A suggestion box for comments	.11	.70 < p ≤ .80
Periodic individual interviews with RNs allowing them to express concerns	.20	.50 < p ≤ .70
Periodic meetings with RN committees allowing them to express concerns	1.85	.10 < p ≤ .20
Other	1.50	.20 < p ≤ .30

*All respondents report use of this individual policy.

APPENDIX J

SUPPLEMENTARY TABLES--CHAPTER SEVEN

Table 48.--Relation between policy variables and workload measures

	Beds/FTE RN (Chi Square, p Value)	Occupancy Rate (Chi Square, p Value)
Significance of Policy Category to RN Job Satisfaction		
Wage-benefitspackage	2.29 .10 < p ≤ .20	2.29 .10 < p ≤ .20
Work schedules	.62 .30 < p < .50	0 p > .95
Advancement-transfer	2.29 .10 < p ≤ .20	2.29 .10 < p ≤ .20
Women's issues	2.29 .10 < p ≤ .20	0 p > .95
Management-RNrelations	3.74 .05 < p ≤ .10	1.35 .20 < p ≤ .30
Participation in policy making	4.09 .02 < p ≤ .05	.16 .50 < p ≤ .70
Number of Individual Policies in a Category		
Wage-benefitspackage	1.47 .20 < p ≤ .30	4.09 .02 < p ≤ .05
Work schedules	.19 .50 < p ≤ .70	.19 .50 < p ≤ .70
Advancement-transfer	.37 .50 < p ≤ .70	.37 .50 < p ≤ .70
Women's issues	.24 .50 < p ≤ .70	.24 .50 < p ≤ .70
Management-RNrelations	.57 .30 < p ≤ .50	2.29 .10 < p ≤ .20
Participation in policy making	2.19 .10 < p ≤ .20	1.29 .20 < p ≤ .30
Change Made in Policy Category		
Wage-benefitspackage	.79 .30 < p ≤ .50	.32 .50 < p ≤ .70

Table 48.--Continued

	Beds/FTE RN (Chi Square, p Value)	Occupancy Rate (Chi Square, p Value)
Work schedules	2.29 .10 < p ≤ .20	1.29 .20 < p ≤ .30
Advancement-transfer	.02 .80 < p ≤ .90	.02 .80 < p ≤ .90
Women's issues	.03 .80 < p ≤ .90	.53 .30 < p ≤ .90
Management-RN relations	.63 .30 < p ≤ .50	.19 .50 < p ≤ .70
Participation in policy making	2.93 .05 < p ≤ .10	.18 .50 < p ≤ .70

Table 49.--Relation between use of individual policies and beds/FTE RN

	Chi Square Statistic	p Value
RN wage-benefits package		
Uniform wage rates for specific job titles	.24	.50 < p ≤ .70
Wage grade/step structure	0	p > .95
Vacation policy	1.04	.30 < p ≤ .50
Retirement benefits	0	p > .95
Medical insurance cover	.84	.30 < p ≤ .50
In-house health services	0	p > .95
Discount services	0	p > .95
Reimbursement for college courses	1.04	.30 < p ≤ .50
Other	3.59	.05 < p ≤ .10
RN work schedules		
Overtime work	1.11	.20 < p ≤ .30
Shift preference	1.17	.20 < p ≤ .30
Layoff/recall	4.09	.02 < p ≤ .05
Flextime	3.59	.05 < p ≤ .10
Other	9.33	.001 < p ≤ .01
RN advancement-transfer		
Promotion	.37	.50 < p ≤ .70
Transfer	1.04	.30 < p ≤ .50
Continuing education	2.15	.10 < p ≤ .20
Other	0	p > .95
Women's issues		
Sexual harassment	.24	.50 < p ≤ .70
Day care	2.33	.10 < p ≤ .20
Maternity leave	1.04	.30 < p ≤ .50
Other	1.04	.30 < p ≤ .50

Table 49.--Continued

	Chi Square Statistic	p Value
Management-RNrelations		
Planned orientation for new RNs	*	
Exit interviews with departing RNs	0	$p \geq .95$
Head nurses encouraged to spend additional time on their floors	1.71	$.10 < p \leq .20$
Bulletin boards carrying management's messages	.24	$.50 < p \leq .70$
Speeches by top management	.15	$.70 < p \leq .80$
An employee handbook	2.15	$.10 < p \leq .20$
In-house newspaper or newsletter	1.04	$.30 < p \leq .50$
An "open door" policy giving RN a chance to take complaints to top management	0	$p > .95$
Complaints handled through the RN's direct supervisor	.84	$.30 < p \leq .50$
Formal grievance procedure	*	
Other	1.04	$.30 < p \leq .50$
RN participation in policymaking		
A suggestion box for anonymous comments	0	$p > .95$
Periodic individual interviews with RNs allowing them to express job concerns	0	$p > .95$
Periodic meetings with RN committees allowing them to express job concerns	.19	$.50 < p \leq .70$
Other	3.39	$.05 < p \leq .10$

*All respondents report use of this individual policy.

Table 50.--Relation between policy variables and hospital size measures

	No. of Beds (Chi Square, p Value)	No. of FTE RNs (Chi Square, p Value)
Significance of Policy Category to RN Job Satisfaction		
Wage-benefitspackage	.57 .30 < p ≤ .50	.57 .30 < p ≤ .50
Work schedules	0 p > .95	0 p > .95
Advancement-transfer	5.14 .02 < p ≤ .05	5.14 .02 < p ≤ .05
Women's issues	0 p > .95	0 p > .95
Management-RNrelations	1.35 .20 < p ≤ .30	1.35 .20 < p ≤ .30
Participation in policy making	1.47 .20 < p ≤ .30	1.47 .20 < p ≤ .30
Number of Individual Policies in a Category		
Wage-benefitspackage	8.02 .001 < p ≤ .01	8.02 .001 < p ≤ .01
Work schedules	.19 .50 < p ≤ .70	.19 .50 < p ≤ .70
Advancement-transfer	.37 .50 < p ≤ .70	.37 .50 < p ≤ .70
Women's issues	.24 .50 < p ≤ .70	.24 .50 < p ≤ .70
Management-RNrelations	5.14 .02 < p ≤ .05	5.14 .02 < p ≤ .05
Participation in policy making	2.19 .10 < p ≤ .20	2.19 .10 < p ≤ .20
Change Made in Policy Category		
Wage-benefitspackage	.79 .30 < p ≤ .50	.79 .30 < p ≤ .50

Table 50.--Continued

	No. of Beds (Chi Square, p Value)	No. of FTE RNs (Chi Square, p Value)
Work schedules	2.29 .10 < p ≤ .20	2.29 .10 < p ≤ .20
Advancement-transfer	.02 .80 < p ≤ .90	.02 .80 < p ≤ .90
Women's issues	1.15 .20 < p ≤ .30	1.15 .20 < p ≤ .30
Management-RNrelations	.63 .30 < p ≤ .50	.63 .30 < p ≤ .50
Participation in policy making	.73 .30 < p ≤ .50	.73 .30 < p ≤ .50

Table 51.--Relation between use of individual policies and number of hospital beds

	Chi Square Statistic	p Value
RN wage-benefits package		
Uniform wage rates for specific job titles	.24	.50 < p ≤ .70
Wage grade/step structure	4.66	.02 < p ≤ .05
Vacation policy	1.04	.30 < p ≤ .50
Retirement benefits	2.15	.10 < p ≤ .20
Medical insurance cover	*	
In-house health services	7.64	.001 < p ≤ .01
Discount services	2.15	.10 < p ≤ .20
Reimbursement for college courses	1.04	.30 < p ≤ .50
Other	1.29	.20 < p ≤ .30
RN work schedules		
Overtime work	1.17	.20 < p ≤ .30
Shift preference	1.17	.20 < p ≤ .30
Layoff/recall	1.47	.20 < p ≤ .30
Flextime	3.59	.05 < p ≤ .10
Other	4.76	.02 < p ≤ .05
RN advancement-transfer		
Promotion	.37	.50 < p ≤ .70
Transfer	1.04	.30 < p ≤ .50
Continuing education	2.15	.10 < p ≤ .20
Other	2.15	.10 < p ≤ .20
Women's issues		
Sexual harassment	.24	.50 < p ≤ .70
Day care	2.33	.10 < p ≤ .20
Maternity leave	1.04	.20 < p ≤ .30
Other	1.04	.20 < p ≤ .30

Table 51.--Continued

	Chi Square Statistic	p Value
Management-RNrelations		
Planned orientation for new RNs	*	
Exit interviews with departing RNs	0	$p > .95$
Head nurses encouraged to spend additional time on their floors	.19	$.50 < p \leq .70$
Bulletin boards carrying management's messages	.24	$.50 < p \leq .70$
Speeches by top management	1.35	$.20 < p \leq .30$
An employee handbook	0	$p > .95$
In-house newspaper or newsletter	1.04	$.30 < p \leq .50$
An "open door" policy giving RN a chance to take complaints to top management	0	$p > .95$
Complaints handled through the RN's direct supervisor	7.64	$.001 < p \leq .01$
Formal grievance procedure	*	
Other	1.04	$.30 < p \leq .50$
RN participation in policymaking		
A suggestion box for anonymous comments	.16	$.50 < p \leq .70$
Periodic individual interviews with RNs allowing them to express concerns	.58	$.30 < p \leq .50$
Periodic meetings with RN committees allowing them to express concerns	.19	$.50 < p \leq .70$
Other	3.39	$.05 < p \leq .10$

*All respondents report use of this individual policy.

Table 52.--Relation between policy variables and measures of city size*

	Chi Square Statistic	p Value
Significance of Policy Category to RN Job Satisfaction		
Wage-benefitspackage	.57	.30 < p ≤ .50
Work schedules	0	p > .95
Advancement-transfer	2.86	.10 < p ≤ .20
Women's issues	0	p > .95
Management-RNrelations	.15	p > .95
Participation in policy making	.16	.50 < p < .70
Number of Individual Policies in a Category		
Wage-benefitspackage	4.09	.02 < p ≤ .05
Work schedules	1.71	.10 < p ≤ .20
Advancement-transfer	3.36	.05 < p ≤ .10
Women's issues	.24	.50 < p < .70
Management-RNrelations	.57	.30 < p ≤ .50
Participation in policy making	2.19	.10 < p ≤ .20
Change Made in Policy Category		
Wage-benefitspackage	3.14	.05 < p ≤ .10
Work schedules	10.75	.001 < p ≤ .01
Advancement-transfer	4.30	.02 < p ≤ .05
Women's issues	3.88	.02 < p ≤ .05
Management-RNrelations	6.42	.10 < p ≤ .20
Participation in policy making	6.60	.10 < p ≤ .20

* Cities were classed as either below the median or as at or above the median in size.

Table 53.--Relation between use of individual policies and city size

	Chi Square Statistic	p Value
Wage-benefitspackage		
Uniform wage rates for specific job titles	.24	.50 < p ≤ .70
Wage grade/step structure	1.17	.20 < p ≤ .30
Vacation policy	1.04	.30 < p ≤ .50
Retirement benefits	2.15	.10 < p ≤ .20
Medical insurance cover	*	
In-house health services	3.39	.05 < p ≤ .10
Discount services	2.15	.10 < p ≤ .20
Reimbursement for college courses	1.04	.30 < p ≤ .50
Other	1.29	.20 < p ≤ .30
RN work schedules		
Overtime work	1.17	.30 < p ≤ .50
Shift preference	4.67	.02 < p ≤ .05
Layoff/recall	.16	.50 < p ≤ .70
Flextime	.14	.70 < p ≤ .80
Other	1.71	.10 < p ≤ .20
RNadvancement-transfer		
Promotion	3.36	.05 < p ≤ .10
Transfer	1.04	.30 < p ≤ .50
Continuingeducation	0	p > .95
Other	0	p > .95
Women's issues		
Sexual harassment	.24	.50 < p ≤ .70
Day care	2.33	.10 < p ≤ .20
Maternity leave	1.04	.50 < p ≤ .70
Other	1.04	.50 < p ≤ .70

Table 53.--Continued

	Chi Square Statistic	p Value
Management/RNrelations		
Planned orientation for new RNs	*	
Exit interviews with departing RNs	0	$p > .95$
Head nurses encouraged to spend additional time on their floors	.19	$.50 < p \leq .70$
Bulletin boards carrying management's messages	2.19	$.10 < p \leq .20$
Speeches by top management	.15	$.70 < p \leq .80$
An employee handbook	0	$p > .95$
In-house newspaper or newsletter	1.04	$.30 < p \leq .50$
An "open door" policy giving RN a chance to take complaints to top management	.84	$.30 < p \leq .50$
Complaints handled through the RN's direct supervisor	3.39	$.05 < p \leq .10$
Formal grievance procedure	*	
Other	1.04	$.30 < p \leq .50$
RN participation in policymaking		
A suggestion box for anonymous comments	1.47	$.20 < p \leq .30$
Periodic individual interviews with RNs allowing them to express job concerns	.58	$.30 < p \leq .50$
Periodic meetings with RN committees allowing them to express job concerns	1.71	$.10 < p \leq .20$
Other	0	$p > .95$

*All respondents report use of this individual policy.

Table 54.--Relation between policy variables and state in which hospital is located

	Chi Square Statistic	p Value
Significance of Policy Category to RN Job Satisfaction		
Wage-benefitspackage	1.35	$.20 < p \leq .30$
Work schedules	.75	$.30 < p \leq .50$
Advancement-transfer	1.35	$.20 < p \leq .30$
Women's issues	1.35	$.20 < p \leq .30$
Management-RNrelations	.29	$.50 < p \leq .70$
Participation in policy making	1.62	$.20 < p \leq .30$
Number of Policies in a Category		
Wage-benefitspackage	4.41	$.02 < p \leq .05$
Work schedules	.45	$.50 < p \leq .70$
Advancement-transfer	.05	$.80 < p \leq .90$
Women's issues	1.10	$.20 < p \leq .30$
Management-RNrelations	.15	$.70 < p \leq .80$
Participation in policy making	.001	$p > .95$
Change Made in Policy Category		
Wage-benefitspackage	.27	$.50 < p \leq .70$
Work schedules	.31	$.50 < p \leq .70$
Advancement-transfer	.58	$.30 < p \leq .50$
Women's issues	1.64	$.20 < p \leq .30$
Management-RNrelations	.28	$.50 < p \leq .70$
Participation in policy making	.92	$.30 < p \leq .50$

Table 55.--Relation between hospital size and workload measures vs. union activity and consultant use

Size or Workload Measure	Union Activity (Chi Square, p Value)	Consultant Use (Chi Square, p Value)
No. of beds	4.21 .02 < p ≤ .05	.91 .30 < p ≤ .50
No. of FTE RNs	2.89 .05 < p ≤ .10	.39 .50 < p ≤ .70
Beds/FTE RN	.85 .30 < p ≤ .50	.29 .50 < p ≤ .70
Occupancy rate	4.21 .02 < p ≤ .05	2.89 .05 < p ≤ .10
City size	.04 .80 < p ≤ .90	.02 .80 < p ≤ .90
State	.91 .30 < p ≤ .50	.39 .50 < p ≤ .70

* Data were derived from 2x2 contingency tables in which hospitals were classified as either below or above the median in size or workload (those at the median were included with those above).

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