A Caring Class: Labor Conflict and the Moral Economy of Care in California Hospitals

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Abstract

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This dissertation examines the connections between the moral evaluation of caring labor and the patterns, practices, and potential effectiveness of hospital workers' collective economic conflict in California hospitals over the latter 20th century. The study begins in the post-war years, where many found the notion of hospital workers joining unions and striking as a violation of their sacred duty to care. While hospitals and their workers self-sacrificially cared for the sick, hospital managers, professional associations, and policy-makers successfully painted unions as uncaring and instrumental. My goal is to explain how, by the late 1980s and early 1990s, unions came to adopt a common, powerful framework in which care workers and their organizations understood the exercise of coercive economic power in the workplace not as a violation of their calling to care, but rather as consistent with their moral obligations; one where care workers would strike *because* they cared, while capital was uncaring.

I argue that the cultural and moral meaning of caring labor for workers, managers and patients—the 'moral economy of care'—acted as a powerful social force capable of both retarding and advancing unionization. At the heart of the 'moral economy of care' was the fundamental antinomy between a moral obligation to care and instrumental, economistic action. It was a cultural opposition that remained in place, often uneasily, even as healthcare delivery grew to be increasingly governed by market forces, and as unions and professional associations expanded their activities to increase material rewards for their members. This moral opposition helped people define the meaning of work, identify violations of norms, and define the appropriate forms and targets of economic contention.

The study relies primarily on archival data, which is supplemented with key informant interviews. The empirical narrative is divided into three parts, roughly corresponding to three periods in which the moral economy of care work reshaped the practices and organizational forms of healthcare workers' unions. Part 1 examines how the leaders and members of the California State Nurses' Association, a professional association of nurses affiliated with the American Nurses' Association, worked to reconcile the moral injunctions against economic action with an increasingly restive rank and file in the years 1946-1974. Empirically, I focus on explaining the moralization of the strike—the process through which advocates of collective bargaining for nurses came to frame collective economic action against hospital employers not as an abandonment of their caring obligation, but as an enactment of that obligation, as a defense of the moral obligation to care against uncaring capital. Part 2 takes as its backdrop the passage of the 1974 healthcare amendments to the Taft Hartley Act, which ended the 25-year old exclusion of workers in non-profit hospitals from the protections of the National Labor Relations Act. Part 2 introduces a comparison case: the Service Employees International Union (SEIU), the other major union that would come to dominate healthcare organizing in California. Comparing how the two organizations responded to the 1974 opening of new organizing opportunities, I argue that the key distinctions between the two organizations were the cultural boundaries they drew between different categories of healthcare workers. Part 3 follows the same cases into the 1980s and early 1990s, a period in which hospitals shifted decisively toward corporate control. Part 3 argues that this industrial turbulence triggered political crises in the organizations, allowing insurgent groups to draw upon culturally salient frames built around the moral economy of care. In both cases, this new form of care worker unionism was a pragmatic reaction to employer strategies and vulnerabilities. But its form was informed by the moral economy of care, and the cultural opposition of workers' moral obligation to care against uncaring capital.

Table of Contents

Chapter 1. Introduction **1**

Part 1: Nurses' Power and the Moral Economy of Care: The Dilemmas of Economic Contention **30**

Chapter 2. The Moral Dilemmas of Nurses' Power, 1946-1966 ..... **33**

Chapter 3. Moralizing the Strike, 1966-1974 ..... **55**

Part 2: The Rise of Hospital Unionism **72**

Chapter 4. The Boundaries of Taft-Hartley: California Hospital Worker Organizing Before and After the Summer of 1974 ..... **73**

Part 3: Toward a Caring Class: The Crisis of Care Work and the Convergence Toward Moralized Class-Antagonistic Contention **118**

Chapter 5. The Commodification of Care and the Challenge to Care Workers, 1983-1988 ..... **123**

Chapter 6. The Crisis of Collective Bargaining **136**

Chapter 7. The Crisis of Professionalism **164**

Conclusion: Can Capital Care? **184**

References **186**

Notes **195**

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Chapter 1. Introduction

Morality and Labor Struggle in the Hospital

Healthcare is big business. We often hear in contemporary debates on healthcare policy in the United States that healthcare accounts for one-sixth of the US economy.[1] Fully nine percent of Americans work in some aspect of the healthcare industry, a level of employment that has eclipsed manufacturing.[2] In many communities, this proportion is much higher—the healthcare industry is geographically disperse, such that in many cities and towns hospitals and healthcare labor form a significant economic anchor, employing an even greater share of total workers.

But the act of providing healthcare for money often leaves us uneasy. At the level of public policy, the question of how to allocate resources in the distribution of care—who should pay for whose care, how we should make allocation decisions—has remained one of the most contentious questions in politics. Debates concerning healthcare policy often center on whether the state or the market should ration scarce resources in the distribution of expensive care. But even as the state has assumed a steadily growing burden of healthcare costs over the years, healthcare delivery systems remain overwhelmingly private, and the use of market mechanisms to determine the allocation of resources and care services has been repeatedly enshrined in regulation and law (Robinson 1999; Schmidt 2000). Yet for most of those workers involved in the provision of care, the meaning of their labor is not limited to its market value. Healthcare work—be it in hospitals, nursing homes, or patients' homes—has long straddled the boundary between moral obligation and instrumental economic activity. Even as the industry has shifted progressively toward market governance in recent decades, care workers have contested this transition through a variety of bureaucratic structures and everyday acts (Reich 2014). The uneasiness we feel about the commodification of caring may be felt most acutely among the workers who find value in the intimacy of caring, and a sense of worth in doing good and fulfilling their duties.

This incompatibility of market rationality and moral obligation is an assumption we often take for granted. That we should not mix economic transactions (instrumental, crass, and selfish motivations) with intimate relations and social bonds (the moral, the meaningful, the ties that bind) is as intuitive as it is cliché. It is this assumption of fundamental antagonism that has driven substantial social theory on the social effects of commodification, undergirding the utopian moments of Marx and Engels, as well as more recent theories concerning the dangers of the commodification of life from Habermas (1985) to Hochschild (2003). One of the clearest and most influential articulations of this thesis comes from Karl Polanyi (2001), who argued that the commodification of

'fictitious commodities' posed a threat to society, and could trigger insurgent responses. There is good reason for the persistence of this theoretical notion of antinomy. The commodification of the social and the sacred is something that, historically, *has* been contested (Thompson 1971). Theoretically, this presumed antagonism has been useful for scholars attempting to find the causes of social conflict, in ways that help us grasp the intersections of cultural meaning and economic change.

Yet, it is an assumption that has come to be contested by those who question the presumed separation of 'moral' questions concerning the provision of care and market actors' instrumental economic motivations. Economic sociologists in the 'moralized markets' school have drawn attention to the social and moral foundations of markets and economic actions (Fourcade 2011; Fourcade and Healy 2007; Healy 2006; Livne 2014; Steiner 2008; Wherry 2010, 2013; Zelizer 2005, 2010). The moralized markets school emphasizes the creativity of people in reconstructing and rearticulating moral values and economic actions. This means that much of what we might consider to be purely economic, instrumental behavior, such as activity in a market for goods, is in fact strongly shaped by morality and cultural forces (Zelizer 1997). It also means that some goods or services thought to be governed by strictly moral concerns, such as human tissues or care for the dying, can be converted into tradable commodities through a process of 'moralization' (Healy 2006; Livne 2014). From another perspective, some feminist theorists have argued that the presumed moral obligations inherent in care work can obscure the underlying power relations of capitalist production and gender domination (Federici 2012; Nelson 1999).

The intermingling of morals and markets has certainly played a role in shaping the contemporary healthcare industry. In some respects, the process of moralization has occurred in ways that appear rather seamless. Physicians, who for over a century have leveraged their control over healthcare distribution to secure very high wages, have long justified this control through the language of moral obligation. Hospitals once owned and run by religious orders have consolidated into some of the largest, most competitive, and sometimes most economically exclusive healthcare delivery systems in the market today. In other respects, the uneasiness remains—with access to services limited to those who can pay, and with increasingly corporate "non-profit" hospitals putting the balance of revenues and costs before patient care, cutting corners in care provision and economically squeezing the workers who provide the care. How should we understand the interconnections of the moral and the economic in the hospital industry? How does it shape how hospital workers understand their work, and whether and how they exercise power together?

This dissertation probes these questions by examining how moral conceptions of work shape patterns of economic conflict. I do this through a historical analysis of labor contention in California hospitals. Using primary archival data, my analysis follows two organizations, the California Nurses Association (CNA) and the Service Employees International Union (SEIU), as they grappled with the pursuit of collective bargaining and the exercise of economic power in California's private voluntary, or non-profit,

hospitals. The study begins in the post-war years, where many found the notion of hospital workers joining unions and striking as a violation of their sacred duty to care. While hospitals and their workers self-sacrificially cared for the sick, hospital managers, professional associations, and policy-makers successfully painted unions as uncaring and instrumental. My goal is to explain how, by the late 1980s and early 1990s, these organizations came to adopt a common, powerful framework for economic conflict that successfully turned this old logic on its head: a framework in which care workers and their organizations understood the exercise of coercive economic power in the workplace not as a violation of their calling to care, but rather as consistent with their moral obligations; one where care workers would strike *because* they cared, while capital was uncaring.

Put somewhat differently, my goal is to explain the emergence of *a caring class*. In this, they were more than a group of workers defined by their structural position as care workers in a hospital. Many workers in California's voluntary hospitals emerged as a caring class because they came to define themselves by the obligation to care, which in some instances required them to define themselves in opposition to those who would undermine that moral virtue, and act collectively and self-consciously in defense of their common interests as a class of caregivers.

In the background of this story—the exogenous causal force—is the dramatic transformation of the American hospital: first, through bureaucratization and the construction of large, physician-controlled organizations that grouped a growing number of workers under their roofs; and later, through their transformation into corporate-controlled, market-governed 'non-profit' firms. But at the heart of the story lies what I call 'the moral economy of care,' the set of normative assumptions that governed caring labor and conflict in the hospital setting. The moral economy of care changed over time, through iterated struggles, with evolving definitions of the appropriate targets of economic contention and the appropriate forms that contention could take. But one of its most consistent, animating principles remained the antinomy of moral obligation and economistic action.

Theoretical Tensions

The Moral Economy

A useful starting point for considering the relationship between shared moral frameworks and economic contention remains E.P Thompson's concept of the 'moral economy.' The term 'moral economy' has since been mobilized to refer to more orderly relationships between moral frameworks and economic processes. But in his opening sentences on his essay on the concept, Thompson discusses not an idea, but a riot. For Thompson, *contention* was at the core of the moral economy and its working. Thompson developed the concept through his investigations of popular uprisings against price increases for bread and grain in English towns (Thompson 1966, 1971, 1993). He argued that what

drove food riots was not deprivation or scarcity; it was not a spasmodic act of the dispossessed, a "rebellion of the belly" (1993:77). It was instead a deliberate action tied to moral understandings of production and distribution: a reaction to merchants' and millers' violation of the crowd's 'moral economy,' that is, the "consistent traditional view of the social norms and obligations, of the proper economic functions of several parties within the community" (1993[1971]:188). The moral economy was "the *mentalité,* or, as I would prefer, the political culture, the expectations, traditions, and indeed the superstitions of the working population most frequently involved in actions in the market" (1993:260).

If the 'moral economy' was the widely shared framework for understanding legitimate and illegitimate economic practices, the riot was a collective act that served as the communal enforcement mechanism of the framework, the "collective alternative to individualistic and familial strategies of survival" (1993:266). To Thompson, then, the food riot was not merely a pursuit of common interests, nor a response to the exogenous stimulus of famine. Instead, he argued that the incitement to riot was rooted in the moral order, in the violation of what was widely perceived to be customary and just. Rioters' actions were "legitimized by the old paternalist moral economy" (1966:66). They were driven to collective action to enforce a sacred code; indeed, Thompson found that rioters enacted practices that had been stipulated in earlier Elizabethan-era rules (224-228).

This preexisting moral order of the crowd served in part as a threshold, a trigger for mobilization. But perhaps more importantly for our purposes, the moral order structured the form of mobilization itself. Thompson found that the riot, while often treated as the breakdown of social order, was instead a patterned and habitual set of routines that were structured by the same moral frameworks that stimulated them. Riots, "self-disciplined and often bloodless direct actions" (1993:289), were a structured form of "orderly disorder," beginning with ritualized public cries and continuing to more aggressive steps. This habitual structure of the riot had cemented itself through repeated success at controlling prices, and through the complicity of authority figures, despite occasional violence. According to Rule (1970:93; quoted in Biernacki 1995:18), food rioters were known to request permission from authorities to riot in order to determine prices; other local authorities remained inactive during riots, in part due to common sympathies and in part seeing riots as necessary to enforce the law. Through the means of measured violence, the riot had become a form of moral market regulation, a ritualized imposition of popular moral order upon the price of bread, as essential a factor as supply and demand. In this context, an abstract 'market' could not be divorced from the social and legal relations in which it was embedded—and the key fulcrum of its continual re-embedding was the contentious act.

This framework, much like Thompson's earlier and more famous argument in *The Making of the English Working Class*, places the culture, morality, and decisions of ordinary people at the center of broad historical transformations. In this sense, it is a useful framework for addressing potential connections between the moral weight of care work and union mobilization. However, scholars have raised some important

shortcomings that will be relevant for the current inquiry. First, Thompson saw rioters as attempting to "re-impose the *old* moral economy as against the economy of the free market" (1971:67). Despite Thompson's rich descriptions of how markets as they existed were shaped by popular morality, he retains a conceptual distinction between the 'moral economy' of the crowd and the 'free market' thought then ascendant in England. As such, the moral economy concept assumes what Zelizer (2010) has called the "hostile worlds" approach to the relationship between morality and markets—the assumption that markets and morality constitute inherently antagonistic logics. This approach is at odds with recent work within economic sociology on the intersection of morality and economic action, which has come to identify many ways in which 'markets' are themselves constituted through social, and indeed moral, processes. Second, the approach takes moral orders as a constant, preexisting contention, and there is little sense of how they might change through recursive conflict. While Thompson's narrative holds working people at the center of the process of market regulation and the enforcement of moral standards, they play little role in the construction of these moral orders. If the 'moral economy' is at once causal and seen as a constant, it is a poor theory of historical change in economic contention.

Morality and economic action

Zelizer (2005) labels approaches like Thompson's the "hostile worlds" approach to understanding morality and markets in order to highlight what she sees as a central fallacy of the approach: the idea that markets can ever be amoral, impersonal, and purely instrumental arenas of action. Much of Zelizer's work has been dedicated to demonstrating how our moral frameworks and social bonds shape economic action, and how moral judgments distinguish different types of transactions. For instance, her work on money (Zelizer 1997) questions the widespread assumption that money is a morally neutral medium of exchange. Money should in theory be the pure instrument of commodification, allowing anything to be easily purchased and traded, due to the presumed fungibility of money. And yet, Zelizer finds that in practice, people map profound moral categories onto money, ritually earmarking money for specific meaningful social relations, and in the process, imbue it with meaning. Rather than destroying or undermining social bonds and values, Zelizer argues, how we use money is in fact buttressed by these basic moral categories.

Similarly, economic sociologists have found that the practice of production and exchange, rather than undermine culture and moral values, can in fact reinforce and reproduce moral orders. Wherry (2010) finds that "ritual interactions in the secular market possess a moral character [...] This chain of interactions and the varying moral evaluations they generate become inculcated in market actors who can take for granted from there their moral evaluations come." We have also learned that "morality" is not necessarily fixed when it comes to economic action—instead, people actively manage moral categories to make sense of and justify certain types of economic exchange. For instance, Livne's (2014) account of the expansion of hospice care in an era of spiraling end-of-life costs finds that various actors mobilized the preexisting moral claims of the

hospice movement to justify curtailing expenditures at the end of life, thereby moralizing economic scarcity, and in a broader sense, the commodification of death. Other work within the 'moralized markets' perspective identifies how some objects that might once have been considered sacred, such as religious objects (Wherry 2010), life and death benefits (Quinn 2008; Zelizer 1978), or human blood and organs (Healy 2006; Titmuss 1971), can, through a process of contestation and institutionalization, come to be traded as commodities in markets.

How, then, can the moralized markets approach aid in understanding the relationship between the meaning of work and economic contention? One major benefit of this approach is allowing us to see the relationship between economic and moral orders as ongoing and dynamic. Where Thompson saw the 'moral economy' as a constant, the concept of 'moralization' allows us to see how moral categories, while continuing to exercise social force in shaping economic action, are also re-worked through economic action. If all markets and economic processes have at their foundations this type of moral re-working, 'commodification,' then, is not the process of stripping a product of its social and moral value—it is instead a rearticulation of these social and moral values in ways that facilitate production and exchange.

The challenge of using this approach to the moral economy, however, is that it has lost sight of the *riot*. For the most part, this approach centers on institutional settlement, rather than conflict and contention. If the commodification of certain products is contested, the moralized markets approach usually sees people working through moral categories to arrive at a consensus position concerning the moral status of a transaction among those engaged in the market. If the tension and antagonism between morals and markets provides a useful animating force to understand economic conflict, how can we explain ongoing conflict when that tension is removed, without resorting to purely instrumental theories of action?

Culture and class formation

A partial solution to the challenge of understanding change in moral orders and economic conflict lies in Thompson's *The Making of the English Working Class,* and the many debates spurred by the text. In the case of *The Making,* the outcome Thompson wishes to explain is in many ways a cultural phenomenon. The formation of a working class capable of collective action was as much about the perception of identity and common interest as it was about a structural location. "Class happens," wrote Thompson, "when some men [sic], as a result of common experiences (inherited or shared), feel and articulate the identity of their interests as between themselves, and as against the other men whose interests are different from (and usually opposed to) theirs" (1966:9). Yet he also saw this cultural process as intricately tied to specific contentious practices and the exercise of power. Thompson saw working class consciousness—at the root of workers' capacity to engage in collective action—as shaped by longstanding radical political traditions forged through years of battle and defeat. They had "formed a picture of the organization of society, out of their own experience and with the help of their hard-won

erratic education, which was above all a political picture" (1966:712). This argument accounts for the role of culture and preexisting institutions in the shaping of collective action. It also highlights the historically contingent nature of the development of class-centered identity and practice, demonstrating the importance of history and actor creativity relative to structural, economic forces. For Thompson, the making of the working class was a product of these two forces— the culture that working people inherited from earlier traditions and political struggles, and the creativity with which they repurposed these tools to struggle in a new arena. While this process was of course situated in the context of rapid and violent industrialization, it was more than a simple response to a changing institutional context. It was a product of the cultural categories that workers brought to the disruption. The key point here is that while preexisting morals, identities, and ideas formed the basis upon which workers developed new forms of struggle, these cultural constructs were continually reworked and changed by activists themselves, through repeated confrontations with employers and state targets.

Thompson's cultural approach became the foundation for extended debates on the nature of class formation, concerning the circumstances under which class becomes the basis of solidarity, as opposed to other axes of difference. These debates on class formation capture the central tension considered here: the relative weight of economic and cultural forces in workers' active reshaping of union movements. Thompson made his case, in part, as a rebuttal to overly structural theories of workers' collective action. Thompson's primary targets were Marxist theories that viewed the development of class-based collective action as simply a product of capitalism itself; he made his most explicit case in his extended engagement with Althusser's rigid structuralism in *The Poverty of Theory* (Thompson 1978). The outcome of interest in the class formation debate—the development of a group of working people with a common conception of a common interest *centered on class divisions*, and capable of collective action—was matter of subjective states, of political orientations and ideas. As such, the question of class formation often hinges on morality, values and ideas, even in the context of a body of theory that often gives these short shrift as a causal force.

But, as has been pointed out by Anderson (1980), Biernacki (1995), Katznelson (1986) and others, while Thompson's *The Making* effectively showed how culture affected workers' responses to industrialization, the historical engine of the narrative remained industry, and the salient political categories—labor and capital—remained inscribed in macro-structural processes. Despite this critique, many prominent narratives of cultural influences of class formation retain Thompson's contingent structuralism, an approach Katznelson defines as follows: "Class behavior and organization had a *contingent but not unbounded* or entirely open relationship to changes in the structure of society and the ways of life these alterations made possible" (1986:23). Sewell's (1986) analysis of French workers' mobilization in the 18th and 19th centuries takes this approach. Sewell argues that in France, workers' conception of themselves as a class did not emerge out of their agglomeration on a factory floor, as Marx once suggested; he finds that the key actors in this process were skilled artisans in small workshops, rather than factory workers. Instead, he traces the development of the class category to Old Regime

corporate guilds, which inculcated journeymen with a social understanding of labor, "both in the sense that it was and ought to be given shape by collective regulations of the corporation and in the sense that men working in the same trade formed a solitary moral community" (1986:53). More recently, Chibber (2017) has questioned the notion that culture can ever by an *autonomous* determinant of workers' economic action, calling instead for a theory where "class does operate through culture, but it does so in a way that preserves the autonomous influence of economic structure."

Biernacki (1995) addresses this challenge through a focused comparison, attempting to identify an independent role for culture in establishing different patterns of industrial relations in Britain and Germany. He finds that early national cultural differences--specifically, differing conceptions of how labor should be treated as a tradable commodity--had a hand in shaping how workers worked and how they engaged in collective action. Germans saw the purchase of labor as the purchase of a workers' time; the British saw labor as embodied in a workers' product. This subtle difference produced distinct measures of labor, how workers were paid, how employers kept their books, and how traders measured cloth; it produced different practices of labor and structures of workplace regulation, from the timing of the workday to the spatial distribution of the workshop, to the disciplinary practices of bosses. These cultural differences also shaped how workers struck. While German wool workers tended to stay seated at their work stations, emphasizing the "precise, timed withdrawal of labor" (1995:443), British workers did not see a work stoppage in itself as a cessation of the employment relation, and took their complaints to the mills' central yards, with ostentatious displays of unity and discontent. Where Germans sought to demand changes to the process of production, the British tended to restrict their demands to matters of pay.

While Biernacki is the most committed to identifying the independent effects of ideas, the mechanism that he identifies as linking culture and the exercise of power is *practice*. Early concepts of labor "became entrenched instruments of practice [...] the schemas encoded in silent practices within a private factory lent workers the concept of labor they used to voice demands in the public sphere" (1995:2-3). The tactics these unions used during work stoppages had become habitual and regular, but they were not arbitrary, nor were they just what had happened to work. The form of the exercise of power was tied up in the meaning of work. In a basic sense, strikes looked different because work had come to mean different things to these different groups of people.

Meaning and Movement Form

One of the broad arguments of this dissertation is that, when observing the historical trajectory of moral understandings of industrial conflict in hospitals, the antagonism between moral orders and market governance is real. This 'moral economy of care' is not, as Thompson might have envisioned it, a constant, inherited from some earlier social order and continually invoked to 're-embed' the market. Rather, as the moralized markets school has argued, the moral economy of care is rearticulated over time, such that some economic actions that were once considered contrary to care workers' moral obligations,

such as the strike, become reframed as consistent with those moral obligations. Yet the fundamental antinomy between moral action and instrumental economic action recurs. The history examined here shows that this antinomy recurs because care workers use it as a *tool*—to define themselves and articulate common identities and interests, and to wield leverage over other groups.

The notion that moral frameworks can serve as tools for activists has a long history in social movement theory, particularly in the concept of the "cultural frame" (Snow and Benford 1988). Benford and Snow (2000:614) define frames as "action-oriented sets of beliefs and meanings that inspire and legitimate the activities and campaigns of a social movement organization." They are essentially ideological tools that movements can use to mobilize and achieve their goals. Like in the other frameworks outlined above, movements are seen as strategic actors who use these tools within a broader political struggle. Ultimately, framing tools are only effective insofar as they resonate with people's preexisting ideas. Thus, while movements can actively transform ideas and affect the salience of some ideas relative to others, they must do so within the framework of an existing culture and stock of symbols. One of the challenges with this framework, however, is that it holds ideas primarily as instruments, failing to capture how the use of ideas can shape the practices of contention or potential organizational forms (see Goodwin and Jasper 1999). A related challenge is reminiscent of the shortcomings of Thompson's argument concerning the 'moral economy'—if 'morality' is a constant, how can that help us explain change over time?

Clemens' (1996) concept of the "organizational form as frame" offers an important corrective in this regard. The approach allows us to see how actors *use* ideas, moral codes, and identities as *tools* for acting in the world. Clemens analyzes the particular organizational forms of labor movements in the 19th century US, and their reliance on the model of the fraternal order as a key determinant of broader working class development during that period. In showing that labor activists drew upon organizational forms that helped them make sense of conflict in a particular social world, Clemens argues that movements, when building organizations and debating their forms, strategies, and practices, tend to draw upon existing models of organizations and practices, models that are imbued with meaning and assumptions about salient social categories. "Organizational models," she argues, "may be categorized as 'appropriate for men,' 'appropriate for politics,' 'appropriate for rural communities,' and so-forth" (1996:208). To explain this process, she draws on Levi Strauss' concept of 'bricolage,' seeing organizational forms as "condensed expressions of necessary relations" (Levi-strauss 1966:35, quoted in Clemens 1996:208).

The mapping of practice and organizational form onto actors' conceptions of social relations--in particular, their understanding of salient categories and axes of difference--allows for a fluid and contingent approach to understanding the development of organizational forms. There are, of course, many objective axes of difference that actors' subjective orientations can potentially draw upon, and various organizational traditions that may correspond to these orientations. Variation in the potential salience of these

different cleavages and models is important to empirically untangle, and not assume. But a key point of entry into this empirical examination is the nature of preexisting moral orders and organizational traditions. This allows for the simultaneous consideration of changing structural conditions—including resources, opportunities, and economic change—as well as changing moral orders as causal forces in the evolution of contentious practice.

Treating variation in the potential salience of different social cleavages allows us to see organizational form and contentious practice as an outcome of actors' *political projects* (see Fligstein 1996; Larson 2013). As structural conditions change, various internal groups will work to define the organizational form that best adheres to the cultural frameworks of the membership. Importantly, these political projects involve the drawing of boundaries (Lamont 2002; Lamont and Molnár 2002), as they work to define potential organizational forms not only as strategic considerations, but as reflections of activists' cultural conceptions of organizational membership.

Thinking of alternative models of collective labor organization as *political projects* rooted in alternative moral frames has a rich history in the labor movement, and in the sociology of work and the professions. The longstanding distinction between craft unionism--focused on organizing workers around specific practice jurisdictions--and industrial unionism--organizing workers around specific employers--illustrates this. Within the American labor movement, at one level, the debate between advocates of craft unionism and industrial unionism that led to the formation of the Committee on Industrial Organizing appeared to be a simple matter of debate concerning jurisdictional boundaries. For those who advocated either model at the time, however, the stakes of the debate related to the ultimate goals of the labor movement. Advocates of craft unionism argued that unions should focus on maintaining the power of skilled workers who could monopolize the labor market in a specific jurisdiction, maintaining power not through industrial combat or through state intervention, but through the control of work itself. Advocates of industrial unionism argued that only by uniting skilled and unskilled labor could unions address the needs of workers engaged in mass production (Lichtenstein 2013; Zieger 1997).

Beyond the specifics of the dispute, however, the cleavages between craft and industrial unionism reflected broader political conflicts within the American labor movement. Industrial unionism was associated with a left project in the labor movement-- it was "a rallying cry," according to Zieger (1997:14), "on behalf of a 'new' unionism that would move beyond the craft workers who comprised the core of AFL strength to embrace the millions of semiskilled workers and operatives who made the modern industrial machine work." The Industrial Workers of the World, formed in 1905 as a specific left counterpoint to the conservative AFL, sought to position industrial combat and the abolition of the wage system as the key tenets of industrial unionism. Communist-led unions, committed to workplace democracy and consistent shop-floor confrontation, took on the 'industrial union' mantle, even when their practical models of organization were structured by craft and driven by efforts to control work, such as in the case of the

ILWU's hiring halls (Kimeldorf 1992; Lichtenstein 2013; Stepan-Norris and Zeitlin 1996, 2003). AFL leaders seeking to contain the growth of the CIO worked to protect not only the strong craft jurisdictions in industries such as construction and printing, but also to protect a more politically conservative orientation for the movement (Lichtenstein 2013:65). But as Cobble's (1991) study of occupational unionism among waitresses demonstrates, organizing by craft had a radical potential, allowing women to organize on the basis of their extra-shop identities, to take pride in the quality of their work, and to exercise control over when and where they labored.

Sociological considerations of professional organization also adopt a project-centered account of the professions and the professionalization process. While mid-century research on professions tended to see them as logical outgrowths of a broader division of labor (Parsons 1939), by the 1970s and 1980s, a very different perspective had emerged, seeing professions as actively *created* over time. In an early and influential articulation of this perspective, Magali Sarfatti Larson (1979) suggested that professions emerge as such when laborers in a common occupation organize around a *professional project*, a deliberate effort to assert control over a certain arena of labor, and to seek broad social legitimacy for that control (see also Berlant 1975; Macdonald 1995). Professional projects, or what Larson also refers to as 'collective mobility projects,' are mounted to pursue both economic and status rewards; they marry bald economic drive with people's deep desire for social recognition. In short, professionals establish privileged positions within the labor market by engaging in what Weber first defined as social closure (Weber 1978; see also (Tilly 1999a; Weeden 2002). Professional representatives establish a set of norms, ethics, and standards that define the qualifications of the profession; they establish training programs and certifications in these standards; they seek regulatory control from state allies to restrict unqualified individuals from participating in the portion of the labor market that they have defined as their professional prerogative. Abbott (1988), while turning his focus toward the relationship between professions and the specific work they did, expanded upon this line of thinking: he suggests that professional projects unfold within a system of professions, wherein they compete with each other for *jurisdiction* over specific forms of work.

From this perspective, a profession is the outcome of a deliberate course of action on the part of its members and their organizational representatives to achieve a new social order in which they, rather than outside forces, control work in that field. Professions are occupations-for-themselves, with members aware of their common interests and capable of acting collectively to further these interests. In more recent elaborations of her theory, Larson (2013) uses the language of professional movements to get at precisely these points—gaining a foothold as a profession involves overcoming collective action problems, defying established social orders, and winning over allies in civil society and among state elites. What these varying perspectives on the professions thus have in common is that a 'profession' is not inherently defined by occupational characteristics—rather, a profession is *achieved* through collective coordination and mobilization.

If these organizational models—industrial unionism, occupational unionism, and professionalism—were options available to skilled healthcare workers, the competition between these alternative models was always rooted *in moral claim-making, bounded by structural context*. This dissertation will show that disputes concerning the appropriate definition of membership and the appropriate practices of economic contention were rooted in the cultural entanglements of these different organizational forms in the changing context of the hospital. Those advocating professionalism mobilized moral injunctions against any workplace antagonism, premised on the moral obligations of care workers; they drew boundaries based on divisions of gender and occupation, rather than class. In contrast, early advocates of an industrial approach sought to draw boundaries demarcating class divisions, premised on the moral claim of class solidarity. And yet, the competition between these political projects always took place within the structural constraints of a healthcare delivery system—one that was continually changing in ways that tested these basic moral categories.

Justifying the Case: California Hospitals and Healthcare Labor Organizations

Hospitals provide an exceptional venue for examining the connections and antinomies between moral values and economic conflict. Hospitals in the United States have long exhibited uneasy tensions between market forces and social forces more commonly associated with morality and culture. This tension dates back to the historical origins of healthcare institutions as charitable organizations, often with formal religious affiliations, and their subsequent transition into one of the largest money-making sectors of the American economy (Starr 1982; Stevens 1999; Vanore 2013). Throughout the 20th century—as they slowly expanded their bureaucracies, incorporated increasingly expensive technologies, drew in ever increasing revenues, and hired a steadily growing number of people—healthcare institutions sought to retain an ethos of service and commitment to caring, while incorporating market governance and corporate practices.

The roles of collective bargaining, strikes, and the exercise of collective power in hospitals have also been tense and ambiguous. As hospital unionism began to take root in California in the late 1930s, early union organizers with the Building Service Employees International Union (BSEIU) approached the project with trepidation—they feared the strike, and the public opprobrium that would follow care workers' abandonment of their caring obligations. Professional associations, such as the American Nurses' Association (ANA), opposed unionization entirely, and grounded their opposition in this same moral injunction. The Taft Hartley Act, in effect in 1948, excluded hospital workers from coverage under the act in large part because of hospitals' image as charitable institutions; by the time these exclusions were repealed in 1974, the new law included special restrictions on economic action for similar reasons.

But the paradoxes of care provision and the exercise of collective power are important not only because of their ambiguity—they have also seen dramatic changes in terms of how they are understood by care workers, employers, and the public. By the early 1990s, where this dissertation ends, both unions and professional associations were engaging in

increasingly contentious actions, which they framed as a defense of the caring obligation against uncaring capital. It was a class-antagonistic moral framework, that had moralized economic combat as not only an option for care workers, but as an obligation where employers refused to acknowledge the standards of care they demanded.

Theoretically, there are four unique aspects of hospital work that justify examining hospitals as a setting for tensions between moral orders and economic contention. First, there is *inherent meaning inscribed in caring,* given how workers and the public experience the hospital workplace. Second, the *meaning of caring labor is highly gendered*, and these gendered understandings are reflected in hospitals' occupational hierarchies. Third, hospitals exhibit *anomalous patterns of union growth,* as unionization was restricted in the post-war decades, and then accelerated in the 1990s, when other unions were in decline. I argue that this anomalous density curve is a product of changes in the moralization of care work. Finally, hospitals are workplaces with *a longstanding tradition of professionalism,* where social closure strategies are grounded in professionals' moral obligation to care.

Meaning inscribed in care work

One of the unique characteristics of labor in hospitals and nursing homes is workers' intimate connection to patients. Every day, hospital workers work with people in their most vulnerable of states, facing illness and vulnerability; they are often present at our moments of both birth and death. By the nature of what transpires within them, hospitals are sites of deep cultural meaning. This is no less true of those who spend their working days within them. To work in that setting requires emotional commitment, and it can be intensely draining—itself a form of labor, and one way in which we buy and sell intimacy (Hochschild 2003; Parreñas and Boris 2010; Zelizer 2005). But it also provides a source of meaning for workers and patients than many more strictly structural theories of economic conflict overlook. According to Reich (2014:8), healthcare itself is often considered a moral good, to workers and patients, even when it is traded:

> Hospital care is often a deeply emotional experience for patients and their loved ones, and it depends--at least to an extent-- on professionals' and other workers' vocational commitments. […] Well before the hospital was able to provide much in terms of medical cures, those within it were able to offer spiritual guidance and emotional support. And even today, many of us look for emotional connection and support from those with whom we interact in the hospital.

Yet, as Reich's (2014) ethnographic accounts make clear, those who work in hospitals are compelled to actively manage the tensions between the deep meaning of their work—meanings that they themselves maintain and reinforce through their actions—and the fact that their services are bought and sold. As healthcare has become increasingly commodified, the hospital and the work that takes place there is an important point of tension between moral frameworks and instrumental action. Thus, rather than focus on the act of buying and selling care, this dissertation focuses on how hospital workers'

organizations have understood the *work* of caring, the boundaries between obligation and work, and the industrial conflict strategies that these understandings facilitated.

Gendered meanings and occupational hierarchies

One of the key ways in which cultural meaning has affected the organization of care workers is through gendered understandings of care. Hospital work has long been rigidly hierarchical, and the hospital's occupational hierarchies remain highly gendered. Physicians, who control the distribution of healthcare in hospitals, were overwhelmingly men in the post-war years, where this study begins. Nurses were overwhelmingly women. While a growing number of women have entered the ranks of physicians, nursing remains to this day a largely female profession. But just as important as the distribution of women and men among the healing occupations has been the way in which the concept of "care" in itself has long been highly gendered, and understood as womanly duty.

In recent decades, there has been a profusion of research into the nature and politics of what we have come to call "care work," the paid labor of caring for others. Definitions of care work vary, but tend to include healthcare work, education and childcare, social work, domestic labor, and other forms of individual service. A growing proportion of the workforce is employed in occupations that require direct caring service for others, and that draw upon workers' emotional resources. This is in part because of sectoral shifts, as service industries have grown relative to other sectors. But it is also due to the growing trend toward paying wages for work that had previously comprised the unpaid labor of women. According to Duffy (2011), the shift of this nurturant and reproductive work into the market for wage labor can be attributed in part to growing women's labor force participation, driving up both supply of, and demand for, labor which was previously unpaid (Folbre 2006). Demand was also driven by the independent growth of large, bureaucratic care systems that developed new ways to commodify and monetize care work.

Many of those who have examined this work attest to the importance of the social meaning of care to both employers and workers themselves. Beginning perhaps with Hochshild's *The Managed Heart* (1983) and the concept of 'emotional labor,' feminist sociologists have come to understand that a central dilemma of care work is dealing with the commodification of intimacy, the buying and selling of social bonds and emotions that had been previously separated from the labor market (see also Boris and Klein 2012; England 2005; England, Budig, and Folbre 2002; Hochschild 2003; Leidner 1993; Parreñas and Boris 2010). That care work involves not just the selling of our time and product, but also our compassion and empathy, lends profound significance to the moral valence of caring labor.

In terms of how the growth of care work and the commodification of caring labor will affect care workers' exercise of collective power, the evidence remains mixed. On one hand, there are reasons to believe that care workers have traditionally been harder to organize than workers in the traditional blue-collar union strongholds. Indeed, the growth

of care work has in many ways appeared as a mirror reflection of union trends, growing as unions have declined. These trends have had opposite effects on broad patterns income inequality: if unions help promote the growth of middle-income jobs (Western and Rosenfeld 2011), the growth of care work has been shown to have increased job polarization, as the industry has created a few high-paying jobs, many low-paying jobs, and few in the middle (Dwyer 2013). According to Dwyer (2013), this polarization is in part due to the concentration of women, immigrants, and people of color at the bottom of the care work hierarchy, where most of these jobs are, and due to the traditional devaluation of feminine nurturant and reproductive labor (Duffy 2011, 2015; England et al. 2002; Federici 2012). As a result, care work occupations, often classified as feminine, tend to pay less than other occupations with similar requirements.

But it is not just the social devaluation of feminine labor that constrains unionization from outside. The cultural meaning of women's work outside the home, and the tropes of women's virtue and vulnerability so common in the late 19th and early 20th centuries, also constrained the organizing of traditionally feminine work in hospitals (Malka 2007; Reverby 1987). As the narrative below will explore, care workers operating within these patriarchal cultural schemas often eschewed unionization, believing unions and workplace-centered action incompatible with caring devotion (Duffy 2011), leaving them vulnerable to what Folbre (2001) calls the "prisoner of love" dilemma. Many turned instead to professionalization and social closure strategies that offered hopes of professional respect and monetary reward, but tended to further stratify the labor market and undermine potential bonds of solidarity (Weeden 2002). The obligations inherent in this moral order and the intimate connections to the people workers care for may have impeded union action and power, and in a broader sense, undermined the mobilization of class-centered solidarity and values that have traditionally been the key tools of union organizers.

At the same time, there is also evidence that these intimate connections and moral authority may lend unions a unique power. Folbre (2006) identifies what she calls the "high road" strategy for building a care workers' movement, which is centered on emphasizing the common interests of caregivers and patients. Reich (2012) argues that hospital workers can build power through "the mobilized heart," where care workers' passion for patient care can bring people together, making collective action more powerful and enduring, and that ultimately, can come to see "unionization as enhancing the capacity to care" (2012:11). Boris and Klein (2012), in their historical account of homecare workers' movements in the late 20th century, emphasize workers' intimate relationships with clients as a critical component of that movement's growth. Homecare labor is a profoundly important case in this regard—while primarily concentrated in the public sector, it is most likely the largest source of growth for organized labor in recent decades, and unions achieved this growth with remarkably few instances of striking. Furthermore, we might expect the relationship to be exacerbated—or at least mediated—by the transition toward market governance in healthcare. As many scholars have identified, the commodification of care work in recent decades has had profound effects on healthcare workers and on the provision of care (England 2005; Glenn 2012; Lopez

2010). If the commodification of hospital care has undermined the basic values and meanings that previously undergirded care work, as Reich (2014) suggests, this may be a circumstance where we might expect a reaction from care workers, including labor protest and unionization.

If the direction of the association between the commodification of care work and workplace conflict remains ambiguous, there are critical theoretical insights that can point us in a useful direction. What the care work literature shares is an attention to the meaning of work for workers, employers, and the public at large. How people think about the meaning of care work—its moral valence, its worth to society, and who should be doing it—has a powerful material effect on how much people earn and how they mobilize politically. The challenge remains to assess whether union mobilization can emerge out of the interaction of the cultural meaning of care work and the economic processes through which it is created and traded.

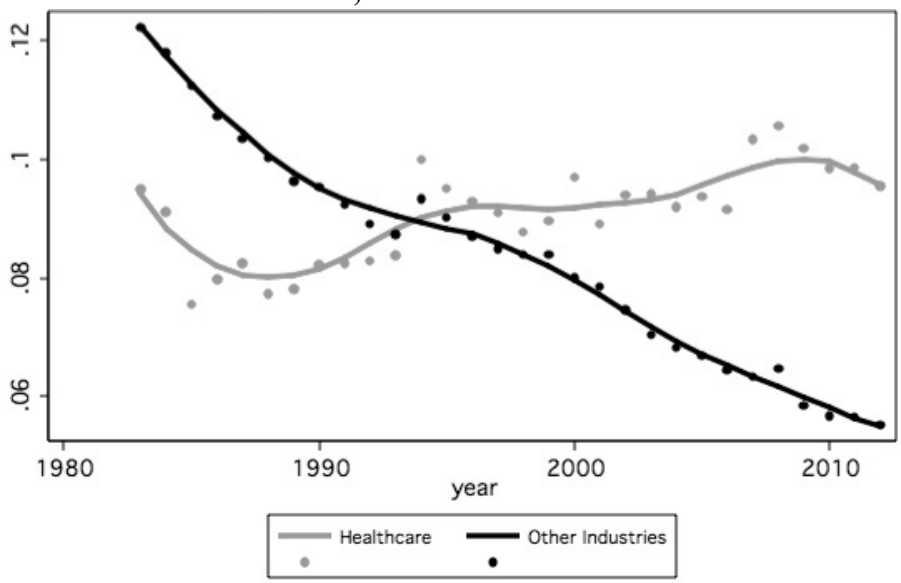
Anomalous union growth

On its own, this shift of the healthcare industry toward marketization would likely foretell a decline in unionization. The most prominent articulation of this thesis is the institutionalist approach, which holds that a variety of social institutions, including political parties, collective bargaining institutions, and market-insulating corporate governance structures can protect workers from market pressures. These protections facilitate union growth, while the erosion of these institutions produces union decline (Scruggs and Lange 2002; Western 1999). Western (1999) suggests that unions grow when workers are "institutionally insulated" from market forces, by institutions such as centralized bargaining and union-run unemployment insurance. According to this perspective, the general union density decline that we observe across the developed world since 1980 is related to workers' greater exposure to markets and the erosion of institutions that 'de-commodify' labor (Esping-Andersen 1990; Friedman 2013). Further, the shift toward market orientation in corporate governance may have also negatively affected unionization levels. According to Fligstein and Shin (2007), corporate managers came under pressure from financial markets during the 1980s, and shifted the orientation of firms toward the maximization of 'shareholder value,' undermining earlier governance institutions that had centered on serving a wider variety of constituencies, including labor. They show that the timing of industries' transition toward shareholder value governance had a significant impact on the timing and extent of their de-unionization.

As this dissertation will discuss, this theoretical approach may well help us understand changes in union density in the sector during the 1980s, when union density in hospitals declined. During these years, as in other industries, healthcare employers developed new tools to thwart union organizing drives, bargained hard to weaken contract standards, and in many cases engaged in aggressive de-unionization. But as we approached the 1990s, labor's fortunes appeared to turn, even as marketization in healthcare continued apace.

Figure 1[1] below compares union density in private hospitals and nursing homes to union density in the rest of the private sector. Figure 2 presents the same data for California. We can observe in the figures that after a period of decline nationally and stagnation in California, union density trended upward beginning in the 1990s.

Figure 1: Private Sector Union Density in the United States, Hospitals and Nursing Homes vs. other Industries, 1983-2012

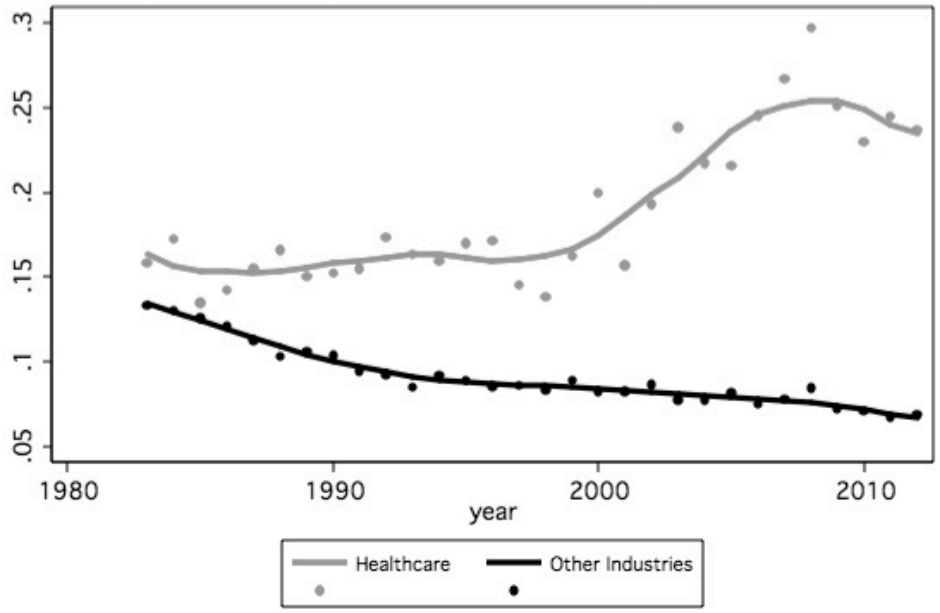


This dissertation will show that this anomalous union density curve is in large part *a product of changes in the moralization of care work*. This relationship began in the early decades of the 20th century. During the years of greatest union membership expansion in the United States, the 1930s-1950s, the unionization of hospital workers was constrained by a perceived incompatibility between the nature of caring labor in charitable hospitals and the crass instrumentality of industrial conflict. Professional associations, such as the American Nurses Association, actively worked to dissuade RNs from unionization, and worked to stymie organizing drives when they occurred. Those unions that did organize hospital workers during this period, such as the Building Service International Union (BSEIU) in the AFL and the United Public Workers in the CIO, perceived that striking in a hospital would produce strong moral condemnation from local communities, and often forswore the use of the strike. By 1947, the Taft Hartley amendments to the National Labor Relations Act specifically excluded workers in non-profit hospitals from coverage under the Act, all but ending these early organizing drives; the legislators making these changes justified the exclusion by appealing to the charitable nature of hospital care; these non-profit exemptions remained law until 1974. Chapters 1 and 2 will demonstrate how moral understandings of care work played a critical role in constraining unionization

[1] Source for Figures 1 and 2: Current Population Survey Outgoing Rotation Groups, 1983-2012. Figures include only private sector workers. Healthcare figures reflect density among workers at hospitals and nursing homes.

rates through the early 1970s.

Figure 2: Private Sector Union Density in California, Hospitals and Nursing Homes vs. other Industries,1983-2012



Moral frameworks surrounding care work, however, also played a role in enabling the union growth demonstrated in the plots above. By the 1980s and 1990s, as hospitals and the delivery of healthcare were increasingly subject to corporatization, consolidation, and market governance, the traditional association of hospital care with charity and obligation had begun to fray. In this context, care worker organizations had an opportunity to moralize workplace conflict, framing as the defense of traditional forms of caring obligation in the face of uncaring capital. Chapter 3 shows how, after a period of challenge and density decline in the 1980s, unions and professional associations converged toward a class-antagonistic model of workplace conflict that was nevertheless reliant on mobilizing upon the moral authority of care workers in the public sphere.

The traditions of professionalism

The tensions between market governance and the values of care have been important sources of power for professional groups, particularly for physicians. As perhaps the paradigmatic case of a professionalization project, physicians long exercised autonomous control over healthcare delivery (Larson 1979; Robinson 1999; Scott et al. 2000; Starr 1982). Like other professions, physicians established privileged positions within the labor market by engaging in what Weber first defined as 'social closure' (Weber 1978; see also Tilly 1999; Weeden 2002). Organized medicine achieved this remarkable autonomy in large part by establishing professional control of expertise, scientific knowledge, and ethical codes, insulating decision-making over healthcare from competing forces,

including markets. The profession resisted commercialization, implementing legislative bans on the 'corporate practice of medicine' and retaining a strong ethos of medical service. According to Robinson (1999), "The ban on corporate practice [...] drew a line demarcating medicine, where financial incentives, private capital, and the entrepreneurial ethos were disdained, from the commercial sector, where they were tolerated and even acclaimed." This insulation from markets and states established physicians' monopoly control of care, which proved very remunerative (Larson 2013).

For other workers on lower rungs of the professional hierarchy, the ideologies of professional responsibility and the primacy of care have been similarly salient, though not as effective as they were for physicians. For much of the 20th century, registered nurses and other healthcare occupations sought to emulate the physicians' model through their own professionalization projects: grounding their occupation in science, erecting barriers to entry and justifying them with claims to expertise and strict ethical codes, and policing the boundaries of their jurisdiction against incursions from competing occupational groups or other outside forces (Abbott 1988). But these groups were always subservient to physicians, and often struggled to exercise the same moral and expert authority over care. The exceptional, value-laden nature of care work in many cases foreclosed alternative routes to institutional leverage for these groups, including unionization.

To the extent that the professional model has worked to insulate healthcare workers from competition and allowed them to control their scope of practice, this power has been rooted in cultural evaluations of moral worth. One articulation of this Weberian perspective that is important for this dissertation comes from Robert K. Merton, who was closely involved with the American Nurses' Association during the 1950s and 1960s, when he was working on his theories of professionalism. For Merton, professionals' control over entry into practice endowed them with such privilege and material rewards, it was justifiable only insofar as it furthered the professional's positive social function. As he wrote regarding the medical students' acculturation to their broader social obligations (Merton 1957): "Just as cognitive standards of knowledge and skill in medicine have a manifest function in facilitating sound medical practice, so the moral standards have the same, though often less readily recognized, function." And as Weeden's (2002:68) more recent analyses make clear, the effectiveness of social closure strategies is rooted in their legitimacy before the state and the public. Successful attainment and maintenance of this legitimacy is a cultural phenomenon, a product of moral valuation of the social importance of the work, and of the workers themselves:

> Association representation is but one tool occupations have at their disposal to shape public opinion. Other closure strategies allow an occupation to signal that it provides services of a particular quality by demonstrating that its *members* are of a certain quality. Unlike association representation, these devices ostensibly exclude on the basis of individual merit and achievement. By selecting its members according to these culturally legitimated rules, an occupation can maintain prestige and 'the consequent opportunities to enjoy honor and even profit' (Weber 1978, p. 46)."

One of the key limitations of the professional model is that in order for the moral injunctions to be effective in improving the material lives of workers, they must be successful in legitimately restricting others' access to their scope of practice. In the healthcare industry, physicians were successful in doing so early on in the development of modern medicine (Starr 1982). Other occupations, such as nursing, have long had difficulty in establishing this exclusive jurisdiction, in part because of the early dominance of organized medicine; this left these occupations classified as "semi-professions" (Etzioni 1969; Hugman 1991; Levi 1980). As the narrative of this dissertation will show, this limitation left the professionalization model subject to recurrent challenge from insurgent staff nurses, who objected to the strong moral injunctions in support of an organizational model that failed to improve working conditions or increase control of work.

Cases and Data

Narrowing the empirical focus to a single state is useful in many respects, allowing the analysis to control for policy variation. This study focuses on hospital worker organizing in California, which is an exceptional location in many respects. California has proven to be an effective site for recent sociological research on the transformation of healthcare delivery and its social effects (Eaton and Weir 2015; Reich 2014; Scott et al. 2000). The state is widely seen as having played and important role in shaping broader patterns of healthcare delivery, particularly the rise of 'managed care,' while exhibiting a mix of traditional and innovative organizational forms (Hendricks 1993; Kochan et al. 2009; Scott et al. 2000).

Hospital unionism was also to a large extent born in California, and in the San Francisco Bay Area in particular. The first hospital workers' union was established by workers at San Francisco General Hospital in the aftermath of the 1934 San Francisco general strike; this incipient local affiliated directly with the American Federation of Labor in 1935 because no national union claimed jurisdiction over healthcare work or hospitals at the time. Affiliating with the Building Service International Union shortly thereafter, the upstart union local would negotiate the first multi-employer hospital workers contracts in 1941. Nurses, too, would organize for the first time in the Bay Area, in 1946, with the CIO-affiliated United Public Workers and with the California State Nurses' Association, a nurses' professional association. As the Taft Hartley Act largely stalled hospital organizing elsewhere in the country after 1947, this early foothold of hospital unionism remained, and even grew southward, riding the expansion of Kaiser Permanente, the Oakland-based managed care behemoth.

California healthcare unionism also exhibits a unique political history. While in New York City, the other major epicenter of hospital unionism in the 1960s, Local 1199's communist-affiliated leadership established a militant unionism that grew in sync with the Civil Rights Movement, California's trajectory was stewarded by more conservative leaders. The CIO-affiliated United Public Workers played a role in triggering hospital

organizing in the 1940s, but the UPW was dismantled in the CIO's anti-communist purges in 1949, leaving two organizations with near complete control over hospital-based collective bargaining in the state. The first was the Building Service International Union (BSEIU, later SEIU), an AFL-affiliated International Union led for decades by the Hardy family, which worked toward the union's shift to upright business unionism in the 1950s and 1960s—though they also cultivated a commitment to organizing and growth that was relatively uncommon elsewhere in the union. SEIU locals, the largest of which were Local 250 in the Bay Area and Local 399 in Los Angeles, organized non-professional hospital personnel from a variety of occupational categories. The second organization was the California State Nurses' Association (CSNA, later CNA), previously a strictly professional association of nurses affiliated with the American Nurses' Association (ANA). Under the leadership of Shirley Titus in the 1940s and early 1950s, the CSNA innovated new forms of collective bargaining for professional associations, while working under an ANA-imposed ban on striking. Other unions would successfully organize smaller groups of hospital workers during these years, including the United Steelworkers, the Teamsters, the International Longshore and Warehouse Union, the Hotel and Restaurant Employees, and others, but the SEIU and the CNA would dominate hospital worker representation for most of the 20th century.

These two organizations constitute the major objects of analysis examined in this dissertation. The two major organizational cases are not completely independent from one another—indeed, the chapters ahead will show that they repeatedly interacted, often uneasily, but in ways that helped establish a common approach to hospital labor struggle in later years. However, conceiving of healthcare unions in California as a single 'case' masks substantial heterogeneity. There is in fact a great deal of variation within the industry across occupational groups, sub-industries, regions, and unions. This study takes advantage of this internal variation to obtain analytical leverage, particularly in Parts 2 and 3.

In terms of data, this study relies primarily on archival sources. I amassed an archival collection, numbering about 4,100 individual documents, concerning hospital worker bargaining, healthcare and labor relations policy, the dynamics of key case organizations and their national parent organizations, and hospital employers in California from the 1930s through the 1990s. The specific primary documents consulted are quite varied, ranging from individual correspondence, notes, and memoranda; organizational documents such meeting minutes, conference and convention proceedings, and reports; organizational publications such as leaflets, pamphlets, newsletters, white papers and other grey literature; preserved oral histories and written first hand accounts; and legal briefs, court findings, and arbitration proceedings. I also consult secondary sources such as contemporaneous newspaper and magazine publications; historical and scholarly accounts; and third-party publications and memoranda.

A small number of documents were obtained from private collections, from people who I interviewed for this study or from other informants. Most of these documents are accessible to the public—though some, including a large new collection of documents

relating to SEIU Locals 250 and 399, were made available only recently. Major public collections accessed include the Labor Archives and Resource Center at San Francisco State University; the UC San Francisco Special Collections; the Bancroft Library at UC Berkeley; the Urban Archives at CSU Northridge's Oviatt Library; the Archives of Labor and Urban Affairs at the Walter P. Reuther Library, Wayne State University; the Richard J Daley Library and the Library of Health Sciences at the University of Illinois at Chicago; the Howard Gottlieb Archival Research Center at Boston University; the Kheel Center for Labor-Management Documentation and Archives at Cornell University's Catherwood Library; the Kaiser Permanente Heritage Resources Department; and the Superior Court of California. Where possible, documents were scanned, and were collected, tagged, and analyzed using Devonthink, a document management software package. For documents from archives where scanning was prohibited, notes and quotes were imported as document-specific text files into Devonthink.

I supplemented the archival data with a number of key informant interviews, focused on first-hand accounts of the events described herein. I conducted twenty-two interviews with union and association officers, organizers, researchers, and member activists, as well as federal mediation officials. For those who chose to donate the transcripts of these interviews as oral histories for preservation, the transcripts will be deposited at the Labor Archives and Resource Center at San Francisco State University. I conducted four interviews with key informants who chose to remain off the record, for a variety of reasons; I do not identify them, quote them or use their comments as evidence in the chapters ahead, but these interviews did guide the interpretation of other data.

The Argument Ahead

This dissertation examines the connections between the moral evaluation of caring labor and the patterns, practices, and potential effectiveness of care workers' collective economic conflict in California hospitals over the latter 20th century. I argue that the cultural and moral meaning of caring labor for workers, managers and patients—the 'moral economy of care'—acted as a powerful social force capable of both retarding and advancing unionization. At the heart of the 'moral economy of care' was the fundamental antinomy between a moral obligation to care and instrumental, economistic action. It was a cultural opposition that remained in place, often uneasily, even as healthcare delivery grew to be increasingly governed by market forces, and as unions and professional associations expanded their activities to increase material rewards for their members. This moral opposition helped people define the meaning of work, identify violations of norms, and define the appropriate forms and targets of economic contention.

But if the antinomy between caring and economism persisted, neither its form not its effects were constant. How people perceived the relationship between the moral valence of caring labor and economic action was a product of how people *used* the 'moral economy of care.' These uses, furthermore, changed over time, driven by the transformation of hospitals and healthcare delivery, and by internal political conflicts. In this sense, the moral economy of care—unlike Thompson's (1971) articulation of the

concept—was not constant, but evolving in relation to iterated workplace conflicts and internal organizational settlements.

In the post-war years, the moral injunction to care was used to retard unionization, as hospital administrators and advocates of professionalism argued that the crass instrumentality of collective bargaining, and the ultimate power of the strike weapon, were incompatible with workers' sacred obligation to care. The strike violated the values of many care workers, particularly those of a more 'professional' persuasion, encountered substantial public criticism, and left most union organizers with a distinct perception of weakness. Even early union organizers forswore the use of the strike in a hospital setting. By the 1990s, however, unions and professional associations had come to claim the moral high ground, framing their increasingly assertive collective actions as a defense of the caring obligation against uncaring capital. It was a class-antagonistic moral framework, a rearticulation of the central point of conflict in the hospital as that between a class of managers, bent on the commodification of care, and a class of care workers committed to the defense of a long tradition of commitment to patient care. In the 1990s, healthcare unions organizing on the basis of this conceptualization were able to reverse the trend of union density decline, and grow—even while unions in other industries did not.

The narrative of the dissertation follows a series of moments in which the transformation of the structures of healthcare delivery and finance challenged the existing moral economy of care. Hospitals' progressive movement from charitable, often religiously inflected organizations into large, bureaucratic and complex gains-seeking "non-profit" organizations was part and parcel of the commodification of care and caring labor. These transformations had dramatic effects on the labor process, the availability of money, and the distribution of power in hospital workplaces. But among those working in hospital settings, these repeated restructurings also confronted entrenched understandings of the meaning of work, status hierarchies and group boundaries between the people providing caring labor, and the practices of contention and cooperation available to workers trying to improve their lot. At each stage, as hospital workers and their organizations confronted the changes in healthcare delivery, these two orders—on the one hand, the 'material' order of work organization, relative structural power, wages, and contentious practice; on the other, the 'moral' order of the meaning of work, the value of care, the justice of coercive action, and the boundaries between people—were always intimately connected.

For much of the 20th century, physicians and hospital administrators deftly exploited the tension between the 'sacred' nature of caring labor on the one hand, and on the other, the 'profane' demands for money and the exercise of economic coercion. They used this tension to contain wages and to aggressively fight unionization. They achieved, with the Taft Hartley amendments of 1947, the full exclusion of employees of voluntary hospitals from the rights defined under the NLRA, an exclusion that remained in place until 1974. And they used this distinction to maintain rigid gendered hierarchies between male physicians—who had few qualms demanding substantial compensation for their expert, scientific practice—and the overwhelmingly female workforce from the RN on down. But these distinctions did not only characterize the conflict between employers and

employees. With the growing commodification of caring labor, these tensions also produced conflicts among workers and unions, who grappled with the dilemmas of exercising power in a setting suffused with moral responsibility. Among healthcare workers, the moral meaning of care work could never be divorced from the moral meaning of its withdrawal. The tactics and strategies of healthcare workers' unions and professional associations have been as wrapped up in this tension since then, even as they have also confronted the more mundane questions of labor process and structural power.

In order to understand the anomalous growth of healthcare unionism in the 1990s, we must first examine this interplay between the moral meanings of care work and the development of new contentious practices among healthcare workers' unions in the decades prior. This means a careful historical evaluation of both the material and moral orders of care work, and how these evolved over time in relation to changes in healthcare delivery. I will not argue that there is a universal, pre-market 'morality' that care workers will inevitably rise to enforce. Rather, the moral order of labor contention evolved through iterated conflicts and settlements, as workers and unions grappled with the dilemmas of contention in a care work setting, arrived at uneasy and unstable settlements, and generated new forms of practice and organizational structures that reified these settlements. It is my contention that this iterative interplay between the material and moral orders can help us understand not only how healthcare workers exercised power, but also why it worked when it did.

One potential alternative explanation of the emergence of this new form of unionism is that these frames are primarily an outgrowth of the transformation of the American hospital, particularly its turn toward corporate control in the 1980s. Indeed, during this period there was a substantial body of research that argued that hospital work was increasingly proletarianized (Chernomas 1986; Coburn 1988, 1994; Ehrenreich and Ehrenreich 1975; Larson 1980; McKinlay and Arches 1985; Moody 2014; Navarro 1988; Wagner 1980); this transformation of union contention might simply be an outgrowth of that proletarianization process. Several of the participants in the events described herein frame the changes they implemented this way, as well, as a "reaction to the corporatization of healthcare."[3] My investigations into this process, however, generate some questions about this thesis. First, as I will show in Part 1, the basic contours of the class-antagonistic, care-centered model of organizing emerged years before the transition, in the early 1980s, toward what we now understand as the period of market domination of hospital care. I will show that, in the 1960s and 1970s, a clear precursor to this model emerged among key factions of staff nurses and their allies within organized nursing, the product of repeated staff-nurse insurgencies and accommodations within the professional association. Second, Parts 2 and 3 will demonstrate the crucial role of moral values in the generation of divergent organizational models, as well as the role of contingent internal political processes in generating new organizational forms.

The empirical narrative is divided into three parts, roughly corresponding to three periods in which the moral economy of care work reshaped the practices and organizational forms of healthcare workers' unions. The first period, 1946-1974, involved the

institutionalization and growth of healthcare employment in large hospitals. It roughly corresponds to what Scott et al. (2000) define as the "Era of Professional Dominance" (1945-65) and the early years of the "Era of Federal Dominance" (1966-82). It was during this period that collective bargaining for hospital workers was first institutionalized in California. The second period, 1974-1982, involves a brief window in which unions dedicated substantial resources to hospital organizing, after the repeal of the amendments to the Taft Hartley Act that had excluded hospital workers from the National Labor Relations Act. The third period, 1983-1996, roughly corresponds to what Scott et al define as the "Era of Managerial Control and Market Mechanisms" (1983-present), and traces the unions' responses to the commodification of care.

Part 1 examines how the leaders and members of the California State Nurses' Association, a professional association of nurses affiliated with the American Nurses' Association, worked to reconcile the moral injunctions against economic action with an increasingly restive rank and file in the years 1946-1974. Empirically, I focus on explaining the *moralization of the strike*—the process through which advocates of collective bargaining for nurses came to frame collective economic action against hospital employers not as an abandonment of their caring obligation, but as an *enactment* of that obligation, as a defense of the moral obligation to care against uncaring capital.

I focus exclusively on the California Nurses Association in Part 1 because it was among bedside staff nurses that a class-antagonistic, patient-care centered moral economy of care first emerged. The moralization of the strike, I argue, occurred through iterated internal conflicts, as association leaders sought to address periodic staff nurse insurgencies by reconciling their demands for stronger workplace representation with the moral frameworks of professionalism. It was a conservative effort, intended to contain staff nurse insurgency and to prevent their turn toward traditional unionism, but it nevertheless led to a radical rearticulation of the moral obligations of care workers. Importantly, Part 1 will show that this process occurred in the 1960s and 1970s, *well before the industry's shift toward corporatization*, or what Scott et al (2000) call the "Era of Managerial Control and Market Mechanisms" (1983-present).

The California State Nurses' Association began committed to a professional model, which sought to exercise control over the labor market through certification and other social closure mechanisms. The model drew heavily on gendered, moralized notions of women's work to draw stark boundaries between nurses and 'working class' workers who worked alongside them in hospitals. One of the main ways that nurse leaders drew these boundaries was by appealing to the moral dilemma inherent in the strike, the ultimate tool of unions, which they counterposed to their own reliance on expertise and the goodwill of the public. But a growing number of staff nurses worked in institutional settings, as salaried employees of the hospital itself. This left many staff nurses open to the arguments of unions who attempted to organize them. It was at this point that advocates of collective bargaining within the CSNA (and the ANA) prevailed, establishing a collective bargaining program primarily as a bulwark against union encroachment. To cement the notion that nurses' moral obligation to care stood in

opposition to the strike, however, the ANA implemented a ban on strike activity.

Chapter 2 follows the CNA from the origins of the collective bargaining program in 1946 through 1966. The tensions between the 'professional' nursing leaders and the staff nurses seeking more militant workplace representation never disappeared. Staff nurses and their organizational allies pushed the boundaries of the strike ban throughout the 1950s and 1960s, while others dominant in the professional organizations pushed for greater reliance on expertise and social closure through the implementation of more stringent educational requirements. But over the years, CNA organizers worked to defuse these tensions by developing a repertoire of practice that drew upon both class-centered and professional traditions. While this development occurred in fits and starts and confronted substantial internal opposition, overall they shifted toward building power in the public sphere, mobilizing on the moral authority of the nurse, but turning against employers rather than other workers. As they worked to figure out how to exercise power without the strike, they codified these practices in a series of manuals that, with their emphasis on public relations and external alliances, prefigured what union activists would later come to call "corporate campaigns." In the workplace, they moved toward using contracts to enforce professional standards, and implemented workplace committees charged with enforcing staff nurses' control over the labor process.

Chapter 3 examines the CNA's changes in contentious practice from 1966, when the organization first embraced large-scale economic contention, through 1974, when they organized a large Bay Area-wide nurses' strike. By 1974, the CNA for the first time went out on strike over staffing demands—a set of frames and demands centered on patient care and moral obligation that reconciled internally contending forces, and would dominate in virtually every subsequent strike among California nurses, and within a few years, other hospital workers.

To assess the influence of moral framings on organizing projects and patterns of economic contention, **Part 2** introduces two axes of comparison. First, it continues analyzing the CNA case while introducing a comparison case: the Service Employees International Union (SEIU), the other major union that would come to dominate healthcare organizing in California, which focused on organizing ancillary healthcare workers during this period, despite an early attempt to organize nurses in Los Angeles in the 1940s. Unlike the CNA, SEIU locals were firmly grounded in their identity as workers' unions. After successful efforts to remove the exemption of workers in voluntary hospitals from the NLRA, both Locals 250 in the Bay Area and 399 in Los Angeles led substantial, if traditional, organizing drives for hospital workers through the 1970s. Second, Part 2 introduces a regional comparison, analyzing organizing drives in the Bay Area and Los Angeles, as opportunities to expand hospital unionization beyond the original Bay Area base emerged in the 1970s.

Chapter 4 takes as its backdrop the passage of the 1974 healthcare amendments to the Taft Hartley Act. The legislation ended the 25-year old exclusion of workers in non-profit hospitals from the protections of the National Labor Relations Act. In the decades since

the passage of Taft Hartley in 1947, the non-profit exclusion had effectively halted organizing drives among hospital workers, with the exception of some pockets where unions and professional associations had established a foothold in the sector before the Act. The San Francisco Bay Area was one of those pockets, and in the intervening years, hospitals, the CNA and SEIU Local 250 had established an informal system of collective bargaining premised on mutual agreement and custom. Excluded from mainstream labor law, these customs did not reflect the legal structures governing the rest of the labor movement, but rather what one management attorney called "the law of the jungle"[4]: organizing and bargaining customs evolved within the peculiar workplace structure of the non-profit hospital, the cultural traditions of professionalism, and the balance of power between the parties in the particular political context of a labor-friendly region in a labor-hostile state.

The removal of the non-profit exemption in 1974 opened up new opportunities for both the SEIU and the CNA, while attracting competition from other labor organizations. But it also compelled both organizations to bring their organizing models into alignment with established labor law, in ways that unsettled their existing projects. The unfolding of these tensions in the years after 1974 helps to reveal how different cultural models helped produce different strategic orientations and patterns of contention, as well as different organizing outcomes.

In Chapter 4, I argue that the key distinctions between the two organizations were the *cultural boundaries* they drew between different categories of healthcare workers, demarcating the care workers that were potential members from those that were not. SEIU organizers demarcated their membership with *horizontal boundaries,* with class-based distinctions separating blue-collar workers from professionals. These blue-collar workers spanned occupational categories and skill levels, similar to an 'industrial union' model; they were united by a conception of a common interest distinct from that of the employer. CNA organizers, on the other hand, sought to draw *vertical boundaries* separating the practice of nursing from other occupational jurisdictions, while maintaining an internal hierarchy that spanned class lines. This difference defined how the CNA and SEIU Locals 250 and 399 pursued the opportunities opening in 1974, and the challenges they confronted. Both organizations faced obstacles, as an early generation of anti-union consultancies innovated new ways to weaponize NLRB procedures to halt organizing drives, techniques that were most effective against the CNA's professional model.

Part 3 follows the same cases into the 1980s and early 1990s, a period in which hospitals shifted decisively toward corporate control. Federal reimbursement procedures changed in ways that triggered aggressive efforts to cut costs. Community hospitals began to consolidate into larger systems, and in California especially, the managed-care HMO model became the predominant cost-containment strategy. Within workplaces, this was a period of aggressive control over labor costs, given that labor is by far the largest expense in the industry; this meant aggressive efforts to control wages and benefits, speeding up the labor process, and the blurring of traditional occupational lines.

Part 2 shows that CNA and the SEIU entered the 1980s with very different organizing projects, which had weathered internal political strife, and significant changes in labor law; in contrast, Part 3 shows how the dramatic transformation of healthcare delivery in the 1980s upended many of these distinctions. As turbulence in the healthcare system destabilized existing models of organization, the organizations *converged* toward a new model of organization that drew upon a common reinterpretation of the moral economy of care. Each organization came at the problem form a very different vantage point, and there remained key organizational differences. But by the early 1990s, CNA, Local 250, and Local 399 were articulating a class-antagonistic model of organization, that conceived of hospital administrators as the key objects of contention, but which centered on occupational identities and the moral obligations of care workers.

This common shift toward a class-antagonistic, care-centered model suggests a shared response to a common structural transformation. However, a close inspection of how these changes occurred reveals the critical importance of moral categories, and the cultural inheritance of earlier conflicts and settlements. Through an analysis of internal political processes in CNA and in SEIU Locals 250 and 399, I show that while the strategic convergence was *triggered* by exogenous structural transformations, this outcome was not inevitable; rather, it was the outcome of contingent political processes, as insurgent groups drew upon culturally salient—and tactically potent—conceptual frames built around the moral economy of care, specifically the persistent opposition between the moral obligation to care and instrumental, economistic action. Hospital cost containment efforts in the late 1980s challenged care workers' capacity to provide the care that brought meaning to their labor, and challenged the fundamental belief, forged through decades of collective bargaining, that those who cared deserved to be taken care of. The inability of the existing organizational projects to confront this challenge produced crises of legitimacy and political rupture, opening opportunities to insurgent groups. In the aftermath, the moral economy of care provided hospital workers not only with a diagnosis of the problem, but also with the tools to articulate a new path forward. The antinomy of caring obligation and market governance offered a moral framework built upon the deeply felt meaning of caring labor.

Chapter 5 summarizes the transformation of healthcare delivery in the 1980s, which served as an exogenous structural transformation that triggered the strategic transformations. These changes include NLRB decisions that upended bargaining unit designations for both organizations; changes to federal reimbursement procedures; and the corporatization of non-profit hospital governance. Chapter 6, *The Crisis of Collective Bargaining,* examines the effect of these changes on the internal politics of SEIU Locals 250 and 399. Aggressive bargaining strategies on the part of increasingly assertive employers led to concessionary contracts, and to massive expenditures in a series of defensive battles; this in turn created political instability in both locals, which led to organizational crises and leadership changes. Local 250, in part through collaboration with militant factions within the CNA, emerged with an organizing model that was a composite of traditional workplace-centered unionism and care-centric approaches. Local

399, through collaboration with the International Union, developed a model that instrumentalized 'patient care' as a strategic frame, integrated with a broader corporate campaign strategy.

Chapter 7, *The Crisis of Professionalism,* turns its focus to CNA. In the 1980s, nurses benefited from a nursing shortage, as hospitals looked to place more bedside work on their shoulders; this insulated them from some of the more aggressive bargaining efforts faced by Locals 250 and 399. But at work, nurses faced dramatic work speed-ups, as hospital stays decreased in length, and patient acuity increased. Institutionally, organized nursing also faced powerful attacks seeking to undermine nurses' traditional practice jurisdictions. These changes similarly led to legitimacy crises among Association leadership, allowing dissident staff nurses to seize control of the organization, after decades of repeated staff-nurse insurgencies and co-optations by nursing elites. While the Association retained the patient-care focus so meaningful to working nurses, it integrated a militant, class-centered ideology.

In both cases, this new form of care worker unionism was a pragmatic reaction to employer strategies and vulnerabilities. But its form was informed by the moral economy of care, and the cultural opposition of workers' moral obligation to care against uncaring capital.

Part 1: Nurses' Power and the Moral Economy of Care: The Dilemmas of Economic Contention in California Hospitals, 1946-1974

Part 1 deals with how California hospital nurses and nurses' associations conceptualized and practiced economic conflict, and how these conceptualizations and practices changed over the post-war decades. Between 1946 and 1974, California nurses moved from being one of the least organized groups in hospitals, underpaid relative to their skill, to becoming arguably the most active and militant group. In particular, it follows the transformation of the California Nurses Association (CNA) and its parent organization, the American Nurses Association (ANA). By 1974, the CNA had transformed from a strictly professional association, engaging in collaboration with employers to deliberately thwart the unionization of nurses, into the (reluctant) organizer of the largest healthcare workers strikes to date.

The CNA, ANA, and staff nurses provide key cases for examining the impact of morality and cultural constraints on economic action and conflict. As providers of care in hospitals, nurses operate in a highly moralized environment, which has long highlighted the moral obligations of caregivers and valued nurses' intimate connections with patients. Bedside nurses, often called "the caring profession," have long been the principal source of direct care for hospital patients, and have over the years cultivated a strong occupational identity grounded in this caring role.

Within organized nursing, particularly within the confines of the ANA and its affiliates, there were always substantial disagreements concerning collective bargaining for nurses, and in particular concerning the exercise of the strike and other forms of economic coercion in the hospital setting. These disagreements permeated both CNA and ANA, which throughout this period housed both staff nurses and nurse administrators as members and officers. The association's collective bargaining program began as a conservative rearguard action intended (by some) to prevent the spread of unions among nurses. The program remained controversial, and it remained largely contained by the elite nurses—nurse managers and educators—who most often held leadership positions in the association. However, as the narrative will show, periodic insurgencies from staff

nurses, coupled with an ongoing threat of labor union incursion, maintained the program and pushed it toward expansion and increasing militancy. This pressure from below empowered a group of staff nurse allies within the ANA and CNA, who pushed against institutional boundaries to grow the program when they could, often following moments of staff nurse insurgency.

Through a series of compromises and creative actions, staff nurses and their organizational allies worked to reconcile the basic building blocks of unionism—collective bargaining, worksite representation structures, and coercive practices including striking and strike-like actions—with the moral constraints seen as inherent in nursing labor, widely shared among nurses and jealously guarded by advocates of professionalism. It is my contention that this series of compromises was responsible for generating new bureaucratic forms and new practices of contention throughout these years. By 1974, the CNA came to rearticulate a class-based conception of social difference in the language of expertise, patient care, and the moral authority of nurses. This led to the development of a variety of extra-workplace practices of contention, even as they used the strike weapon more frequently. They shifted toward linking workplace power and the public interest, mobilizing on the moral authority of the nurse, but turning that authority against employers rather than other occupational categories. They came to see themselves as care workers, and as defenders of the quality of care against uncaring capital. As later chapters will show, this generated the basic contours of a new repertoire of contention that would be adopted by later generations of healthcare organizers.

I argue that this transformation of contentious practice is rooted in a changing 'moral economy of care.' The 'moral economy,' as Thompson (1966, 1971) defined it, concerns the set of normative, moral assumptions that govern economic action in a specific social context. The *moral economy of care,* as I use the concept here, concerns the moral order governing labor, organization, conflict, and exchange in healthcare industry settings—peculiar settings because in the United States, the giving of healthcare is almost always an economic transaction, but one suffused with intense feelings and moral obligations. The moral order governing labor contention evolved through iterated conflicts and settlements, as nurses grappled with the dilemmas of contention in a care work setting, arrived at uneasy and unstable settlements, and generated new forms of practice and organizational structures that reified these settlements. And at each stage, these practices and organizational forms reshaped the moral order, altering understandings of "who we are," "who we are fighting," and what "people like us" could legitimately do. In short, the exercise of economic power was premised on a set of moral and cultural assumptions, which themselves changed through repeated economic conflict.

This argument has important theoretical implications. What is the connection between shared moral values and the practice of conflict in the economic sphere? When E.P. Thompson first advanced the concept of the 'moral economy' (1966, 1971), it was a concept grounded in conflict. Food riots in eighteenth century England, he argued, were a product of the fundamental incompatibility of the free market economy, which was increasingly coming to govern the distribution of bread and grain, and the 'moral economy,' the set of norms and

moral values that traditionally governed food production and distribution. In this sense, Thompson counterpoised action grounded in the 'moral economy,' based on common values, against purely instrumental economic action. In recent years, however, economic sociologists have advanced a more nuanced perspective than Thompsons, arguing that all markets have cultural, and even moral, underpinnings (Fourcade and Healy 2007; Wherry 2013; Zelizer 2005). But in demonstrating the deep compatibility of moral values and economic action, much of this research has turned away from the essential role of conflict and contention. In contrast, Part 1 seeks to retain a dynamic model of morality and economy action, while reclaiming the central role of conflict and contention.

The historical narrative proceeds as follows. I begin with a brief description of the moral frameworks that constrained economic action by nurses, stemming primarily from the history of hospitals as charitable institutions and an ideology of professionalism in nursing that dominated the occupation throughout the 20th century. These moral constraints, I argue, formed the framework through which nurse association leaders viewed the challenges of nurse organizing, and responded to periodic staff nurse insurgencies within hospitals. The historical examination of the California case takes the form of three historical vignettes that identify a critical juncture, and trace how association leaders and nursing elites managed the dilemmas of conflict and care. The first, in 1946, describes the creation of the collective bargaining program in response to union competition and staff nurses' push for unionization; the second, in 1966, describes the first large-scale "mass resignation," in which thousands of nurses defied a strike ban; the third, in 1974, describes the first large scale nurses' strike in the Bay Area.

Chapter 2. The Moral Dilemmas of Nurses' Power, 1946-1966

External Moral Constraints and the Meaning of Care Work

The practice of hospital nursing and the collective strategies of nurses' organizations have long been governed by moral constraints, constraints rooted in longstanding, uneasy tensions between market forces and social forces more commonly associated with morality and social authority. Some of these constraints have roots the early days of nursing in the 19th century, stemming from the religious organization of early hospital systems and the gendered ideologies governing women's work outside the home. By the mid-20th century, the focus of this chapter, these had become subsumed by a broader ideology of professionalism, an instrumental project of collective labor organization that was nevertheless grounded in its own moral foundations. This section examines these constraints in turn.

1. Religious Charity: Part of this structure of moral constraints emerges from the institution of the hospital itself. In California as elsewhere, religious institutions played a critical role in the formation of early hospitals (Reverby 1987; Vanore 2013). Hospitals began as almshouses, sites of service to the indigent, most of which were supported by religious communities (Stevens 1999; Vanore 2013). These were sites for the provision of charity. Until the 20th Century, the wealthy rarely used hospitals, instead contracting with private duty nurses and physicians for care in the home when they grew ill, even enduring surgeries at home (Starr 1982). Those requiring care and unable to obtain it in the private market, on the other hand, often ended up in a hospital associated with religious communities. The precise relationship between hospital facilities and their supporting religious communities varied; Protestant congregations often supported independent hospitals, many of which were managed by laypersons and publicly-owned, while Catholic orders tended to own, manage, and labor as nurses in their facilities (Kauffman 1995; Vanore 2013). But by the turn of the century, hospitals remained sites of missionary service.

These religiously incubated hospitals were the forebears of the non-profit, voluntary hospital model. While there were some experiments with healthcare organization in the early 20th Century, by the post-war period the non-profit voluntary hospital became the backbone of the American healthcare delivery system (Starr 1982). The model endured, in large part, because of its institutional stickiness and integration with large and small healthcare policies (Fennell and Alexander 1993). According to Vanore (2013), the durability of the hospital model, which in turn allowed it to endure through this critical period of policy consolidation, was in part rooted in the ethnic and religious communities that supported hospitals and helped them through some difficult financial straits. But the nonprofit hospital model also became sticky because it resolved some important moral

tensions emergent from the growth and institutionalization of healthcare delivery: hospitals were built on selling care, which was still seen as charity. Absent state control, which powerful interests were aligned against (Hacker 2002; Quadagno 2006), this tension kept the non-profit hospital at the center of healthcare delivery, including religious hospitals. According to Vanore (2013:xiv; see also Reich 2014; Stevens 1999), "Non-profit hospitals, and particularly religious non-profit hospitals, walked the line of both worlds, as they were both benevolent *and* private. As such, they offered a path to keep health care outside of public government control, but also untainted by private profit-driven greed."

2. Gendered occupational hierarchies. Nursing was, and for the most part remains, a woman's occupation. The nursing occupation was created alongside the modern physician. Before the 19th century, a "nurse" was a woman who nursed, who cared for the sick, or the young and elderly; most nursing care was carried out unpaid, as a woman's domestic duty. As Ehrenreich and English (1973) outlined in their polemical history of women's healing labor, before the 19th Century, care for the sick was long the purview of women, including of skilled healers and midwives; as physicians worked to establish their profession through the association of healing with modern science, however, women were relegated to more subordinate positions, dictated by their gender. "When women had a place in medicine," they wrote, "it was in a people's medicine. When the people's medicine was destroyed, there was no place for women except in the subservient role of nurses."

Florence Nightingale, often credited with founding the profession of nursing following her service in the Crimean War, sought to endow nursing with upper-middle class respectability, cementing the modern conception of the nurse as a caring woman, operating within the ambit of modern scientific medicine: moral, knowledgeable, respectable, and subordinate to physicians. A later generation of elite social reformers, seeking to expand nursing as a legitimate vehicle for respectable women to work outside the home, maintained this basic construction (Melosh 1982, 1989; Reverby 1987). Nurses' obligation was not limited to the physician—nursing developed within a broader cultural environment in which women as a gender were obligated to care. According to Reverby (1987:2), nursing developed as an early, paid occupation for women, but one which was subject to the "order to care": "as nursing moved out of the realm of unpaid family labor into the marketplace, the assumption that it would still be work of love, not money, remained." This sense was grounded in caring as a womanly duty.

Hospitals expected tremendous commitment and dedication, which nursing faculty and supervisors framed as a moral commitment. After graduation, staff nurses' salaries remained low, on par with waitresses and domestic workers in the 1940s.[5] Work shifts, even for nursing students, could stretch past twelve hours daily, and ranged from 48 to 60 hours weekly, until 1946 when California nurses became the first in the nation to obtain a 40 hour week.[6] It was customary for student and unmarried staff nurses lived in a dormitory close to the hospital, extending the hospital hierarchies into their social lives; supervisory nurses sought to police the everyday behaviors of young nurses, enforcing

curfews and moral codes (Arthur 2001; Malka 2007; Reverby 1987). In practice, the role of gender became clearest with the gendered division of labor in the hospital. The strong professional hierarchies established in the modern hospital reflected, and reified, the subservience of nurses to male physicians. They were considered, as Melosh (1982) illustrated, the "physician's hand," unthinkingly carrying out the care dictated by medicine. This gendered division was inscribed in the workplace and social lives of nurses in the 1930s and 1940s, given how much their social lives and living arrangements tended to overlap with their workplace structures. Well into the 1960s, nurses were expected to stand when physicians entered the room, and to offer their seats to them.

This gendered occupational position strongly influenced the ideology of organized nursing, in the associations and in hospital workplaces, even as nurses sought and gained greater autonomy. As nursing evolved over the early 20th century, elite nurses sought to establish nursing as a modern *profession*—grounded in education and science, with control over its own jurisdictions of practice and institutional structures. This meant, of course, establishing some semblance of autonomy vis-à-vis physicians. This was a challenge given medicine's longstanding stranglehold on decision-making concerning legitimate healthcare delivery. In this context, the professionalization project, including the pursuit of autonomous control over a scope of practice and the extraction of nurse training from the hospital setting (see #4 below), would hinge on nurses' ability to proclaim the practice of 'nursing' as separate and distinct from the practice of 'medicine' (Bixler and Bixler 1945). Institutionally, this separation allowed nursing maintain its own career ladder that offered women a pathway to leadership positions in the healthcare industry, as well as within the network of professional associations and educational institutions that developed during these decades, at a time when women enjoyed few such avenues for advancement in other large industries. As Malka (2007) documents, by the 1960s, some elite nurses came to advocate the professionalization project through the lens of second-wave feminism, as a pathway to power for women in the workplace. They thus maintained and reified the gendered occupational boundaries even while shifting to a more confrontational stance.

3. Professionalism and moral constraint. By the post-war years, the most profound moral constraint on nursing was embedded in a broader ideology of professionalism. While professions worked to benefit its members economically by monopolizing practice jurisdictions, healthcare practitioners also worked diligently to eschew the instrumental logic of the market. As perhaps the paradigmatic case of a professionalization project, physicians long exercised autonomous control over healthcare delivery (Larson 1979; Robinson 1999; Scott et al. 2000; Starr 1982). For much of the 20th century, registered nurses sought to emulate the physicians' model through their own professionalization projects: grounding their occupation in science, erecting barriers to entry and justifying them with claims to expertise and strict ethical codes, policing the boundaries of their jurisdiction against incursions from competing occupational groups or other outside forces, and actively separating themselves from the unskilled (Ehrenreich and Ehrenreich 1975).

For the purposes of understanding the moral meanings of professionalism for nurses in the post-war decades, particularly those associated with the American Nurses Association, it is critical to understand the thinking of Robert K. Merton. Merton served as a consulting sociologist to the ANA Board of Directors for sixteen years, from 1954 to 1970. For several years after that, he remained involved in the American Nurses Foundation and the National Commission for the Study of Nurses and Nursing Education.[7] In that time, he played key roles in some of the most critical decisions and organizational actions of the ANA, leading efforts to help the ANA articulate and justify the expansion of educational standards required for entry into nursing practice, and remaining closely involved in the Board's decision-making surrounding efforts to expand collective bargaining and nurse organizing in the late 1960s. Most importantly, he exerted a subtle influence over how nurse leaders, including advocates of collective bargaining, would understand the nature of professionalism and frame their arguments over strategies and tactics. Over the ensuing years, his concepts and words repeatedly appeared in speeches, published articles, and meeting notes in the Association at the national and state levels, on the part of both advocates and opponents of expanded collective bargaining for nurses. Association leaders frequently cited Merton's series of articles in the *American Journal of Nursing*.[8]

To sociologists today, Merton is not often remembered as a theorist of the professions. But during the 1950s and 1960s, precisely the time he was working with the ANA, he was rather deeply engaged in an effort to establish a theory of professionals and their role in modern society. Merton began his inquiry into the professions following his leadership of a Columbia University Seminar on the professions, which convened leaders of the university's various professional schools. The Seminar, sponsored by the Russell Sage Foundation and meeting in 1950 and 1951, had the missions of understanding broad changes in professional practice in the post-war years, of informing future strategies for Columbia's professional programs, and of developing a long term research program surrounding the role of professions in society. Merton and the Foundation also had the objective of generating a book, a "casebook on the professions in modern society." Originally projected to take two years to write, Merton, along with Wayne University sociologist William Goode and Columbia graduate student Mary Jean Huntington (later Cornish), worked on the manuscript intermittently for over nine years, producing a tome of over 1500 pages. Many of these pages addressed the problems of nursing, with which Merton was most familiar. The ambitious book was never published. According to (Bloom 2002:fn46), the unpublished manuscript "for years enjoyed an underground vogue in mimeographed form among insiders at the Columbia Bureau of Applied Research." This project led to Merton's narrower inquiry into the sociology of medical education, which through various collaborators, produced multiple dissertations and dozens of articles. During this period, he also authored a number of articles specifically concerning professionalism among nurses, most of which were published in the *American Journal of Nursing* and various other association publications.[9]

While he indeed retained an understanding of professions as fulfilling specific social functions, in many ways, Merton's thought on the professions prefigured the relational,

jurisdictional model of the professions later advanced by Abbott (1988), Larson (1979), and others. Specifically, Merton and his colleagues saw the professions as interrelated with regards to their social functions and their scopes of practice. The boundaries of practice, he notes, correspond to what he calls the "zone of ambiguity," where the scope of practice is at least somewhat undefined and open to contestation (see also Goode 1960). In this sense, Merton defined as one of the key objectives of a professional association, and professional education, the continual definition and expansion of the practice jurisdiction of the profession relative to those nearby.

But perhaps most importantly, the framework elaborated in his writing during this period established a critical role for *morality and values*, both in shaping the actions of the individual professional, and in framing the goals of professional associations. His key insight here was that the social regulation of professional work was uniquely dependent on social status. The importance of moral obligation lied in what he saw as a difficult social dilemma (see Rueschemeyer 1964). Professionals apply abstract knowledge to solve difficult, non-routine problems, and the degree of dependence on this specialized abstract knowledge meant that professional practice could not be adequately monitored and controlled by non-professionals. At the same time, the high social value of the profession's services makes it critical to establish some mechanism of social control. The way to resolve this dilemma was to build institutions, in the form of regulations, state bodies, and professional associations, that were built to harness the professional's individual self control in the service of broader moral obligations. This adherence to a code of professional responsibility had the effect of maintaining the profession's orientation to a positive social function, thus cementing its role in the broader social system.[10] Rather than viewing the professional's high income as a return on investments in the form of education and human capital, Merton's perspective sees high status as a return for the professional's adherence to a moral framework and the pursuit of a broad social good.

4. The legacies of hospital-based nurse instruction. In 1947, Claire O'Sullivan, a native of Ireland who migrated to Oakland to pursue a nursing career, sought to enroll in one of several hospital-based nursing programs in the East Bay. Highland Hospital, a public hospital in Oakland, would not accept non-citizen nurses; Providence and Merritt Hospitals, most upscale hospitals at the time, charged upwards of $500 for their programs. Kaiser Nursing School, on the other hand, offered to cover all of the young nurse's room, board, and educational costs, and to pay a small stipend of ten dollars a month for her first six months at the hospital. O'Sullivan enrolled in the Kaiser Nursing School in 1948. At 21, she was older than most of her classmates, most of whom enrolled at around 18.[11] In the first six months, nurses trained in Vallejo, combining class work with targeted clinical practice. They took courses at the local community college, in anatomy, nutrition, chemistry, microbiology, and sociology; clinical practice involved learning how to bathe patients, make beds, turn and ambulate patients, and administer medications, working with patients at the Kaiser Vallejo facility. After the first six months, nurses moved down to Oakland, taking up residence in the old Piedmont Hotel building downtown, just down the street from the hospital. From there, Nurses worked at

the Oakland facility for two years. As a pre-paid medical service--controversial at the time--Kaiser Permanente cared for "members," most of whom came through institutional connections, including many unions; one of the largest populations coming into the Oakland facility was composed of longshoremen. In Oakland, a common core of nurse leaders assumed the dual roles of faculty for the nursing students, and as directors of nursing service for patient care. In the late 1940s and 1950s, while many graduate nurses stayed on to work as staff nurses at the hospital, student nurses provided most of the care.[12]

Schools like Kaiser's had been in place since the late 19th century, and had proliferated in the early decades of the 20th. They had been introduced, according to Reverby (1986), by

> elite social reformers, concerned with finding 'respectable' service work for the daughters of the 'middling classes' and with improving hospitals... These nursing schools provided hospitals with a workforce that made their institutional growth possible, while training provided women with a 'secular ministry' within the expanding 'benevolent empire' of Christian voluntarism.

This educational model trained most nurses for the first half of the century, and it appeared to "work" for some time. Hospital nursing schools, also called "diploma schools," were often the fulcrum of nurses' social lives, even long after graduation; the earliest professional associations, including the CSNA, had evolved out of hospital-specific alumni associations. Nurses, many of whom were young women from middle class families, were seen as being taken care of within a traditionally patriarchal structure.[13] While earlier generations of RNs would conclude their hospital training and enter private duty service through the local nurse registries, by the 1940s and 1950s, most graduate nurses were finding work in hospital settings, and many would continue to work in the hospital they trained in. The arrangements worked for hospital administrators, too, providing them with a steady supply of inexpensive (or often free) labor; this earned the hospital schools substantial support from hospital administrators and the medical community.[14]

It was this steady font of cheap labor, often competing with graduate nurses, that led many nursing leaders within the professional associations to advocate the closure of hospital schools, despite their centrality to institutional nursing work and to nurses' social lives. These professionalization efforts dated back to the 1920s.[15] For those elite nurses most concerned with increasing nursing standards, hospital-based instruction was seen as insufficient to impart the abstract knowledge necessary for higher advancement within the healthcare delivery setting. As nursing students were assigned extensive care duties, "...heavy demands of the wards made it impossible for all students to attend their weekly lectures and it was always arranged that some students would choose to take very full notes and read them later to the assembled groups of less fortunate."[16] In terms of the establishment of nursing as a profession, the necessary increase of autonomy vis-à-vis medicine and hospital administration was undermined by the absence of an autonomous training program, over which the profession could not establish standards of curriculum or admission. And for those concerned with the economic advancement of the profession, the presence of inexpensive labor on the wards undermined graduate nurses' capacity to

obtain living wages. Moving nurse training into universities would allow nurses to gain the prestige that comes with higher education, and the generally applicable understanding of profession (as opposed to trade) in the contemporary economy; and further, the hospital school provided an incentive to for hospital administrators to keep using "indentured apprentice" labor.[17]

In 1948, Dr. Esther Lucille Brown, as social anthropologist and researcher at the Russell Sage Foundation, published "Nursing for the Future," often referred to as the "Brown Report." The Report called for the movement of nurse training into university settings, and for the creation of clinical specialties. Within the ANA, the publication of the Brown Report was recognized as "beginning the final major move toward preparing nurses in educational institutions."[18] The Brown Report triggered years of committee work and analysis of the problem of nurse education within the association. These efforts were delayed in the 1950s, by the aborted efforts to merge the ANA with the National League of Nursing Education, an educators' association, but by the 1960s the ANA was prepared to take on the task of publicly advocating the closure of hospital schools, and the shifting of nurses' education into the university setting. In 1962, the ANA Committee on Current and Long-Term Goals published a guide to promote study of "goal 3," which was:

> To insure that, within the next 20-30 years the education basic to the practice of nursing on a professional level, for those who then enter the field, shall be secured in a program that provides the intellectual, technical and cultural components of both a professional and liberal education. Toward this end, the ANA shall promote the baccalaureate program so that in due course it becomes the basic foundation for professional Nursing.[19]

But despite these longstanding efforts to extract the nursing school from the hospital, the legacy of hospital-based nursing education established some enduring effects on hospitals, and the division of labor and authority within them. Key among them was the enduring institution of the 'department of nursing,' which would supervise nurses throughout the many units of the hospital. While the heads of these departments would no longer fill the same educational role, elite RNs maintained control over nursing care and the supervision of staff RNs, Licensed Vocational Nurses, Nurses' Aides, and other ancillary bedside labor. These RNs often enjoyed privileged positions within hospital hierarchies, reporting directly to hospital CEOs.[20] As such, the institutional legacy of the hospital nursing school allowed for the maintenance of a stable career ladder, although one which only a few nurses would ever be able to climb.

This meant that nursing would, for some time, retain the class divisions that pervaded the profession in its early years (Reverby 1986). The rules and customs associated with the hospital-school model of labor exploitation created durable institutional structures within hospitals survived the training itself, structures that integrated “nursing” across class lines, joining rank and file staff nurses and elite nurse managers and educators. The profession’s unity would rest less in a common economic interest, than in a shared occupational identity grounded in gender difference, and in a shared commitment to the moral valence of caring labor. While these were broadly shared commitments, they were

most routinely reinforced by those enjoying privileged positions in the nursing hierarchy.

Early Approaches to Unionism in Organized Nursing

While widely shared among nurses, these moral constraints—the view of care work as sacred service, the rigid maintenance of a professional care obligation, and the pursuit of status—triggered recurring conflicts within organized nursing over its orientation toward unionism and collective bargaining. Unionism represented crude, instrumental collective action for the purposes of nurses' financial gain, a stark contrast to the caring, outwardly oriented professionalism that many nurse leaders had advocated during this period. As the history examined below will demonstrate, one of the key sources of moral contention was over the exercise of the strike weapon in a context of a sacred commitment to care. The strike violated the values of many nurses, who expressed a deep moral obligation to provide care to ailing patients. Equally significant was the sense that striking endangered the status attainment efforts critical to the professionalizing project. Many nurses drew stark boundaries between nurses and 'working class' workers who worked alongside them in hospitals, and who were beginning to organize with unions. One of the main ways that nurse leaders drew these boundaries was by appealing to the moral dilemma inherent in the strike, the ultimate tool of unions, which they counterpoised to their own reliance on expertise and the goodwill of the public.

In the 1930s, there were sporadic accounts of unions attempting to organize nurses.[21] By 1939, the CIO had established locals focused on healthcare workers in nine states, including a United Public Workers local in California, though these often drew from a broader base of healthcare workers. The AFL, through its SEIU locals, was bargaining for hospital workers in San Francisco, through they had not organized nurses at this point.[22] But unlike other organizing drives during this period, none of these nurse-organizing appear to have been very systematic, at least as perceived by nurse leaders. Even by the mid 1940s, ANA leaders were unable to identify more than a few indirect efforts to organize nurses into unions.[23] However, the prospect of union incursion among nurses alarmed the leaders of the ANA. In 1937, the ANA Executive Board formed a committee to address this alarm, the "ANA Committee to Study the Question of Unions For Nurses and the Setting Up of Policies on the Subject." The committee included key Association leadership and was by most accounts structured to impede union organizing among nurses. As the minutes of the inaugural meeting of the committee stated, "Activity in the growth of nurses unions is assuming alarming proportions. It is essential that statements pointing out the values of professional associations as compared with other recently organized groups be widely distributed to nurses and among the lay public."[24]

The committee began its informational campaign by planting numerous editorials and articles in the *American Journal of Nursing*. In one unsigned editorial from May of 1938, subtly titled "Union Membership? NO!," the committee laid out its substantive objections to unionism, grounded in the perceived opposition to both professionalism and individualism:

> The ANA stands for the fulfillment of all professional obligations. It cannot therefore recommend or approve membership in any organization which has the power to interfere with a nurse's professional or personal obligations to a patient. [...] Nursing occupies a unique place in the minds of the people. It is one of respect, even of affectionate respect. To our people the nurse is essentially a giver—a giver of comfort. This fundamental concept psychologically is at war with the need of the individual nurse for reasonable working conditions and for economic security. It is also at war with the methods of the unions. [...] By encouraging active cooperation with other organizations, such as hospital associations and hospital councils, and through the promotion of the concept of community nursing service, the ANA constantly extends the scope and usefulness of nursing. It promotes understanding of its particular problems by demonstrating to employers that "a contented personnel contributes to the better care of patients."[25]

The committee's strategy was built on extolling the potential of the professional model to improve the economic lot of working nurses. The committee created and circulated a booklet, entitled "The American Nurses Association and You," which detailed how the professional association strategy was working to improve the nursing profession through education and the development of professional ethics and practice standards. By improving the status and stature of nursing, these efforts would allow nurses to benefit economically. At least 180,000 copies were circulated by 1940, with copies sent to every accredited school of nursing in the country.[26] Externally, the committee established the strategy, which ultimately persisted well beyond the committee's existence, of appealing to managers and the public to support better working conditions for nurses, on the basis of what they saw as the moral authority of nurses, recommending to the board in 1938: “That, as a national organization, the ANA use every effort to arouse the interest of hospital boards and managers and hospital administrators in helping to solve the problems of the hours, incomes, health, and working and living conditions of graduate nurses in hospitals."[27]

At the national level, the threat of union encroachment led the ANA to pursue some further efforts to improve the salaries of staff nurses, although ANA leaders sought to do so through collaboration with hospital administrators. In 1943, former ANA President Julia Stimpson approached American Hospital Association president Frank J Walter to convene a high-level joint committee to address how to improve working conditions for nurses. "It is essential that our two organizations work together in dealing with these problems," she wrote, "because we are confident that they are becoming acute and require immediate attention.”[28] The first meeting of the Joint committee was held in a Cleveland Hotel in October of 1944. At the meeting, ANA representatives framed their efforts in response to the union threat, claiming that "this was the strategic time to develop and establish desirable personnel practices in hospitals and that if the professional organizations do not take leadership at this time, others will.”[29] The Joint Committee then proceeded to negotiate a framework for a voluntary policy for hospital employers that included language on hours, overtime, salaries, holidays, and other common elements of

a contract that might be achieved through collective bargaining.[30] [31]

In California, however, the collaborative approach quickly reached its limit when confronting the mobilization of staff nurses. As the ANA collaborative efforts unfolded, CSNA leaders were compelled to create the first collective bargaining program exclusively for nurses.

The program was created under the leadership of Shirley Titus, the Executive Director of the California State Nurses Association (CSNA) from 1942-1956. Born in Alameda, California in 1892, she became Assistant Director of Nursing at St Luke's Hospital in San Francisco while still a nursing student within hospital nursing school. In her 20s, she worked as a field staffer in the Children's Bureau, which at that time was within the US Department of Labor, working on infant and maternal mortality prevention in rural communities in the South. She then entered the field of nursing education, obtaining degrees from Columbia and Michigan, and holding academic positions in Milwaukee, Ann Arbor, and Vanderbilt.[32] She served with the National League of Nursing Education, editing "A Curriculum for Schools of Nursing" while there, as well as multiple other commissions on nursing education.[33] Titus was thus well versed in the challenges of nursing education, and known as an advocate of professionalization through education, before returning to California. Her writings during this period highlight this overarching concern, pointing to the need to professionalize nurse training in university settings, and of overcoming the resistance of physicians to basic educational requirements for nurses in the 1920s.[34]

Upon her return to California at the onset of WWII, however, she encountered a new set of challenges relating to the working conditions of staff nurses. Prior to her arrival, the CSNA had relatively limited programming, and did little with regard to nurses' economic conditions. It was, in this sense, like most other state nurses' associations affiliated with the ANA. But nurses were facing increasingly bleak conditions during the War. An internal salary survey showed that California nurses had a median annual salary of approximately $1200, for 48-hour weeks—slightly above the national median in the survey, but below what they considered sufficient for basic maintenance,[35] and on an hourly basis, came out to less than what an average day laborer could earn.[36] The War Labor Board fixed nurses' wages, while costs of living on the west coast were climbing.[37] As early as 1942, nurses, at this point unrepresented by unions or by the Association in terms of collective bargaining, were engaging in what Titus called "strike situations," what appear to be wildcat strikes, in response to the failure of hospitals to respond to rising costs.[38] According to a later account, a group of nurses had "threatened to go on strike but it did not materialize. This threat was independent and not under the leadership of the Association but it did support the fact that nurses were becoming restive and perhaps was one of the many factors which pointed up the need for the association to assume an active role in nursing economics."[39]

This necessitated both a reorientation of the mission of the CSNA, and the expansion of services, programming, and permanent personnel. According to Titus, CSNA's expansion

during this period "may be largely attributed to the outbreak of war and the spread and dynamics of the labor union movement," and to the "interest labor unions have been manifesting in bringing RNs within the labor union organization structure." Titus' first step toward addressing these challenges was to appeal to the War Labor Board for an increase in nurse salaries. In order to appeal to the Board, the Association had to establish its position as a representative of the workers in question; and as nurses had no formally recognized collective bargaining agent at the time, CSNA would have to canvas members in order to establish itself as their representative. They mailed ballots to members asking for their votes on two matters: first, as to whether to appeal to the War Labor Board for a fifteen percent wage increase; and second, as to whether to authorize the creation of an "Economic Security Program" representing nurses before employers.[40] The "ballots" they used were essentially union authorization cards—more than authorizing the appeal before the War Labor Board, they sought to establish the CSNA as the collective bargaining representative for members.[41] This would have the effect of not only facilitating the War Labor Board appeal, but also providing an impediment to unions who might seek to represent CSNA members. CSNA took this step at a special meeting of the Board of Directors in Los Angeles, in December 1942. They collected the ballots in the early months of 1943, obtaining a 97% majority in April. In September, the War Labor Board agreed to a substantial wage increase for nurses.[42]

Following these initial efforts with the War Labor Board, Titus went about establishing a more fulsome representation initiative, which she termed the “Economic Security Program.” It was, according to Titus, a rather hasty endeavor, "precipitously launched as an emergency measure designed to control an immediate and critical situation" in response to the "strike situations" in hospitals.[43] Collective bargaining as a mechanism was critical, she reasoned, because "unless collective action and collective bargaining is used, all the standards in the world that CSNA might project relative to improved employment conditions of nurses will be merely words on paper."[44]

At the same meeting where they authorized the Economic Security Program, the CSNA Board hired Paul St. Sure, an Oakland labor attorney who tended to represent management clients, to lead the effort. In the early 1940s, he represented the East Bay Hospital Conference, a relatively new employer association. His hiring was consistent with the broader mission of establishing the ESP as a bulwark against labor unions, even as they paradoxically sought to develop collective bargaining relationships with hospitals. The distinction between the ESP and a labor union, according to St. Sure, lied in the logic behind the exercise power: "We very quickly determined we would never want to use the strike. We determined first to talk about representation and next to discuss directly with the hospital authorities the need for improved conditions."[45] Through a broadly class-collaborative strategy, St. Sure argued, nurses could exercise a subtle, non-economic coercion, building on the implicit threat of unions, and the potential to go to the public to appeal to their sympathies.[46] As he reportedly told the CSNA board years later, in 1954:

> The objective of CNA's economic security program was not to act as a labor union, but essentially they desired to have collective bargaining on a professional basis . . . the hospitals were quite pleased at that time to have CNA stand between

them and the type of organization they feared.[47]

Titus' own feelings about the strike were somewhat more ambiguous, and would apparently change over time. But in the early days of the ESP, they designed a program that conceived of the exercise of power roughly in line with what St. Sure articulated. The early program entailed the drafting of a statewide salary standard, which established proposed salary levels for various nurse positions; the publication of these standards; and, where appropriate, the securing of voluntary recognition by hospitals as nurses' collective bargaining agent. While the organization began a broad member education effort and collected authorization cards from nurses in 1943—presumably as an impediment to unionization—it made no concrete efforts toward obtaining collective bargaining contracts until 1944, when nurses in the East Bay district association (District 1) asked to organize within the ESP. They sought recognition from the East Bay Hospital Conference, an employer association of independent hospitals, as well as with Kaiser Permanente. These appeals were, at this early point, unsuccessful.[48]

Contending with Staff Nurse Insurgency: The Crisis of 1946 and the Consolidation of the Economic Security Program

Insurgent pressures from staff nurses did not abate, and would continue to push Titus and the CSNA further toward an organizational commitment to collective bargaining. What had been sporadic and isolated workplace upheavals gained an institutional weight in 1946, with the formation of a staff nurses' guild, organized in within the Alameda County Nurses Association (ACNA) by nurses in Oakland and Berkeley. Nurses formed the guild in the months leading up to the Oakland General Strike that December. At the national level, 1946 saw a great deal of labor unrest, made clear during what became the largest strike wave in US History, involving over 4.5 million workers (Rhomberg 1995). In the East Bay, it was a period of growing working class organizing and consolidation around the AFL and CIO labor councils. Having served as a key center for war industry during WWII, the East Bay had developed a large, multi-racial group of factory workers who were eager to organize, while rivalry between the AFL and the CIO accentuated the organizing efforts during this period (Rhomberg 1995). By December, a strike of a few hundred clerks at two Downtown Oakland department stores quickly cascaded into a broad strike involving 100,000 workers in AFL unions, with many more CIO members honoring picket lines across the city.

In the months leading up to the General Strike, nurses were not yet formally organized into unions. Nevertheless, the atmosphere of the time was clearly infiltrating into hospital workplaces, and into the association meetings themselves. In the ACNA, a group of nurses in the association began agitating for unionization among nurses. In November of 1945, a group of nurses led by ACNA President Kathleen Toepke, then also serving as the Assistant Director of Nursing at Alta Bates Hospital, formed the Nurses Guild of Alameda County by membership vote. Toepke and her colleagues formed the Guild as a staff-nurse-centered organization within the ACNA, one that would retain ties to the professional association, but nevertheless exist as an autonomous entity of staff nurses.

Guild nurses saw the conflict of interest inherent in the professional association, which united nurses along occupational lines, but spanned class lines and lines of authority within the workplace, incorporating administrators and educators who would frequently hold leadership positions in the association. This was made clear in their efforts to create a guild whose membership was restricted to staff nurses.[49]

The ANA, which had previously taken a firm stance against collective bargaining for nurses, reacted negatively to the development of the formation of the guild, with the Executive Board affirming that the Guild was not authorized under the ANA constitution and bylaws.[50] Within CSNA, however, the reaction was more ambivalent, and a bit less clear. Shirley Titus, the Executive Director of the CSNA, was clearly committed to the interests of staff nurses, had developed and encouraged the maintenance of the Economic Security Program, had published articles advocating the use of collective bargaining for nurses,[51] and was by then already known within the ANA for her advocacy for a national program.[52] In early 1946, the CSNA board under Titus had made the first call within the ANA for a 40-hour workweek for nurses. Yet, she was also clearly threatened by the Guild, as a threat to her own authority and in its potential to generate pressure to organize nurses outside of the association, which she saw as antithetical to the interests of the broader interests of staff nurses. In a February 1946 letter to ANA Secretary Alma Scott, Titus lamented "this Guild affair is throwing a great deal of work, as well as worry, on the shoulders of the Administrative staff of the CSNA."[53] She would later state clearly that while "It would be very short-sighted to have the ANA condemn unions [...] [it is also] very important to have state associations take the stand that they do not disapprove of labor unions as such, but that nurses intend to take care of their own. The point is, that labor unions cannot serve the needs of a professional group."[54]

Titus had established the Economic Security Program in response to pressure from below, from increasingly militant nurses who were agitating for more forceful representation, and who she saw as at risk of defection. The program "was established in great haste" she would tell her colleagues at the height of the Guild conflict. "We had mass resignations in hospitals, various threats [...] nurses were bound to get in trouble. [...] Also, a group in the CIO has their organizers out among the nurses, many of whom thought this a pretty good idea.... The fact that the CSNA set up an economic program nipped in the bud this other movement."[55]

But, there is also evidence that Titus was not only interested in establishing a collective bargaining program, but was also considering merging a unified CSNA bargaining program into the CIO. In a letter to Toepke, Goodman Brudney, Regional Director of the United Public Workers of America, CIO, described a meeting with Titus and CNA President Edna Behrens at the San Francisco CIO office in February 1946, shortly after the Guild was formed. At the meeting were Brudney, Titus, CSNA President Edna Behrens, SF Labor Council President Paul Schnurr, California State CIO Council Secretary Melvyn Rathbone, and Barney Young, International Rep for the United Office and Professional Workers, CIO. In the meeting, Titus was said to have expressed admiration for the CIO, for its organizing and legislative programs, and sought to move

the CNA as a whole into the Congress while maintaining its occupational identity and commitment to professional unity.[56] It was reported elsewhere that Titus had held similar meetings with the AFL.[57]

In the months that followed, the ACNA Guild nurses continued to agitate, and CIO activists decided to integrate the nurses without waiting for the CSNA to move. In June of 1946, The Alameda County Nurses Guild affiliated with Local 699 of the United Public Workers of America, a CIO union known at the time for its strong associations with communist groups. A number of the nurse activists leading this defection from the association resigned their positions at the CSNA, including Toepke and several of her lieutenants in the ACNA.[58] Writing to her members in September, Toepke framed the departure from the CSNA as primarily a response to the hostility of the ANA to an autonomous organization of staff nurses.[59]

CSNA officers fought back this effort, ultimately winning the votes of most of the Alameda County nurses and retaining them in the Association. In order to stem the pressure from the Guild activists, over the course of that summer and fall, the CSNA greatly accelerated its representation program, hurriedly signing contracts with hospitals as a state association, rather than allowing Districts to negotiate their own contracts. In July 1946, the CSNA signed its first formal collective bargaining agreements with hospitals, the first such agreements in the nation: Alameda Hospital, in Alameda; Alta Bates Hospital and Berkeley hospital, in Berkeley; Oakland, Peralta, and Merritt Hospital, in Oakland. Through early 1947, the CSNA negotiated several other contracts across the Bay Area.[60] By 1948, eighteen Bay Area hospitals had signed contracts with the CSNA.

The precise details of how these first East Bay contracts were negotiated were a matter of controversy at the time. CSNA leaders held that members had authorized the association to bargain, both through the initial balloting preceding the War Labor Board hearings and through a subsequent re-canvas.[61] But CIO organizers charged them with collusion with the hospitals to obtain those contracts, as both groups had an interest in preventing the growth of the Guild and a CIO foothold among nurses. Guild leaders claimed that they used employer pressure to get nurses to authorize the CSNA representation and contracts; they called instead for a secret ballot election.[62] Laura Lee Swan, a nurse working with the Guild, expressed in a statement that the contracts came only due to the pressure from the Guild: "The CSNA can hardly overlook the help given to them by the CIO Nurses' Guild. Without the pressure created there would have been no reason for the East Bay hospitals to sign any contracts. We have purposely stayed out of San Francisco to avoid being put in the position of a lever for the CSNA to use in signing up hospitals."[63]

The UPWA Guild represented between 50-100 nurses for the next few years, primarily at Kaiser Permanente.[64] Shortly after their inception, the hospitals in the area agreed to require RN membership in the CSNA, which Guild organizers claimed decreased membership. The UPWA dissolved in 1949 after being expelled from the CIO for its Communist Party affiliations. [65]

While the primary challenge to CSNA representation came from the Guild in the Bay Area, the association was also facing pressure from an AFL union in the South. The Building Service Employees International Union (BSEIU-AFL) had recently chartered a new local, the Registered Nurses, Technicians and Professionals Guild Local 295. Like the USWA organizers, BSEIU organizers clearly saw the CSNA as a "company union."[66] At the time, BSEIU locals represented about 200 hospital workers in Los Angeles, but no registered nurses—nevertheless, they had substantial hospital membership in the Bay Area, as well as in other cities, and some leaders perceived the new CSNA collective bargaining program as a dangerous encroachment upon their jurisdiction.[67] The Guild, operating with the support of various Los Angeles BSEIU locals, began an initial organizing drive among the nurses working at Cedars of Lebanon Hospital. Despite their claims of distinction from the professional association, BSEIU leaders declared that nurses were "morally bound against striking," and sought to build pressure against Cedars through pickets and solidarity actions with other groups in the area, including movie-star members of the Screen Actors Guild.[68]

In short, while Titus had been an advocate within the ANA for more forceful economic security advocacy, the initiation of the formal collective bargaining program in California was broadly triggered by nurse agitation and competition from the CIO and AFL. However, the union encroachment threat also provided Titus with leverage over the entrenched opposition to collective bargaining within the broader ANA. In the months that followed, she would use the threat of "external" unions to push for a more aggressive program of staff nurse representation. In September of 1946, Titus, Behrens, and other California nurse leaders arrived in Atlantic City New Jersey for the Annual Convention of the ANA. Fresh from having established the first collective bargaining of the new CSNA Economic Security Program, Titus and her allies looked to legitimize their new model.[69] At the meeting, the body authorized state associations to develop collective bargaining programs.[70] Within a few years, Economic Security Programs were established in several other states, most of which had also seen union organizing efforts among nurses.[71]

The development was not universally acclaimed.[72] Despite its embrace of some collective bargaining, many within the association continued to resist the notion that they were somehow engaging in unionism; indeed, for many, one of the key reasons for embracing an Economic Security Program was to avoid allowing nurses to turn toward unionism. To maintain this distinction, the ANA implemented a ban on all strike activity, from the inception of the Economic Security program and for two decades thereafter. The Association's article introducing the program to the state associations made this clear: "Under no circumstances would a strike or the use of similar coercive measures be countenanced." In 1949, the Board of Directors formalized this policy with a resolution stating,

> In recognition of the fact that the nursing profession and employers of nurses share responsibility for provision of adequate nursing service to the public, the American Nurses Association, in conducting its Economic Security Program, (l)

> reaffirms professional nurses voluntary relinquishment of the exercise of the right to strike and of the use of any other measures wherever they may be inconsistent with the professional nurses responsibilities to patients: and (2) reaffirms its conviction that this voluntary relinquishment of measures ordinarily available to employees in their efforts to improve working conditions imposes on employers an increased obligation to recognize and deal justly with nurses through their authorized representatives in all matters affecting their employment conditions.[73]

Tactical Adaptations: How to exercise power without the strike?

The introduction of collective bargaining relationships with employers, even while still limited in these early years, challenged many facets of nurses' existing moral order. Newly thrust into a relationship that was, by law and tradition, geared toward mediating inherently antagonistic relations between employers and employees, many saw the new relationship as contradicting existing moral conventions. The dominant strategy of professionalization through social closure implied the embrace of collaborative relationships with administrators and physicians, and the distancing of nurses from other occupational groups further down the hierarchy; collective bargaining, to many nurse leaders, impeded both of these goals. Many saw the very discussion of collective bargaining and unionism as challenging the status orientations and moralized images of nursing. The introduction of collective bargaining into this ongoing professionalization project, in other words, created profound dilemmas in the eyes of many association leaders.

Perhaps the most significant of these dilemmas was the question of how nurses should exercise power. In the years following the introduction of collective bargaining within the CNA, nurse leaders within the association were deeply ambivalent about nurses' exercise of power. This is not to say that these mostly elite nurses doubted whether nurses should be powerful—most agreed that the further empowerment of the profession was critical. Indeed, for advocates of the professionalization project, the matter of how to build nurse power was fairly straightforward: nurses could advance the profession through building expertise, social closure and increased status. Unionism and collective bargaining did not fit into this framework, and in the eyes of many, undermined it.[74] Out of this ambivalence, nurse leaders tasked with implementing this program faced a profound strategic dilemma: how could they exercise power through a collective bargaining relationship, when many considered coercive action within a workplace to be in violation of basic moral standards?

Within workplaces, nurses themselves pushed CSNA leaders. Throughout the 1940s, 1950s, and 1960s, nurse organizers and staff nurses routinely pushed the boundaries of the strike prohibition. As early as 1942, well before the events of 1946 and shortly after Titus' arrival at CSNA, some CSNA nurses in the Bay Area threatened a strike. Some of the scarce accounts of the event suggest that the strike threat was a deliberate action intended to demonstrate to the War Labor Board that there was a risk of labor unrest among nurses, thus justifying the Board's intervention and the imposition of higher wage

levels—an intervention they achieved in 1943. On the other hand, some leaders would later maintain that the strike threat rose directly from staff nurses rather than CSNA staff, but that Titus took advantage of the situation to push for wage increases before the War Labor Board.[75]

Beyond this explicit strike threat, there were other instances of small, strike-like actions within workplaces in the 1950s. For the most part, these actions were small and contained to single workplaces.[76] Some of these actions, such as sickouts, were likely carried out with the support of CSNA staff.[77] There were also multiple instances of mass resignations, in which all or most of the nurses at a facility simultaneously submitted letters of resignation. Titus herself appears to have personally skirted the line on the strike ban during this period, in support of small-scale mass resignations. During a period of conflict at Vallejo General Hospital in 1955, hospital administrators agreed to match the East Bay wage rates after six months of delay, but refused to make the change retroactive. Titus visited the facility, and is said to have publicly told managers:

> The nurses' professional organization does not condone mass resignations, but the CSNA has no authority whatsoever to dictate to its members where they should work, or for how long... If they feel their employment conditions no longer are satisfactory, and if they feel like resigning and seeking nursing positions elsewhere, then it becomes solely their own choice. There is nothing the CSNA can do about it.[78]

Another tool that nurses used, perhaps paradoxically, was the refusal to accept pay for their work. In this case, nurses would work, but attempt to use moral suasion to get patients to refuse to pay hospitals for their services. At the time, nursing care was listed as an item on hospital bills, allowing nurses to point out to patients which component of the bill they should decline to pay. In one attempt to gain recognition at a hospital, after several months of the employer's refusal, CSNA nurses

> Agreed to notify management and the patients that on a certain date they would be reporting to work but would be donating their services and at this time the nurses urged the patients to seek adjustments to their hospital bills which would reflect the deletion of the cost of registered nursing service which was being donated... Management went so far as to grant salary increases and other improved conditions of employment which were being proposed by the nurses but refused to negotiate with the association.[79]

But even as they pushed the boundaries of the strike ban, they also focused on developing a series of tools that built upon non-strike practices. The ANA's 1956 economic security program manual, authored by Titus' group, delineated how state nurses associations could go about turning public legitimacy into economic power for nurses. The strategy laid out—which reflected the practices of the CNA at the time—was the establishment and distribution of employment standards. These standards would be disseminated widely to the many potential allies of nurses, from patients to physicians, who would be receptive to nurses' needs and who were seen as having particular sway over hospital administrators. The authors grounded these strategies in a reframing of economic

demands as consistent with the moral responsibility of nurses:

> Professional nurses have a dual responsibility. First, they have a responsibility to the public - their patients - and, second, a consideration of their own welfare or economic security. The first obligation… has been regarded mistakenly as a reason why nurses should not pursue their rights, as Americans, to a standard of living and working consistent with their professional status. It has even been exploited by some in order to maintain conditions of employment that are inconsistent with nurses' professional responsibility and with generally accepted employment standards, and that prevent nurses from obtaining some of the tangible fruits of their labor.[80]

Critically, the authors also laid out a mode of exercising power in the absence of the strike. This new mode conceptualized the hospital workplace as a nexus of social relations that could be influenced by moral authority. Rather than outlining how to engage in strikes and grievances, the manual advocated collecting and disseminating data on nursing conditions and patient care, building alliances with legislators and other groups in the healthcare field, and an emphasis on public relations. The manual encouraged a "long-range, continuous educational and informational campaign to create a favorable climate of opinion for nurses' efforts in this area, and to build understanding and united support among nurses themselves."[81]

This approach of obtaining economic leverage by capitalizing on public legitimacy was also reflected in the association's longstanding commitment to advocating for patient care, both in rhetoric and in organizational structure. In terms of membership, the CNA's commitment to professionalism implied a continued commitment to representing nurses in management positions, including in many economic security activities—in a statement on the place of nurse directors, the ANA argued that "the economic security interests of the director are closely aligned with those of the other nurses in administrative positions. Her employment problems may be considered and acted upon by her group within her occupational section."[82]

Organizational Adaptations: Bureaucratic Restructuring and the Organizational Insulation of Collective Bargaining

At the national level of the American Nurses Association, the conflicts over collective bargaining and professionalism led to the creation of semi-autonomous commissions[83] that broke down along nursing's class lines, but which retained limited authority. First initiated at the national level, the commission structure would soon come to be adopted by many State Nursing Associations, including in California. This organizational structure had its roots in a series of efforts at organizational reform dating to the 1946 production of a report by Rich and Associates, a consulting firm jointly hired by the major national nursing organizations to propose a broad restructuring of the profession.[84] The Rich Report envisioned a series of interconnected organizations centered on the ANA.[85] Within the ANA, one of the most important recommendations was the creation of clinical "Sections," organizational units structured around distinct areas of clinical

nursing practice. The other major reorganization proposal concerned the creation of semi-autonomous "Commissions," charged with studying and proposing plans to carry out the key functions of the association, which would break down along program emphases.[86]

Conversations concerning organizational restructuring continued through the 1950s, again, focused primarily on the goal of unifying existing nursing organizations, a goal which would prove elusive.[87] Within the ANA, with leaders now recognizing that it would restructure largely on its own, they returned in the early 1960s to the Rich report in an effort to restructure itself. In 1959, the ANA Board appointed a 'Study Committee on the Functions of the ANA.' After several years of internal discussions, the Committee formally proposed a restructuring program to the House of Delegates in June of 1964. Francis Powell, Chair of the Study Committee, wrote a series of three articles in the AJN articulating the outcome of the Study Committee's work, the proposals for organizational restructuring, and the reasoning behind them.[88] While not all of the prescriptions of the Rich report were followed, several critical ones were. Perhaps most importantly, the Committee called for the creation of three Commissions: the Economic and General Welfare Commission, which would absorb the functions of the Committee on Economic and General Welfare, with the addition of some additional authority (with conflicting interpretations of whether the proposal would give the Commission control over the Economic Security Department, which housed the staff); the Nursing Service Commission, which would focus on service provision within institutional settings, i.e., representing the interests of administrators and nurse managers; and the Nursing Education Commission, which would focus on educational standards and accreditation. The Commissions would be composed of a combination of members elected by the membership at the House of Delegates (at large), with remainder appointed by the Board. While the Commissions were established to focus on different programmatic areas of the Association rather than to represent different groups of nurses, it became clear rather quickly that the commissions would come to represent nurses in different structural positions, within the profession as well as within hospital workplaces themselves. The EGWC would come to represent the interests of staff nurses; the NSC the interests of nurse managers (indeed, in California this body would come to be called the Nursing Service Administrators Commission); and the NEC, the interests of faculties of nursing.

The creation of the three commissions cemented a broad recognition that the three main programmatic areas of the Association were becoming more stable. And creating a body charged with moving forward the collective bargaining program, which was at least formally at the same hierarchical level as the bodies focusing on management and education, was a step that left many elite nurses uncomfortable. The commission structure was vigorously debated at the June 1966 ANA Convention in San Francisco, at which the final structure was to be ratified—held just weeks before the Bay area strike later that summer. Perhaps fearing a potential loss of control, nurses from the floor moved, unsuccessfully, to make the commissions fully appointed, rather than partially elected.[89] Another amendment to the resolution creating the commissions, while symbolic, clearly communicated the disdain many in the room felt toward the collective bargaining program. While the original bylaw proposal creating the commissions had

listed the EGWC first, followed by the NSC and NEC, the amendment changed the order to NEC, NSC, and EGWC. Anne Zimmerman, a member of the bylaws committee and future Chair of the EGWC, protested that while achieving nothing substantive, "the proposed amendments to Article XIV would replace all present references to sections," the amendment nevertheless passed.[90]

While the commissions retained limited autonomy, the creation of the Economic and General Welfare Commission—both at the ANA and CNA levels—nevertheless created an institutional home for advocates of collective bargaining, where staff nurses could elect institutional advocates. Following the events of 1966, these institutional homes would become critical centers of militant agitation and leadership development for staff nurse advocates within the association.

Challenging the Professional Model: The Politics of Nurse Education

In December of 1965, the Board of the American Nurses Association published in the *American Journal of Nursing* a report covering recommendations concerning educational requirements for entry into the practice of nursing.[91] Entitled "The ANA's First Position on Nursing Education," the report was a sweeping denunciation of the way in which most nurses were trained at the time, in hospital-based nursing apprenticeship schools, or "diploma schools," and set as the Association's policy to work toward extracting nurse education from hospitals and building new programs in universities and community colleges. The autonomy of the profession, these leaders argued, required the severing of the subservient occupational relationships inscribed in the hospital school structure, and for the development of training programs that were independent of the service delivery organizations. Autonomous programs within higher education institutions would allow nurses as a whole to gain the prestige that comes with higher education, and the generally applicable understanding of profession (as opposed to trade) in the contemporary economy. The hospital schools were also, the report argued, a key impediment to the improvement of nurses' economic conditions:

> The earliest nursing schools in the United States were independent and adhered to the Nightingale pattern. This pattern did not continue and nursing education has spent a century trying to re-establish the basic premises of the Nightingale school. Although some of these early schools did not survive, those that did lost their independence. Voluntary hospitals expanded at an extremely rapid rate, and schools of nursing with their system of indentured apprenticeship were the cheapest possible answer to desperate staffing problems.[92]

A second goal was to formalize the distinctions within the ranks of nursing. As part of this general up-skilling, the report also called for the occupational differentiation between nurses of different levels of training. At the time, graduates of existing Bachelors of Nursing programs and graduates of the diploma schools were both considered Registered Nurses--equal with regards to the formal certification requirements inscribed in hospitals' occupational hierarchies. The report called for the restriction of the RN license to those who obtained the Bachelors of Science in Nursing (BSN) degree, or higher; graduates of

Associate Degree programs would obtain a technical nursing license.

Both of these goals generated controversy in the ranks of staff nurses. At the time, the vast majority of working nurses in the hospital wards were graduates of diploma schools; the ASN and BSN programs were still relatively small and recent innovations. For decades, the professional association had taken great pains to argue that all nurses were "professional," deserving of the material rewards and status distinctions inscribed in the label. But implicit in the publication of the education position paper was a perceived attack on the diploma school majority, a status demotion to “technical” capacity; for many, it was a position that was premised on the incompetence of the nurses populating hospital wards at the time. The position also represented a monopolization of the "professional" label for a small elite group of nurses. It exacerbated what many perceived as a longstanding and growing distance between "nurse leaders"--the association officials, nursing department executives, and nursing faculty--and the staff nurse rank and file.

At the ANA's subsequent convention, held in June of 1966 in San Francisco, these tensions came to the fore during discussions of the controversial plan, according to the convention report: “Many individual nurses and many groups of nurses had recorded their concern over possible loss of professional status; practical nurses saw in it a loss of their identity."[93] Discussion of the report continued for two days, with many delegates speaking in opposition. During a debate concerning a proposal to amend the report that currently practicing nurses would be considered "professional" under the new system, one CNA delegate rose to question the entire debate: "By what right to we call ourselves professionals?" she asked. In response, ANA President Elliott called on Robert K Merton, the ANA consulting sociologist who had been closely involved in helping the association craft the Position Paper, to address the question. His reply:

> If there were ever any doubt that mid-twentieth Century nursing represents a profession, surely that doubt has been erased at this historic convention. The field of nursing has all the attributes that have historically marked the existence of a profession. It is enlarging a systematic body of knowledge which is applied to the public interest. It has a moral code governing the behavior of practitioners that assures a commitment first to the patient and only secondly to the practitioner. Above all, it has a commitment to the future to enlarge both the knowledge available to the nurse practitioner and to insure that each generation will move beyond the one before. The action that you have taken in expressing your approval of the Position Paper does, I believe, capture your entire development as a profession. The Position Paper does not in any way affect what you already have—a full professional identity. The Position Paper addresses itself exclusively to the impending and long overdue changes in the system of nursing education. During the interim between 1966 and that unknown time at which the vast majority of practicing nurses will have acquired at least a baccalaureate education, every nurse practitioner will continue to enjoy and deserve by virtue of the quality and work she does, the standing of a professional man or a professional woman.[94]

Given his participation in ANA affairs at their headquarters in New York City, and his involvement as a consultant on professional education concerns, it is unclear how aware Merton was of the restive state of the staff nurse rank and file at the time. But even as the Association leaders managed the opposition to the education position from among a minority of convention delegates that June in San Francisco, a more concrete form of opposition was brewing outside the doors of the San Francisco Civic Auditorium.

Chapter 3. Moralizing the Strike: 1966-1974

The Summer of 1966 and the Reclaiming of the Strike Weapon

The strike ban would remain in place until 1966.

The CNA, now representing nurses in 33 hospitals across the Bay Area, was in the process of negotiating a new set of contracts for RNs. Nurses working in Kaiser facilities in Vallejo and Richmond requested permission from the CNA to engage in informational picketing, protesting the slow pace of negotiations and the perceived discrimination in pay relative to largely male occupations in the hospitals. In June of 1966, at its San Francisco Convention, the ANA had adopted a goal of achieving $6500 as a minimum annual salary. Over the course of the summer of 1966, CSNA nurses took the salary demands that had been articulated at the ANA convention and steadfastly held to them during prolonged negotiations with two hospital employers' associations—Associated Hospitals in San Francisco and Affiliated Hospitals in the East Bay.

The years preceding this round of negotiations were not ones of extraordinary militancy, beyond the scattered workplace conflicts mentioned above. After Titus' retirement from the CNA and ANA in 1956, the Economic Security Program remained under the direction of A. Lionne Conta, a Titus protégé, a sociologist who drew on Merton and Selznick in her writing, and well-known advocate for collective bargaining who would soon serve as a member of the ANA Committee on Economic and General Welfare. But by some accounts, the economic security program was deemphasized within the overall scope of the organization. This change was reflected in the Board's appointment of Marian Alford as Executive Director upon Titus' retirement. Alford received a specific request from the Board, "that there be concentrated effort to build and rebuild organizational relationships," primarily to reestablish harmonious relations with hospital and physicians associations where they had been frayed by collective bargaining.[95] While Alford had worked with Titus on her Economic Security efforts, she was known for her commitment to the profession's service orientation.[96] By some accounts, during Alford's tenure, CNA was seen as having "sat upon" the collective bargaining program.[97] Alford instead emphasized establishing liaison committees with the California Hospital Association, Affiliated Hospitals of San Francisco, and the Hospital Council of Southern California, which at the time was staunchly opposed to collective bargaining.[98] These committees focused on the establishment of "joint statements" to define workplace policy. These joint statements, negotiated at the statewide level beginning in 1957, were also used to define the scope of nursing practice in hospitals and other workplaces, primarily for the purpose of containing nurse liability.[99] In the view of contemporary CNA leaders, these joint statements were part of a sustained strategy of defining and

growing nurses' scope of practice.[100] In the view of their rank and file critics, however, they amounted to collusion with medicine and hospital administrators, which failed to exercise sufficient pressure to assure that nurses' wages would keep up with those of other occupational groups.[101]

Within hospital workplaces, many nurses were becoming increasingly incensed with the wages they were earning, particularly in relation to other occupational groups. According to many observers, there was a noticeable uptick in militancy among nurses in the mid 1960s, which the association had until then been unable, or unwilling, to harness. But if the aging association leadership was reluctant to embrace a more militant stance, they were committed to maintaining the Association as the principal representative of staff nurses in economic and professional matters, a positioned they perceived was threatened by insurgent staff nurses. Multiple contemporaneous accounts characterize the relationship between CNA leadership and rank and file nurses in this way.[102].[103]

Nurses' wages in the Bay Area, at a median of approximately $505 per month, were lower than most other occupational groups in hospitals, including many which they saw as requiring less skill; anecdotes in contemporary press frequently highlighted how nurses earned less than many gardeners and maintenance workers represented by Local 250.[104] Nurses also complained of accelerating work of increasing difficulty and complexity, a product of short staffing as hospitals sought to adapt to increasing case loads and high-technology tools.[105] Multiple early accounts discussed staff nurses' frustration with the CNA negotiators. Nurses were organizing autonomously to share their grievances. Arda Vonderheid, who would later be President of the Golden Gate district association, wrote:

> Small groups of nurses gathered together to share ideas and to write bylaws for their groups in order to state their philosophy, purpose and objectives, and to create a structure for their endeavors. Real, imagined and distorted gripes, concerns, and problems were explored. Every possible kind of internal information was collected and agency profiles were laboriously compiled like giant jigsaw puzzles. Community, economic, political, legal, and labor organization information was collected and shared. Relationships were established inside and outside of the employment setting that had never existed before. Peer pressures were applied and membership cards were signed. Meetings were held in homes, in college and high school auditoriums, in labor union meeting halls, and in churches.[106]

These autonomous meetings also apparently included meetings with SEIU Local 250 and Teamsters to discuss affiliation.[107] Both organizations had had repeated contacts with working nurses across the Bay Area in the months prior.[108] Local 770 of the Retail Clerks Union, which represented some pharmacists and laboratory technicians at Kaiser, also made moves to form a new Nurses' Guild in Southern California that summer, to take advantage of this perceived disaffection among staff nurses, as well as Southern district associations' noted reluctance to develop their collective bargaining program.[109] The Retail Clerks circulated letters claiming "prayers alone won't bring adequate incomes,"

and arguing that the rebelling nurses "have demonstrated their contempt for the listless and inept leadership of the spineless professional association."[110]

The most important step toward pushing CNA leadership, however, was taken by small groups of nurses who had decided to revive a tool they had not used since the 1950s—the mass resignation.[111] A mass resignation entailed organizing a large group of nurses to simultaneously submit letters of resignation to their employer, effective a short period after delivery. The tactic was a de facto strike threat, while remaining technically in accordance with the strike ban. It was also a very risky move, as the nurses risked their jobs while enjoying none of the protections accorded to workers under the NLRA.

In early July, nurses at Eden and Washington Township hospitals were the first to threaten mass resignation. CNA represented the nurses at Eden, but not at Washington Township. While some employers believed that the events had been orchestrated at the highest levels of the ANA, that unrepresented nurses were among the first to engage the mass resignation tactic is indicative that this pressure was in part emerging from workplaces.

Washington Township Hospital conceded to the resigning nurses on July 7th, offering monthly salaries ranging from $505-$663.[112] Eden Hospital, however, did not concede. On July 10th, a majority of nurses failed to report for duty. After four days, all were rehired under the conditions granted by Washington Township. After Eden, several other independent or private hospitals not included under the Associated or Affiliated employer groups also instituted the Washington Township wage rates, apparently similarly under thread of mass resignation from nurses.[113] Shortly after the Eden and Washington Township resignation threats were made, the Affiliated and Associated employer associations, along with Kaiser Permanente, the single largest healthcare employer in the region, began meeting to coordinate activities, according to Kaiser, "treating salary considerations as a Bay Area problem."[114] A few days later, CNA contacted all groups to coordinate negotiations together. The first joint negotiation was convened by the State Conciliation Service July 8th.

A July 15 internal Kaiser Permanente memo from Clifford Keene, MD, then the Director of the Kaiser Foundation Hospitals and Health Plan, to Edgar Kaiser outlined the CNA's persistence on the salary demands. Keene suggested that for Kaiser, the nurses' salary demands would mean an 85% cost increase for nurses, as well as increases for other occupational groups whose pay and benefits were tied to nurses'.[115] On July 17th, Associated and Affiliated employers unilaterally instituted their last proposal, a Bay Area-wide salary structure of $500-570. On July 20th, the hospitals "announced that there was no basis for a settlement." CNA leaders threatened further mass resignations, across the thirty three hospitals at which it was negotiating contracts, and submitted 1,979 resignation letters representing 71% of affected nurses.

According to internal correspondence, it was Kaiser Permanente negotiators who first introduced the idea of a fact-finding commission, first convincing the employer

associations to advance the idea. Having reached a negotiation roadblock and facing substantial unrest across the region, Kaiser negotiators hoped that pushing the responsibility for determining wage rates onto an impartial body would ease the tension and end the dispute.[116] The proposal was to submit the still-contested matters to a three-man body with members appointed by the California Governor, the Secretary of Labor, and the Secretary of Health, Education and Welfare. The employers' associations submitted the proposal.[117] CNA, at first, rejected the fact-finding proposal, before ultimately acceding to it in the days before the mass resignations were to take effect.[118]

During the fact-finding hearings, CNA leaders argued that their long-time rejection of the strike had deprived them of the opportunity to exercise power, which had in turn hurt them economically. It was not lost on those in attendance that they were all in the room because staff nurses had, indeed, exercised coercive economic power. But they articulated the need for a salary increase by grounding their argument in professionalism. On the first day of the hearings, as the CNA laid out its case for higher salaries for nurses, they began by emphasizing professionalism and educational credentials as an indicator of just pay. In their opening statement, attorney John Jennings laid out this distinction:

> This is no ordinary labor-management dispute. We will not be dealing with the typical factors in collective bargaining disputes involving blue-collar workers. We will, instead, be considering the unique nature of registered nurses as an occupational group seeking salary increases. Our case cannot succeed unless this uniqueness is fully understood... The occupation of the registered nurse is universally recognized as a profession; yet, the registered nurse is not treated as a professional. She is not paid a professional salary.[119]

Their first five witnesses, affiliated with nursing programs at Bay Area universities, did not touch upon workplaces or the work of staff nurses; instead, they gave testimony regarding "the academic and clinical experience required for nursing."[120] The second and third days of testimony centered on the changing role of the nurse in hospital care. Witnesses noted that changes in the practice of medicine, including increasing use of technology, the growing complexity of medical practice, and the growing reliance on registered nurses for immediate care decisions, that had increased the caring responsibility of nurses in the years since World War II. Physicians and RNs noted that nurses had come to fulfill many functions that had previously been performed by doctors. The fact finding commission ultimately sided with the nurses, granting them salary increases close to their final demands during the resignation.[121]

Institutional Response: Tactics and Structure at the National Level

The events in the Bay Area had broad effects on nursing, within the ANA and elsewhere—but it many ways it served to heighten, rather than resolve, the tensions and divergent interests within the association. For our purposes here, it is important to highlight two sources of tension that persisted in the immediate aftermath. First, the organization's new militancy with regard to workplace rights led many within to question the priorities, foci, and distribution of resources in the institution itself. And second, as I

will discuss below, there remained simmering tensions concerning how this new militancy would manifest within hospital workplaces themselves.

In terms of changing policies and projects of the CNA and the ANA, the summer of 1966 served to animate many internal advocates of economic action. Ann Zimmerman, the Chairman of the ANA Economic and General Welfare Commission, wrote that the quasi-strike had captured the imagination of California staff nurses, allowing them to see the CNA as the avenue for achieving big outcomes for their common interest: "Since the 1966 collective bargaining breakthrough in California, CNA membership has jumped from 12 to 25 thousand. This is not a mass change in what nurses want. They have decided that they can get what they want now (and wanted in 1965) through the CNA."[122] For many observers, the events marked a decisive shift from the traditional "professional" approach to collective bargaining that eschewed coercion, and which in the eyes of many staff nurses, amounted to systematic collaboration with management.

In terms of practice, the tactic of the mass resignation quickly went national: before the end of the year, there were multi-week work stoppages among nurses in New York (smaller-scale resignations had occurred in New York weeks earlier), Youngstown, Chicago, and Kellogg, Idaho; there were large-scale threatened mass resignations in Colorado, New Jersey, Maryland and Minnesota.[123]

The events also clearly marked a change in how hospital administrators perceived the nurses in their hospitals. In the weeks following the fact-finding commission's report, hospitals unilaterally increased wages in Los Angeles, Santa Cruz, Portland, Seattle and Reno.[124] When in late 1966 the Western Region Director of the Bureau of Labor Statistics interviewed a number of hospital administrators in the region, he asked them why nurse salaries and conditions had remained sub-par despite labor shortages and the growing complexity of nursing work:

> The best assessment the administrators could offer was that the treatment of nurses had remained traditional, despite substantial changes in the nursing function. As long as the nurses accepted that treatment, there was no pressure to change it... The reasons they had not taken any action themselves were that nurses were quiescent, and other matters demanded attention. Some of them blamed the nurses themselves for accepting the status quo for so long.[125]

A more significant lasting effect of the summer's events was the end of the strike ban. On August 21, the CNA Board moved to abrogate the no-strike policy, resolving that the CNA "will take all necessary steps, including economic action where necessary, consistent with the law and nurses' professional responsibilities, to achieve these just demands."[126] Discussing the instances of mass resignation in the preceding months, the board

> Recognized that nurses are becoming increasingly more "militant" and are looking to CNA for responsible leadership in economic security matters. They also considered the fact that labor union activity to recruit nurses as members is being stepped up.[127]

In a memo to the heads of the District Nursing Associations, CNA leaders directly acknowledged that this change challenged presumed conventions of professionalism. Asking whether the CNA will "remain a professional association," they answered,

> Yes. CNA's philosophy and goal continues: to foster high standards of practice, promote the educational and professional advancement of nursing and protect and promote the welfare of nurses. Responsible pursuit of all these ends will continue. Responsible participation in good faith negotiations on nursing practice conditions and salaries and other benefits will continue. Ultimate economic action will not be undertaken in any irresponsible way.[128]

The morning after the meeting at which the abrogation of the no-strike policy was made official, CNA announced the decision at simultaneous press conferences in San Francisco and Los Angeles.[129] One day after the announcement, several Southern California hospitals gave wage increases to upwards of 14,000 registered nurses, amounting to about a 25% raise, above the interim rates agreed to by Bay Area hospitals.[130] Over the next year, the no-strike policy would also be reexamined at the national level. In 1968, the California delegation to the ANA Convention made known that they would be bringing a resolution to the convention calling for a nation-wide rescinding of the no-strike policy. After the Board referred the matter to the newly formed ANA Commission on Economic and General Welfare, at the urging of Chair Anne Zimmerman, the Commission urged the passing of a resolution rescinding the no-strike policy on a nation-wide level.[131] The national policy was discarded later that year.

Shirley Titus died shortly after the abrogation of the strike ban, in March of 1967. But according to Conta's account, she was delighted with the development, having advocated the change since the 1950s, and was pleasantly surprised that the Board would come to that decision.[132] "One of her last wishes," Conta would later write, "was for the ANA to revoke its no-strike policy and replace is with support for creative policies developed by nurses to suit their needs."[133]

Turning this agitation and reinvigorated approach to risk-taking into institutionalized support for staff nurses, however, would require substantial investment. Within the ANA, the newly-formed Economic and General Welfare Commission housed a number of nurses dedicated to nurturing nurse militancy in support of a more expansive professional-unionism. These nurses moved quickly to attempt to use the new Commission structure to take hold of the collective bargaining program, and to move it toward a more aggressive posture.

The plan the Commission developed, which they would term the "New Approach" to economic security, entailed empowering the newly formed Commission to direct broad, comprehensive organizing drives from the national level. The campaigns would be relatively autonomous from both the ANA and the SNAs that would ultimately represent the nurses. The plan was, according to the original proposal, explicitly modeled after national organizing drives conducted by the CIO in the 1930s and 1940s, particularly the Oil Workers International Union's 1942 Oil Workers Organizing Campaign, which

included a national director, research and publicity staff, and organizers on leave from local affiliates.[134]

Since the beginning of the Economic Security Program activities in 1946, the responsibility to pursue collective bargaining remained the prerogative of the state associations, which retained considerable autonomy and latitude over what activities to pursue, and even what to call "economic security." Grounded in a broad, holistic definition of economic security, itself a product of considerable debate and disagreement over what activities were appropriate, different state associations adopted remarkably different approaches. Indeed, by the time of the events of the summer of 66 and the subsequent initiative for the New Approach, many states still declined to do any collective bargaining at all, considering public relations campaigns for increased wages sufficient and appropriate. In 1968 almost 40% of hospital contracts were on the Pacific Coast, primarily in California.[135] Eighteen states did not have worksite representation of any form.[136]

In many states, according to Commission members, longstanding professional customs hindered the development of strong collective bargaining programs. This obstruction was often rooted in the social structures and hierarchies of nurse labor itself. State Nurses Associations were often staffed by nurse leaders who had risen through the ranks of hospitals or educational institutions, who were often ignorant of organizing practices, if not openly hostile to collective bargaining itself.[137] These growing regional differences, Commission members worried, would continue to be exacerbated as some states grew, and other states fell behind. Perhaps more importantly, for Zimmerman and her colleagues, these differences in capacity would ultimately lead to greater polarization in membership composition, with some states with strong organizing and bargaining programs integrating greater numbers of staff nurses into leadership positions, while other states would continue to be dominated by elite nurses. This could ultimately exacerbate the philosophical tensions between class-centered and education-centered advancement strategies that had existed since the 1940s, potentially undermining the unity of the ANA and the broader nursing profession.

Zimmerman and her allies sought to support and expand collective bargaining activities, infuse states with resources geared toward this expansion, and make space for more militant action. While the collective bargaining agents would remain at the state level, Zimmerman saw an opportunity to shape the state programs toward a more aggressive posture by offering national level resources and support for aggressive and experimental organizing programs. In California, organizing victories and wage increases had driven membership from 12,000 to 25,000.[138]

Zimmerman's account of the New Commission's initial meetings suggested a relatively broad consensus for a more aggressive approach. A "New Approach," they argued, was indeed a departure from previous interpretations of the purpose of the Economic Security Program, but the call for change was grounded in the changing industrial and social conditions of the late 1960s, as well as the original documents and ANA positions around

the founding of the program, including the original 1946 House of Delegates resolutions establishing collective bargaining and subsequent ANA platform documents. Fundamentally, they argued, the goals of economic security and control of practice would be achieved only through aggressive organization within the place of work, geared toward establishing nurse autonomy relative to employers and physicians in the worksite.[139]

In order to develop an autonomous program, Commission members envisioned hiring a core cadre of dedicated organizers who could lead the organizing initiative and move from project to project. They sought to hire about two dozen organizers, both nurses and non-nurses, who would approach the organizing drives "with some missionary or peace corps motivation," and who would be willing to "commit themselves beyond the usual duties of a job for one or a few years. Youthful nurses and young persons with university training in labor relations would make a desirable combination."[140] It was this "cadre" of organizers, they envisioned, who would identify leaders and focus the increasingly restive and militant staff nurses on broader campaign goals. Indeed, the membership gains they were observing in states with stronger bargaining programs indicated to them that growth and workplace-centered power were closely linked:

> It is especially significant that these membership gains resulting from bargaining activities are based on the greatest possible organizational independence. To function as employee representative in dealings with employers, the organization must have the allegiance of the nurses and organize them in sufficient strength to withstand employer pressures. There develops a structure of officers and committees in the work group, along with a sharing of control over work practices in written contracts and payroll dues deduction systems, that stabilize membership at high ratios without annual membership campaigns. *This independent strength is in marked contrast to membership promotion based on permissive relations with employers*.

The proposal for the New Approach met with an icy reception from Judith Whitaker, the ANA Executive Director, and others in the organizational hierarchy.[141] Despite sharing many of Whitaker's reservations, Members of the ANA Board of Directors felt considerable political pressure to consider the proposal, at least in part due to the mobilization of staff nurses in preceding months.[142]Almost across the board, however, board members expressed substantial hesitation.[143] Ultimately, despite almost unanimous reservation, the Board determined to approve the New Approach. However, they resolved to assert control over the initiative and to not let it get out of hand. They would do so by controlling the budget, and by controlling the hiring of the director. In terms of the budget, the Board could approve the initiative for political reasons, while retaining the capacity to cut it later, as one member argued: "There is always the opportunity after a couple years that you cease doing it and you say it didn't work, and you either fish or cut bait kind of thing."[144]

By controlling the hiring of the Director of the ANA Economic Security Program, the Board could also make sure that the initiative did not actually take off. And while

Zimmerman had forwarded candidates with a labor background, Whitaker would insist that the winning candidate be a nurse. Whitaker had chosen Elizabeth Cantwell, Executive Director of the Washington Nurses Association, because Whitaker was "convinced that she has the necessary sensitive appreciation of the wide range of attitudes and concerns within the nursing profession about the content of a sound Economic Security Program."[145] And indeed, Cantwell became the Director of the Economic Security Program. According to Cantwell, in a 2008 interview, her hiring for this position was largely in response to her record of peaceable negotiation, conciliatory approach to hospital management, and an effort to quiet nurses down:

> We dealt nicely with the hospital folk and so ANA which is in New York City learned about this. Of course they had nurses all over the place, California, really big places, not too representative, but anyway they said we did that without any salt in the wound. We didn't have a hard time. The hospitals were very complimentary and so they hired me. I wasn't sure I wanted to go to New York, but I thought, well, I'll give it a whirl. […] So we drove on to New York and I was with ANA and in charge of trying to help nurses. ANA wasn't thrilled about all this, the contracts. They said we need somebody that knows how to do it and keeps the nurses from getting out of control.[146]

By 1969, the ANA began supplying direct organizing assistance to State Nursing Associations, beginning with expanded support for federal employee organizing efforts, primarily in the VA system, which had been in place since May 1967. The ANA provided support for 18 field staff working under New Approach projects. In state, municipal, and private hospitals, they launched New Approach projects in Southern California, Georgia, Illinois, Iowa, Kansas, Missouri, Maine, Massachusetts, Montana, North Carolina, North Dakota, Pennsylvania, Rhode Island and South Carolina. These efforts marked the first collective bargaining agreements for Association nurses in Rhode Island, Missouri, and North Dakota. In Pennsylvania, they obtained their first private sector agreement. In North Carolina, while the New Approach project did not result in any agreements, they obtained a 10% salary increase for public sector nurses via the legislature. In Southern California, New Approach staffer Sam Bottone was involved in various campaigns to organize nurses in federal facilities, including at VA, Navy, and Air Force facilities. He also helped organize a nurses' strike at Cedars of Lebanon hospital.[147]

Despite the early successes of these initial New Approach projects, however, the program did not last through the year, falling victim to dramatic budget cuts across the Association in late 1969. ANA leadership gave few public explanations for the causes behind the financial crisis that precipitated the cutbacks, referring primarily to errors related to the Association's conversion to a central billing system.[148] But overall, the cuts were quite deep. On December 15, 1969, a week after the ANA President informed the staff of the Association's economic condition, the project was terminated.[149] Cantwell informed the Commission members that the state projects were to be terminated as soon as the letters of agreement concerning the funding allowed. Not including the staff hired under New Approach projects, the Economic Security Department terminated twenty-six positions, with an additional ten vacated through voluntary resignations.[150] Of the 14 projects

initiated, only seven were completed.[151]

Institutional Response: Workplace-Centered Integration of Professionalism and Collective Bargaining

If the New Approach represented a failed effort to cement space for a more militant collective bargaining program at the national level, in California, the program remained central to the state association. One critical way in which this was reinforces was through the concerted effort to create worksite-based organizational units, and to use them as a key basic unit of the association.

The "Professional Performance Committees" (PPCs) were worksite-based organizational units that the CNA had been developing for some years, and had recently begun advocating as an organizational structure for adoption in other states. They were an effort to combine collective bargaining goals and practices with the broader professional orientation of the association. PPCs brought the concerns of nursing practice and standard-setting into the workplace, directly into the work lives of staff nurses, rather than restricting these matters to the more outwardly-oriented policy and educational efforts of the association. They mobilized members on the basis of their professional identify and their commitment to patient care. And they mobilized the moral authority inherent in the standard setting and patient-care approaches to support collective bargaining efforts. These worksite units were, according to member activists of the 1960s and 1970s, critical to the fomenting of nurse activism within the organization during this period, and they played particularly important roles in the strikes of 1966 and 1974. And due in no small part to this, the PPCs were also a matter of deep controversy within the broader American Nurses Association, where they struggled to gain the acceptance among elite nurses committed to protecting the interests of nursing administrators.[152]

PPCs were first formulated in the late 1950s, under Lionne Conta, who at the time led the CNA Economic Security Department. They were first formally recognized in a collective bargaining agreement with Kaiser Permanente in 1961. Originally called "Committees on Employment Standards," they were modeled after labor union worksite committees, and developed exclusively for the purposes of the Economic Security Program. As Conta told the story of their inception, CNA staff was looking to establish worksite-based committees for contract enforcement, but came to see a broader mission in the PPCs when encountering staff nurses:

> We are concerned with standards of patient care, educational and professional advancement of nurses, and the economic and general welfare of nurses. So what had been stated as ANA's overall purpose or the major purpose of improvement of patient care was, in fact, what nurses were doing at the agency level. So we began to identify expressly that the committees working at the agency level were, in fact, working on all three of these kinds of activities, and in different points of time one or another had greater emphasis.[153]

These worksite units, however, became solidified as a major organizational structure at

CNA in the late 1960s. In part, this was likely due to Conta's ascent to Executive Director in September of 1966, weeks after the abrogation of the strike ban. But the committees' role in the mobilization itself was also important. According to member activists of the 1960s and 1970s, PPCs were critical to the fomenting of nurse activism within the organization during this period, and they played particularly important roles in 1966. As the basic unit of workplace organization, the Committees became the key meeting site for staff nurses, critical for the organization of any sort of collective action on that scale. In May, June and July, the venues in which nurses made decisions about bargaining, including the decision to mobilize the mass resignation, were a series of meetings of the Chairmen of the worksite PPCs.[154] Contemporaries reported instances of nurses meeting in the committees and workplaces, hearing each others' frustrations with the CNA leadership, and then meeting autonomously, a situation which may well have placed further pressure on CNA leaders.[155] And while most observers had attributed the increased militancy to staff nurses overcoming a more conservative CNA leadership, an internal Kaiser Permanente memo pointed to the ESP leadership's role in agitating the nurses through increasingly union-like actions, including the decision to push for a high salary goal, their refusal to accept Kaiser's salary proposals, and their decision to picket in protest.[156]

For Conta, the promise of the PPC lied not only in its base-building organizational capacity, but also in furthering the professional goal of control over nursing practice. The committees, she argued, were structured to shift the locus of this control to the level of the staff nurse, so as to use the collective bargaining agreements to make nursing standards enforceable.[157] That the Committees became one of the organizational hubs of more militant staff nurses during the summer of 1966 was an indication of their effectiveness in this regard.

But in the aftermath of the 1966 mass resignations, Professional Performance Committees came under attack from within the ANA. Specifically, there was substantial opposition from the Commission on Nursing Services, which represented nursing administrators within the association. The PPC structure advanced an institutional vehicle for staff nurses to exercise an autonomous voice over nursing practice concerns. By virtue of being related to the collective bargaining process, they necessarily excluded nurses who worked in hospital management—while they shared membership in the profession, they were excluded from bargaining units. This, in itself, threatened those who saw the PPC as impinging on the authority of nurse administrators.

In 1967, nurse administrators within the ANA obtained copies of CNA bargaining proposals that included efforts to further develop the PPC concept. Hospital administrators in other states had apparently appealed to the leaders of these state associations, expressing alarm over the proposals and potentially seeking intervention. In a series of meetings that year involving the CNA, the ANA Commission on Nursing Services, and Anne Zimmerman's CEGW, administrators in the association raised a number of concerns. As Conta would tell it, in 1968:

> This idea of committees on professional performance has engendered anxieties and

> opposition, as well as enthusiasm. Directors of nursing service ask such questions as: Can an elected committee really be constructive? When members are elected by the group rather than appointed by the director of nursing, isn't the result likely to be a group of inexperienced and possibly dissident and hard-to-work-with nurses? Concern has also been expressed that the committee will bypass the director of nursing service and take its problems directly to the hospital administrator, thus weakening the nursing service structure.[158]

Pauline Fahey, Director of the Commission on Nursing Service at the ANA, explained to Conta that the Commission explicitly wanted to avoid situations where "new systems of providing nursing services are determined as part of the collective bargaining situation."[159] They objected, further, to meetings over patient care issues, which excluded managers. They objected to the very goal of using contracts to bargain over patient care concerns, or to the use of worksite meetings to coordinate staff nurses' collective responses to hospital management concerns. This undermining of nursing administrators, they argued, threatened the authority and autonomy of nursing departments within hospitals. The controversy over the Professional Performance Committees stemmed from the fact that in providing an institutional vehicle for staff nurses to exercise power and control over practice within the workplace, they impinged on the hierarchical structures that nurse leaders and advocates of professionalism had long since established. This commission made substantial internal efforts to get Zimmerman's EGWC to commit to curtailing this trend, asking the commission to establish a more formal separation of nursing practice issues from collective bargaining, and outlining a vision in which the Economic Security Program's scope was more circumscribed. They asked that when nursing practice issues were to be discussed, that nursing directors lead discussions rather than staff nurses, and argued that matters of professional practice were not appropriate for collective bargaining.[160] In May of 1967, they took these concerns to the Board.

In the months that followed, Conta and others conducted a broad campaign to legitimate the PPCs, including several essays published in the *American Journal of Nursing*.[161] They worked to reassure others within the ANA that they did not intend to circumvent nursing administrators, and that while they used these committees to bring contracts to bear as a tool for protecting nursing practice, they would advance standards established by the Association itself. But they also rigorously defended the principle of using the collective bargaining mechanism, up to and including the use of economic action, to defend nurses' moral obligations for patient care, and to protect and expand nursing's scope of practice.

While the PPC model originated in CNA, efforts to contain the scope and authority of the PPC reached into the organization as well. In July of 1969, the CNA Board of Directors and the House of Delegates established as a policy of the organization that the first priority of action was to be "nursing practice," with economic interests as secondary. Nevertheless, advocates continued to push the PPC as the structure that could bridge the gap between economic security and nursing practice. If the primary goal of the association was to promote patient care, then the PPC, as the key worksite-centered unit of the association, could operationalize that mission in conjunction with the building of

workplace organization. Bridging this gap, however, involved further imbuing the project of workplace organizing with the moral foundation of nurses' patient-care obligation.[162] In 1970, CNA leaders developed a manual that clarified this joint mission, establishing a philosophy that grounded the mission of the PPC in service and patient care:

> The purpose of the PPC is action: action to close any gap which may exist between desired standards of nursing practice and actual practices, the overall goal being the best possible health care for all people.[163]

Burton White, the Director of the CNA Economic and General Welfare Department, articulated this vision clearly in a 1971 forum on PPCs. He contrasted his prior work as a union officer for broadcast technicians with what he had come to do at CNA in the 1970s:

> I am very familiar with the concern that organized labor has expressed in its own material interest and in the improvement of working conditions. There is no doubt in my mind that the activities of unions have, in these regards, been progressive. But by and large, unlike CNA, labor has limited its interest solely to hours and wages and conditions of work. Think for a moment if it had been different. […] If broadcasters had, through their organizations, taken an interest in the quality of what went out over the airwaves; if the purpose of broadcasting were not merely more effective advertising and increased profits and even higher wages. Think what might have been if the broadcasting unions were as concerned about the product they produced as nurses are about their work. […] But the traditional aspects of collective bargaining have not been addressed to these types of issues. That is why collective bargaining as the California Nurses' Association does it is so important, so new, so exciting. Collective bargaining for nurses is collective bargaining for people who are primarily interested in the quality of the product they produce and who see collective bargaining as a means by which they are made more free to practice their profession and its ultimate end of improved patient care.[164]

The Strike of 1974, Against "An Uncaring Administration in an Industry of Care"

1966 had been a turning point for nursing—it signaled nurses' capacity to mobilize collectively for the improvement of the profession, and their willingness to take economic action. The events triggered a realignment within the broader association, empowering staff nurse advocates, and permitting dramatic growth in the collective bargaining program in California and nationwide. But in focusing primarily on wages and pay, the events also produced a substantial internal backlash that, as in the case of the New Approach, had limited the potential effectiveness of the more militant approach to nurse representation. As internal advocates struggled to expand the program and defend what they saw as its basic components, they were compelled to rearticulate the missions of worksite organization, collective bargaining, and potential economic action in ways that were consistent with the patient care obligation.

It would not be long before they would be compelled to test this new model. In June of 1974, 4,400 nurses across 44 healthcare facilities in the Bay Area, including Affiliated,

Associated, and Kaiser hospitals, went out on strike. A few days later, nurses at Stanford hospital followed suit. Since the 1966 abrogation of the no-strike policy, CNA had organized at least four nurses' strikes, mostly at a small scale. This one was far larger, encompassing the majority of organized bargaining units at the time. The strike would last three weeks before they returned to work. But beyond its size and duration, the 1974 Bay Area strike marked a critical turning point for the association. This was because of its demand: rather than demanding wages, the nurses demanded control over patient care, and used economic coercion to gain it. By 1974, the CNA for the first time went out on strike over staffing demands—a set of frames and demands centered on patient care and moral obligation that reconciled internally contending forces, and would dominate in virtually every subsequent strike among California hospital workers.

Prior to the strike, the core of contention between the CNA and the hospitals was a clause that established a right for nurses to have a say in staffing patterns and the requirements of patient care, through the meeting of the Professional Performance Committee, calling for "participation of Staff Nurses in the assessment of patients' daily needs for nursing care and the basis upon which nursing personnel are assigned." It was a relatively weak clause, which had rarely been enforced. It had been inserted in the prior contract in 1972 though mediation. Beforehand, it had been a recurring demand from nurses, though it had not been included in earlier contracts.[165] But according to Burton White, the Director of the CNA Economic Security Program at the time, "After 1971 neither the RNs nor the CNA pushed the staffing issue; we hadn't really resolved our ambivalence about collective bargaining, and never really carried out contract enforcement."[166] Hospital representatives came to bargaining intent on removing the clause. The head of the employers' associations negotiating team outlined that their opposition to nurses' demand for responsibility over patient care was primarily out of principle:

> This is a critical matter and it involves the overall question of who is responsible for patient care; that is, who has the decision-making authority… The staff nurses say that they want a major voice in the decision-making process as to how staffing takes place and how nursing care is delivered at the hospital. They are the ones closest to the patients and they know what should be done. This is a position with which we disagree. We believe that the decision-making process regarding the manner in which staffing is accomplished and how patient care is delivered is a matter for the physicians, for hospital administration and for nursing administration to accomplish.[167]

But nurses responded to the call for greater work control and improved staffing patterns. CNA members rejected the hospitals' offer, including the removal of the consultation clause, and in May, authorized a strike. On June 7, they walked out and onto the picket lines. They picketed with signs reading "Patients are our business," "Patients deserve better care," "Better Staffing—one night nurse for patients is unsafe," "Nurses need a voice in patient care." ""Most nurses," Children's Hospital nurse Margaret DeCarlo said on the picket line, "used to grumble in silence or quit and leave the nursing profession, but that's all finished now. Now we stay and fight."[168]

As in 1966, the nurses' strike coincided with the national convention of the ANA in San Francisco. This time, after six months of negotiation, nurses walked out two days before the convention commenced. The strike action was predictably divisive. At the convention, there was substantial support for strikers and CNA leaders—delegates joined the picket lines, wore blue armbands to signal solidarity, and raised funds for strikers. The body passed a resolution expressing support. But there were also opponents among the delegates, including from the Commission on Nursing Services, who "were voicing their frustration at the increased emphasis the program had been receiving" given the expected lifting of the Taft Hartley healthcare amendments. At several panels, nursing administrators voiced strong concerns that they were facing conflicts between "their loyalties as nurses and their loyalties as managers."[169] They also protested the orientation of strikers toward the empowerment of local unit PPCs. Sister Alameda, delegate from the Alabama Nurses Association, moved that "ANA study and disseminate information about methods for collective action by nurses that are alternatives to local units," which narrowly passed the body.[170]

Irene Pope, the President of the CNA, defended the strike and its focus on sustained worksite representation as grounded in the commitment to patient care and nursing practice:

> This strike really has developed into something very different from any other kind of strikes we have had. Negotiations were in progress for six months. It became very obvious as we were negotiating that the major issue would not be benefits and wages. It became particularly obvious when management came to the table with a proposal to remove from the contract a section which gave the staff nurse the privilege and the right to work with administration in terms of the kind of practice they would be performing.[171]

Burton white described some "pockets of dissatisfaction"[172] among the membership in a report to the CNA Board, where he claimed that nurses were disappointed that the settlement agreement "did not go far enough in relieving the onerous conditions under which nurses worked and delivered their care."[173] But on June 27th, however, nurses approved the settlement. They had successfully defended the staffing consultation provisions, and they had doubled the paid hours that nurses could devote to their Professional Performance Committees. About 85% of Kaiser members voted to approve, with 77% of Associated members and 2/3 of Affiliated members voting to approve. [174]

Despite the pockets of dissatisfaction, the strike had largely succeeded. In its demands and framing, it was a critical departure for the organization from its smaller strikes in previous years. CNA leaders had recognized that the issue of control over staffing levels translated their demands for work control into the language of patient care and moral obligation. This had the effect, according to contemporary accounts, of cementing the strikers' support among nurses themselves, among other occupational groups, and among the public.

This re-moralization of the strike weapon for nurses was also evident in how striking nurses comported themselves with regard to patient care. They took care to make sure that patient care—production—did not cease. Nurses from the picket line, selected by their peers, would enter the hospital to make sure that critical care was being delivered. This practice defined a peculiar approach to economic contention—while the nurses were legally striking, they did not exclusively conceptualize their action as a halt to production. In this sense, they drew on the logic of some of the quasi-strike actions they took in the 1950s, when nurses refused to accept pay for services rendered, out of respect for their moral obligation of patient care. Burton White, in the days after the strike, reported to the CNA Board:

> Perhaps the most important overall development was the growth of RN (and employer) awareness that Nursing is a profession *allied with but not subordinate to medicine*… This recognition by the Nurses of their legitimate part in decision making; their growth during the first few days of the strike to set up their own institutions to evaluate the patients' need for nursing care; their *unity in imposing upon the hospitals a nursing standard the employers were unwilling to recognize* and their persistence in the face of increasing pressure to "cave-in" marked — for me — the highest manifestation of the interrelation of Nursing Practice and collective bargaining in Economic and General Welfare history.[175]

The broad framing developed in the 1974 strike took hold after that point. In a subsequent 33-day strike in a Santa Rosa hospital in July of 1975, nurses drew on the strategy of striking to defend caring practice from their employers. "RNs were then faced with the choice of withholding their services or swallowing their personal and professional integrity and capitulating to an uncaring administration in an industry of care," they wrote in their newsletter. "RNs opted for their professional integrity and their professional responsibility to patients."[176]

Conclusion

In their reflections upon the meaning of the 1974 strike, Irene Pope and Burton White had articulated a new and unique orientation toward nurses' exercise of economic coercion. Nurses were striking against employers for the right to control their practice, in defense of their moral obligations to provide the best care to patients. At its core, it was a reflection of the traditional hospital nurse's moral imperative, inherited from the professional service ethic and the hospital's charitable tradition. But turned against the employer, and against nursing's persistent subordinate status relative to medicine, it adopted a radical new hue; nurses were simultaneously fighting for control of the product of their labor and for the moral meaning of their work. And in this sense, it was a radical response to the problem of workers' alienation from their labor under capitalism, an effort that American unions had largely abandoned since the Treaty of Detroit. If mid-century American unions had become crassly instrumental in their approach to exercising economic coercion, in the minds of these nurses, CNA was doing something different. Of course, using economic action to further control of practice was not altogether a new

idea, even from within the conservative confines of the CNA. It was the philosophy of the Professional Performance Committees, which were created to translate the essential building blocks of workplace unionism into the context of a professional association. It was a cognitive frame that built upon the language developed by those seeking to justify collective bargaining and organizing in the face of opposition from nursing elites, who couched their work in professionalism. Despite its conservative origins, forged through years of concessions and compromises with internal opponents, it was a model of action that proved remarkably potent among nurses, hospital workers, and the public.

A moral economy of care endured, but changed through practice and internal contention. One constant feature was the conceptual separation of a moral obligation to care and instrumental, economistic action. Around WWII, most elite nurses grounded their opposition to unionism in this assumption, and even many who strongly advocated collective bargaining assumed that striking was immoral. By the 1970s, nurses had translated this conceptual separation into an obligation to strike, in defense of their obligation to care. Subsequent chapters will show how in later years, resistance to the marketization of care would come to be framed, by many in the healthcare field, as a defense against care workers' alienation from the inherent meaning of care work, and as a defense against the undermining of care workers' moral obligations. Throughout, the ethic of caring was counterposed to purely instrumental economic action.

What changed, however, was equally important: nurses altered the target of their moral claims. The position that prevailed in the early period, and which elite nurses maintained into the 1970s, was that the moral obligation to care was part of a broader effort toward professionalization, premised primarily on social closure. But the insurgent nurses and their sometime allies within the association had turned this moral fire against employers, generating a class-antagonistic model of action. This process of translation occurred through a series of compromises and organizational responses to staff nurse activism. The PPCs, for instance, were an effort to construct workplace committees—an essential component of union representation—while accounting for the need to maintain a broader commitment to nursing practice and patient care. In practice, this effort to bring control of practice to the worksite level, and place it in the hands of staff nurses themselves, began to turn "patient care" into an object of contestation against employers.

Part 2: The Rise of Hospital Unionism

Part 2, consisting of one chapter, focuses on the rise of union organizing in non-profit hospitals in the 1970s. The key juncture for this growth in organizing was the summer of 1974, when Congress passed an amendment to the Taft Hartley Act lifting the exclusion of non-profit hospital workers from the protection of labor law. The lifting of the non-profit exclusion, I argue, constituted a critical structural opportunity for unions seeking to represent healthcare workers. Comparing how different organizations approached this common opportunity, and how successful they were at seizing it, helps reveal the effects of these organizations' cultural frameworks and organizational models.

While Part 1 dealt exclusively with the California Nurses' Association, Part 2 introduces a comparison case: the Service Employees International Union (SEIU). The analysis focuses on two SEIU locals, Local 250 in the Bay Area and Local 399 in Los Angeles. While other SEIU locals represented healthcare workers in public facilities through the union's broader efforts to organize public employees, Locals 250 and 399 focused on private hospitals, the object of study here. These SEIU locals represented non-professional workers, though as the analysis will show, these boundaries were occasionally pushed.

Chapter 4. The Boundaries of Taft-Hartley: California Hospital Worker Organizing Before and After the Summer of 1974

The Taft-Hartley Act defined the early history of hospital worker organizing in California. Passed in 1947, the Taft-Hartley amendments to the National Labor Relations Act excluded non-profit hospitals from the Act's definition of 'employer,' effectively eliminating the rights of workers in these institutions to compel hospitals to engage in collective bargaining. Hospitals, Congress apparently assumed, were charities, not workplaces with antagonistic relations between labor and capital. The passage of the Act effectively halted incipient efforts to organize hospital workers across the country, save a few pockets where unions and professional associations had established an early foothold.

The San Francisco Bay Area was one of these pockets, with BSEIU Local 250 having obtained the first hospital contracts in the late 1930s in San Francisco, and the California State Nurses Association representing RNs in several East Bay hospitals since 1946. Over the 1950s, as both organizations cemented their foothold across the Bay Area, they did so outside of the purview of established labor law—organizing hospital by hospital and care worker by care worker, struggling to obtain union security clauses that other unions enjoyed. For the next two decades, hospitals, Local 250, the CSNA, and several smaller organizations established a system of collective bargaining premised on mutual agreement and custom, reified through iterated conflicts, contract settlements, and occasionally the courts. In that context, the customs governing collective bargaining did not reflect established NLRB precedent, but the balance of power between the parties in a specific political context, the peculiar workplace structure of the voluntary hospital, and the cultural and moral traditions of care work and professionalism. This informal structure remained in place until July 1974, when the Congress—after years of lobbying from the SEIU, the ANA, and the AFL-CIO—removed the legislative exemption, suddenly bringing these workplaces under the umbrella of the NLRA.

The lifting of the non-profit hospital exclusion constituted an important structural opportunity, common not only to SEIU and CNA, but to other unions as well. Between 1948 and 1974, the organization of hospital workers took place without the protection of the NLRA, and organizing drives in that context were most often unsuccessful. Bringing these hospital workers into the main institutional structure for union recognition brought

social legitimacy to these organizing drives, and offered unions the ability to use the National Labor Relations Board and the courts to compel employers to bargain. It was a change in institutional context that provided both organizations a common opportunity to organize and grow. The two organizations, however, brought drastically different strategies to this moment.

In this chapter, I argue that one of the key distinguishing factors between the two organizations were the *cultural boundaries* they drew between different categories of healthcare workers, demarcating the care workers that were potential members from those that were not (see Lamont and Molnár 2002). In SEIU, organizers defined their potential membership with *horizontal boundaries,* distinguishing blue-collar workers from those above them—the "doctors, nurses, and administrators" who not only possessed more formalized skills, but also a greater allegiance to the interests of management.[177] This broad set of workers spanned specific occupations or jurisdictions of practice, and exhibited a broad variety of skill levels; they were a 'community of interest' defined in opposition to the interest of the employer, united by class solidarity. CNA leaders, on the other hand, endeavored to draw *vertical boundaries* demarcating nursing as a separate group defined by its scope of practice, and as separate from other occupational groups in the hospital. Rather than incorporating a variety of occupational distinctions within that boundary, CNA sought to define its own internal hierarchy, incorporating both bedside staff nurses and administrators within its vertically bounded group. Leaders referred to the CNA as a "multi-purpose organization," claiming to simultaneously represent the interests of nurse managers, nurse educators, and staff nurses, because all of these shared an interest in the practice of nursing and the improvement of patient care.

In the context of American labor history, this cultural distinction is reminiscent of long-running debates concerning the distinctions between industrial unionism and craft unionism (Lichtenstein 2013; Zieger 1997). By the 1970s, the early rivalries between the AFL and the CIO had been resolved by their merger over two decades prior. But more importantly, this longstanding distinction fails to capture the various identities that inform the drawing of cultural boundaries. The distinction between industrial and craft unionism fails to capture, importantly, the importance of gender difference in the drawing of these boundaries; for nurses, the definition of their occupational community (Cobble 1991) encompassed a long running struggle to define a practice jurisdiction available to women. Nursing, in the 1960s and 1970s, remained one of the only professions with internal career ladders through which leadership positions were open to women. For many nursing leaders—including some who were influenced by second-wave feminism—the maintenance of vertical boundaries around nursing was critically important.

These differences defined how the two organizations would pursue the new opportunities opened during the summer of 1974, as well as the obstacles they would face. Critically, their definitions of worker boundaries would suddenly come under the purview of the boundary conceptualizations defined by Taft-Hartley and NLRB precedent—which were much more congruent with the horizontal boundaries defined by SEIU. By the end of the

decade, both organizations confronted profound challenges, in the form of aggressive opposition from employers, the extensive use of NLRB challenges to delay and stall union representation elections, and the emergence of union avoidance consultants. But while SEIU faced serious challenges organizing hospitals in Los Angeles, their Bay Area base remained stable and strong. CNA, on the other hand, faced several existential crises that all but ended their nurse representation in the South and seriously threatened their collective bargaining program in the North. The distinct boundary projects that the two organizations brought to their organizing—and the boundaries of Taft-Hartley—played a key role in determining these outcomes.

The chapter proceeds as follows. Part 1 offers a brief legal history behind organizing rights for workers in non-profit hospitals. These workers were originally excluded from the of labor law by the Taft-Hartley Act. In the decades that followed, a few unions and professional associations continued to engage in collective bargaining and organizing in hospitals, but these negotiations occurred outside of established labor law—what one Bay Area management attorney aptly labeled "the law of the jungle." In the absence of legal constraints, these organizations negotiated contracts and established bargaining units in ways that were specific to hospitals, and the traditions of professionalism that dominated work life in that setting. In 1974, the non-profit exclusions were lifted, but other restrictions—specifically, the demarcation of 'employees' and 'supervisors' under Taft-Hartley—remained in place. I argue that the imposition of Taft-Hartley upset the established order—the boundaries between workers—in ways that were particularly in conflict with nurses' organizing strategies.

Sections 2, 3 and 4 examine the case of SEIU (BSEIU in the early period). Section 2 examines the union's early history of hospital organizing in California. BSEIU conceptualized their constituency as the blue-collar workers in the hospital. While their membership in hospitals began with the janitors, gardeners, and maintenance workers that BSEIU tended to organize in other sectors, they soon began representing bedside patient care workers, as well. These bedside workers, however, were considered another component of the blue-collar working class in the facility. Section 3 shows how this conceptualization worked in the case of Licensed Vocational Nurses (LVNs), who were represented by SEIU but whose blue-collar classification was contested by some LVNs and outside organizations. In Section 4, I examine how this blue-collar conceptualization of potential membership affected the union's organizing initiatives and tactics after 1974, as well as some of the obstacles they encountered.

Sections 5, 6 and 7 turn attention back to the CNA. In earlier chapters, I showed how nurses developed a unique model of organization by 1974—"moralizing" the strike, and highlighting the moral authority of the nurse as a source of leverage over employers. This model, I argued, was a product of struggles internal to nursing, to make sense of the exercise of workplace power in the context of a broader professional project, which assumed the incorporation of the exercise of power into the project of policing the boundaries of nursing's practice jurisdiction. As such, the CNA retained a conceptualization of its potential membership that relied on *vertical boundaries* between

workers. In Section 6, I show how this model clashed with the *horizontal boundaries* established by Taft-Hartley, and examine the organizational adaptations undertaken to deal with these clashes. Section 7 examines how these clashes threatened the CNA's leadership, exposing them to external raids and potent internal dissent among staff nurses.

1. "The Law of the Jungle": Hospital Organizing and Bargaining, 1948-1974

The 1948 Taft-Hartley Act was a piece of profoundly anti-labor legislation, which in many ways laid the foundation for the anti-labor assault in the neoliberal era. By banning closed shops, the legislation strongly undercut the foundations of union security measures in contracts; by allowing states to outlaw union-security clauses in contracts through right-to-work laws, the law effectively cut unions out of entire regions of the country, particularly the southeast. Through its ban on secondary boycotts, Taft-Hartley strongly constrained unions' capacity to exercise power. Its anti-communist provisions undermined some of the most aggressive unions in the country, destroying some, and depriving many others of committed progressive leadership and staff.

These measures are all well known. Less well known are the historical effects of provisions of the law that affected smaller groups of workers, including those that fell outside of the conceptualizations of potential union members that were broadly shared in the post-war years. In this respect, it was the employees of non-profit hospitals who were, on an industrial level, most deeply harmed by Taft-Hartley, for they were excluded completely from the protections of the NLRA. Taft-Hartley excluded from the definition of "employer" any non-profit hospital, thus relieving them of the obligations toward their employees to which other organizations were bound by law. No such exemption for healthcare workers had been included in the Wagner Act, and prior to Taft-Hartley, courts had found that the Act applied to non-profit hospitals.[178] Non-profit hospital care was the only private industry specifically excluded from protection by the Act.[179] As the US Senate debated Taft-Hartley, the non-profit exemption was added as a floor amendment, and was retained thereafter. Senator Millard Tydings of Maryland, whose wife was a volunteer nurse in Washington DC, introduced the amendment, arguing that:

> This amendment is designed merely to help a great number of hospitals, which are having very difficult times. They are eleemosynary institutions, no profit is involved in their operations, and I understand from the hospital association that this amendment would be very helpful in their efforts to serve those who have not the means to pay for hospital service.[180]

The exclusion of non-profit hospitals from the definition of "employer" under Taft-Hartley thus rested on several key assumptions.[181] First, legislators argued that healthcare, a locally oriented and governed industry, did not constitute interstate commerce. Indeed, as healthcare is a place-based service, the industry's product is not easily exportable. In the late 1940s, hospitals were growing, but remained locally governed institutions catering to specific regions. Second, they were considered charitable organizations, dedicated to caring for people, and not the rapacious capitalists from whom the original

Wagner Act was intended to protect employees; their public mission and their service to the poor and the sick made them deserving of protection from the higher wage bills that unionization could bring.

For most of the country, the Taft-Hartley amendments brought incipient efforts to unionize hospital workers to a halt. Throughout the 1950s, the establishment of a collective bargaining agreement where one did not predate the law was a rare occurrence. This was true of the unions, including SEIU, who by the 1950s under President William McFetridge was settling into a "business union" model that, by definition, did not push the boundaries of established labor law. It was also true of the professional association model promulgated by the ANA. According to Anne Zimmerman, formerly a staff member of the CSNA and by this point the Executive Director of the Illinois Nurses' Association, in the decades after Taft-Hartley "seeking recognition as the collective bargaining representative for nurses was a primitive struggle for the SNAs, often with harsh and unsuccessful results. Always present was the yearning for protection under the National Labor Relations Act."[182]

Of course, not all hospital worker unionization efforts stopped. In California, particularly in the Bay Area, the BSEIU and CSNA had secured an early foothold in the industry before 1948. And while the CSNA's first contracts in the East Bay and Local 250's first contracts in San Francisco were obtained before Taft-Hartley, both organizations established a solid foundation across the region in the 1950s, when the law was in effect. Despite California's status as one of the early sites of hospital unionism, these early footholds were not recognized in law. While in the intervening years several states saw legislation or court orders extend organizing rights to some hospital workers—including Connecticut, Massachusetts, Michigan, Minnesota, New Jersey, New York, Pennsylvania, and Wisconsin—California, a largely conservative state in the post-war years, did not. As a result, the early foundations of hospital unionism were largely established outside of the purview of established labor law. Hospital labor relations, according to prominent management-side labor attorney Laurence Corbett, was "an area of activity governed by the law of the jungle."[183]

With federal laws governing recognition specifically excluding hospital workers, and with California state courts finding that state laws did not cover them, either, hospital workers had little formal recourse outside of the favorable context of a strong regional labor movement and their own capacity for organization. This meant that even if all workers were union members, employers could decline to recognize them. It meant that there were no written rules governing the bargaining process itself—"good faith bargaining" could be enforced only through strikes, lockouts, or mutual agreement between the parties.[184] It meant that while unions faced constraints on their capacity to exercise power in the workplace, these constraints were based less in regulation than in the shared moral conceptions of acceptable collective action. It also meant, importantly, that the precise composition of bargaining units was driven not by the law, but by mutual agreement and custom developed through ad-hoc recognitions and iterated negotiations.

These mutual agreements and customs, developed primarily in terms of the hospital workplace and the traditions of professionalism, existed *because* they were developed outside of the confines of established labor law. Developed in the context of the factory, where labor was routinized and there were often strict lines of authority, Taft-Hartley drew firm boundaries that demarcated those workers who could enjoy the protections of the NLRA—"employees"—from those who could not. These boundaries were established *horizontally*, separating "employees," who could not exercise independent judgment in their work, or who were fully alienated from the product of their labor, from "supervisors," who could exercise such judgment but whose interests were assumed to align with the employer. This had not always been the case. Indeed, as Vinel's (2013) legal history of the supervisory classification illustrates, the interregnum between the Wagner and Taft-Hartley Acts saw the flourishing of a number of Foreman's unions whose organizing efforts crossed these horizontal demarcations. Taft-Hartley's boundary drawing substantially restricted the body of workers whose collective action was protected by law.

The bargaining relationships and unit demarcations that evolved in California hospitals during this period, on the other hand, reflected both the dynamics of a different kind of workplace, and the different cultural and moral traditions of care work and professionalism. As charitable institutions and the worksites of institutional physicians, the paradigmatic profession of the early 20th century, hospitals never functioned quite like a factory floor. By the 1950s, hospitals were workplaces with extensive and intricate occupational divisions and hierarchies, each of which carefully policed its boundaries. As the earlier chapters on nurses demonstrated, the logic of professionalism often conceived of these boundaries as *vertical demarcations*—separating occupational groupings according to their control of a scope of practice, and incorporating hierarchies within those vertical demarcations. Hospitals were also a work context where care workers' professional ethics obligated them to exercise judgment in the interest of patients, rather than in the interest of the employer, which also ran against the underlying logic of Taft-Hartley's demarcations of the 'employee.' The eventual regulation of hospital labor relations, if it were to occur under the existing structure of Taft-Hartley, meant that they would eventually come to clash with the conceptualizations of labor relations inherent in the Taft-Hartley Act.

The summer of 1974 represented a sea change in labor relations in hospitals. After several years of intense lobbying driven primarily by the SEIU, Congress passed a series of amendments to the Taft-Hartley Act that defined non-profit hospitals as employers under the act, thus guaranteeing hospital workers the right to organize under the NLRA for the first time since 1948.[185] The legislation made two key changes. First, it established a new form of "employer," namely "healthcare institutions," which was defined to include both the non-profit organizations that had been excluded, as well as other organizational forms that had more recently come under the jurisdiction of the NRLB, such as for-profit hospitals and nursing homes. New rules would apply this broader set of organizations; while they were now considered "employers" by the law, they were nevertheless a unique category. The second change involved the placement of a series of

restrictions on contentious practice for healthcare unions. These included the creation of lengthy notice requirements before striking or picketing. Workers striking in violation of these requirements would lose protections under the NLRA.[186] No other industry was subject to such restrictions under the law. On July 26, 1974, President Nixon signed the amendments into law—precisely the day that the CNA ended its 1974 strike, and a day before the House Judiciary Committee adopted articles of impeachment against the President.[187]

While SEIU, the ANA, and the AFL-CIO had long advocated the removal of the healthcare restrictions, and the American Hospital Association had strongly opposed it, several contemporary observers saw the legislation as a move to control incipient organizing activity in the industry and to make the procedures of unionization predictable.[188] The Report of the Senate Committee on Labor and Public Welfare stated that the Committee was "impressed with the fact, emphasized by many witnesses, that the exemption of nonprofit hospitals from the Act had resulted in numerous instances of recognition strikes and picketing. Coverage under the Act should completely eliminate the need for any such activity."[189] This rationale was signaled by the inclusion of the contention restrictions for unions organizing in "healthcare institutions." ANA and SEIU leaders, arguing that regulating the process of recognition would lead to greater stability in hospitals, echoed this position. "The vast majority of strikes by nurses and other healthcare workers," Anne Zimmerman told international nursing leaders at a conference in Moscow, "were over recognition of their organization rather than over money or employment conditions."[190] SEIU President George Hardy similarly argued that the extension would "provide a peaceful method for employees to obtain recognition from their employer."[191] Expanding the coverage of the NLRA, in other words, would lead to labor peace through negotiation, not conflict.

Organized labor had taken a unified public stance that they would accept only the removal of the non-profit exemption, and nothing else—essentially putting non-profit hospital workers on equal footing with other workers with regards to their rights and obligations under the law. Earlier iterations of the legislation, put forth by Senators Harrison Williams of New Jersey in 1972 and Alan Cranston of California 1973, were simple repeals of the exemption, though neither bill progressed far in Congress, due in part to the entrenched opposition of hospitals.[192] By 1974, however, American Hospital Association leaders signaled their willingness to compromise on the extension, with some restrictions on unions' capacity to coerce, and some labor leaders also signaled willingness to compromise on the matter. The unions "were willing to talk," according to General Counsel of the Senate Committee on Labor and Public Welfare, "about the public necessity involved in the interruption of patient care delivery services."[193]

The restrictions on contentious practice that ultimately made it into the bill reinforced the moral frameworks seen as inherent to healthcare. Established in the name of protecting patient care, they were the outcome of compromises in the Senate between Senators facing lobbying from the unions and from the American Hospital Association. "In the Committee's deliberation on this bill," wrote Senator Cranston of the 1974 bill, "it was

recognized that the needs of patients in health care institutions required special consideration in the Act."[194] To reduce the possibility of strikes and lockouts in hospitals, the law mandated an extended notification period for all contract terminations. It required unions to notify the employer and the Federal Mediation and Conciliation Service of any anticipated strikes or pickets ten days prior to the event, a requirement that extended to no other industry under the law. The law further required parties to submit to non-binding mediation in the event of a work conflict.[195] These requirements set healthcare institutions apart from other private industries with regards to the rights of organized labor under the law, specifically in terms of their capacity to legitimately exercise power over employers. In the eyes of many legislators, the damaged party in the event of a work stoppage was not only the employer, but also the broader public; indeed, the impact of a strike on the employer's bottom line was arguably less pronounced than in other industries, particularly in the case of pre-paid providers such as Kaiser Permanente. These compromises were necessary to protect, as Senator Peter Dominick of Colorado argued in opposition to the bill, "the paramount *public interest* in having access, unimpeded and unhindered, to the best possible care."[196] Dominick cited the President of the Texas Hospital Association, who testified that

> Hospital care is not storable. It is essentially an immediate service to the sick and injured. There is no stockpile from which to draw, no storage yard, or warehouse backup potential as that found in many business fields. If the health care nurse, radiologic technician, laboratory technologist, electroencephalographic technician, physical therapist, surgical nurse, critical care nurse specialist, and many other numerous health care specialists are not at or near the bedside or responsive on call to the need of patients, the hospital ceases to function and the public interest is immediately downgraded and its welfare endangered.[197]

But despite these practice restrictions, the removal of the non-profit exemption legitimized the organizing of hospital workers, and provided a powerful institutional framework for recognition. It ended, in other words, the "law of the jungle"—which may have been a workable set of arrangements in highly organized pockets like the Bay Area and New York, but paralyzed organizing almost everywhere else. The lifting of the exemption created a profound opportunity for organizing and growth—and many organizations jumped in to take advantage of it. According to a survey by the American Hospital Association, unions filed 1,659 representation petitions in the healthcare industry in fiscal year 1975, mostly in non-profit hospitals, up from 461 in fiscal year 1974. Unfair labor practice filings were up almost three fold during the same span. The AHA counted 20 recognitions strikes in hospitals. Of those elections completed in that first year, unions had won over 60%.[198]

2. SEIU: Organizing the Blue-Collar Care Worker

Local 250

BSEIU Local 250 was by most accounts the first union to represent hospital workers in the United States. A small group of hospital workers in San Francisco General Hospital established the union in the wake of the 1934 San Francisco General Strike. In its earliest

years, the union was directly affiliated with the American Federation of Labor as a 'federal union,' since no international union claimed jurisdiction over health care workers or hospitals at the time. The union obtained its first collective bargaining agreement in 1937, and a year later affiliated with the Chicago-based Building Service Employees International Union. After an extensive organizing drive in the city, the union obtained its first citywide contract in 1941, covering ten hospitals. [199] This first master contract—the first multi-employer agreement in the healthcare industry—was two pages long: it assumed a six-day, 48-hour week, and offered one week off after five years' employment. The contract, further, grouped all non-professional members into the same category in terms of wage determination, failing to distinguish between occupations: it included only two categories of workers: 'male employees' at $92.50 per month, and 'female employees' at $87.50 per month.[200] It was not until several years later, when the contract had to be renewed through the War Labor Board, that the union developed job descriptions and occupational classifications in its contracts, as a requirement for War Labor Board bargaining procedures.[201]

In its early history as a Chicago-based union, the Building Service International Union (BSEIU—SEIU after 1968) was often associated with organized crime. To a significant extent, however, this deep penetration by the mob did not extend all the way to the west coast, certainly not to the degree it did in Chicago and the east coast. This relative insulation of the west coast locals was a product, in large part, of the decentralized nature of the BSEIU in its early decades, characteristic of AFL unions. Also insulating the western locals was the longstanding influence of the Hardy family, beginning with Charlie and later George Hardy, who remained enormously influential in the union in both San Francisco and Los Angeles. Charlie Hardy, an Englishman by way of Vancouver, had established himself shortly before the Depression as the head of San Francisco's Local 9 of the BSEIU, a theater janitors' local and one of the oldest unions in the IU. From there, he became the BSEIU's first west coast organizer, and established the California State Council.[202] Hardy's position on the West Coast was further reinforced by his defiance, and eventual defeat, of BSEIU International President George Scalise over the latter's connections to organized crime, and his efforts to centralize authority in the International Union.[203]

Following the passage of the Wagner Act, Hardy led the union's expansion across California, including its first bargaining units in Los Angeles. George Hardy rose to be Secretary of San Francisco's Local 87, before shipping off to WWII; after the war, George Hardy headed to Los Angeles, where he founded a number of locals that would eventually merge into Local 399.[204] While the younger Hardy would be primarily based out of Los Angeles until his ascension to the Presidency of the International Union in 1970, his close colleague Tom Kelly, and later his son in law Tim Twomey, would run Local 250 into the 1980s, and he continued to exercise influence over the whole state for decades. Throughout this period, the Hardys jealously guarded the autonomy of the California locals.

Scalise' successor as BSEIU President, William McFetridge of Chicago's Local 1, set

about cleaning out the international union, focusing on professionalization among the international staff, in order to improve its badly maligned reputation. It was under McFetridge that BSEIU established itself as a prototypical "business union," characterized by staff professionalism and focused inward toward service and contract improvements, while maintaining a more conservative outward political orientation.[205] It was McFetridge, after several years of dealing with regional fiefdoms (such as Hardy's) as an obstacle to his efforts to professionalize the union, who would make substantial moves toward the centralization of political authority in the International Union, efforts which had undone Scalise. But he was also mindful of the longstanding influence of the Hardy family, and after the Charlie Hardy passed away at 56, McFetridge appointed George as the Western Vice President.

In 1957, Local 250 was trusteed by the international, ousting incumbent Secretary treasurer Jimmy Murphy. Hardy led the trusteeship, perhaps ironically given his and his father's defense of local autonomy. After the trusteeship, officials promised a more aggressive profile—what Research Director Richard Liebes referred to as the Local's "new look."[206] Business agents were pushed to be more aggressive with workplace access, where under Murphy's leadership they had been more deferential to managerial restrictions—a substantial problem for the union, when union security clauses in collective bargaining agreements were still not widespread.[207] Hardy himself, in communicating to employers regarding the trusteeship, informed them that while the Local would commit to respect existing agreements, its new leaders were also "determined to carry on an effective organizing program." "I am not at all satisfied with the progress Local 250 has made," he wrote to East Bay employers' attorney, Laurence Corbett, "in organizing its jurisdiction covered by the Associated Hospitals agreement."[208]

While these early San Francisco hospital workers enjoyed the protections of the National Labor Relations Act, this protection was cut short by the Taft-Hartley amendments. Local 250's early growth in the Bay Area—obtaining its second master contract covering East Bay hospitals in 1953, and Kaiser Permanente hospitals in 1954—occurred in the context of Taft-Hartley, without a legal structure for recognition. Organizers tended to organize quietly, remaining "underground" as long as they could, and restricting worker contact to house visits and off-site meetings.[209] When confronted with a request for recognition, hospitals had significant leeway in terms of their response; they were constrained more by local custom and political context than by the law. Hospitals could ignore a recognition request altogether, and face no legal complications; their only risk was potential disruption from unions. Where hospitals chose to accede to unionization, they could call upon the State Conciliation Service to conduct an election or a card-check recognition process.

Local 250 often sought recognition in hospitals via a card-check in the 1950s and 1960s, a process that, while legal, was not widespread at the time. This election procedure was not entirely unique at the time, but it was relatively rare during a period when most unions sought NLRB elections. Card-check recognition would emerge, decades later, as a recognition strategy common to "revitalized" and "social movement" unions[210]; at the

time, however, Local 250 pursued this strategy largely from a position of weakness, given that institutional recognition procedures were unavailable. As Laurence Corbett wrote to his colleagues in 1967,

> Unions often insist upon this procedure [card-check] and refuse a secret ballot election because they fear an employer election campaign might succeed in undercutting majority support for the union. Employers, on the other hand, often reject the pledge card procedure because they are led to believe employees are sometimes not aware of the full significance of signing a pledge card and would prefer to cast their votes in secret.[211]

Mediated elections also occurred. According to FMCS arbitrator Dorothy Christiansen, outlining the collective bargaining dynamics in Bay Area hospitals,

> The basic method of gaining recognition during the early period of organizing was to gather enough authorization cards to force the hospital into an election. Thereafter, the State Conciliation Service was called in to conduct an election and the union's position was thereby "certified."[212]

As such, this lack of a legal framework for organizing during this period, while it constrained potential growth, nevertheless allowed some space for organizers to bypass the specific representation elections processes stipulated by the NLRB. Unions benefited from relatively wide latitude in terms of their potential actions, as they, too, were unconstrained by the law itself, and only by popular custom.

Being governed by "law of the jungle" meant that both employers and unions faced few legal constraints. This did not mean, however, that conflict was widespread, or that there were no constraints at all. As earlier chapters explored, there were substantial moral constraints that left unions unable, or unwilling, to exercise coercive power, particularly during the early history of collective bargaining in hospitals. While this moral injunction against the exercise of power was particularly strong in organized nursing, it also clearly informed the thinking of more traditional unionists in the BSEIU, who saw these constraints as a critical weakness. In 1939 correspondence between Charles Hardy, one of first hospital worker organizers, and A.R. Bowles, a Business Agent in Toledo, the two unionists outlined the constraints stemming for the charitable image of patient care and hospital managers. As Bowles put it, “As we realize they are mainly considered institutions of mercy and charitableness, we as a union are somewhat handicapped in our negotiation because of the fact that we feel that we might not have the sympathy and support of the general public in case of a strike.”[213] Hardy responded,

> [Hospital workers'] fight has been a long hard struggle and as you stated, *they have to fight the public*. A picket line on a hospital is a tough thing to beat when the public hears about it. We have fought these hospitals by publishing in the newspaper the terrible conditions the employees are subjected to, and this has helped... Above all things never put yourself in the situation of having to call a strike in any hospital as it is a 10 to 1 shot you will have the whole city on your neck.[214]

Hospitals, too, faced constraints. Particularly in the San Francisco Bay Area, they

operated in a political context in which labor militancy was common, and enjoyed substantial political support. Bay Area employers had a longstanding tradition of engaging in multi-employer bargaining, leading to the formation employers' councils that would act collectively, in bargaining and in politics, to contain labor unrest; hospitals in the area established similar structures, namely the Associated Hospitals and Affiliated Hospitals.[215] Richard Liebes, Research Director for Local 250 and the Northern California Joint Council from the 1940s through the 1970s, saw this tendency toward organized employer associations as a distinctive feature of Bay Area labor relations. His doctoral dissertation in economics from UC Berkeley traced this tradition back to the 1930s, when employers at the ports organized in response to the 1934 San Francisco general strike. In short, by the mid-century, Bay Area employers operated in a broader political context in which cooperation with organized labor was common and taken for granted, and this too served as a constraint on overly aggressive practices. This was one of several factors that produced such stark differences in terms of organization between the Bay Area and Southern California, despite the early organization of the Kaiser facilities in the South.

During these early decades of collective bargaining, Local 250 relied extensively on the broader labor movement, both as a model of organization and as a source of solidarity. As it organized and bargained, the union worked to impose patterns of collective bargaining upon the hospital industry that reflected broader practices of the American labor movement, seeking the rights and standards other workers enjoyed under existing institutional frameworks. As the union moved into the East Bay after 1953, it was unable to obtain union security clauses in its contracts—clauses that would compel union membership or the payment of agency fees for non-members. The 1950s saw several strikes, including a 21-day strike across all unionized hospitals in the East Bay, which hinged on the question of union security. As Secretary Treasurer Tim Twomey put it, "We asked that, in good democratic fashion, a small selfish minority be required to share the responsibility as well as the benefit of collective bargaining." It was not until 1964, after another bitter strike, that Arbitrator Adolph Koven imposed union security provisions across East Bay hospitals.[216]

A later strike, against Kaiser Permanente in 1968, signaled the union's significant reliance on the regional labor movement. The confrontation was, by some accounts from within Local 250 itself, inspired by the militancy of the nurses in the summer of 1966.[217] Beginning on December 15th, 1968, union members set up pickets at Kaiser facilities from Sacramento to San Jose, launching a strike that by some accounts involved almost 3,400 workers. The union relied on tried and true labor solidarity to put pressure on Kaiser—with the support of multiple county Central Labor Councils, other unions respected the strike and refused to cross the line. Pickets in San Francisco led to some violent confrontations, during which police were heard yelling racial epithets at the striking workers, attracting greater media scrutiny. After eight days, Henry Kaiser himself took control of negotiations from his labor relations chief, and presented himself at the offices of Alameda County Central Labor Council head Dick Groulx. After 72

hours, the parties produced a settlement that included wage increases above those achieved in San Francisco.[218]

This labor-friendly climate in the Bay Area helped the union expand beyond acute-care hospitals, and into 'convalescent hospitals'—or, nursing homes. Nursing home organizing began in 1956; by 1960, the union had obtained initial master agreements with the Hillhaven, Hacienda and National Health Enterprises chains.[219] The industry expanded quite dramatically in the 1960s, spurred by the establishment of Medicare and Medicaid (MediCal in California). In 1962, George Hardy, by then an International Vice President, told Local 250 members that organizing in nursing homes and unorganized hospitals was the "prime objective" of the international union. Organizers during this period told of myriad organizing initiatives, primarily in convalescent homes.[220] When the NRLB asserted jurisdiction over for-profit nursing homes in 1967, Local 250 aggressively organized these worksites. In a period of about 18 months, the union organized 53 nursing homes, extending it well into the growing industry, as well as growing its geographic footprint beyond its immediate Bay Area base.[221]

Local 399

The union's push southward, however, was decidedly more complicated. As in the Bay Area, the story of early worker organizing in Los Angeles was also the story of the Hardy family. As WWII drew to a close, George Hardy was charged with leading the BSEIU's southward expansion into the Los Angeles area. Hardy drew a team of experienced San Francisco organizers, including Jack Depo, Luke Daniels from Local 87, Stanley Isaacs and Bill Sloan of Local 14. The organizers drove South with their partners and eight children between them, and packed in together into a pair of houses on West 69th St in South Los Angeles. For the first few years, those houses would be the home base of the union's southern beachhead, housing visiting organizers from Local 9 and Local 87 who would come down to work for a week at a time. This early infusion of out-of-town organizers quickly became Local 300, an industrially diverse union combining healthcare, building maintenance, and bowling alley workers, among others. Local 99, a small janitorial local established during Charlie Hardy's earlier effort at southward expansion, already had a number of local organizers, who were eventually integrated into the new organizing effort.[222] In 1946, the local merged into Local 399, which then proceeded to integrate several other locals in the area.[223]

Very early on, Hardy and his colleagues spoke of Local 399 as an "organizing union," focused on establishing a toehold for organized labor in Los Angeles, a city in which political and economic elites remained unified, politically powerful, and hostile to unions in the post-war years.[224] This vision was reflected in the size and industrial diversity of the local, which would seek to unite workers from across industries and occupations, rather than concentrate on a single employer context or skill set.[225] They carried out substantial organizing drives in the late 1940s and early 1950s, particularly in the building maintenance industry and in bowling alleys, through which they spread beyond downtown LA and into the outer stretches of the region. These campaigns pushed their

membership from less than 5,000 in 1951, after the series of mergers that would form Local 399, to almost 9,000 by 1956.[226]

In terms of hospital workers, however, the union began with a base in Kaiser Permanente facilities in the 1950s, but had relatively limited success in expanding from there during these early years. In large part, organizers saw hospitals as a difficult industry to organize because of the character of employers—charitable organizations, insulated from the legitimate exercise of workers' coercive power, and well connected to the city's social and political leadership. But they saw hospital workers as largely similar to those toiling in the bowling alleys, office buildings, and theaters: the hospital workers they targeted for organization largely represented the maintenance and cleaning labor that Local 399 advocated for in other industrial settings. Through the 1950s and 1960s, until the union dropped the word "building" from its name and became the SEIU in 1968, Local 399 presented itself as a "building service union" that operated in the hospital and nursing home industries.[227]

Hospital organizers in Local 399 explicitly conceptualized their membership as the non-professional workers in a hospital—those blue-collar occupations that were not necessarily grounded in education and expertise, and which were comprised of the more vulnerable populations of the working poor.[228] They expressed a sensibility similar to Local 250, in this sense. But in terms of contentious practice, these early hospital organizers felt constrained with regards to the exercise of workplace power. In one of Local 399's early organizing battles, at the Cedars of Lebanon Hospital in Los Angeles, organizers sought to develop alternative approaches to workplace coercion, including the mobilization of community ties. This included the targeting of members of the hospital board, "prominent members of this community," as an alternative to traditional union tools. "The only reason we hesitate in taking this drastic step," read one leaflet on the Cedars campaign, "is because of the serious effect a strike in a hospital would have on the health and welfare of the people in this community."[229] While in the 1960s, Local 399 did make use of strikes on a hospital-by-hospital basis, these often ended in setbacks for the union. In 1961, the Local conceded defeat in the Lincoln Park Memorial and Edgemont strikes, both of which had dragged on for a year and a half.[230]

3. SEIU: Class, Profession, and the Organizing of LVNs

The BSEIU's class-centered conceptualization of hospital care workers was longstanding, and they extended this logic of organization not only to the workers cleaning and maintaining hospitals, but also to the less-skilled aides engaged in direct patient care. It was one of the many reasons that BSEIU leaders resented the relative success of the CNA in organizing Bay Area hospitals in the 1940s and 1950s. The CSNA's model of organization—drawing vertical boundaries around an occupation, rather than horizontal boundaries of class and authority—undermined their own efforts to organize hospital workers, despite the BSEIU's historical commitment to craft organizing. A 1948 internal assessment of bedside care staff organizing (including nurses) along the west coast labeled the ANA affiliates as "nothing more than a company union," in large part because

of the dominance of managerial nurses in the associations.[231] Robert Henderson and Robert Lafollette Sucher, two young organizers out of Seattle, authored the report. Noting that early ANA collective bargaining successes—in California, followed by Washington State and Minnesota—were driven primarily by unionization attempts among Registered Nurses, the report's authors argued that the management-friendly approach of the ANA threatened the rights not only of RNs, but the broad spectrum of bedside care workers. Since the research, practice, and educational goals of elite nurses required collaboration with the AMA, AHA, and local facility administrators, they argued forcefully that this presented a substantial conflict of interest. "Allowing the ANA program to go unchecked," they argued, "would simply mean that thousands of nurses, practicals [LVNs/LPNs], and aides would be deluded into believing that an organization was going to improve their conditions, which in fact, in the long run, can accomplish nothing. The implications of such a scheme are large since many of these people are at present fertile ground for collective bargaining…"[232] In short, they argued, organizing these bedside workers required struggling to define these groups as *care workers*, forming a community of interest with the janitors, elevator operators, and gardeners that formed the core of BSEIU membership at the time.

As the BSEIU locals, particularly Local 250, were working to spread beyond their first hospitals in the 1950s, these organizing efforts took place alongside the emergence of the Licensed Vocational Nurse, or LVN. The union's conceptualization of class-centered boundaries becomes visible when examining the conflicts in the organization of LVNs during this period, in part because the occupation's historical trajectory blurs the lines between blue collar and professional groups in hospitals.

Following the CSNA's recognition by the Bay Area multi-employer associations in 1946, SEIU locals reached their first agreements with the East Bay employer groups in 1950, with Local 250 succeeding to the representation of most of this membership in 1953. As non-profit hospitals were by this point excluded from the NLRA under Taft-Hartley, bargaining unit designations were for the most part negotiated based upon the early representational breakdowns in the industry formed during these years. BSEIU members were drawn from the lower portions of the hospital occupational hierarchy, including within departments: they represented dietary department workers excluding cooks, laundry and maintenance departments, and importantly, nursing department workers excluding Registered Nurses. Cooks, engineers, and RNs were represented by other organizations, while laboratory and x-ray technicians established their own independent associations later in the 1950s.[233] Thus, while many skilled workers tended to segregate along occupational lines, in its early years organizing hospitals, BSEIU instead tended to integrate lower-skilled workers across departments and classifications.

In 1951, the California legislature created the California Board of Vocational Nursing to certify the new occupational group, in an attempt to address persistent shortages in RN labor since WWII. LVNs would work under the supervision of RNs and physicians. While the legislation established that LVNs could acquire a license through training in a

vocational school setting, the law also extended licensure to those who had served in WWII and had combat medic experience.

While administrators in Bay Area hospitals acknowledged the designation and hired LVNs to deliver direct patient care, in these early years, they most often did not distinguish between LVNs, hospital aides, and other ancillary bedside workers who had worked in the wards for some time.[234] More broadly, though they were considered as practicing within the field of "nursing," LVNs remained in a relatively low stature on the hospital occupational hierarchy. In 1966, the Kaiser Permanent Compensation and Benefits Division conducted a study evaluating the "job worth" and status of various occupations within its facilities, and putting forth various potential evaluation plans; of these plans, five of the six of them gave LVNs a score of 3 out of 8 in terms of evaluated worth, alongside occupations such as senior gardeners, technical aides, receptionists, and clerk-cashiers, with LVNs paid the least among these. (RNs received a score of 6 or 7.)[235]

The LVNs, in part because of this early history unfolding alongside the first collective bargaining agreements with Local 250 and other unions, were thus grouped in with the non-professional, blue collar occupations that BSEIU tended to organize. This was a product of these early negotiations that predated the rise of the LVN occupation in California, and it appears that at no point did the Local specifically seek authorization from the emergent LVNs themselves.[236] In the early years after the creation of the occupational group, Local 250 established a body within the union, the "Bay District Vocational Nurses Association, No. 250," in an effort to appeal to these workers' occupational identities, holding meetings of LVNs, and creating a Local 250 specific LVN pin they could wear.[237] Similarly in Southern California, Local 347, a public sector local representing county hospital employees, created an "Attendant and Vocational Nurses Employees Committee" during this period.[238] In Local 399, the union established the "Professional Guild of Licensed Vocational Nurses" in 1966, shortly after (and inspired by) the CNA's mass resignation that summer.[239] LVNs remained in the same bargaining units as other hospital workers represented by SEIU. They were, nevertheless, among the higher-paid workers represented by SEIU in California, and the union made efforts to obtain differentials for workers who had obtained the LVN certification.[240]

In June of 1959, during the negotiation of Local 250's contract with the Associated Hospitals group in the East Bay, a new group called the California Licensed Vocational Nurses' Association wrote to the union and member hospitals demanding to be recognized as representatives of the LVNs, and claiming to have collected signed authorizations for a majority of the approximately 200 LVNs in the association hospitals. The hospitals, already having recognized Local 250 as the unskilled hospitals workers' representative, including LVNs, contested the claim.

The CLVNA was an autonomous organization, but in many ways it was modeled on the CSNA, and the two organizations collaborated frequently, particularly in the late 1950s, when the more conservative director Marian Alford ran CNA. CLVNA was incorporated into "Joint Statements" that CNA helped develop with medical and hospital

associations;[241] both organizations maintained formal liaisons;[242] and district nurses' associations' professional registries sometimes had LVNs among their membership.[243] The CLVNA's literature echoed the CSNA's language of "economic security," couching it in the prioritization of the patient care and professional status. The association established a salary schedule, along with "minimum" personnel policies, and encouraged the hospitals to meet them, much as the CSNA did. They established practice-centered and geographic divisions, and adopted the CLVNA's leadership model of rotating, working LVNs as President, with a more consistent Executive Director.[244] Importantly, they also grounded their identity in the advocacy of patients' interests. According to a statement of the President (later Executive Director) of the CLVNA, Mrs. Lura Bryant, to the Superior Court, the association existed for the purposes of

> promoting better patient care, educating and training licensed vocational nurses in working more effectively together, obtaining increased recognition of the professional status of licensed vocational nurses, and advancing the welfare of licensed vocational nurses. One of the methods by which [the CLVNA] seeks to improve the economic security of its members is by representing them in negotiations with their employers with respect to wages, salaries and working conditions.[245]

In terms of how the organization chose to build member identity, the CLVNA strongly mimicked the nurses' language of status attainment and the exclusion of other workers. "An organization will represent you," Executive Director Lura Bryant wrote to potential members in 1961. "How will you vote? For a labor union, where you will be grouped with non-professional hospital employees, or for your professional organization which will identify you in nursing?"

Perhaps most significantly, the CLVNA adopted a version of the CSNA's no-strike policy, claiming that their membership in the profession of nursing prohibited them from engaging in coercion that could harm patient care: "Licensed vocational nurses, employed in an institution or industry, are accountable to management for the satisfactory performance of the services for which they are employed. As licensed members of the nursing profession they also have direct legal, moral, and ethical obligations to their patients."[246]

In taking these steps, the CLVNA was rather overtly seeking to collaborate with hospital employers to resist unionism and prevent further organizing among a growing occupational group in hospitals. Bryant articulated this clearly in an October 1960 letter to hospital administrators:

> The California Licensed Vocational Nurses Association is recognized officially as a labor organization, but is not a labor union… We are not opposed in any way to unions, but do not believe that nurses should belong to them or that they should strike. As a deterrent to this statewide union drive to force nurses to leave their official membership organization and to join a union, our organization suggests the following simple steps, giving recognition to the licensed vocational nurses and their organization. This action would be mutually helpful to hospitals and to the licensed vocational nurses who serve in them.[247]

Tom Kelly, the Secretary Treasurer of Local 250, argued in court that they had represented LVNs since before LVNs existed as such, and that the people doing that less-skilled work within nursing departments had long been incorporated into the broader bargaining units that BSEIU organized. He argued further that LVNs participated in the life of the union, and had gone on strike with other workers in the bargaining unit just one year prior.[248] Indeed, local leadership likely saw this problem coming—as early as 1954, the local had reached out to hospital employers and LVNs alike to establish the Local's continued representation of LVNs.[249] After running a second card count, Judge Joseph A Murphy sided with the CLVNA, the plaintiffs, and issued an order that hospitals should recognize the CLVNA.[250] By March of 1960, however, the judge reversed himself, and held that the hospitals could not be compelled to undo their contracts with Local 250.[251] The jurisdictional issues raised in this lawsuit would be litigated between the union and the employer associations repeatedly through arbitration for years.[252]

The California Licensed Vocational Nurses Association made periodic attempts to sever the relationship between SEIU and its LVN members through legal channels, from these early attempts through the 1980s.[253] Eventually, they merged into the Laborer's union, primarily to protect itself from raiding, including by SEIU. This ongoing, simmering conflict over the representation of LVNs represented more than a battle for the right to represent them, or even for their hearts and minds. It reflected fundamentally different views of the *boundaries* dividing the many people working in a hospital, and different definitions of the community of interest. The CLVNA, like the CSNA, drew the boundaries v*ertically*—while they certainly recognized a hierarchical divide between LVNs and RNs, they nevertheless saw these groups as engaging in a common practice of *nursing,* distinguished from other groups with vertical demarcations. According to this framework, these nurses, while emerging from a category of workers only barely distinguished from bedside maids in the 1940s, nevertheless had more in common with nurse supervisors than with other ancillary healthcare workers. SEIU organizers approached LVNs from a very different perspective in the 1940s, and maintained that orientation well into the 1970s. They saw the salient boundaries at work in the hospital workplace as *horizontal* demarcations of class. LVNs were blue collar, their interests opposed to the nurse managers who acted as their supervisors.

4. SEIU: Organizing after 1974

After years of lobbying to remove the non-profit exemption, the summer of 1974 represented an immense opportunity for SEIU. George Hardy, President of the International Union since 1970, had been working to streamline the International's organizing and strategic research operations in order to take advantage of this opening. According to Hardy, SEIU was responsible for the amendments, and therefore needed to step up its organizing capacity. "It is our bill," he wrote to local leaders. "We in SEIU have worked for two and a half years in order to get it enacted. But while it is our bill, we cannot keep other unions from taking advantage of it. As a result, we must get there first."[254] Within a month of the passage of the bill, he took actions to double the

International Union's organizing budget—to about $2 million per year, up from an already historic $1 million in the first years of his Presidency.[255] The goal, he told his staff and local leaders, was to double the size of the union through new organizing, and reach 1 million members by the end of the 1970s. Unorganized workers in non-profit hospitals were to be a major component of that growth.

SEIU leaders brought into this moment a model of organizing that mirrored their blue-collar organizing traditions, and incorporated a conceptualization of their potential constituency that was structured by horizontal, class-centered boundaries. "In SEIU," Local 399 organizer David Stillwell told me,

> We thought of everybody below RN as just one hospital worker. We really – there was never really in my memory much differentiation either spontaneously from the workers or from the organizing side of separating anybody. That was just sorta the way we rolled. That was just sorta the culture. And yeah, [workers] were receptive to it but they felt that way too. That's a – one of those instances where rank and file and the union leadership were just organically on the same page.[256]

These organizers were of course aware of the prevalence of professionalization projects in the hospital workplace, and they tended to view these dynamics as an impediment to union organizing. At an organizers conference in January of 1974, as the union began to prepare to organize in anticipation of the lift of the non-profit exemption, SEIU Research Director Anthony Weinlein told organizers that they would have to work hard to overcome the status-orientations and jurisdictional silos that were the legacies of the dominance of professionalism. "In hospital organizing over the years," he said, "we have found that many people in hospitals who are working at very low wages and poor conditions, have resisted unionization because they believe that their professional status or supposed professional status made them too important to join unions. This conception still exists and must be recognized by the organizer."[257] He went on to argue that the professional control of practice, while it could impede unity across worker groups, could also serve as an organizing issue among the blue-collar hospital workers that the SEIU would target:

> Secrecy, incidentally, plays a very important role in the health service industry, and not only in hiding the finances of non-profit institutions, but in keeping so-called professional secrets as the property of a relatively small group of people, which helps reinforce the hierarchical structure of the hospital. The secrecy and professional character of the occupational structure in the hospital mean that here, more than in other industries, promotion is hard to come by. Promotion all the way to the top is impossible without leaving the job to acquire professional training. This fact should be an aid in organizing since most of the people employed in hospitals have very little opportunity to advance.[258]

At the international level, the SEIU set out to mobilize a national campaign to take advantage of the new opening to organize hospital workers. It was a "national campaign" in that the impetus to push for a large-scale organizing drive was pushed by the International Union, where the newly expanded organizing and research departments

were distributing centrally produced literature and campaign checklists. The campaign would mobilize locals across the nation, targeting a broad swath of hospitals as quickly as possible. The national scope was strategic, though not in relation to hospital employers—rather, SEIU leaders saw the NLRB opening as one that would invite increased competition from other unions, as well as for an opportunity for SEIU to establish long-lasting leadership in the growing sector. Under Article XX of the AFL-CIO constitution, a union's contracts were protected from raiding by other unions only once a relationship with an employer was in place, with no guaranteed industrial or occupational jurisdictions; in setting the agenda for rapid organizing in hospitals, George Hardy laid it out plainly: "The union that gets there first is the union that winds up with the jurisdictional rights. This is why we have to go out and organize every hospital and nursing home [...] as quickly as we can."[259]

In January of 1974, to prepare for the NLRB opening, Hardy organized a "healthcare organizing conference." It was the first of the union's "industry conferences," gatherings that would eventually become important organizational bodies within the union. In 1974, the goal was to corral as many locals into organizing in hospitals as possible, to take advantage of the moment of opening. "If we are able to amend Taft-Hartley," Hardy told attendees, "we must immediately put our entire resources to the task of organizing all of the non-profit hospitals that are unorganized. We must utilize the entire headquarters staff, the field organizers, the research specialists, and we may have to borrow organizers from some of you here in order to send them to other states."[260] The conference was a three-day conference for union staff and elected leaders from across the country, with sessions led by Hardy himself, core west coast research staff such as Richard Liebes and Ralph Eliaser, Research Director for Local 399 and former bargaining consultant for the CNA.[261] In addition to corralling locals, the IU researchers sought to convey some of the complexity of the healthcare industry to local organizers who, at that point, often failed to understand the obscure power dynamics at work in nonprofit hospitals. "Out of SEIU's 700 full-time staff," said John Geagan, International Organizing Director, "it's unlikely that more than 50 really understand this industry."[262] Sessions covered the basics, from the proliferation of occupational categories working in a hospital, the traditions of professionalism and technical specialties, to the various decision-makers with influence of managers of non-profit facilities.

With regard to employer targeting, the national campaign adopted the precision of a carpet-bombing. Their focus was on getting petitions going at as many hospitals as possible, before other unions; they produced a series of leaflets, and pressured local unions to distribute them on a weekly basis, with the expressed goal of getting a leaflet into "every unorganized hospital in the United States," as soon as the healthcare amendments went into effect.[263] The centrally produced literature was standardized and useable in any state; the International Union sent locals the leaflets with their names and addresses pre-printed, to make them as easy as possible to distribute.[264] They were "mail-back organizing leaflets," allowing an interested worker to mail a stub to the union to express interest in organizing. They branded the SEIU as "the union for hospital employees," featured quotes from doctors, hospital administrators, and religious figures

celebrating the growth of collective bargaining in the sector, and touting the contracts they had won in the Bay Area, New York, and elsewhere.[265] They also published a newsletter, "The SEIU Hospital Organizer," that was distributed to locals and was oriented primarily toward staff and local leaders. The Hospital Organizer summarized organizing campaign victories and defeats, debriefed successful elections, and reviewed relevant National Labor Relations Board decisions.[266]

In terms of worker outreach, the International asked locals to embrace the leafleting approach that Local 399 had used since the 1960s. A 1968 summary of organizing practices, submitted by Michael McDermott, the Director of the Hospital Workers division of Local 399, laid out an organizing strategy that conceptualized hospital workplaces as independent entities, and structured targeting based on worker interest in unionization on a workplace basis. The strategy emphasized the blanket coverage of hospitals with union literature, and a focus on "hot shops," or workplaces where there was already significant dissatisfaction and an inclination among workers to organize. This broad strategy was reflected in the process of selecting and training an organizing team, the distribution of routes and duties, and the selection of targets for elections.[267] The first step of the organizing process involved blanket coverage of hospitals, distributed along geographic routes, with union literature. The union would spread the same piece of literature across the hospitals until the route was complete, and then move on to a different pamphlet. The organizing teams, which in the 1960s paired a male and female organizer for a route, would set out from the office at 5:00am to catch the morning shifts at the hospitals; a second team would depart on the route in the afternoon. Teams were tasked with penetrating each hospital, preferably during visiting hours, and making contact with different occupational groups. From these initial contacts, organizers would ask workers to express interest in person, or to mail in tear sheets from the pamphlets they received. The organizers would then focus their efforts on the hospitals where contacted workers expressed some initial interest. The Organizing Director, who maintained a roster of hospitals in the jurisdiction, would tally where most expressions of interest were coming from, and assign an organizer to a hospital "When he notes that a strong movement is indicated in any hospital."[268] Once the targeting was settled, organizers would then go about an organizing drive that followed still-familiar steps: they would begin with individual house meetings, and follow up with a group meeting with an early core group outside of the workplace; they would identify issues likely to address the key concerns of a wide set of employees; they would establish an "in-plant" organizing committee, composed of committed union partisans on each shift and in each organizational unit, making sure the committee also spanned the ethnic and social network groupings that governed work life in the hospital. They would file for an NLRB election once they obtained cards from 80% of potential members.[269]

McDermott, by 1974 the President of Local 399 and overseeing the national campaign roll-out for Hardy, compiled monthly reports from local leaders informing how the leafleting was going, where leads were being generated, and where election petitions were being filed.[270] According to David Rodich, a young organizer with Local 399, the practice continued there, too:

> [Local 399] was the local that the international president came out of, and George Hardy was a maniac on the subject of organizing. The pressure was always on. And, of course, he wanted that local to produce – this is in the 1970s – on a very, very high level because it was a matter of pride for him. [...] About once a month, we would get the entire staff in at 6:00 in the morning and send them out and the rule was get to the hospital, pass out the literature until you get kicked out and move onto the next one until you've gone through your list... By doing that constant leafleting, it created a sense of identity for SEIU as the hospital union back then.

The carpet-bombing organizing strategy may well have increased the visibility of the union, as Rodich suggests, and cemented a broader identity in the organization as one in which organizing was a core value and objective. This sentiment was certainly reflected in the rhetoric and literature coming out of the IU President's office, as well as from the leadership of Locals 250 and 399. But in terms of union growth, the evidence of its effectiveness is mixed in the early years, and quickly declined. While the union was quite active in the early years after the nonprofit legislation—within the first year after the non-profit extension, SEIU displaced 1199 as the most active organizer in the healthcare field[271]—the union did not win many of the elections it ran. Between 1970 and 1979, locals ran elections in 794 hospitals, with 113,729 employees. They won 410, gaining 39,836 new members, but lost 384, losing 73,893 potential members. This does not include elections from which the union withdrew—which could often be many, as organizers would attempt to withdraw if they expected a loss.[272] According to SEIU Organizing Department measurements, the two years after the lifting of the non-profit exemption were among the most active in the union's history. But even during this period, the International Union lost a greater share of the hospital workers it competed for than it won—35/59 elections won, with 2853/9412 potential members won.[273] 1978, however, marked a substantial drop off: 27/76 elections won, and 1696/9691 potential members won. "The drop off," explained the 1979 Western Conference organizing report, "is across the board with virtually all active SEIU locals conducting fewer elections, certainly in the healthcare field..."[274]

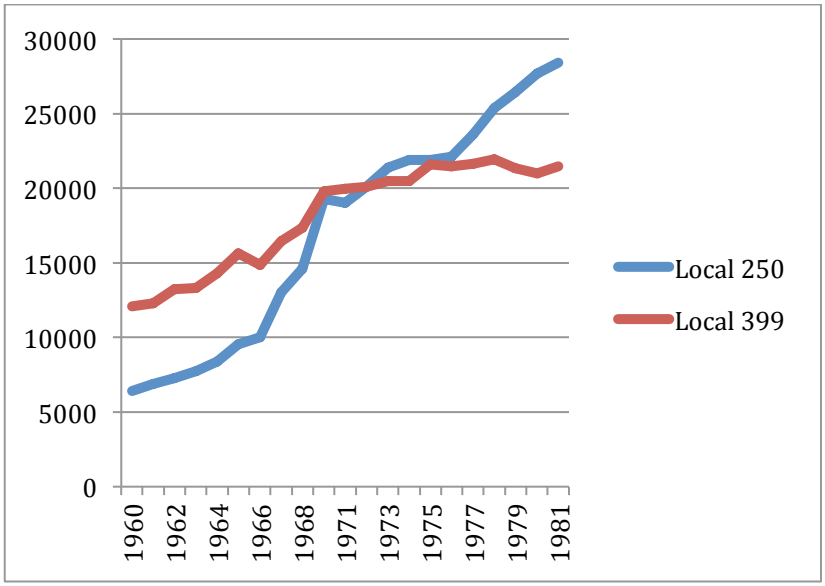
It was not only the dearth of organizing successes that drove the decline in growth rates just a few years after the 1974 opening. They were also encountering aggressive de-unionization efforts, particularly in Southern California hospitals. By 1979, Local 399 organizer David Stillwell recalls, the local "lost hundreds, maybe thousands of members—actually lost them through the decertification process. And then it was obviously very difficult to organize new ones while that was going on on your flank."[275]

The overall growth trend, furthermore, masks substantial heterogeneity in growth rates across geographic space. Compared to the rest of the country, California was one of the major centers of organizing and growth in the healthcare field for SEIU in the 1970s. The organizing approach the union adopted, however, appears to have been more effective in the Bay Area than in Southern California. These trends are summarized in the figure below, drawn from annual membership reports produced by the International Union

between 1970 and 1982, and a November 1971 report on growth patterns in the 1960s.[276] In addition to several small mergers in the 1960s, both unions gained members over the two decades between 1960 and 1980. Both unions benefited from the opening of organizing of proprietary (that is, for-profit) convalescent nursing homes in the 1960s. After 1974, however, while there was appreciable growth in the membership of Local 250, Local 399 had much more constrained growth.

This discrepancy is even more remarkable given stark differences in International Union investments in organizing in the two locals. Over the course of the decade, the International Union paid almost $16 million in organizing subsidies to local unions, joint councils, and other organizing committees, and gained over 241,000 members. [277] Looking at the effectiveness of these organizing subsidies by local, however, it is evident that organizing in the Bay Area was more efficient than in Los Angeles—due in no small part to Local 250's overall size and strength in the health sector at the time. Local 250 gained 10,962 members over the course of the 1970s, on an organizing subsidy of only $18,230 over that time. Of these, 816 members were gained from local mergers. Local 399, on the other hand, gained about 2,400 members over the same period, on a subsidy of over $300,000. Of these, 721 members were gained from mergers.[278]

Figure 1: Total Membership, Locals 250 and 399, 1960-1980



Part of the reason behind this discrepancy had to do with vastly different legacies of labor mobilization in Northern and Southern California. Organizers felt that the labor movement was simply "stronger and more deeply embedded in communities in Northern

California."[279] Indeed, the "law of the jungle," what management attorney Laurence Corbett called the patchwork of uncodified rules and customs governing collective bargaining in hospitals before 1974, differed starkly across regions. In the Bay area, it was a set of informal arrangements, but one that was established in a metropolitan area with a longstanding tradition of labor militancy, and a parallel, similarly strong tradition of organized employer associations forged in the heart of the New Deal era and in the aftermath of the 1934 San Francisco General Strike.[280] These relatively strong employer associations, while certainly established to defend the interests of employers, nevertheless operated in, and helped sustain, an atmosphere where collective bargaining was accepted as a fact of life. It was in this context that SEIU had managed to spread beyond its initial organizing enclave in San Francisco, and CNA beyond the first organized hospitals in the East Bay, despite the lack of legal protection for organizing under the NLRA. By the middle of the 1950s, both organizations had established collective bargaining in hospitals on all sides of the San Francisco Bay, and had begun to expand further afield.

Los Angeles was a different area entirely—conservative, with a strong anti-labor tradition, and organized employer associations that protected this business-friendly environment. Hospitals, despite their charitable public image and deep ties to local religious communities, nevertheless reflected this strongly labor-hostile climate.[281] The Hospital Council of Southern California remained staunchly anti-union throughout the 1950s, 1960s, and 1970s. The Council coordinated pay rates for hospital employees across the region, maintaining wages well below those enjoyed by northern workers. Member hospitals would tell the press as well as workers themselves that they were simply "following the recommendations" of the hospital council for wages, continually undercutting even those hospital workers engaging in collective bargaining.[282] Southern California Kaiser nurses, for instance, had their wages pegged to the Council rates until 1977.[283]

It was in this strongly anti-union context that a new set of actors would come onto the scene to push back against the opening of NLRA in 1974: union avoidance consultants. SEIU organizers first encountered these firms during their hospital organizing drives in the 1970s, and report being surprised by a level of sophistication in the employer counter-organizing response that they had not previously encountered; labor historians have similarly noted the early emergence of these firms in the healthcare industry.[284]

Some of the most important union avoidance consultants who would play a large role in facilitating the de-unionization wave of the 1980s were born in the midst of the brief healthcare-organizing wave of the 1970s, specializing in hospitals because of the intensity of organizing in the industry during this period.[285] According to several people working as SEIU organizers in Southern California in the 1970s, they encountered anti-union consultants for the first time in the mid-late 1970s, as the initial organizing growth spurt began to peter out. It was apparent to many that within just a few years, employers quickly learned to use the courts and the NLRB to slow organizing efforts—most often through contesting the boundaries of bargaining units—as well as to use captive audience tactics to turn workers against the union during prolonged campaigns. In some cases,

hospitals used Medicare and Medicaid funds to pay for these anti-union consultants.[286]

In California, organizers often confronted the West Coast Industrial Relations Association (WCIRA), a regional consultant initially specializing in healthcare, with offices in Newport Beach and Mountain View. Still a young firm in 1975, promotional material advertised their services to hospitals, specifically advising employers to take advantage of the healthcare-specific notification requirements in the Taft-Hartley amendments to slow down organizing drives. They offered to help employers identify illegal pickets and strikes, use these actions to stall elections or to sue unions.[287] Where employers could claim that such actions were illegal, WCIRA informed employers, they could permanently replace hospital workers. While aggressive use of the permanent replacement mechanism was not very common at the time, it would become a far more common event in the 1980s, and a key tool for de-unionization.[288] The promotional material also pointed out the warning signs that workers might be "salts," or "professional infiltrators," a process that required sophisticated procedures, as interrogating workers as to their sentiments toward unions could be construed as a violation of the law, and explicitly warned against hiring anyone who might take a pay cut, appeared overqualified, or who seemed like the "leader type."[289]

At one point in the late 1970s, David Stillwell, a young organizer at Local 399, surreptitiously attended one of these captive audience meetings that WCIRA ran in hospitals during organizing drives. "I snuck in. I hid in plain view among a bunch of members in uniforms," he told me.

> It was the union busters who were doing the presentations. It was this very good combination of folksiness and earnestness... It was very well structured and I was noticing people, even people who ended up being our supporters, but they were staring at them with this look of disbelief in their eyes and a kind of wonderment, too... And they made the point of keeping the supervisors and managers—they had pretty good intelligence on which supervisors were the real assholes, and so they kept them far away... It was just these nice folksy guys who attempt help [workers] understand the labor movement from the outside.

Another young organizer at Local 399 in the 1970s, David Rodich, recalls encountering consultants in the late 1970s in their few already-organized hospital facilities. Firms like West Coast Industrial Relations Association "specialized not only in union avoidance, but in kind of tearing the fabric apart." "Their model was a very recognizable model," he told me.

> In their model, the way I experienced them… you do a couple of things. One is you create an extremely hostile environment. This is not an environment where you're just trying to make it about the union going away. This is where you try to create an environment where people just feel unsafe. “Oh, my god. What have we done here?” Because all of a sudden there's all of this conflict and stuff going on. No. 2, where they were very artful was in trying to change the subject... They would put outlandish things out in an attempt to get the union to start responding to that. While in essence what you are doing is you are changing the frame of the

> conversation. You're changing it away from what the issues are that brought you to want to form a union in the first place, to, “Oh, my god. This union is something that I need to fear.”

According to James Zellers, who at the time worked in the Research Department and would soon become President of Local 399, the fear that workers felt in these circumstances was legitimate:

> Uh-huh. Whatever we organized, we had to face a captive audience… They would hire someone to come in, basically, then they'd have the captive audience speeches. Then there were the firings and then our unfair labor practice charges. But if they fired somebody, that somebody was gone. I can't recall our being successful in winning back their jobs.

After a couple years, hospitals used similar tactics to turn from union avoidance to union breaking. Consultant firms helped coordinate a wave of hospital decertification campaigns in the late 1970s and early 1980s, particularly in the South, most of which the union ended up losing. Hospital employers would provoke strikes, organizers suggested, by demanding unreasonable concessions or attacking fundamental union security clauses in contracts; once a strike began, employers could hire permanent replacements. This would create a broad environment of fear, in which employers would then move a decertification petition; in most cases, they could count on the votes of the replacement employees and demoralized workers who valued their jobs over their union. "It was all new," said Rodich. "We weren't particularly used to that level of animus, and that level of hostility. You ran and election and they took a shot to beat you, but if they lost life went on. You just negotiated the contract, and moved on. But, this kind of a systemic approach to wanting to break the union was something we hadn't seen before."

5. CNA: Professionalism and the Boundaries of Taft-Hartley

The politics surrounding Taft-Hartley were a longstanding point of contestation within the American Nurses’ Association. The most critical implication of the passage of the Taft-Hartley amendments was that at a national level, the growth of the Economic Security Program was all but halted in its infancy. The California Nurses Association had cemented its foothold in the Bay Area, and within the Kaiser Permanente system statewide; a few other state associations had similarly launched collective bargaining programs under the Economic Security Program. But in the 1950s, this growth stalled dramatically. ANA leaders saw the Taft-Hartley amendments as immediately detrimental to their efforts to establish the Economic Security Program where it did not already exist.

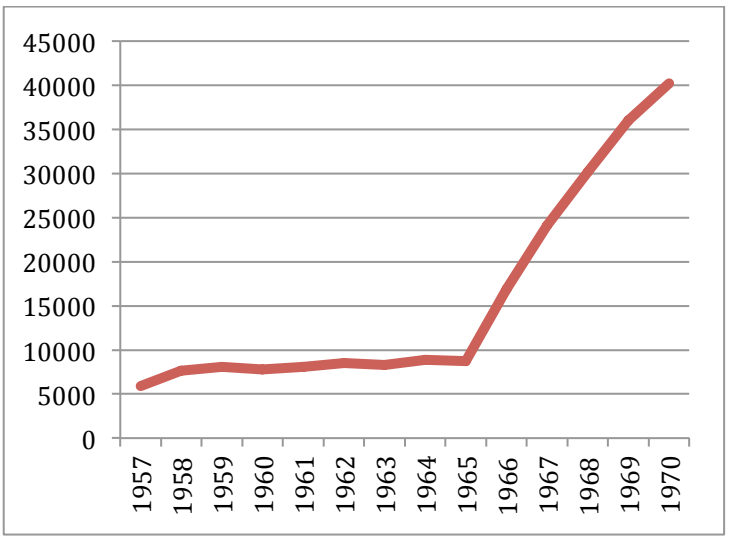
Formally, the Taft-Hartley amendments relieved nonprofit hospitals of the obligation to recognize unions under the terms outlined in the NLRA. These exemptions did not prohibit unions operating in hospitals, invalidate the existing contracts or collective bargaining arrangements already established in the Bay Area and Southern California (or the few established elsewhere), nor prohibit future recognition in any formal sense. But

the terms of the amendments set a powerful institutional standard that made hospitals--both public and private--thoroughly resistant to new unionization efforts for the next two decades. In the eyes of some within the CNA and the ANA, this institutional standard re-established and reified the incompatibility of unionism and care work. For instance, state-level labor legislation, passed after 1947, tended to exclude non-profit hospitals from coverage; and when they did not, some found that courts and regulators called upon the Taft-Hartley exemption as "desirable public policy."[290] ANA organizers seeking new collective bargaining relationships with hospitals found administrators not only saying they did not have to recognize the union, but implying that unionism for nurses was somehow unlawful.[291]

At its 1954 convention, the ANA took a strong stance against Taft-Hartley, passing a resolution calling for the repeal of the act, and the non-profit exemptions in particular.[292] But despite the nearly unanimous front of opposition to the Taft-Hartley exclusions, there remained internal divisions as to how to respond. Advocates of vigorous economic security programs were of course supportive of aggressive opposition, seeing the lack of legal protection for nurses as the single largest impediment to the growth of collective bargaining programs, particularly in those states that did not have well established programs already.[293] Following Johnson's landslide election victory in 1964, many within the labor movement considered it an opportune moment for labor law reform, and within the ANA, collective bargaining supporters sought to devote association resources to seeking the removal of the Taft-Hartley non-profit exemptions.[294] But some elite nurses were clearly more comfortable with this external institutional constraint on the growth of the collective bargaining program. The ANA legislative committee, which had in previous years endorsed the introduction of an amendment ending the exclusion in each succeeding congress, met in November of 1964 to discuss legislative priorities. It was at that meeting that they decided to express to the ANA Board "its reservations about a vigorous pursuit by ANA of the removal of the non-profit hospital exemption from the Taft-Hartley Act."[295] Committee members were apparently concerned that nurse supervisors would be excluded from the act, and that the "National Labor Relations Board would take jurisdiction over hospitals." The Board agreed to *not* put "all available resources" into the effort.[296]

In the late 1960s and early 1970s, however, both the CNA and the ANA were rapidly changing organizations. The militancy of San Francisco nurses in the summer of 1966, the national wave of mass resignations that followed, and the lifting of the strike ban in 1968 exposed the association to many staff nurses who saw an opportunity to better their lot. At the national level, the number of nurses under contract saw an explosive growth: from under 9,000 nurses in 1965, to over 40,000 nurses by 1970, all accomplished before the opening of collective bargaining in non-profit hospitals in 1974.[297] By the end of the decade, ANA would claim to represent almost 100,000 nurses through the collective bargaining program.

Figure 2: Estimated Nurses Under Contract, ANA Affiliates



At the cusp of the passage of the 1974 healthcare amendments, nurses engaging in collective bargaining had built this membership on a framework emphasizing the positive role that bargaining could play in organized nursing's control of nursing practice, as the CNA had so forcefully demonstrated in its 1974 strike over staffing concerns examined in the previous chapter. Internally and externally, nurses' associations were forcefully legitimizing their use of contentious collective action as a tool for bringing the power to make nursing care decisions into the nursing field itself.[298] This was always a tenuous compromise, driven by advocates of collective bargaining in the context of an organization with many internal opponents. But coming into 1974, the lifting of the non-profit exemption represented an unprecedented opportunity to continue riding this wave of momentum, to expand the number of nurses under contract, and to deepen nurses' capacity to exercise power in the interests of patient care and the professional project through collective bargaining.

As with SEIU, however, what appeared to be a profound opportunity in 1974, quickly became a series of road blocks and organizational challenges just a few years later. CNA also encountered employers who engaged the services of union avoidance consultants, and developed rather sophisticated legal strategies to delay elections, appeal votes, and obstruct the organizing of nurses. CNA, however, entered the decade with a different approach to care worker unionism—rather than conceptualizing their members as blue-collar workers, they worked to establish a model of collective bargaining and workplace contention that relied upon the moral authority of their advocacy for placing control over patient care in the hands of a caring profession. But in the case of CNA attempts to organize, however, these employers were handed a series of potent strategic tools, centered on the incompatibility of the NLRA with the practice-based, occupation-centered unionism that nurses had developed.

6. CNA: Organizing, Conflicts of Interest, and the Boundaries of Taft-Hartley

With regard to the practices of organizing in the 1970s, the contradictory status of nurses as “supervisors” profoundly shaped the CNA, and the ANA itself. In hospitals, nursing services tended to be organized in a department of nursing. Registered Nurses occupied various positions in an internal hierarchy within these departments, from directors of nursing to nurse supervisors to bedside staff nurses. This was an established custom derived from earlier institutional arrangements, a legacy of hospital-based nurse education, where nurses taught and learned the practice of nursing in the context of a hospital workplace. It was also one of the key forms of occupational mobility for nursing—the field of nursing itself held its own career ladder, even if positions at the top were always limited. This structure was not only established and defended by organized nursing, as a key tool of maintaining control over nursing practice; at the time, it was also "a requirement of the Joint Commission on Accreditation of hospitals, an in many state laws."[299] Importantly, departments of nursing did not just supervise bedside RNs, but also nurses' aides and licensed vocational nurses. RNs consistently played leadership roles within this structure. Anne Zimmerman, who would assume the presidency of the ANA in 1976, told the American Bar Association that these supervisory roles that existed in hospital practice were not the "supervisors" envisioned by the framers of Taft-Hartley; their loyalty was not for the employers, but to the patients and the practice of nursing itself: "It is the responsibility of the nurse to direct other employees in the management of patient care, not because the hospital has made her a boss, but because she is the one with the professional expertise of what has to be done for a patient and she often is the only one who is qualified and legally obligated to do it."[300]

The 1974 opening of collective bargaining protections to workers at non-profit hospitals compelled the Board to rather quickly make sense of a workplace context that had gone largely unorganized. In the pockets of hospital unionism that existed such as the Bay Area, the “law of the jungle” had reigned, and had led to alternative institutional arrangements and patterns of bargaining unit designation, as unions and employers developed their own rules through iterated organizing drives, disputes, and court battles.[301] In that context, the precise supervisory classifications established under Taft-Hartley informed these institutional arrangements, but did not determine them.[302] The history of professionalism and relatively strong professional associations among nurses had led to the development of RN-only bargaining units embedded in associations with broader missions and broader memberships; and by 1974, almost three quarters of nurses under contract were represented by these ANA-affiliated programs. (CONFIRM)

ANA and CNA lawyers were acutely aware of the complications that the Taft-Hartley framework would generate for Nurse Associations once the non-profit hospitals were brought into the NLRA fold. During the deliberations around the 1974 bill, ANA leaders had lobbied Congress to exclude such professionals from the definition of “supervisor” under the law. But as the Labor and Public Welfare Committee wrote in its report,

> The Committee has studied this definition with particular reference to health care professionals such as registered nurses, interns, residents, fellows, and salaried physicians and concludes that the proposed amendment is unnecessary because of existing Board decisions.

The retention of the supervisor definitions in Taft-Hartley created two problems for organized nursing. The first problem concerned nurses' leadership role in patient care provision, and their relationship to other direct care occupational groups. One of the more complex and contested policy issues undertaken by the NLRB concerned the supervisory status of nurses. The problems emerged from the difficulties of mapping a regulatory infrastructure developed in the factory onto an industry of high skill, where even routine work requires significant judgment calls on the part of many care workers, and in which occupational groups had a long history of professionalization projects. A nurse, in the course of her work, would make judgments about patient care that other groups were expected to pay heed to, just as she was expected to follow the direction of physicians and other specialists in the hospital. This was a relationship between occupations that was not mirrored in work contexts where the labor process was more routinized, or where those issuing instructions were assumed to always act in the interest of employers. In the context of a law designed around routinized factories, the regular exercise of such judgment meant that nurses and several other occupations blurred the boundaries between supervisors and employees that had been established by Taft-Hartley.

Taft-Hartley excluded supervisors from workers' bargaining units because the institution of collective bargaining was premised on the negotiating parties constituting a community of common interest. Including supervisors, who despite their drawing a salary nevertheless represented the interests of employers relative to workers, was seen as creating conflicts of interest and impeding the smooth functioning of bargaining units. Taft-Hartley thus established three elements of supervisory authority to empirically distinguish supervisors from non-supervisors in a workplace: they must work in the interest of the employer; they must have authority to hire, fire, and discipline employees; and the exercise of their authority must "require the use of independent judgment."[303]

It was a legal structure that made sense in the context of the factory, where those defined as workers could be expected to have relatively limited latitude with regard to the scope of work. But as Vinel (2013) shows, it was a categorization that did not adequately capture the dynamics of authority in the environment of the hospital, where care workers with relatively high levels of technical skill routinely exercised judgment with regard to the care of patients, but did not always have the responsibility or the right to discipline others. In drawing a stark distinction between those with and without authority to determine the conduct of labor, this was a strict legal distinction that, perhaps, reflected the status-oriented professionalism of the ANA's early years, as well as the SEIU's more blue-collar conceptualization of hospital labor in the 1940s and 1950s. But the changing healthcare system made these distinctions more difficult, precisely because nurses had assumed a greater share of responsibility for routine patient care in the intervening decades. As Leon Despres, legal counsel to the Illinois Nurses' Association put it in 1976, "Many a "supervisor," as defined in the NLRA, is not regarded by the profession as a genuine supervisor, because her supervision is of the patient's care and not of personnel per se."[304] Further, the act's definitions of supervisory authority contradicted the underlying logic of the emergent, class-antagonistic framework of nurse unionism in the

1970s. Through iterated conflicts in the 1960s and 1970s, CNA activists and staff nurses had transformed the moral conceptualization of the strike and other forms of nurses' power—the force of that conceptualization lied in framing the exercise of nurses' professional judgment as being always in the interest of the patient, rather than in the interest of the employer. These debates over the supervisory functions of staff nurses would continue through cases for decades, leading up to the Kentucky River decisions in the 1990s that would threaten nurse organizing across the board, as well as millions of other workers who were caught under these decisions' more expansive definition of 'supervisor.'

The second problem that the supervisory definition created for the CNA concerned the class divisions within the association itself, and their relationship to association governance. The supervisory clauses under Taft-Hartley challenged the social boundaries and classification structures that nurses' professional project had forged over the decades. The nurses' associations had long made the case that nurses were not simply an employment classification; they were defined by their practice of nursing. Their power rested in defining and claiming exclusive jurisdiction over a specific scope of practice, and defending that scope of practice through networked institutions that nurse spanned education and work. In short, professionalization entailed drawing *vertical boundaries,* protecting the scope of "nursing" from encroachment at the top of the hospital hierarchy, at the level of management, and at the bottom, from other occupational groups. Under this model, the association was a "multi-purpose" organization that incorporated nurse managers, nurse educators, and staff nurses alike. It did not fit the institutional assumptions of established labor law, which relied on a conceptualization of communities of interest that cleaved along *horizontal boundaries*, separating owners, managers, and workers.

In December 1974, with the ANA having failed to obtain new language to fix the supervisory problem in the language of Taft-Hartley, CNA board members and activists met to consider different ways forward in terms of structuring and financing the nurse organizing program. They convened an "ad hoc task force regarding Economic and General Welfare," composed of representatives from the board, the Program, and the regional bodies. Among the alternatives discussed were a) to withdraw from collective bargaining as an association, b) to affiliate the CNA with the AFL-CIO, c) to spin off the program as a union separate from the CNA, d) to allow regional bodies to act as unions, e) to contract out representation services, or f) to retain the statewide EGW program within the CNA. It is unclear how seriously these various options were considered, but the fact that they were on the table suggests that EGW leaders were cognizant of the pressures they would face from the NLRB, as well as other unions. Despite some expressed reservations for representatives of Southern California regional associations, where the EGW program was less developed, they ultimately chose to retain the status quo—a belief that CNA could engage in collective bargaining, with limited autonomy for the EGW program. The Board resolved to explore the concept of further autonomy for the EGW, in the form of a Commission, much like the structure of the ANA Commissions. They further committed to aggressively organizing all RNs, to retain their

broader focus on merging the push for collective bargaining with the practice orientation of professional nursing, and to back these goals up with funding. They did not approve the committee's proposal, however, to move dues funds from represented nurses directly into the Economic and General Welfare Program's budget.[305]

The problem of nurse managers playing leadership roles in organizations conducting collective bargaining on behalf of staff nurses had first come before the NLRB in 1968, when an employer contested the Alabama Nurses' Association's claim to represent industrial nurses due to the presence of nurse managers in the association leadership.[306] The NLRB found in that case that because bargaining decisions would be made by a local unit, the Alabama association was a bona fide "labor organization" able to negotiate legally.[307] It was after the 1974 healthcare amendments, however, that the problem took on new force. The incongruence between the *vertical boundaries* inherent in the professionalization strategy pursued by organized nursing and the *horizontal boundaries* assumed by labor law became a much larger threat to nurses' associations with the Anne Arundel and Sierra Vista cases heard by the NLRB in the late 1970s.

In 1977, the US Court of Appeals found that an NLRB order requiring Anne Arundel Hospital in Maryland to negotiate with the Maryland Nurses' Association was unlawful. The MNA, which had nurse supervisors among its Board members, had argued that a local worksite unit could serve as the primary bargaining agent, in keeping with the Alabama precedent.[308] The hospital argued that the local unit could not be considered autonomous from the Association Board, leaving it open to managerial domination. After the NLRB found for the MNA, the case was appealed, and the NLRB finding overturned by the Fourth Circuit—the local unit did not collect dues, its budget was set by the MNA, and MNA staff did much of the negotiating.[309] In other words, the court found that the Board could not assure that local units were sufficiently autonomous to prevent managerial domination.

Overturned by the courts, the NLRB revisited the question of the "multi-purpose association" as bargaining agent in the Sierra Vista case, which examined these issues in the context of a recognition campaign at Sierra Vista Hospital in San Luis Obispo.[310] CNA had sought to represent nurses there in 1975, and had won the election. After the Hospital moved to revoke certification, the Board found for the association, arguing that

> CNA has effectively delegated its collective-bargaining authority...to an autonomous local unit of nonsupervisory registered nurses, and that said local unit is properly exercising this authority on its own behalf. Therefore, we find no merit to the Employer's contention that...CNA is disqualified to act as the representative of the unit herein, and we shall deny the Employer's motion to revoke certification.[311]

The employer contested this finding, and litigation concerning Sierra Vista dragged on until 1982. Closely monitored by actors across the labor movement, the impact of the litigation was very acute for nurses, particularly the exclusively-RN associations in the ANA. While the courts would ultimately rule that, with certain organizational

precautions, associations like CNA could engage in collective bargaining, this outcome was not a foregone conclusion, and remained in doubt for the remainder of the decade. This gave employers an opportunity to contest virtually every election petition brought forward by the CNA, as well as nurses' associations in other states. The irony of employers alleging that they should not be compelled bargain with an organization they dominated was not lost on CNA leaders. According to Sam Bottone, Director of the CNA Economic and General Welfare Commission,

> Hospital attorneys are advising that hospitals should refuse to bargain with state nurses' associations... A clever legal argument has been concocted: CNA is not a bona fide labor organization. The rationale: CNA is management dominated; the evidence of domination: the membership in CNA of nurses who hold management positions. Clearly, the hospitals must refuse to bargain with an organization it dominates.[312]

Employers' persistence in their pursuit of these employer-domination cases was particularly debilitating for CNA precisely because it undermined the fragile (if powerful) compromise strategy that CNA had developed between 1966 and 1974. That fragile truce between elite nurses and staff nurses within the association was premised on the exercise of staff nurses' coercive power in the interest of patient care and nurses' control of practice. But hospitals, argued Bottone, were heavily resistant to bargaining with nurses *as professionals*:

> A hospital attorney told us recently, "Nursing practice matters are management prerogatives." We are being told that what nurses do and how it is done—the scope of nursing practice—should be controlled by hospital administration. As nurses are increasingly demanding more control of their practice and conditions under which they practice, that is, striving to be able to function as real professionals, those who control the hospital industry are determined to deny them this right."[313]

The stasis of the courts and the NLRB, particularly concerning an issue that was driving a stark wedge between supervisory and staff nurses in the hospitals as well as within the Association itself, had profoundly negative effects on the CNA's potential to grow. CNA's membership had expanded substantially in the late 1960s and early 1970s, in response to the upsurge in militancy following the 1966 mass resignation. This occurred under a legal regime that did not recognize nurses' right to organize. Most had assumed that the 1974 opening would lead to an expansion, rather than a contraction, of the Association's membership and clout. But by 1976, the early organizing successes had stalled. According to one staff nurse at the time, "The CNA seemed to have made the decision not to try and organize, just to stay with what they had."[314] This lack of growth was compounded by the loss of members, including among nurse managers and educators, who felt alienated by the association's organizing drives and employers' legal maneuvers meant to stall them. As CNA President Irene Pope wrote in an essay on the Sierra Vista decisions,

> One of my major concerns has been the gradual change in composition of our organization because nurses in administrative and educational positions have been

> withdrawing their memberships or not renewing… It has become obvious that employers are aware of the situation and have felt that one way of removing this possibility of collective bargaining from various situations is to divide the profession of nursing by putting pressure upon the administrative nurses. Unfortunately… they have been quite successful in doing this.[315]

The membership decline was substantial, if uneven. The crisis for CNA was particularly acute in the Southern California regions, where the Economic and General Welfare Program was quite weak and the regional nurses' associations were more likely to be dominated by nurse managers and educators. Between 1976 and 1979, membership in the Bay Area regional associations remained relatively stable, or grew; Region 11, based in Alameda County, saw a 25% growth, though the large San Francisco regional association saw membership decline by 8%. Southern regions, on the other hand, saw substantial declines, albeit from smaller initial numbers: Region 1, Santa Ana, saw membership decline by 32%; Region 2, Van Nuys, by 35%; Region 6, Greater Los Angeles, by 38%.[316] According to CNA organizers, the attorney for Sierra Vista Hospital confidently assured the attendees of a Southern California Hospital Council meeting that within two years, "CNA would be decertified as a labor organization and would no longer bargain for nurses."[317] The decline of southern membership was accelerated by the formation of a rival organization, the United Nurses Associations of California, discussed in the next section.

In November, 1978, representatives of the ANA board met with NLRB representatives,[318] to impress upon them that the pending litigation was severely hampering their organizing efforts; that employers would continuously file lawsuits contending that nurses' associations were employer-dominated, the irony of which the Association frequently made clear; and that they were subject to raids by unions who did not share the same conflicts of interest.[319] Lawsuits around the country were imposing "immense financial strains" on state associations. The internal divisions within the nursing associations over the pursuit of collective bargaining had persisted, and in the context of financial strain and external attacks, were becoming more acute. This produced, according to ANA leaders, significant schisms.[320] Altogether, many within the ANA saw the Sierra Vista litigation, and the vulnerability it produced vis-à-vis other organizations, as an existential crisis: "It was impressed—with vigor—upon the Board representatives that the very future of the professional association hinged upon a rapid determination by the Board of these important cases."[321] This was not an idle concern; between 1976 and 1979, various employers brought at least fourteen cases challenging ANA affiliates' role in collective bargaining, due to the risk of employer domination.[322]

The pressures resulting from the Anne Arundel and Sierra Vista litigation threatened the nurses' association collective bargaining programs from within, as well as from outside. One significant effect was the empowerment of internal opponents to nurse unionism, who saw the internal bureaucratic reorganization required to insulate collective bargaining from managerial domination as too much of a threat to traditional authority structures in organized nursing. In several states, including Rhode Island, Texas, Utah,

Virginia, and Wisconsin, state nurses' association boards moved to eliminate collective bargaining programs altogether.[323] One of the more dramatic upheavals along these lines occurred in the Wisconsin Nurses' Association. In that case, in order to forestall legal challenges made under the Arundel precedent, a group of nurses had lobbied the association to increase the autonomy of the EGW program. As in Maryland, nurse supervisors were excluded from the bargaining process, but still held leadership positions in the Association, and were able to make policy, hire staff, and allocate resources in ways that affected the governance of the collective bargaining arm. Autonomy advocates presented a set of bylaw proposals that would allow the EGW program to hire its own staff and manage its own budget, and would exclude managers and educators from the governance of the commission. The ANA opposed the bylaw changes, leading to the intervention of Barbara Nichols, the President of the ANA (and future Executive Director of the CNA), who worked to convince the WNA to maintain the status quo; according to some, ANA leaders had communicated that the state association would be out of compliance with ANA policy if they went ahead with the bylaw changes. Several months later, in response to the contention, the WNA moved to eliminate all new organizing for nurses—communicating clearly that if the association could not be a "multi-purpose" organization integrating leadership from managers and educators, it was their commitment to collective bargaining that would waver.[324] For several years thereafter, the Minnesota Nurses' Association EGWC assumed jurisdiction over collective bargaining in Wisconsin.[325]

CNA pursued a different bureaucratic solution to the problem of managerial domination. Because the local regional units had nurse supervisors on their boards, the CNA had made the decision that rather than delegate bargaining authority to the local unit, a statewide Economic and General Welfare program would serve as the bargaining agent.[326] In 1977, they undertook further bureaucratic reforms intended to insulate the collective bargaining and professional programs of the association, in order to avoid the claims of a conflict of interest. At the 1977 Convention, the CNA established four "commissions," modeled after the relatively autonomous bodies within the ANA: the Economic and General Welfare Commission, which would run the collective bargaining program, along with the Government Relations, Nursing Service Administration, and Nurse Education Commissions. This was, according to CNA President Irene Pope, a direct response to the Sierra Vista decision:

> The arguments used by the employer made it necessary for the NLRB to decide whether or not a multi-purpose, multi-membered professional association could represent nurses in collective bargaining, as well as be involved in the myriad of professional issues which a professional organization has to deal with. The results of the decision make it very clear that as long as certain kinds of policies, which CNA has always followed, are in effect, there is no reason to believe that a professional organization such as CNA should not be involved with both the promotion of professional rights in a work situation and ultimate goals for the profession itself. The NLRB reaffirms the fact that CNA is a multi-purpose organization.[327]

In California, the CNA's Commission model formalized these decisions and adopted what was the traditional organizational structure within the broader ANA, reinforced to meet the requirements established by Sierra Vista. The EGW Commission was composed of elected non-supervisory nurses, but the Board of the Association—which did include supervisors—retained the authority to set the budget and hire the Executive Director, who in turn hired the director of the Economic and General Welfare Program, along with its staff.[328] The Commissions were a way to legally insulate the various components of the organization, to keep in compliance with Sierra Vista, while retaining the traditional leadership role of elite nurses in the organization. Local regions, dominated by nurse managers, could be held apart from the collective bargaining arm, and avoid being labeled as "labor organizations" under the law.[329] This was not the only structure in existence: Washington State, for instance, would grant charters to local units, and these would coordinate with a much more autonomous EGW program; in DC, the EGW program controlled collective bargaining but enjoyed full autonomy to set its budget, bylaws, and hire staff.[330]

Even with the new formal autonomy, staff nurses serving on the Commission soon encountered the limitations of its autonomy. The Commission did not govern the EGW program itself—including the management of staff and the administration of contracts. Some nurses serving on the Commission spoke of a pervasive distrust of CNA staff, and mentioned that they maintained minimal contact with the nurse advocates or the EGW leaders themselves.[331] This distance between the elected Commission and the conduct of collective bargaining was a product of the CNA's bureaucratic restructuring to deal with the legal risks associated with Sierra Vista. "Nurse Advocates," the association staffers assigned to deal with workplace units on a regular basis on both "economic" and "practice" issues, split their time between the EGW program at the state level and the regional associations, most of which were dominated by nurse managers.[332] While the EGW Program itself was coordinated at a statewide level, Nurse Advocates were regional staffers that were the first contact between worksite units and the Association with regard to contract enforcement and workplace committee organization. It was the Nurse Advocate who met with individual nurses to determine if they had a grievance, educated staff nurses on their rights under their contracts and the law, and coordinated the activities of the worksite Professional Performance Committees.[333] For all intents and purposes, they were the workplace manifestation of the EGW program. But they were regional employees, hired by the Regional Associations, which could not act as a collective bargaining agent. In March, 1977, CNA established a set of policies concerning the nurse advocate positions to clarify that even when the Regional Associations paid them, the money for the component of their time dedicated to collective bargaining was coming from the central organization for that purpose.[334]

7. CNA: Internal and External Threats

Employers rather deliberately sought to exploit the divisions between supervisory and staff nurses within the CNA and other state associations. These efforts were premised

on a broadly shared legal strategy that was coordinated through union avoidance consultants, including the West Coast Industrial Relations Association.[335] With organizing campaigns among nurses, consultants designed campaigns that built upon the class cleavages within organized nursing that had plagued nurses' associations for decades, in an effort to undermine the cross-class, "multi-purpose" professional model that ANA promoted. How the consultants operated during this period becomes clear through an examination of the case of St Francis Hospital in Milwaukee. The case was brought by the Wisconsin Federation of Nurses and Health Professionals, an AFT affiliate that emerged in the wake of the Wisconsin Nurses' Association's move away from collective bargaining. After a substantial campaign, coordinated by Modern Management, Inc., a prominent union avoidance firm, the initial vote went against the union in that case. In bringing charges concerning violations of rules governing union elections, the union adopted an innovative strategy, bringing charges against Modern Management for its role in violating the National Labor Relations Act. The union argued that because Modern Management was "responsible for and controlled the antiunion campaign." Modern Management representatives were "at the hospital on almost a daily basis during the course of the campaign."[336] While Modern Management was ultimately not found liable for the conduct of the campaign, the case against the firm hinged on its close coordination of antiunion messaging, meetings, and individual-level coercion on the part of nurse supervisors at St. Francis Hospital, which according to the Board, amounted to a systematic campaign of unfair labor practices:

> From the very day that the Union filed its election petition with the Board's Regional Office, the Hospital embarked on a course of retaliatory unfair labor practices. The Hospital sought to eliminate any employee support for the Union by interrogating employees about their union activities; by threatening employees with changes in working conditions, loss of previously obtained benefits, and loss of access to management if the Union won the election; and by promising benefits to the employees if the Union lost the election.[337]

Modern Management's strategy, similar to that used by WCIRA in California, focused on driving a wedge between the nurse supervisors and the rank and file nurses in the hospital, with messages questioning the wisdom of the model of broad nurse empowerment through collective bargaining for staff nurses. Collective bargaining, organizers argued, could help nurses take control over staffing, contain spiraling workloads, and assert their professional obligation to assure adequate patient care. Supervisors, the Board found, had interrogated staff nurses concerning whether unions could actually achieve these professional goals.[338]

The other external challenge that emerged from the Arundel and Sierra Vista litigation was that it opened up state associations to extensive raiding and disaffiliations. Unions from across the industrial spectrum took note of new organizing opportunities opened up by the 1974 Taft-Hartley amendments; as nurses constituted one of the largest occupational groups in nonprofit hospitals, they were arguably the richest organizing target. By the late 1970s, while most RNs remained entirely unorganized, almost 100,000 of the roughly 150,000 RNs covered by collective bargaining agreements across the

country were members of state nurses' associations. The internal divisions within the ANA affiliates, the longstanding ambivalence toward collective bargaining from many association leaders, and many state associations' apparent reluctance to reorganize in the face of the Arundel and Sierra Vista decisions, created not just opportunities for new organizing, but for campaigning to replace the professional associations.

SEIU had for some time sought to organize nurses, and Local 535 already represented a small number of RNs in Southern California. District 1199 established the League of Registered Nurses in 1977 to organize RNs in New York.[339] But perhaps the organizing effort that most alarmed ANA and CNA leaders at the time was the substantial nurse organizing program launched by the American Federation of Teachers (AFT), the American Federation of Nurses. In late 1978, AFT President Albert Shanker announced plans to spend upwards of one million dollars in a national campaign to organize nurses in 1979.[340] The program was led, at least in part, by three former ANA staff who defected to the AFT.[341] Unlike the ANA, AFT leaders made clear early on that managers would be excluded from membership in the organization. And while AFT campaigns were strongest on the east coast and Midwest, they also reached California. In February of 1979, the CNA EGWC officers fired a Senior Labor Representative, Pat Hancock, after they learned that he had met with AFT representatives "for the purpose of undermining CNA's collective bargaining program," allegedly acting in a clandestine fashion while remaining a CNA employee.[342] Unbeknownst to the CNA leaders, another group of nurses in San Francisco and the East Bay, coordinating with several dissident Labor Representatives, were also meeting with the AFT around this time.[343] In March 1979, in response to the AFT RN organizing drive and the internal conclusions produced by the NLRB decisions, leaders from seventeen state nurses' associations, including the CNA, attended the ANA Board meeting to "impress upon ANA the urgency of maintaining a firm commitment to collective bargaining as the method of choice for promoting the welfare of registered nurses."[344]

Ultimately, the greatest threat to the CNA bargaining program came from within. Many staff nurses had long expressed dissatisfaction and frustration with the CNA's representation—indeed, at virtually every point at which the organization had taken steps toward militancy in the decades prior, this was in response to staff nurses' threats of defection to organized labor. In the years before the end of the non-profit exemption, the CNA's reluctance to push into organizing in the southern portion of the state—and the southern regional associations' longstanding dominance by the more conservative elements of the profession—led some staff nurses to defect. In 1972, this staff nurse defection led in part to the formation of the United Nurses' Associations of California (UNAC), a relatively decentralized organization of worksite-based local units engaging directly in collective bargaining with hospitals.[345] Beginning with RNs at the Kaiser facility in Fontana, the fledgling independent organization was able to quickly recruit several units away from CNA after a number of southern CNA organizers were laid off. These layoffs, according to nurses active at the time, were a product of the CNA's ambivalence toward organizing, particularly in the south. One of the organizers told

Kathy Sackman, a UNAC founder, "We're getting laid off… You gotta understand, they do this every couple years. They run out of money, and they're very political.""

"We had no autonomy within CNA at all," Sackman told me. "We couldn't even address the board. There was nothing we could do and all our dues went to them and that was it." The new organization, its leaders claimed, would remain an independent organization composed exclusively of "working registered nurses."[346] They were able to obtain, through the NRLB, a new election in which they soundly defeated CNA, as well as the steelworkers, which represented other hospital workers at the Fontana facility and had intervened. The Fontana nurses soon heard from nurses at other Kaiser facilities who were similarly disappointed with CNA, and who had heard of the new independent group. Within a year, still operating out of members' living rooms, UNAC was able to disaffiliate a number of other CNA-represented facilities, and soon eclipsed CNA itself as the collective bargaining representative of RNs in Southern California outside of the University of California system hospitals.

The new organization was explicitly structured around staff nurses, though it retained a certain ambivalence toward its status as a care workers' organization. Rather than create an organization that centralized authority and resources and allowed for domination buy elite nurses, the founders envisioned an organizational structure that hewed closely to the worksite and the work life of staff nurses: a network of largely autonomous worksite-level local units that retained considerable control over resources and staff. What UNAC did not do, at least in these early years, was call itself a "union." According to Sackman, "we didn't think you needed a union to do collective bargaining. You could get a professional association. Now, there is no damned difference between those two words. But for us at that time it was very, very much different. It really meant a difference."

The Bay Area, of course, was the CNA's collective bargaining stronghold. Even there, however, internal dissent emerged that challenged the program, especially in the wake of the first Sierra Vista decisions and the halt in organizing that followed. A number of staff nurses who were serving on local bargaining teams began to meet outside of the formal meetings, discussing ways they could push the organization toward a better representation of staff nurses' needs. An informal network of progressive staff RNs in the Bay Area grew from there, attracting new people through their efforts to push the CNA in a more political direction with regard to broader social issues that were salient in the late 1970s, including anti-nuclear organizing, anti-apartheid and divestment campaigns. They also, importantly, began to run for elected office within the Association, including at the level of the EGW Commission and the boards of directors of the regional associations.

Some of these activist staff nurses who were obtaining these elected positions resented their lack of control, finding the Commission dominated by both elite nurses and an overly autonomous EGW staff. Staff nurse Frances Spector had recently been elected to the board of her regional association, the Golden Gate Nurses Association, in an effort to try to get more resources for organizing at her hospital. She found that the bureaucratic restructurings in response to Sierra Vista had left her and her fellow activists with very

few avenues to influence the direction of the bargaining program. The regional board was insulated from the EGW Program, so her new position could not help in that regard. But trying to make change from within the EGW program had its own barriers:

> On the [Commission], we'd have no authority over collective bargaining. The Executive Director [of the EGW program], he just looked at us and said, "Nice to have you all come. You're supposed to come, and vote on things, but you're not directing us. I'm accountable to the Board." So that was the schizophrenia of this; within the organization, the line of accountability, he was hired and fired by the Board. And yet, they kept him at arms length, because otherwise the CNA would be more prone to the conflict of interest issue. So they hire somebody, they put him in charge of a whole unit, the biggest money making unit of the organization, and there's no real accountability."

This incipient organization grew informally, with regular meetings at their members' homes. They also began to include some CNA EGW staff—according to some activists, the two staff Labor Representatives, Mike Smith and Matt Boden, were the only two who had worked as staff nurses in the past—one of which had formerly worked at Local 250. It was in these meetings that they learned of how the legal challenges facing the CNA were all but halting any new organizing, and that some in the organization were questioning the wisdom of remaining in the collective bargaining game at all. They also confronted the reality that despite their elected positions on the EGW Commission and the Regional boards, the bureaucratic structure in the CNA that "insulated" the collective bargaining program from managerial control also insulated the organization from staff nurse control. At the urging of one of the staff Labor Representatives, they began meeting with external unions—including the AFT, the Teamsters, and SEIU—to discuss the disaffiliation of nurse bargaining units from the CNA.

In December of 1979, while the CNA contract with Affiliated Hospitals of San Francisco was under negotiation, the activists obtained a charter from SEIU, to become their own local.[347] They called themselves the California Union of Healthcare Professionals, and assumed the Local # 723—inspired by the nurses' daytime shift of 7am to 3pm.[348] They began collecting the cards necessary to trigger an election over the Christmas holiday, "because all the management people were away for the holidays and we thought it would be a good time to get off the floor and go around and talk to people," Spector told me. Their goal was to create a new union that would represent professional workers, but which could act in concert with the blue-collar workers represented by Local 250. As such, while they saw the value of retaining their professional identity—and clearly spoke the language of defending patient care in their published materials—they envisioned a more expansive community of interest.

Unlike what they had done in Southern California when faced with the challenge from UNAC just a few years earlier, CNA leaders decided to fight hard to defend their Bay Area members. San Francisco was the core membership base of the CNA, and losing it would greatly imperil the future of the collective bargaining program, as well as the

financial standing of the Association overall. They quickly fired Smith and Boden, and expelled eighteen of the core staff nurse activists from both the CNA and the ANA.

Ultimately, the Local 723 insurgents lost the election to represent San Francisco nurses, 855 to 476. Activists attributed their loss to two major failures. The first was a logistical failure. While they had financial support from SEIU and Local 250, they were conducting the decertification campaign largely on their own. They had assumed they could get the election underway, and have a reasoned debate among nurses as to how to proceed. "The person who came out an disabused us of this notion," said Spector, was a young International Union organizer who arrived to work with them on the election.

> He says, ok, show me what you've got. And we take the cards out. And he says, ok, which ones are ones you know are gonna vote for you, which ones are the maybes, which ones are the nos.... and he says, you know, you guys are gonna lose. The piles were just not right. It was a big shock. At that point, I could see the logic of what he was saying. He said, management is out there; they're talking to people just like you're talking to people. And the initial group that you signed up, those should have been your people on the ground that could counteract whatever management said. And they weren't, they were just people who wanted to have an election.

Hospital managers challenged the initial election petitions. "The hospitals went all out against us," reported Minson.

> They hired Littler Mendelson, which at that time was one of the greatest union busters… They were apparently unlimited in how much money they could put into it, but we were on an allowance, because we didn't have dues. Other than the group of us that signed the initial charter, and some other people that we picked up along the way, we were not able to support ourselves on dues until and unless we could win some elections.

Another failure was their inability to counter the professional image that CNA advocated, and that many staff nurses held dear. SEIU had, in the minds of many staff nurses, represented the blue-collar workers in hospitals, which violated the boundaries and distinctions that, for many nurses, defined their place in the workplace. "It's ironic because most nurses were from working class families," Spector told me.

> They weren't from highly educated families. Nursing was not considered a very advanced profession in those days. It wasn't that common to have a bachelor's degree as a nurse. I think the CNA had fostered this, in their literature and in their approach, because it served their purposes. Professional identity that had this side of excluding...this class-based, artificial distinction between the nurses and everybody else. The hospitals were happy to have that going on.

Facing this internal governance crisis, including growing dissent from staff nurses and some association staff, some CNA leaders sought to shore up their collective bargaining bona fides, and publicly reaffirm their commitment to the program. This meant confronting the broader ANA's lackluster commitment to collective bargaining, and their

internal opponents' efforts to use the NLRB crisis to curtail, rather than fortify, the organization's worksite representation structures. They began to circulate a call for a special House of Delegates' meeting, at which they would pass a resolution to reaffirm ANA's commitment to collective bargaining, arguing that "since 1965 ANA boards have emphasized entry into practice issues at the expense of many other crucial interests of practicing nurses," and that "the ANA Board has failed to act independently or in support of the state nurses associations in the face of organizing threats from other labor organizations." The resolution, intended to "affirm control of the ANA by practicing nurses, and to reaffirm ANA's commitment to an effective Economic and General Welfare Program," was passed at the ANA's 1980 convention.[349]

8. Conclusions

The early 1970s were a period of deep optimism for healthcare worker organizing. When he assumed the SEIU Presidency in 1970, George Hardy—who had been struggling to mobilize hospital workers since he was a teenager—saw an opportunity to reshape not only his union, but, knowing that care workers constituted a fast growing segment of the American working class, the working lives of those who toiled in hospitals. The 1974 amendments opening up organizing in non-profit hospitals constituted, numerically, one of the greatest opportunities for union building and the expansion of working class power since WWII. The organization of hospital labor, like the public sector organizing that was also flourishing in that moment, represented an expanded definition of the working class; this organizing drive would bring union power into the hands of women workers and workers of color. Hardy "had this dream that we would be a million member union, at a moment where we had less than half of that," Rodich told me. "We got the changes made to the National Labor Relations Act in 1974. That was our kick-off, and go, go, go. Go, team, go. And, do as much as we could to pick up as much organizing as we could, believing that we would get a great response to it, and we would grow quickly and nationally."

"Of course, that didn't happen."

1974 was a year of profound transition in the American political economy, even if the workers, organizers and business agents in the trenches did not yet perceive its long-term implications. It was a year of recession and inflation, which would bring to an end decades of income expansion among working people, fueled by relatively high economic growth and strong unions. Real incomes stagnated. It was a year of worker militancy, with a wave of strikes that rivaled the strike wave of 1946; in California, the workdays lost to strike activity in 1974 exceeded that the previous record set in 1946. Strikes in 1974 were long, and bitter.[350] Across the country, internal union affairs were upended by wildcat strikes, as defiant members pushed back against concessionary bargaining, inflation, and a perceived loss of control. If the early 1970s were a moment of energetic organizing and striking, the end of the decade would be characterized by layoffs and union decertifications. Even if Hardy and his hospital organizers were hopeful in 1974, across the board, the working class was losing. 1974 was, in short, the cusp of the

neoliberal era.

This broad political and economic context played a decisive role in the fates of both the SEIU and ANA efforts to organize care workers. Despite a relatively successful two years following the removal of the non-profit exemptions, CNA and SEIU organizers expecting a tumult of organizing and growth in the 1970s found that by the end of the decade, momentum had turned against them. In many ways, they confronted similar obstacles. They were organizing in a looser labor market, during a period of sustained unemployment. Hospital employers, like employers in other sectors during this period, were shifting governance strategies from those developed during a period of high growth and broad distribution toward strategies more suited for lower margins. Employers turned to elaborate, sophisticated manipulations of NLRB procedures to delay and stall representation elections. Helping them do this was a new breed of firm, the union avoidance consultant, many of which got their start in these early hospital organizing drives. These consultants innovated strategies of rule manipulation and workplace intimidation that, just a few years later, would play a critical role in de-unionization efforts across the US economy. These large, structural forces proved detrimental to both organizations as they sought to take advantage of the 1974 opening.

However, the two organizations varied in the cultural and political conceptualizations that they brought to their organizing initiatives, and these conceptualizations shaped both the broad structural obstacles they would encounter, as well as their responses. One of the key distinctions between the two organizations concerned the boundaries that they drew demarcating who was, and who was not, a potential member. In SEIU, organizers demarcated care workers with *horizontal boundaries,* separating the blue-collar workers they tended to organize from their bosses and from professional employees. These class-based demarcations were agnostic to specific areas of practice; while occupational classifications were certainly considered, and while the union made some attempts to mobilize workers on the basis of their different occupational identities, for the most part their bargaining units united blue-collar workers from a broad variety of departments and occupational categories. For organizers and activists, this was not just a functional specialization for the union—it represented deep-seated values concerning the importance of class solidarity and cooperation. In CNA, on the other hand, leaders worked to maintain stark *vertical boundaries* demarcating nursing from other jurisdictions of practice in the hospital workplace. Within the practice of nursing, the organization could contain its own internal hierarchies and career ladders, separate and contained from other, almost always male, professional classifications. In the years before 1974, this distinction between the two organizations' boundary demarcations was perhaps most clear in the case of Licensed Vocational Nurses (LVNs) who, while considered to be practicing nursing and thus a part of the broader scope of practice within the nursing hierarchy, were usually organized by SEIU locals, and grouped in with other blue collar hospital occupations.

These differences mattered in two key ways. First, cultural and strategic distinctions determined who the organizations would target in their unionization campaigns, and how.

CNA organizers, of course, continued to target nurses alone. And, in keeping with the tenuous compromise strategies developed through decades of internal conflict over the morality of unionism and economic coercion in a care work setting, they approached nurses with a specific appeal, focused on professional distinction and on the potential of collective bargaining as a tool for protecting their scope of practice and the imperative of patient care. SEIU organizers also grounded their appeals in a moral message, though it was one centered on dignity and respect at work. And while many of the workers they would seek to organize were engaged in direct bedside care, there were few explicit appeals to this potential source of leverage; instead, care workers were grouped with other blue-collar occupations in the hospital. Second, these different demarcation schemes also determined the organizations' vulnerability to employer attacks. Employers' legal and union avoidance strategies were premised on the boundaries and procedures established by Taft-Hartley and the 1974 amendments. In addition to non-profit hospital workers, another large group of employees that were formally excluded from NLRA protection in 1948 was supervisors and foremen. The 1974 amendments lifted the exclusion of non-profit hospital workers, but the exclusion of supervisors remained in place. In other words, the horizontal boundaries established by Taft-Hartley were suddenly imposed upon the hospital workplace, overriding the more varied demarcations that had evolved through iterated conflicts and negotiations that occurred during the decades when hospital organizing happened outside of the NLRA. The effect of this change was most detrimental to CNA, handing employers a powerful, if ironic, legal tool: the claim of supervisory domination. While CNA had managed to grow substantially in the years before the 1974 opening, organizing was dramatically slowed by employers' legal claim that nurses' professional associations were subject to conflicts of interest. SEIU, on the other hand, was not subject to these challenges, and was able to grow, at least in the Bay Area.

Table 1: The Context of Membership Growth Under Taft-Hartley, 1974-1980

	SEIU: Organizing along horizontal boundaries	CNA: Organizing along vertical boundaries
Northern California: Strong informal union protections	Accelerated Growth	Slowed Growth
Southern California: Weak informal union protections	Slowed Growth	Slowed Growth

The other point of comparison explored in this chapter is the difference between Northern and Southern California. For both organizations, the San Francisco Bay Area was a stronghold of union activity dating back to the immediate postwar years. Southern California, however, remained a challenging site for labor organizing. The comparison is most acute in the case of SEIU. While hospital organizing drives were certainly resisted

across the state, they were substantially more successful in Local 250 than in Local 399. Indeed, Local 399's rate of growth slowed substantially after 1974. This was a product of longstanding regional differences, with regard to organized labor in general, as well as hospital-specific bargaining regimes that had emerged. While in the Bay Area, unions and employer associations had developed a relatively durable labor relations system built upon tradition and custom during the period governed by the "law of the jungle," this informal system was much weaker in Los Angeles, and the local employer associations remained staunchly opposed to the expansion of collective bargaining. This created an environment where employers' union avoidance strategies would be both aggressive and effective.

Employers' aggressive use of NLRB proceedings and the difficulty faced by both organizations in Southern California demonstrate the limitations of the traditional model of union organizing in what we can now recognize as the beginnings of the neoliberal era. The opportunity that both organizations sought to take advantage of, in their own distinct ways, was less open than had appeared in 1974. The difficulties they encountered during this optimistic opening prefigured many of the attacks on collective bargaining just a few years later, and highlighted the limitations of the traditional union organizing approach, absent the political insulation enjoyed by organized labor in the Bay Area. We now know that for organized labor, the country would soon look more like Los Angeles, and a new model of organization would be required. The professional commitments of the CNA, however, demonstrated their own limitations as well.

Part 3: Toward a Caring Class: The Crisis of Care Work and the Convergence Toward Moralized Class-Antagonistic Contention, 1983-1996

In his ethnographic study of a ward at "Pacific Hospital" in the East Bay in the early 1980s, Robert Brannon (1988, 1994) worked to capture changes in the labor process of physicians, nurses and other ancillary care workers during a period of dramatic change in healthcare delivery. He found physicians who, while still powerful, were increasingly alienated from the governance of Pacific Hospital; he found nursing staff that was "pushed to the limit" as auxiliary care staff was removed from the wards. Registered Nurses were increasingly expected to do more of the "dirty work" of patient care: "helping patients use bedpans, urinals, and bedside commodes; changing soiled gowns and bed linens; lifting and moving patients; cleaning patients up after vomiting, incontinence, and diarrhea; and giving patients baths." (Brannon 1994:140). Licensed Vocational Nurses, who had traditionally borne more of this burden, were increasingly pushed out of acute-care hospitals, and into lower-paying nursing homes. The emotional labor of patient care was also increasingly taxing; as acuity increased, so did the aggregate level of patient stress and emotional needs. "They keep adding tasks and heavier assignments in which you have to do everything!" one nurse told him (1994:142). "I don't think we can take on much more."

The squeeze being felt by the healthcare workers at Pacific was indicative of a broader set of changes underway in the healthcare industry in the mid 1980s. Driven by Federal efforts to contain Medicare spending and a growing market-orientation among hospital boards, administrators of even non-profit hospitals were increasingly oriented toward maximizing revenues relative to costs. Hospital managers across California and the country were undertaking a series of aggressive cost-control measures in their facilities--and as the largest component of hospital costs, labor costs bore the brunt of these efforts.

This change in healthcare delivery and hospital governance necessarily had profound effects on the organizations representing hospital workers. In this chapter, I argue that this broad structural squeeze triggered a change in the orientation of both CNA and the SEIU, toward what I argue is a syncretic form of unionism that drew from both the traditional union and professional traditions. In Chapter 3, I showed how CNA and SEIU entered the 1980s with dramatically different organizing projects. SEIU brought a blue-collar orientation to hospital organizing, conceptualizing its membership as the broad spectrum of hospital occupations on the lower levels of the skill hierarchy. CNA, on the other hand, conceptualized its membership as encompassing the cross-class grouping of

those engaged in the practice of nursing. These organizing projects were durable, inscribed in the early moments of organizational formation; they had weathered substantial internal political challenges, changes in labor law, and dramatic industrial changes throughout the 20th century. The years between 1985 and 1995, however, constituted a period of *convergence,* during which both organizations developed hybrid projects that incorporated key elements of both professional and class-based organization. By the early 1990s, both SEIU and CNA were articulating a class-antagonistic model of organization, that conceived of hospital administrators as the key objects of contention, but which centered on occupational identities and the moral obligations of care workers.

In Part 3, I argue that these convergent outcomes were a product of the 'moral economy of care'—the preexisting moral order governing work and exchange in the healthcare industry, characterized by a persistent opposition between the moral obligation to care and instrumental, economistic action. The 'moral economy of care' played a role in producing political crises in both organizations, and in shaping their convergent responses. For much of the 20th Century, the dominance of the medical profession delayed the corporatization of healthcare delivery, but by the 1980s healthcare came to be treated as a commodity (Starr 1982). As many scholars have identified, the commodification of care work (see England 2005, Lopez 2006, Nakano Glenn 2010) in recent decades has had profound effects on the provision of care and the labor of care workers. And as Reich (2014) argues, the commodification of hospital care undermined the basic values and meanings that undergirded care work: it forced the denial of care to those who could not pay, undermining notions of healthcare as a right, and it 'debased' care work by supplanting traditional moral and ethical motivations with the profit motive. It also challenged fundamental beliefs, forged through decades of collective bargaining, that those who cared deserved to be taken care of. The violation of these fundamental standards and the perceived inability of the leaderships of the CNA, SEIU Local 250 and SEIU Local 399 led to crises of legitimacy in these organizations, producing political ruptures, which have been found to be important preconditions for strategic change (Voss and Sherman 2000).

These traditions rooted in the moral economy of care did more than help workers and union leaders understand the crisis. They became tools that they used to dig themselves out of the crisis, and to articulate a new path forward. The late 1980s was a period of worker agency, during which existing orders were destabilized. But people brought into that turbulent time a variety of visions for new models of organization that drew upon the moral frameworks inherent to care work, and which had been mobilized in earlier decades of collective bargaining: frameworks the built upon the deeply felt meaning of care work, on the broad sense of reciprocal obligation, and on coercive strategies that relied upon the public's perception of these meanings. As such, while the anti-labor assault of the 1980s was not unique to healthcare, what were unique were the moral traditions that healthcare workers and their organizations could draw upon.

In order to understand how these moral injunctions helped produce a strategic convergence in the face of a broad structural challenge, it is helpful to view the

organizations' organizing models as *political projects* (Fligstein 1996, Larson 1979, Sartre 1968). This chapter examines how the exogenous crisis of hospital cost containment affected the internal politics of the CNA and SEIU Locals 250 and 399. The power struggles that occurred within these organizations were clearly about people, and the specific groups of people who would exercise control over the organization. But these factions also articulated visions for the future that drew upon preexisting traditions and moral frameworks, and worked to convince union membership that their particular articulation could address the external structural crisis. As such, these political projects were necessarily pragmatic solutions bounded by specific situations (Joas 1996; Katznelson and Weingast 2005), but they were ultimately rooted in contested meanings and interpretations. These competing projects constituted a 'bricolage' (Clemens 1996)of preexisting organizational forms, conceptualizations of "who we are," "who we are fighting," and "how we win."

Chapter 5 examines the exogenous forces that triggered the political upheavals and strategic transformations of the late 1980s and early 1990s. The 1980s were a turbulent period in American healthcare, stemming from Federal policy changes and bureaucratic restructuring in healthcare delivery systems. This turbulence, driven by exogenous forces, served to undermine the projects of unions and professional associations. National Labor Relations Board decisions, Medicare policy shifts, and the marketization and consolidation of nonprofit hospital systems all worked to undermine the strategies that SEIU locals and the CNA brought into the 1980s. The NLRB, with its 1984 St Francis decision, established a new procedure for bargaining unit designation in order to recognize fewer, larger bargaining units in hospitals. These larger bargaining units stretched SEIU organizing efforts beyond the traditional blue-collar membership it traditionally represented, and forced the union to contend with workers with a broad array of occupational identities; for the CNA, the decision impeded the organization's efforts to organize RN-only bargaining units, a critical plank of the profession-focused organizing project. In both cases, organizing efforts were paused for most of the decade, and the core boundary-setting efforts described in Chapter 3 were undermined.

More significant were the severe cost-containment efforts among hospital administrators in the 1980s. Driven both by state policy--specifically, Medicare reimbursement procedures--and the trend toward market governance in hospitals, beginning in 1983 hospital administrators embarked on a series of aggressive workplace restructuring initiatives in an effort to control labor costs. These efforts concentrated on lower-skilled hospital workers, whose ranks declined in hospitals in the mid 1980s. At the bargaining table, this translated into highly aggressive bargaining on the part of employers. Across the board, it meant a significant work speed up, and for care workers at various levels, a compromise of the patient care goals and moral obligations that lent social meaning to their labor.

Chapter 6, *The Crisis of Collective Bargaining,* explores the impact of these external processes on the internal politics of SEIU Locals 250 and 399. Both organizations had encountered, and rebuffed, sustained organizational challenges from dissident worker

groups in the 1970s. But in the 1980s, union leaders faced a profound crisis of legitimacy. In the face of aggressive bargaining strategies on the part of employers, both locals were compelled to accept concessionary contracts in those instances where they would not strike. Where union members and leaders made the decision to confront the employer assault through workplace action, they were pushed into strikes that stretched their organizational capacity, and after which they were forced to either concede, or accept relatively stable contract standards. This created space for insurgent groups to challenge union leadership, leading to periods of political instability. These political ruptures, in turn, created space for new organizational projects. In both locals the SEIU International Union imposed "trusteeships," or temporary leadership take-overs, in order to establish control over the locals and weather the political storms. At Local 250, the International Union was ultimately unsuccessful. The new, more autonomous administration developed a model of labor contention that was a bricolage of earlier models; it drew from both traditional workplace-centered unionism, and from the care-centric approaches of the more militant factions in the CNA. As a result, the local came to rely on a class-antagonistic model of industrial conflict that nevertheless centered on the moral valence of patient care, drawing on the progressive traditions enacted by nurses in earlier decades. At Local 399, the International Union was successful in taking control of the local. There, union leaders developed a model of organization that instrumentalized the patient care "frame," as part of a strategic model centered on growth and corporate combat.

Chapter 7, *The Crisis of Professionalism,* analyzes the impact of these exogenous processes on nurses' work and on the internal politics of the CNA. As patient acuity levels increased and hospital wards lost auxiliary support staff, nurses in the mid 1980s experienced an intensification of work that made their jobs substantially harder, and for some, impeded their ability to provide what they saw as adequate patient care--an important component of the moral justification for the professional project. Early efforts to contain these trends by matching RN staffing levels to patient acuity were slow to produce results. At the same time, organized nursing experienced powerful, gendered attacks from organized medicine, as the AMA responded to physicians' own declining autonomy in hospitals through the introduction of new occupational categories for bedside care. The new worker categories were defined by their subservience to physicians, and would claw back professional jurisdiction from nurses. Introduced ostensibly for the purpose of relieving shortages in nurse and physician labor, the new occupations threatened nurses' occupational practice jurisdictions and their institutional hierarchies. As in the SEIU locals, these challenges to the professional project created space for powerful internal challenges that destabilized association leadership. In this case, dissident staff nurses--whose earlier insurgencies were contained through limited accommodation by the association--were successful in wresting control of the organization from elite nurses, pushing the CNA toward the exclusive defense of the interests of working staff nurses.

Comparing the CNA and the SEIU locals during this period yields two important conclusions. The first concerns the process of political change. Both cases saw a similar sequence of events unfold: external challenges stemming from the transformation of

healthcare delivery interrupted the efficacy of existing projects; this produced crises of legitimacy for incumbent leaders, and space for alternative projects to emerge. This provides suggestive evidence that collective labor projects were shaped by competing visions and cultural frameworks, rather than constituting reflections of the structural conditions of membership. Both organizations had faced challenges from dissident members pushing for greater militancy and more aggressive workplace representation in the 1970s, and their leaderships had weathered these challenges. In the late 1980s and early 1990s, organizational leaders suffered from legitimacy crises, triggered both by the failures of traditional union strategies and the perceived debasement of patient care.

The second concerns the specific content of the models of organization with which the organizations emerged from this turbulent period. Taken together, I argue, the cases demonstrate a strategic convergence between the traditional blue-collar unionism of SEIU and the moralized, patient care-focused organizing of the CNA. In earlier decades, SEIU and CNA had maintained distinct organizational projects, even as they confronted the same employers. Through the 1970s, SEIU leaders conceptualized the union's membership as drawing from the blue-collar workers in the hospital. Organizers tended to see the moral valence of care work not as a tool, but as an impediment to the development of a traditional model of workplace-centered unionism. In CNA, organizers confronted the opposite problem: aggressive worksite representation ran counter to elite nurses' professionalization project, which was itself premised on the moral valence of care work. Coming out of the political turbulence of the late 1980s, both organizations began to turn toward a syncretic form of unionism that drew from the class-antagonistic traditions of the SEIU, as well as the caring orientations of organized nurses. This new form of unionism was instrumental, reacting pragmatically to specific employer strategies and transforming healthcare delivery systems. But its specific form was profoundly shaped by the 'moral economy of care.' Care workers, nurses in particular, not only derived meaning from their labor in a caring setting--their organizations endeavored to reinforce that meaning among workers and the public as part of an ongoing effort to control the labor process.

Chapter 5. The Commodification of Care and the Challenge to Care Workers, 1983-1988

Communities of Interest: Policy Context and the Decline of Hospital Worker Organizing in the 1980s

As unions began to aggressively organize hospitals in the 1970s, the NLRB, in adjudicating challenges to the propriety of bargaining units, typically applied what is called the "community of interest standard." This standard defined a set of workers as having a common set of interests, capable of engaging in bargaining together as a group. The Board evaluated "factors such as the employees' wages, hours, and working conditions; the employees' qualifications, training and skills; the frequency of contact and degree of interchange with other employees; the frequency of transfer to and from the petitioned for unit; commonality of supervision; degree of integration with the work functions of other employees; area practice; patterns of collective bargaining; and the collective bargaining history."[351] Decisions concerning the community of interest were intended to be made with reference to the social relations and work practices of a specific workplace or enterprise.

The "community of interest" was an appropriate label. On a case by case basis, the Board would presumably work to establish a coherent basis for organizing occupational communities that could legally, and in an orderly and peaceful fashion, engage in collective action while minimizing internal conflict and the possibility of labor strife. And as Chapter 3 showed, the boundaries around different "communities of interest" did not only account for the specific labor process in a given hospital—defining the community of interest, while a contested process, involved the collective cultural process of drawing boundaries between types of people, identifying differential positions on hierarchies of class and status, and cultivating the sense of common occupational identity. Importantly, drawing these boundaries also involved defining collective narratives of workplace conflict and who the *opposing* interests were.

One of the challenges in this instance, however, was what the Board—and the Ninth and Tenth Circuit Courts—saw as the problem of the proliferation of bargaining units in hospitals. This proliferation corresponded to the diversity of occupational communities and the tradition of strong professional silos in healthcare delivery. But it was also a product of the legal strategies used by employers in the late 1970s, as they often sought to undermine unions' representation claims by contesting the propriety of bargaining units. Indeed, the community of interest standard, in the context of a workplace with a division of labor and expertise as complex as a modern hospital, offered many opportunities to delay and obstruct organizing altogether. For the Board and the courts, this proliferation

of unit classifications undermined one of the goals of the 1974 Taft Hartley amendments, which was to increase labor peace in hospitals. As the Board wrote in 1984:

> The paramount public interest in maintaining uninterrupted accessibility to health care facilities required that further protection and special care would have to be taken to avoid the ultimate disruptions in health care institutions caused by organizing drives and related activities such as strikes and slowdowns. Congress concluded that the object of minimizing work stoppages resulting from initial organizational activities, jurisdictional disputes and sympathetic strikes could best be achieved and thus the likelihood of disruption to health care reduced, by minimizing the number of units appropriate in the health care industry.[352]

In 1984, in response to adverse decisions from the federal courts, the NRLB issued the St Francis II decision. The decision called for the use of a "disparity of interests" test in the establishment of bargaining units; rather than identifying a proper unit by assessing similarities among workers, this new test would seek to identify cleavages "which would prevent a combination of groups of employees into a single broader unit."[353] Essentially, the Board announced, they would seek to establish fewer, larger bargaining units in hospitals, and divide them only if there were evidence establishing a need for such division. This was in keeping with Congress' intent to establish within non-profit hospitals the conditions most likely to produce labor peace and contain undue proliferation of units. With the new standard, the board announced that within acute care hospitals, in most instances, they saw only two bargaining units as appropriate: one with all professional workers, and one with all non-professional workers. This new structure would remain in place until 1989.

This presented substantial challenges to SEIU and to CNA, as well as other unions in hospitals. For CNA, it was a particularly strong assault against their all-RN organizing strategy, and their strong collective identity as nurses. As early as 1982, CNA had contested the inclusion of other professionals in nurses' bargaining units, a problem that had complicated their efforts to organize nurses across the UC system hospitals.[354] "RNs organizing for a new bargaining unit," read the *California Nurse* in 1987, "have been forced to include other healthcare employees in their unit—social workers, accountants, respiratory therapists, chaplains, and others."[355] By compelling the inclusion of a broader variety of occupational categories in a bargaining unit, this change constituted a fundamental challenge to the vertical-boundary project that formed the basis of ANA organizing and nurse representation.

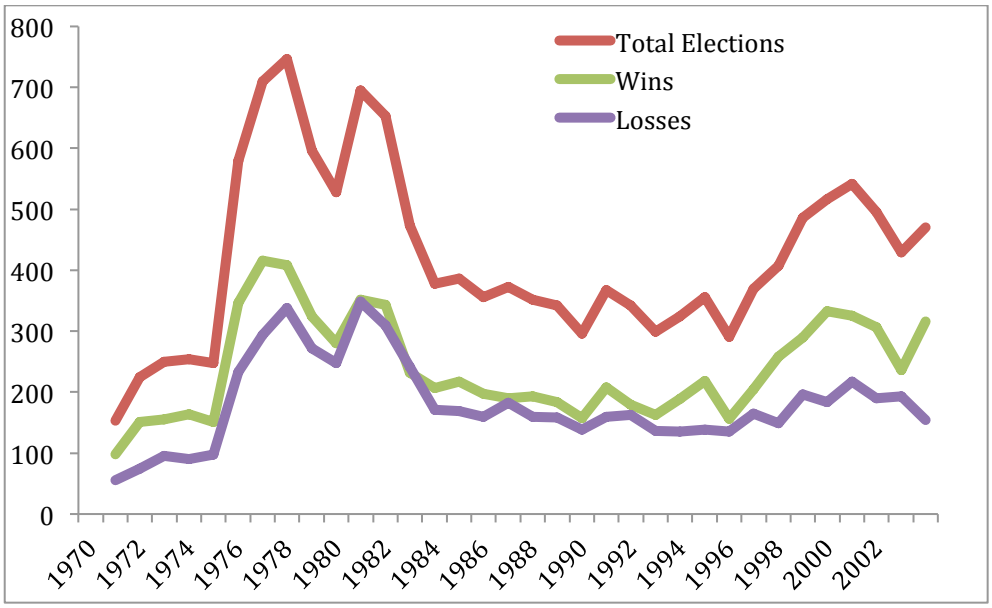
For SEIU, the expansion of the bargaining unit to cover all non-professionals created a more practical burden: the dilution of potential support among workers. Previously, during the underground phase of an organizing drive, organizers assessed the potential for a unionization vote in a hospital's various departments, and filed for an election defining the bargaining unit that balanced the goals of bringing in a broad potential membership, while increasing the likelihood of a successful election. For the most part, this meant carving out a bargaining unit that hewed relatively closely to the traditional SEIU membership of service workers and skilled technical workers. David Snapp, who at

the time worked for the organizing department of the SEIU International Union, outlined some of the challenges that emerged from being forced to file for a much broader bargaining unit:

> You couldn't carve out friendly bargaining units, so the broader they are, the more you have to have a support in a broader group... and there were sometimes antagonisms between those groups. The nurses didn't like to be lumped with the other professionals [...] because they had a very strong nurse identity. They were the biggest occupational category in the group. They had their own issues. The techs tended to be less interested in organizing, and the doctors even less. I mean, sometimes they could even put doctors in the professional units. In the service and maintenance, you had the business office clerical group and the skilled maintenance are very different than the service and maintenance group, so the skilled maintenance, they would love to have a union of just the carpenters, and the skilled trades folks that are different than the orderlies and the dietary workers. The business office clericals, who were closer to the administration, very seldom organized. In a tight-fought election... you had to sign up 65 to 70 percent of the place, and then go through the valley of death to get a union. It's hard enough to get two thirds of the service unit, given that you may have all kinds of other obstacles. Some people are against it, some people are scared, and some people don't wanna organize with a person that's different from them... That, combined with the sophisticated anti-union stuff, and the fairly substantial size diversity of these units made it very hard. You'll just see that St. Francis II kinda killed it.

NLRB elections data confirm this assessment. Figure 1 traces the total elections conducted by the NLRB in the "healthcare services" industry between 1970 and 2003, compiled from the Board's annual reports. As Figure 1 demonstrates, the number of NLRB representation elections in the health services sector declined dramatically after 1984— from a post-1974 high of 746 elections in FY 1978, to 374 elections in FY 1984—and remained low for the remainder of the decade. While the "health services" category includes not only hospitals, but also nursing homes, ambulatory clinics, and other social assistance, the arc of the curve—rising after 1974 and collapsing by 1984—closely reflects the organizing openings and closures in non-profit acute care hospitals. Figure 2 shows a similar curve, but traces the total votes for and against unionization, across all elections. Here, we see that unions tended to get more votes than not, with the exception of the period between 1979 and 1983. Both figures likely understate the potential organizing losses—organizers often sought to pull an election petition when a defeat seemed likely. A defeat meant that the union would have to wait a year before re-filing, while a pulled petition could be re-filed earlier if organizers saw an improvement in the potential outcome.

Figure 1: NLRB Elections in Healthcare Settings, 1972-2003



Care Work and Cost Containment in California Hospitals

The delivery of medical care was long the exception to the primacy of the market in the US economy—a large and growing industry commanding an increasing share of GDP, healthcare remained under the control of a relatively sovereign medical profession. Through the 1970s, physician autonomy remained a core principle of the organization of the healthcare field (Robinson 1999; Schmidt 2000). Physicians were largely free from oversight, regulated almost entirely by the American Medical Association (AMA), the archetype of strong, effectively-organized professional associations (Scott et al. 2000). The profession also resisted commercialization, implementing legislative bans on the corporate practice of medicine prohibiting the employment of physicians by non-physician entities, and retaining a strong ethos of medical service. According to Robinson (1999:1), "The ban on corporate practice […] drew a line demarcating medicine, where financial incentives, private capital, and the entrepreneurial ethos were disdained, from the commercial sector, where they were tolerated and even acclaimed."

This arrangement, however, began to unravel in the 1970s. The implementation of Medicare and Medicaid turned the federal government into the single largest buyer of healthcare services, leading the state to become the first buyer with the capacity to attempt to control what it bought. Perhaps more importantly, however, the combination of professional autonomy and generous state funding triggered a decades-long upward

trajectory of healthcare costs, which states and insurers sought to control. During this period, Congress overrode state bans on prepaid group practice. This lead to the development of Health Maintenance Organizations (HMOs), integrated healthcare systems that combined health insurance and delivery, structured to encourage providers to provide cost-efficient health services; they allowed states to move Medicaid patients into HMOs (California was one of the first to do this); courts overturned the exemption of professional guilds from antitrust enforcement, leading to campaigns to apply antitrust laws to healthcare (Robinson 1999, Scott et al 2000).

By the 1980s, the pages of the New England Journal of Medicine were warning of the growing dominance of the "medical industrial complex," driven by the growth of for-profit hospitals (Relman 1980). Hospital and medical facility boards brought in managers with business backgrounds, and healthcare economists became increasingly influential (Fennell and Alexander 1993; Robinson 1999; Schmidt 2000). The result was a concentration of the industry, as healthcare delivery integrated vertically and horizontally in pursuit of economies of scale, diversification, and greater bargaining leverage with insurers and states. Acute care hospitals, long-term care facilities, and clinics merged into larger delivery systems that offered more services and specialties. Facilities also merged with each other, seeking increased market share in geographic markets.[356] Physicians became far more likely to operate in group settings—in hospitals, HMOs, and large group practices. Overall, delivery systems began to act more like corporations, using stock and bond markets to raise capital, and grew responsive to the exigencies of those markets.

This rapid transition toward market governance had a profound effect on the ground, transforming the working conditions of the physicians, nurses and ancillary employees that provide care to patients. Physicians increasingly shifted toward more remunerative specialties, resulting in a declining proportion of physicians providing inexpensive and effective primary care. Nurses were expected to care for a quickly growing number of patients at a time, and many were replaced with less expensive nurses aides and physicians assistants (Gordon, Buchanan, and Bretherton 2012). At hospitals, care providers at all levels were expected to accelerate the pace of work, in order to reduce patients' average length of stay. In an increasing proportion of facilities, dietary and housekeeping labor were outsourced to outside contractors (Appelbaum et al. 2003). By 1986, about 15% of hospitals in Western states were for-profit, second only to the Southeast (about 23%) at a regional level.[357]

This general market orientation was not the only force that drove hospital managers toward cost containment efforts, however. Perhaps the strongest pressure, according to accounts at the time, came from the federal government. In response to rapidly escalating healthcare costs for Medicare and Medicaid, the Regan administration enacted measures intended to slow the growth. In 1983, the Health Care Financing Administration (later renamed the Centers for Medicare and Medicaid Services) rolled out a new system for reimbursing hospitals for care. Called a "prospective payment system," the new payment structure would set reimbursement rates for diagnoses rather than specific procedures, categorizing a patient's care needs into one of several hundred "Diagnosis Related

Groups" (DRGs). The payment to the hospital would be set according to the DRG and the acuity of the case. This was an attempt to control cost spirals, under the assumption that the traditional fee-for-service payment system (premised on *retrospective* reimbursement), long preferred and defended by physicians and organized medicine, incentivized over-treatment and revenue maximization. The policy projected the phasing out of all consideration of hospitals' actual costs in establishing reimbursement rates over a three-year period. Prospective payments would allow the Federal Government to limit inflation by establishing greater control over prices, and incentivize providers to limit care and reduce costs. Following closely on the 1983 introduction of the Prospective Payment System (PPS) in Medicare, a number of state Medicaid and Blue Cross purchasers developed their own PPS.[358] California began requiring hospitals to accept fixed payments for Medical patients, and to make competitive bids to the state.[359] Other private insurers followed suit, developing a variety of strategies for incentivizing cost containment, shortening hospital stays, and reducing what they saw as unnecessary testing and procedures, as well as incentivizing care delivery in less expensive settings than hospitals.

This change had a profound effect on hospitals' income and management. Medicare constituted about 40% of hospital revenues by the early 1980s, which meant that a massive component of hospitals' income would arrive under entirely new systems. The years following the introduction of the DRGs saw substantial restructuring in hospital employment, as hospitals sought to focus on profits and cost containment. A BLS analysis of OES data from 1983-1989 illustrated how the occupational structure in hospitals changed over the 1980s. Nation-wide, the early period was one of belt-tightening; hospitals saw a 2% decline in overall employment levels between 1983 and 1986. By 1989, however, employment had increased at 4% above the 1983 level.

Compounding the effect of the increasing market-orientation and state-driven cost containment was the rise of a new model of healthcare financing and delivery. In their 2005 study of institutional change in California hospitals, Scott et al (2005) define this era, roughly beginning in 1983, as a period of market governance and managerial control. It was a period characterized by the rise of the HMO, the Health Maintenance Organization, and the associated concept of "managed care." Despite the commonly-held association between HMOs and the market governance of healthcare (see Reich 2014), this association was not always present; managed care began as a strategy for organizing healthcare provision through rationalization, focused on cost-containment and efficiency, rather than profit maximization. This rationalization involved coordination among physicians and healthcare providers, insurers, and hospitals. HMOs were pre-paid healthcare delivery systems, meaning that patients paid a fee to become and remain members, with their subsequent care needs guaranteed by the HMO. Physicians would be paid out of these regular fees, rather than being paid on a fee-for-service basis. Because their per-patient incomes (from membership fees) were fixed while the expenses of care were not, physicians in these systems had an incentive to provide inexpensive preventive care, and to contain costs at the treatment end (see Scott et al 2005). This system of fixed per-patient payments was referred to as "capitation." The prototypical HMO was Kaiser

Permanente, one of the first managed care organizations in the country, and by the early 1980s, the largest.

The AMA, long wary of any healthcare system that undermined either physicians' clinical control of healthcare delivery or their lucrative fee-for-service payment systems, had opposed the formation and growth of HMOs in their early years, and frequently decried them as "socialized medicine" (Starr 1982). But while organized medicine continued to frame managed care as "socialized" even into the 1980s, the longstanding effectiveness of the structure in terms of cost-containment nevertheless offered a potential solution to government actors committed to stemming the growth of healthcare costs. By the 1980s, the capitated payment model was increasingly deployed by purchasers as a method for pressuring providers to cut costs.

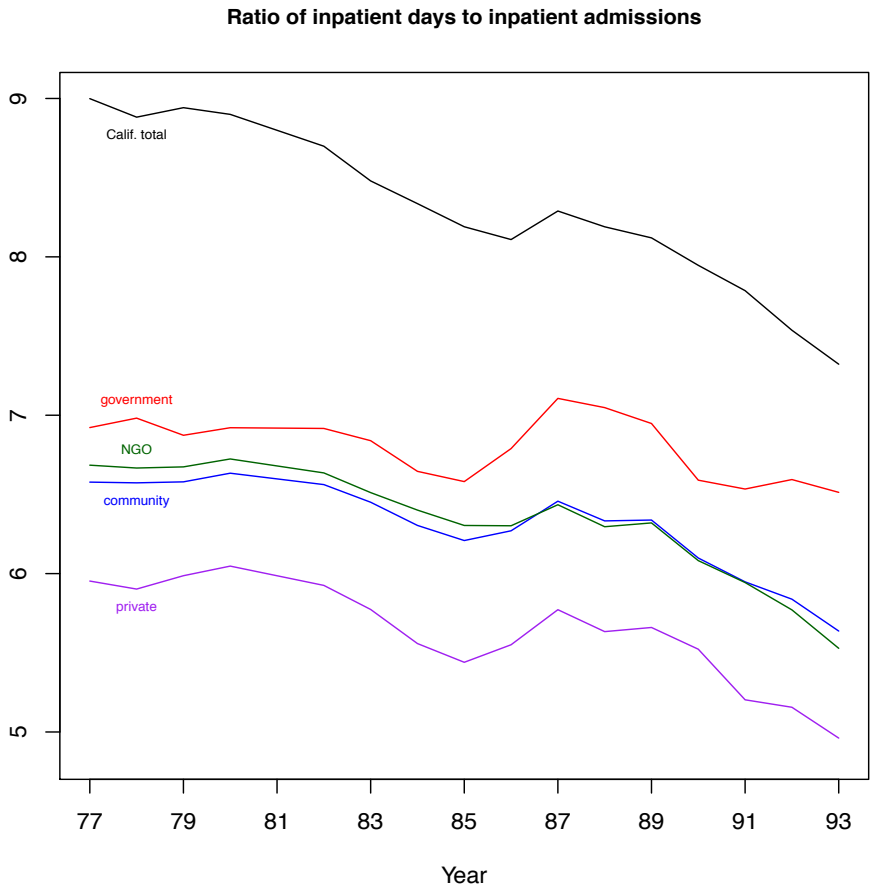
Workplace Effects

The rise of HMOs, the increasing corporatization of hospital governance, the consolidation of hospital systems, and the cost squeeze driven by federal policy all had profound effects on hospital employment and work life. Three key outcomes become particularly important for hospital workers, unions, and associations: work speed up and intensification, the concentration of cost-containment efforts on ancillary care workers, and strong challenges to professional jurisdictions. The three effects impacted all hospital workers, but the impacts differed depending on where a worker fell in the occupational hierarchy.

1. Work speed-up and intensification. The first key outcome was a significant speed up of caring labor. Once revenues were fixed per diagnosis, hospitals devoted tremendous attention and energy to shortening hospital stays, and sending patients home as quickly as possible. At a national level, total inpatient days in hospitals declined by 17% per year between 1983 and 1986.[360] Figure 2, summarizing data from the American Hospital Association,[361] shows the ratio of inpatient days to hospital admissions in California from 1977 to 1993, indicating a steady decline in the amount of time patients spent in hospital rooms after the introduction of the DRGs.

This effort itself pushed tremendous pressure onto bedside workers. But perhaps most significantly, shortening stays meant that while overall, aggregate patient days were declining in number, the patients occupying beds were substantially sicker. Organizers within CNA and SEIU alike perceived this as a speedup of work, enhancing the difficulty of bedside labor overall; this meant that while labor costs were still declining as a share of overall hospital costs, they were increasing per filled bed. In part due to this increase in patient case acuity, throughout the early and mid 1980s, hospitals cut back on their hiring of lower-skilled bedside caregivers, such as LVNs, and increased their demand for skilled nursing care.

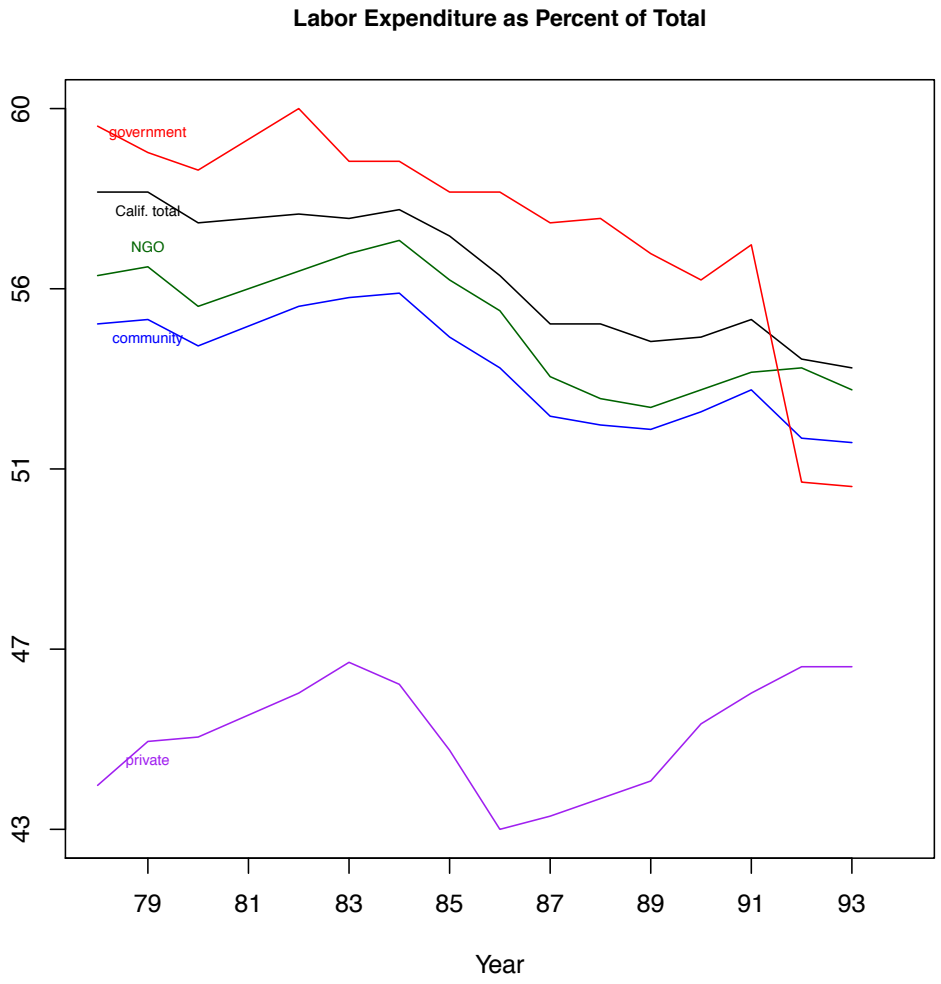
Figure 2: Ratio of Inpatient Days to Inpatient Admissions, 1977-1993



2. Cost containment concentrated among ancillary care workers. The second key outcome concerned managerial strategies, and primarily affected lower-paid service workers: hospital administrators undertook aggressive moves toward cost-containment, which necessarily placed constraints on labor costs. Labor costs were, and had always been, a large portion of hospital expenditures. In 1966, labor costs constituted approximately 64% of total operating costs in California non-profit hospitals, as estimated by the CHA at the time.[362] This proportion had been in steady decline since then, but remained sizable; labor costs reached 50% in 1977, and by 1983, they remained around 48%.[363] Figure 3, also using AHA data, shows the decline in labor's share of

expenditures for hospitals, 1977-1993. While the figure does not show a constant decline, it does show an acute drop after the 1983 introduction of DRGs.

Figure 3: Labor Expenditure as a Percent of Total Expenditure, 1977-1993



SEIU researchers found that in the 1980s, much of this savings pressure occurred at the bottom end of the pay scale, which created job loss and understaffing problems among the union's membership groups. BLS data backed up this perception. Between 1983 and 1989, hospital service workers saw a 13% drop in total employment; during the same

period employment among professional hospital workers increased by 11%, and managerial workers saw a 20% employment growth. Clerical employment remained largely stable.[364] SEIU estimated that between 1983 and 1985, over 80,000 acute care hospital workers lost their jobs.[365] In hospitals represented by Local 250, researchers assessed that 'Hospital Attendants,' once one of the larger units of bedside workers, were essentially eliminated as a category between 1983 and 1985, leading to hundreds of layoffs in San Francisco.[366]

And, as the narrative of this chapter will show, these pressures also produced significant efforts on the part of employers to obtain concessions from these workers at the bargaining table. SEIU researchers saw hospitals becoming increasingly aggressive in bargaining, and they attributed this increased aggression to the shift toward DRGs, the contemporaneous contraction of MediCal, and other external constraints driving cost saving efforts in hospitals.[367] Larger healthcare systems—and in the nursing home sector, ever-concentrating for-profit chains—led to increasingly coordinated and aggressive bargaining. "With the intense pressure to compete and cut costs," read 1987 report from Local 250, "hospitals have shifted from a commitment to public service to a fixation on the bottom line. This new focus on costs, together with the anti-labor atmosphere of the Regan era, has been passed on to health care workers in the form of wage freezes, concession demands, two-tied wage scales, short-staffing, and layoffs."[368] David Snapp, an International Union strategist, argued that both the DRGs and the general market orientation of hospital managers during this period led to a very aggressive focus on labor costs:

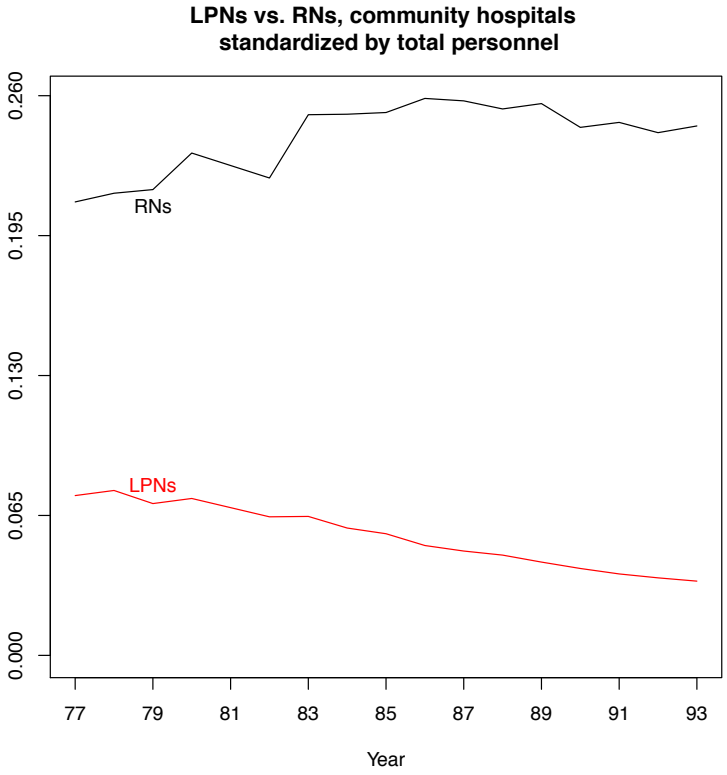
> The general environment was the big change, which was being led at that time, by Medicare, one every those being DRGs, or diagnostically related groups. That's the beginning of capitation, essentially... What it meant is that there was, A, the beginning of shrinkage the bed days, but just in general, a totally different cost incentives for the institutions. They started to look at their variable costs very closely, which was – labor is a big cost in a hospital, and they didn't have the same ways to control the cost of equipment and all that stuff. Labor costs were under the microscope, and then particularly to the extent that the union had established standards that exceeded market levels. In the Bay Area, most of the hospitals were organized, and there was a higher cost of living... Hospitals everywhere, were kinda becoming even more business-oriented about cutting costs where they could, and they saw say lot of things there that looked out of whack compared to other places and just wanted to cut, cut, cut.[369]

Partially in response to this crisis, in 1984, the California Board of Vocational Nurse and Psychiatric Technician Examiners commissioned a Task Force on the Future Role of the Licensed Vocational Nurse and the Psychiatric Technician.[370] The report made a number of recommendations concerning the restructuring of the LVN occupational role. Most controversially, the Task Force recommended a series of measures that would, for the most part, shift LVNs out of acute care hospitals, and into subacute convalescent hospitals and nursing homes. This meant that the key group of skilled labor below the RN would essentially be shifted into facilities that, even in relatively high union density areas

such as the Bay Area, paid substantially less than the acute care hospitals. To facilitate this broad goal, the Task Force recommended the reduction of training hours for LVN programs (which both Local 250 and CLVNA saw as de-skilling), shifting course emphasis from specialty areas such as obstetrics and pediatrics toward long-term areas such as rehabilitation and gerontology, and moving clinical training to sub-acute facilities such as nursing homes, home health, hospice, and other long-term care facilities.

CNA and Local 250 reacted to these changes from very different perspectives. The new policy of the Board of Vocational Nurses, Local 250 argued, would "create serious economic consequences," including the "deskilling" of LVNs, the restriction of career mobility opportunities, the litigation of LVNs' scope of practice, and the elimination of jobs in acute care settings. In the fall of 1987, Local 250 organized a day of lobbying and political visibility to address these concerns.[371] The LVN organizing team—led by future SEIU President Mary Kay Henry—mobilized 150 LVN members to rally during public hearings on the changes in Sacramento. Three Local 250 LVNs testified at the hearings, while others visited legislators' offices.[372] For the CNA, however, this shift toward greater reliance on RNs for bedside care was the culmination of a longstanding professional project: the advocacy of "primary nursing."[373] Primary nursing implied the increased use of RNs in bedside labor, at the expense of "team nursing," which involved a broader set of occupational categories in bedside care. By expanding the use of RNs in acute care settings, elite nurses argued, hospitals could ensure greater quality care, there would be expanded work opportunities for RNs, and RNs could exert greater control over caring practice. But as the 1980s progressed, the employment of LVNs in acute care settings continued to decline, to be replaced by RNs. This created a dynamic where labor markets were loose at the bottom of the bedside care hierarchy, but tight at the top.[374] Figure 4 shows the change in composition of staffing in community hospitals in California, 1977-1993, indicating a growth in RN employment and the decline of LVN employment in hospitals.

Figure 4: Licensed Vocational Nurses and Registered Nurses, Standardized by Total Personnel



3. Challenges to nurses' professional projects. If these shifts in staff composition had a negative effect on lower-level hospital workers, they provided opportunities for RNs. This meant an exacerbation of the long-recurring nursing shortages in the acute care hospital industry. Hospitals in this period developed a variety of strategies for recruiting and retaining RNs. In Kaiser Permanente's Northern California region, the hospital system created an internal RN training program that would allow nurses to obtain a BSN degree, and created a forgivable loan program for nursing education.[375] Other hospitals increased nurse internship and recruitment efforts, and expanded upon the Professional Performance Committee model to involve staff nurses in decision-making.[376] This was a benefit for nurses in terms of their collective bargaining prospects. Nevertheless, this nursing shortage opened up new challenges to RNs in terms of their longstanding professional projects.

The third important outcome concerned physicians' professional autonomy and authority, both in hospital workplaces themselves and in broader questions of decision-making concerning patient care. The mid-1980s were a time of substantial turmoil within the hospital, which affected the traditional boundaries between occupational groups. Physicians, in particular, saw their longstanding autonomy and control over clinical practice slowly erode as both public and private purchasers exercised greater control over patient care decisions, and as the growing cadre of hospital administrators shifted the institutional focus toward profitability and cost containment (Starr 1982, Scott et al 2005). This process led, in the mid-1980s, to a proliferation of anxious accounts of the

proletarianization of physicians as an occupational group (Chernomas 1986; Chernomas and Chernomas 1989; McKinlay and Arches 1985; Navarro 1988). In his assessment of the state of medicine in the 1980s Starr (1982:446) contested the notion of proletarianization, claiming that physicians still exercised significant control over clinical practice, and that hospitals, no matter how "corporate," were still deeply dependent on their expertise. "Nonetheless," he argued, "corporate work will necessarily entail a profound loss of autonomy." Hospital managers, driven by marketization and cost containment, exercised growing control over the pace of work and patient discharge. The growing influence of managed care and capitation after 1983, argued Scott et al (2005:229), "is experienced by many practicing physicians as constraining, if not directly threatening, their clinical autonomy."

But if physicians and organized medicine were increasingly anxious about their professional autonomy, they were not likely to gain ground vis-à-vis the increasingly powerful administrators. In part because of this, throughout the 1980s organized medicine made several attempts to claw back control and practice jurisdiction from other professional groups, including from nursing. Nurses saw professional incursions on the part of organized medicine as a direct affront to the institutional hierarchies that they had built over the decades. In large part due to the legacies of hospital-based nurse training, where elite nurses occupied the dual roles of managers of care and faculty, nurses had established a clear institutional hierarchy with a well-defined career ladder within hospitals. This structure largely endured even as nurse training was moved out of hospitals. By the 1980s, most hospital-based nursing schools had closed or were closing; nevertheless, nurse leaders maintained control over nursing care and the supervision of staff RNs, LVNs, and nursing aides within the organizational structures of most hospitals. A 1987 national survey by the HHS Office of the Inspector General found that in three quarters of surveyed hospitals, chief nursing officers prepared their own departments' budgets.[377]

Elite nurses in hospitals regularly played important roles in key administrative committees, such as joint conference and planning committees (though far fewer served on executive or finance committees). Over 70% of chief nurses reported directly to hospital CEOs, and 57% were paid as much or more than other officers of similar rank.[378] Below the chief, a large number of supervisory and managerial positions were occupied by RNs. Nurses' concerns about professional encroachment and the dilution of their jurisdictions of practice, therefore, were not just clinical in nature. Nurses' professional jurisdiction protected a key institutional role in the modern hospital. And, since the vast majority of RNs were women, this institutional silo with its own internal hierarchy was one of the few established avenues for professional women to establish leadership careers. The institutional hierarchy allowed for the maintenance of a career ladder, a situation that would be compromised should medicine (and men) reestablish authority over bedside patient care.

Chapter 6. The Crisis of Collective Bargaining

As we saw in Chapter 3, the organizing offensive among hospital workers that SEIU had envisioned for the 1970s failed to produce the rapid growth that union leaders had hoped for, in part due to employers' increasingly aggressive posture toward unionization. In the 1980s, this labor hostility extended toward the already-organized hospitals, as employers sought contract concessions in order to deal with competitive pressures and reduced federal reimbursements.

Throughout the 1980s, SEIU Locals 250 and 399 expended tremendous resources on a series of defensive battles, several of which involved large and costly strikes. And while in the 1960s and 1970s, strikes tended to lead to better working conditions for hospital workers, in the 1980s, large strikes led losses and the erosion of standards. This produced, I argue, a *crisis of collective bargaining,* whereby even where unions had been traditionally strong, healthcare workers could no longer rely on traditional unionism to produce positive outcomes, such as improved contract standards or worker control of work.

Chapter 6 shows how this crisis of collective bargaining increased internal political tensions in Locals 250 and 399, and ultimately produced political ruptures. These ruptures, in turn, created space for the development of new organizational projects. In both cases, an increasingly organizing-centered International Union attempted to assert control of the locals. At Local 250, the International Union was unsuccessful. The new, more autonomous administration slowly developed a new model of labor contention that was a bricolage of earlier models; it drew from both traditional workplace-centered unionism, and from the care-centric approaches of the more militant factions in the CNA. As a result, the local came to rely on a class-antagonistic model of industrial conflict that nevertheless centered on the critical importance of patient care, drawing on the progressive traditions enacted by nurses in earlier decades. At Local 399, the International Union was successful in taking control of the local. There, union leaders developed a model of organization that instrumentalized patient care, as part of a strategic model centered on growth and corporate combat.

Internal political challenges in Local 250

Throughout the 1970s, the leaders Local 250, like those of other unions in the Bay Area, were challenged by left communist groups. The most prominent of these in California

were the Workers' Action Movement and their affiliated organization, the Progressive Labor Party, though Local 250 organizers claimed to have encountered the Socialist Workers Party, the Spartacist League, the US Labor Party, and others.[379] These groups published newsletters for members that dismissed SEIU leadership, and frequently advocated no-votes on collective bargaining agreements.[380] One such newsletter, "The Scalpel," was coordinated by workers at Kaiser San Francisco, distributed among Local 250 membership from 1974 through at least 1981; the newsletter published editorials complaining about union leadership, letters targeting specific administrators and supervisors, pointed complaints about short staffing and work speedups, and accounts of the erosion of patient care at Kaiser.[381]

Tim Twomey, Local 250's secretary treasurer, had several alarmed exchanges concerning these groups, requesting help from the International Union in combatting them. In one exchange with SEIU President Hardy in 1974, Twomey called these groups "a serious, coordinated attack on the democratic labor movement," which he saw as an organized and well-financed threat to mainstream labor unions, and that, ominously, "adopted the tactics of the old Trade Union Educational League (TUEL) which was used by the CP-USA in the thirties (their slogan is 'Bore from within')." Their "trigger word," Twomey warned, "is 'Caucus.'"[382] Twomey proposed (though it is unclear if he went ahead and did this) dedicating research department staff to the identification of such rank-and-file caucuses in hospitals, and countering their expansion.[383] Hardy, too, raised alarms concerning the proliferation of WAM chapters in the US and Canada.[384]

In 1975, a group of WAM-affiliated healthcare workers at Kaiser San Francisco, along with allied dissidents in Merritt Hospital in Oakland and Herrick Hospital in Berkeley, began circulating an election platform calling for the right to vote on dues increases, financial reports from union officers, and that business agents should be hired from and elected by the membership.[385] They ran what was called the Rank and File Slate (WAM ran its own opposing slate that year). Local leadership responded, in keeping with Twomey's paranoid approach to left dissent, with what some called "red-baiting tactics," and the aggressive deployment of union staff to campaign for the incumbents. Several of the Rank and File slate activists were ruled ineligible to run. Among them was Helen Lima, a worker at Herrick Hospital in Berkeley, longtime activist in the California Communist Party, and wife of Albert Mickie Lima, longtime Chairman of the Northern California Communist Party.[386] She had been a periodic candidate for office in Local 250 since the mid 1960s.[387] Another of the members denied the opportunity to run, Ruth Eseltine of Kaiser Walnut Creek, was denied because she had only worked part-time; her appeal of this denial ultimately had to be declined by the 1976 SEIU International Convention.[388]

The caucuses would become less active in the late 1970s. But a few of the caucus members did obtain positions over the next few years. One Rank-and-File Slate dissident, LVN Pat Hendricks, won a seat on the Executive Board in 1975; in 1978, x-ray technician Blanche Bebb of Kaiser San Francisco would also win a seat.[389] These few dissident voices began to interface with a variety of external social movements in the late

1970s and early 1980, which in turn led to a new left regrouping among the Local 250 membership.

Two parallel movements deserve particular mention. The first was the South African anti-apartheid struggle. The Southern Africa Solidarity Committee formed in 1978, initiated by Bebb, and incorporating several activists from the Rank-and-File Slate. Over the next few years, the Committee held teach-ins and hosted talks and fundraisers, along with annual "Africa Night" parties at the union hall.[390] In 1978, Bebb traveled to New York to pursue a divestment resolution at the SEIU convention, calling for divestment form Bank of America. In 1984, Committee member and Alta Bates Hospital LVN Kathy Labriola traveled to the SEIU convention in Detroit to push a second divestment resolution there.[391] While a formal committee of the Local, by most accounts its activities were driven largely by rank-and-file volunteers, with the support of some executive board members but with little staff involvement. According to Labriola, "It was through this South Africa committee that many of Local 250's progressive members met in the late 1970's and began to create a rank and file union democracy caucus."[392] By 1981, these dissident groups continued to organize, and increased their coordination across hospitals. Lima, Hendricks, Bebb and several activists associated with the Rank and File Slate, the Southern Africa Committee, and various other groups would come together to form the Committee for a Democratic Union (CDU).

The early 1980s were also a period of intense activism around AIDS in the Bay Area, a concern that was particularly acute for care workers. When AIDS first emerged among young gay men in San Francisco in 1981, safety needles and other technical precautions against needle-stick injuries were far less stringent than in later years. Over the course of the 1980s, thousands of care workers would contract HIV through workplace accidents, and many of these would die. Many fearful nurses and care workers refused to treat the virus' early victims. This led a group of activist members—many of whom were already tied into gay rights movements in San Francisco—to begin to organize for the expansion of AIDS treatment services in the region's hospitals, as well as more extensive training for care workers in the new AIDS wards. According to John Mehring—a CDU activist and healthcare worker at Pacific Presbyterian Medical Center who would go on to become a leader in coordinating the International Union's response to AIDS—most community-based AIDS response organizations worked to ease fears and reassure people's alarmist fears of AIDS infection, but these failed to take into account the risks faced by care workers:

> These agencies wanted to reduce workers' fears and stop what was viewed by many as overreaction, and by some as homophobia and racism. Offering workplace educational programs on AIDS, these agencies hoped to facilitate better public service for their clients and constituents. Management also launched its own programs to reassure workers and prevent workplace disruptions or public relations problems... [These interventions overlooked] the fact that many service workers have more than casual contact with the public, including direct exposure to blood and other body fluids.

In 1983, several members of CDU led the development of Local 250's AIDS Education Committee; among these CDU activists were John Mehring, Denny Smith, and Peggy Ferro.[393] Ferro would herself contract HIV through a needle-stick injury, and after years of working for increased health services for AIDS patients and safety precautions for care workers, she died of AIDS in 1998.[394] While the committee received the support of the Local and the IU, and some local staff were involved—including Sal Rosselli, who would eventually become the Local President—the leadership of the CDU members was clear and further raised the profile of the dissident caucus. The Committee's early educational pamphlet, "AIDS and the Healthcare Worker," was geared toward frontline care workers and focused on informing workers about AIDS transmission and safety, calming fears, and advocating basic workplace safety measures.[395]

In 1984, CDU activists saw an opening to push for greater change in their local union. By connecting with broader movements and taking leadership on issues that mattered to many care workers, CDU had broader visibility and appeal among Local 250 membership, and greater racial and geographic diversity, than earlier left caucuses had enjoyed.[396] They could positively compare their own set of activists against the existing leadership, which was "all male, almost exclusively white, and as far as we know, non has ever worked in a hospital."[397] Sensing an opportunity, they began discussing running to replace Twomey and the existing union leadership; early on, the activists received visits and support from other union democracy supporters, including from Teamsters for a Democratic Union (TDU).[398]

Local 250's leadership, furthermore, was substantially weaker than it had once been. George Hardy, Tim Twomey's father in law and political supporter, had retired from the SEIU presidency. While the major concessionary contract negotiations were yet to come, they had begun before the 1984 election. Internally, the local governance had grown increasingly removed from the membership. A review of the local's monthly membership meetings illustrates this. While in the mid and late 1970s, minutes show membership meetings that tended to be active and involve frequent membership attendance and involvement, by 1979 and into the 1980s, monthly membership meetings were sparsely attended, and the vast majority of meetings during this period were cancelled for lack of quorum. By 1982, these spare minutes were punctuated with activity primarily when dissident activists attended.[399] Many of the Trustee and Executive Board positions were not held by hospital workers, but by Business Agents.

The CDU slate—led by Tommie Crumwell for Secretary Treasurer and Blanche Bebb for Secretary Treasurer—put out literature reading "Vote for your future, vote CDU: A hospital union run by hospital workers."[400] They filled the slate with longtime members of Local 250, many of which had been in the union for a decade or more, some for over two. They grounded their campaign in what they saw as the existing leadership's inability to confront the evident offensive from hospital employers. "We realize our problem is very similar to the problems other unions are having," wrote Executive Board candidate Amy Grossman in a fundraising appeal. "Leaders who were adequate during good times have no program or strategy for dealing with management's offensive."[401]

Challenged by CDU, Tim Twomey and John Ring asked Sal Rosselli, a new business agent in the East Bay, to run their reelection campaign. Rosselli was young at the time, having just recently come over to Local 250 from having staffed the small theatre janitor's union, Local 9. And he had political experience, having run himself for various local offices in San Francisco in the early 1980s. But by many accounts, including among his opponents at the time, he was an effective organizer and negotiator in the East Bay. They named the slate led by the incumbents the "Progress through Unity Team."

In the end, Twomey and Ring retained their offices, winning by 55%-45%— a slim margin by the standards of most union officer elections. Rosselli credited the organization of the East Bay local offices, in part under his own leadership, with saving the election for Twomey and Ring:

> We started changing the union in the East Bay, again with the corporatization of health care and these mergers et cetera, we convinced the leaders to have stewards start talking to each other in different hospitals with common employers... And then this election happened and John Ring came to me and asked for political help on the election because they were threatened by [CDU].

CDU candidates won seven executive board positions, effectively dividing the Board, with neither side holding a clear, consistent majority. On the Board, this was a recipe for conflict. By most accounts, the next two years were highly contentious within the union's Board, with even small decisions subject to polarizing conflict. Throughout this time, Twomey consistently declined to allow the trustees to examine the union's books.[402] Following the election, several members of Twomey's slate began to side with the CDU colleagues in Board debates, and the CDU side of the Board, despite having lost most seats in 1984, began to win votes; Twomey and Ring responded by bringing in Victor Van Bourg, famed San Francisco labor lawyer, to serve as a parliamentary advisor in order to prevent unpredictable votes. In July of 1985, these tensions came to a head, following a conflict over the dismissal of Les Kuykendall, a young Business Agent who had begun attending CDU meetings.[403] After the dismissal, Kuykendall, who was black, filed charges of race discrimination against the Local. At the next board meeting, CDU members moved, and convinced the Board, to reinstate Kuykendall.[404] Twomey again dismissed Kuykendall two days later.[405] In September 1985, a number of CDU activists not serving on the Executive Board filed charges against Twomey and Ring; IU President John Sweeney assumed jurisdiction over the charges shortly thereafter.[406] The hearings on the charges were presided over by SEIU Vice President Ophelia McFadden. McFadden subsequently recommended the dismissal of all charges against Twomey and Ring.

Bargaining Challenges

It was against this tense political backdrop that Bay Area employers unleashed their assault on Local 250 over the early and mid 1980s. Associated Hospitals of the East Bay began to dissolve in the early 1980s. The association had been active since the 1950s, under the leadership of Laurence Corbett. But after a large strike across the East Bay in

1978, the association was undermined.[407] The strike followed an unfortunate lack of coordination within the union. Tim Twomey took charge of bargaining in San Francisco, while John Ring bargained in the East Bay. In the Affiliated negotiations, Twomey settled for a relatively small wage increase, apparently without communicating with Ring or the East Bay bargaining team, who decided to strike to achieve a better deal. This decision upset decades of pattern setting in bargaining between the two employer associations. But the precedent for pattern bargaining remained strong, and the members ultimately had to settle for the San Francisco wage increases even after a seven week strike.[408] After the apparent demise of stable pattern bargaining relationships, several East Bay hospitals began to depart. Merritt and Peralta Hospitals were the first to leave the association, deciding to bargain on their own in 1982. After insisting on a lower wage scale than other East Bay hospitals and a two-tier wage scale, the hospitals provoked a nine-week strike in 1983.

A two-tier contract meant that while current workers would maintain their wages, new hires would be paid substantially less. This bargaining strategy was meant to erode wage standards over time while attempting to curtail unrest among the existing workforce. If enacted, it would be a major concession that reflected bargaining trends in other industries during this period, including most industries that were going through their own process of de-unionization and wage cutting. In holding out for a two-tier contract and, seemingly deliberately, provoking a strike, some members perceived that the hospitals were attempting to permanently replace Local 250 members with lower-paid workers.[409]

The Merritt and Peralta strike—occurring in two of the hospitals that composed the neighborhood in Oakland then referred to as "Pill Hill," with one of the highest geographical concentration of care workers in the Bay Area—was distinguished by attracting solidarity from RNs refusing to cross Local 250's picket lines. Local 250 and the CNA had maintained a strained relationship for some time, and members of both organizations had routinely crossed each other's picket lines throughout the 1970s.[410] In the end, the union defeated the two-tier demand. After the strike, Merritt-Peralta continued laying off dietary and care workers, due to the presence 100 empty beds in the hospitals after management canceled its contract with MediCal. By 1985, Associated Hospitals had all but dissolved, with four additional hospitals departing.[411]

Affiliated Hospitals, the employer association on the other side of the Bay in San Francisco, remained in place in the 1980s. Since the early 1950s, Arthur Mendelson, of the famously anti-union law firm Littler Mendelson, had represented Affiliated Hospitals. Mendelson himself, according to both union representatives and mediators, was not as hostile as the firm, and maintained a productive relationship with the unions representing Affiliated hospital workers.[412] On a system-wide level, Local 250 had never once called a strike against Affiliated Hospitals, dating back to the earliest multi-employer agreement in 1941.[413] By 1985, however, Mendelson had left, and the young management attorney Karen Henry began to represent the association. Union leaders saw Henry as adopting a more aggressive posture in negotiations, and some believed she was "intent on making her reputation" at the expense of Local 250 members.[414] And in 1985, Affiliated came to

the table prepared to challenge the union and determined to cut labor costs. They hired a consulting firm to propose a new, cheaper health plan, and a public relations firm to manage communications during bargaining. At the table, the hospitals demanded a two-tier wage structure, a two-tier vacation progression, and a two-tier health plan.

Organizers were for the most part unprepared for this aggressive posture; it had been, according to Local 250 Researcher Paul McKenna, "coming off a long period of stagnation and ineffective servicing of San Francisco facilities," which had a much weaker stewards structure than the East Bay hospitals.[415]Staff were reeling from earlier strikes, and having just seen their allied union, HERE Local 2, lose a strike in San Francisco earlier that year, were nervous about organizing a strike themselves. Hospital workers, according to McKenna, were expressing substantial fear of job loss and of striking, and telling organizers they "just want to keep our jobs and benefits."[416]

After three months of bargaining, the association was willing to budge only on the amounts of the two-tier proposal, but not on the concept; by May, the membership accepted the two-tier wage structure, in what many saw as a dangerous capitulation that threatened decades of improving standards among what had been the SEIU's strongest healthcare membership base. They did not strike, and by some accounts, the union gave this up without much of a fight.[417] Organizers anticipated that East Bay hospitals would similarly move to impose wage tiers during bargaining that year, and began to prepare for a strike. A combination of stronger union organization and a newly fractured employer association, however, allowed the union to resist the extension of tiered wages to the East Bay without striking; Alta Bates and Herrick Hospitals, the two holdouts, withdrew their tier proposals on April 26th, and contracts were signed by April 30th.[418]

The 1986 Kaiser Permanente strike

For decades, Northern California Kaiser had bargained closely on the heels of the Affiliated Hospitals and Associated Hospitals contracts—the larger employer associations would bargain in the spring, and Kaiser would follow with bargaining in the fall. With a few exceptions—such as the dispute leading to the 1958 strike discussed in Chapter 4—Affiliated and Associated would set broad contract patterns, and the Kaiser contract would for the most part follow on those negotiated a few months earlier. In 1983, Kaiser and the unions had settled on a three-year agreement, which placed the expiration of the contract in the fall of 1986. This gave both parties about a year and a half following the Affiliated bargaining debacle before they would have to hammer out a new agreement. For Local 250 organizers, they saw this as time to prepare to strike. "So there's kind of a build-up," said Paul McKenna, "We're not going to let this happen again."[419]

In January of 1986, according to Twomey, "with full awareness that Kaiser was bound and determined to destroy the enormous strength in this local union in the healthcare industry in Northern California," the local began to plan an aggressive contract campaign.[420] Kaiser's Northern California contract was a pacesetter for the firm on a

national level, and for healthcare worker contracts across the industry. While in earlier rounds of bargaining the Affiliated and Associated agreements had set the "pattern" for Kaiser, the disintegration of Associated Hospitals and the outcome of 1985's Affiliated bargaining meant that Kaiser was effectively the pattern setter in the region. As the Bay Area was of the strongest areas for healthcare worker collective bargaining, the outcome of these negotiations would ripple well beyond the region. International Union representatives closely monitored the Kaiser preparations, and assigned IU staff to work with the Local in the early months of the 1986, at the specific request of Tim Twomey.[421] They assigned IU researchers to look into Kaiser's finances, seeking to argue that Kaiser was "different from the typical hospital... profitable and expanding rapidly with growing market share,"[422] and engaging in labor process changes that were causing a measurable effect on worker stress levels.[423] And while they could not build a public campaign around the issue of "two-tier" wages and benefits before Kaiser itself proposed it, they believed it was likely that Kaiser would indeed make a two-tier demand. They began to draft member education programs to drive home the dangers of two-tier contracts.[424]

Given Kaiser's tenuous position as the dominant provider in California, IU researchers assessed that the public perception of Kaiser's care quality would be a necessary campaign point, requiring a linkage of "workplace demands and an improved patient care attitude or service."[425] They brought in public relations consultants to begin to draft a messaging strategy should a strike develop—centering on the campaign message that "Kaiser works because we do." The International Union assigned a team of bargainers and organizers to take charge of the negotiations, led by Western Regional Director Robert Muscat in bargaining, with campaign coordination support from Gerry Shea, Andy Stern, and Ray Abernathy. Beginning in July, the Local mobilized a team of ten organizers, a field coordinator, and a campaign director, along with a three-person support team to work exclusively on the contract campaign.

Kaiser, like the rest of the industry, was facing its own substantial pressures. Traditionally among the cheapest forms of health coverage, Kaiser saw increasing competition from newer HMOs, was forced to increase its own premiums due to escalating costs within the organization, and some perceived that it was losing its longstanding competitive advantage. This was a substantial transformation for Kaiser, which had for some time avoided casting itself as a corporation at all—indeed, it was not until 1983 that the organization began running advertisements.[426] In a 1986 interview with the journal *Health Affairs,* Kaiser Permanente CEO James Vohs outlined that the rapid growth of HMOs and Preferred Provider Organizations were introducing substantial competitive pressure, which were in turn challenging some of the core principles of the organization:

> Things are changing around us and, as a consequence, we are having to change, too. The whole sphere is becoming more commercial. There are a lot more plans–many which organizationally, at least, look like us–providing comprehensive benefits at a fixed monthly cost. But as we adapt, we are trying to be very careful that we don't throw out the principles that have made us successful; yet *we must not cling to principles that no longer apply in a changing world*.[427]

Kaiser was also seeking to expand into new geographic areas, including the Central Valley, where its competitors were not unionized and where healthcare workers were paid substantially less than in the Bay Area. In 1985, Kaiser had sought and obtained permission from Local 250 to open small new facilities in Stockton and Fresno with lower wage rates, due to the fact that most of the competition in the region was non-union at the time. It is possible that some within Kaiser saw this as an opportunity to introduce more rate differentials in the system, especially following on the Affiliated agreement. Once the Affiliated contract was settled in 1985, Kaiser unilaterally stopped resolving grievances at the step 1 and step 2 levels.[428]

Kaiser arrived at the bargaining table with an aggressive posture, insisting on what Local 250 called "twelve outrageous takeaway proposals." The most aggressive proposal, which the union was set on resisting, was the demand for a two-tier contract that would cut wages for future hires outside of the immediate Bay Area by 30% and add new lower-ranked positions to the pay scale within the Bay Area. Union negotiators, cognizant of the precedent-setting nature of such a concession, flatly refused. According to one account of the negotiations, Kaiser exhibited behavior suggesting that they were inviting a strike: the union's negotiating committee voted to move the negotiations to binding arbitration, but Kaiser refused to do so; they then moved to extend the contract and continue negotiating, but Kaiser refused that, as well.[429]

In early October, Kaiser's negotiators walked away from the table, leading the union bargaining team to ask members to approve a ten-day strike notice, with a strike timed to coincide with the October 25th contract expiration. This impasse set the stage for a long and bitter strike across Northern California. On October 27, nine thousand Local 250 workers across 27 Kaiser facilities walked out. 150 opticians represented by SEIU Local 505, and several hundred laboratory employees represented by the Engineers and Scientists of California soon joined them.[430]

One of the challenges of striking at Kaiser was that it was a pre-paid health provider, and that patients had already paid for services. This meant that in the short term, with income stable and expenses dropping, Kaiser would actually benefit economically from a work stoppage. Kaiser's weakness, however, lied in the long-term impact of a strike on their institutional clients. Organizers thought they had an advantage in that one of Kaiser's largest organized patient groups was organized labor, and that "union members made up a substantial portion, if not the vast majority, of Kaiser members in Northern California... as a result, Kaiser needs to be responsive to the concerns and interests of organized labor, particularly in today's competitive climate."[431] This provided a unique opportunity, organizers felt, to align the interests of patients and care workers—allowing the union to build upon patient concerns with long lines, appointment delays, and impersonal service.[432]

This campaign also involved a variety of other extra-strike pressure tactics. This included working to take measures to slow Kaiser's expansion plans, in California and

nationally—the union coordinated leaflet campaigns in nine cities calling for a withdrawal of support for new facilities or acquisitions of other HMOs.[433] Kaiser's expansion plans, researchers found, were funded by bonds that depended on the HMO's California properties as collateral, allowing them to link campaigns around expansion to the working conditions in the Bay Area.[434]

The union worked to build support from major purchasers of Kaiser care, including unions and public employee groups; they called on organized buyers to withhold funds and demand rebates for slowed services during the strike.[435] IU researchers and Local 250 officials headed to local county and city council meetings, to similarly ask for rebates and withholding.[436] Behind the scenes in Sacramento, the union began to lobby legislators so as to threaten Kaiser's non-profit status, drawing on recent challenges to Blue Cross plans' non-profit status.[437] To support these efforts, researchers sought to frame the campaign as in the interest of patients—in part through the collection of "patient care stories" that painted Kaiser in a poor light. They also worked to build support among Permanente Medical Group physicians—though well into December officials were disappointed in their inability to "crack the lack of doctor contact and put together a group inside of more senior doctors."[438]

During bargaining, in part to bolster the notion of an alignment of interests between care workers and patients, Local 250 and the SEIU pushed for a joint labor-management patient-care committee, likely modeled in part on the CNA's Professional Performance Committees. Negotiators ultimately obtained what were called "common interest forums," which would meet yearly to discuss mechanisms of care improvement.

Many members of non-striking unions held firm with Local 250 and honored the picket lines. This was even the case with the CNA, which had not had the best relationship with Local 250. CNA RNs had settled a contract with Kaiser in 1985, and were thus under contract as Local 250 struck. Nevertheless, a substantial number of nurses honored the picket lines that fall.[439] Kaiser, needing to maintain a level of patient care during the strike, sought and obtained a restraining order preventing CNA from striking, or from supporting the strike. Individual nurses, however, had the right to honor picket lines, and many continued to do so in defiance of the injunction. It was at this point that some of these nurses organized as "RNs for Quality Care," a group of CNA staff nurses that would soon come to organize as a caucus within CNA, and which maintained ties with other dissident staff-nurse groups, including the Staff Nurse Action Project. According to Jean Stumpf, a spokesperson for "RNs for Quality Care" during the strike,

> This temporary restraining order has no impact on our support. The action of the registered nurses was not initiated or sanctioned by the California Nurses Association, and the temporary restraining order only shows the limited view that Kaiser holds of nurses, and the desperate tactics that they will use as a means of intimidating us back to work.[440]

The Kaiser strike lasted for seven weeks. The Local's strike fund, which had been used to pay limited benefits to striking workers, was quickly exhausted. Given the size and

spread of the Kaiser workforce and the logistical challenges of running such a campaign, the local quickly found itself in the red. In 1986, the local lost over $2.3 million; by December 1986, the union had received $200,00 in direct assistance from the International Union, drawn over $1 million from the IU strike fund, and owed the IU over $400,000 in unpaid per capita taxes.[441] The financial strain on both the Local and the International Union signaled clearly that Kaiser was winning the standoff. SEIU negotiators came to a deal with Kaiser that reduced the two-tier concession to a 20% drop for new hires. On December 4th, two smaller unions representing optical workers and medical technologists, who had been bargaining and striking alongside Local 250, settled for the 20% tier. The Local 250 bargaining team submitted the agreement to the membership for a vote without a recommendation—while SEIU leaders knew they could not carry on the strike, accepting two-tier was politically explosive. Union leaders, however, leaned on members to settle.[442] In Local 250, members did not support the capitulation to two-tier—a product of members' resolve, ongoing political dissent within the union with dissident groups opposing settlement, and the ongoing fraying of ties between union leadership and the rank and file over the early 1980s. In the first vote on the contract, the membership soundly rejected the offer, by a 55%-45% margin.

The rejection of the offer produced substantial tumult within the organization. By some accounts, many union leaders were shocked by the membership's rejection of the agreement, and internally, saw it as destructive. The local and IU leadership had been advocating against a two-tier contract for a year, but facing a financial crisis, were now applying pressure on members to approve the deal. Negotiators, fearing the effect of a continuing strike on the union's survival, bargained a new deal that reduced the differential to 15%; this time, they convinced the bargaining team to recommend acceptance of the offer. And to add pressure on members to approve the agreement, they informed strikers that the IU would no longer pay strike benefits. With that, the membership accepted the offer by a substantial margin. With that second vote, Local 250 ratified the contract with the two-tier wage scale.[443] The strike ended on December 13th.

SEIU leaders and Local 250 members alike saw the Kaiser strike as a profound loss. It cemented a lower standard among Kaiser workers, in a contract that had been the industry leader—this set the stage for the erosion of wages and benefits across the industry. Some within the union saw the Kaiser loss as both a failure of the collective bargaining process, and the imposition by union leaders of a substandard contract on a membership that had rejected it. Some dissident members saw the failure as an act of sabotage—pointing to the IU leadership of the strike and the campaign, and their statement after the initial contract vote that strike benefits would soon be drying up.[444]

Blanche Bebb, one of the leaders of the CDU Caucus, told the press that "99% of the picket line activities were organized by the rank and file...the union was only interested in the corporate campaign, which is the 'new strategy for unions.'" Beyond the dissidents, many others within Local 250 and the broader SEIU saw the Kaiser failure as an existential challenge, driven by Kaiser's transformation into a more aggressive, "corporate" organization. "A new cost-cutting, profit-making mentality gripped the

institution," proclaimed the union's newsletter, the *Local 250 Worker*. "Consultants declared that less time as to be spent with patients. New supervisors were hired from outside... and for the first time in the history of the company, management began glossing over the new realities with millions of dollars of fancy advertising."[445] Jerry Shea, the SEIU Healthcare Division Director, stated during a trusteeship hearing in 1987:

> A good situation went bad, and quickly. Because [in the Bay Area], where there is a certain measure of acceptance and recognition of healthcare unionism, the table was turned upside down. Any equilibrium that existed in labor relations has been lost. A huge imbalance has replaced it. There could be no better example than the change at the Kaiser Health Plan, where a 30-year relationship has been stood on its ear by a new round of MBA managers who are out to make Kaiser a winner in the competitive market place—regardless of the consequences for workers or patients.[446]

From external crisis to internal political rupture

Three days after the end of the strike, Local 250 Executive Board members received a mailgram informing them that that, as determined by the International Union President John Sweeney, their upcoming meeting had been postponed, and that International Union representatives Richard Cordtz, Gerry Shea, and Andy Stern would assume temporary leadership duties at the local.[447] Formal trusteeship would follow in January of 1987. According to Labriola's account of the trusteeship,

> Twomey and Ring, fixtures in the union for so many years, quite suddenly disappeared, seemingly without a trace, and certainly without any fanfare. All I know is that when we showed up for our regularly-scheduled monthly Executive Board meeting on Dec 16, they were gone, and Andy Stern and Gerry Shea were sitting at their desks in their former offices.[448]

For many within SEIU, Local 250's failures represented a great risk to the union; trusteeship was a chance to turn the ship. After two disastrous bargaining processes, Twomey and Ring would likely lose in an upcoming election, allowing CDU, or some other group outside of the International Union's orbit, to achieve control of a strategically pivotal local. In producing his report recommending trusteeship, International VP Ted Roscoe grounded his recommendation in the dramatic transformation of health care delivery in the early 80s, and the Local's inability to adequately respond using its existing approaches. This was particularly politically difficult, according to Roscoe, because of San Francisco's longstanding exceptional status as an island of healthcare unionism:

> While locals throughout the country strongly felt the brunt of the reactionary anti-labor policies of the Regan administration, and the new competitive era in healthcare, nowhere have the changes among employers represented such a sharp contrast with the past than here in the San Francisco healthcare industry.[449]

International leaders saw the political crisis roiling Local 250 as a product of this challenging industrial context. In his remarks to the Trusteeship hearings, Shea laid out this argument:

> Of all the problems in which Local 250 has operated in the past, none is more insidious than the extent to which major, objective difficulties in the industry become obscured by political designs or interpretation... Even the most stable, best run, most democratic and strongly organized unions are having an extremely difficult time holding their own in such a topsy-turvy world. Anyone attempting to understand what's going on at Local 250 today... must start with an understanding of the dynamics of this very important, very troubled industry. If someone doesn't, they'll be sunk before they start, and I'm sorry to say the Local 250 story of the past few years is full of people who made that mistake.[450]

The trusteeship was a mixed blessing for CDU activists. The arrival of more explicit International Union control meant that Twomey and Ring would disappear from Local 250 leadership, which they had long pushed for. Furthermore, the IU's bureaucratic justification for the trusteeship largely reflected the political arguments that CDU had been making for years, including in their charges against Twomey and Ring the prior year. In his report to Sweeney, Roscoe described how IU staff involved with Kaiser bargaining reported numerous concerns regarding the Local's capacity to bargain effectively.[451] But more specifically, the report also pointed to the "breakdown of democratic procedures... membership records that were hopelessly out of date, incomplete and inaccurate; serious problems in the non-payment of membership dues; structural inability to conduct fair elections," among other complaints originally laid out in the CDU charges.[452] While noting that Ophelia McFadden had recommended the dismissal of the individual charges against Twomey and Ring, these more structural complaints were reaffirmed in Roscoe's report, and in large part formed the basis of the legal justification for the trusteeship. But the trusteeship also meant that the upcoming election scheduled for the spring of 1987 would likely not take place. Hospital working conditions and union administration had both substantially deteriorated since CDU's relatively strong election showing in 1984, and many activists had hoped that they could take advantage of the polarization emerging from the bargaining defeats at Kaiser and Affiliated to make another run.

Two International Union staffers would serve as trustees for Local 250 between 1987 and 1989. The first was Phil Giarrizzo, a member of the IU Executive Board. By most accounts, during his tenure Giarrizzo was chiefly concerned with rebuilding the governance mechanisms of the Local, working on re-writing the constitution and enacting a series of organizational reforms intended to enhance member participations and improve representation. Among the early actions was the convening of a Local-wide "leadership conference," which brought together 800 stewards and activists from across the local to discuss restructuring.[453] Most broadly, the local was reorganized along industrial, rather than geographic, divisions. Kaiser, as the largest and most dominant employer, would get its own functional division, headed by Mary Kay Henry, then a young IU organizer and now the President of SEIU. The Local would also form a Hospital Division, for acute care hospitals, and a Convalescent Division, for nursing homes; in latter years, other smaller divisions would be added through restructuring and mergers, such as the EMS Division and the Physicians Division.[454] Giarrizzo also

proceeded to move groups of workers that had been in Local 250 but which had not actively worked in the healthcare industry, such as cemetery workers and concessions workers at Yosemite National Park, into other SEIU locals and other unions.[455]

The Local proposed and ratified a new constitution within a year. The constitution established a more transparent division structure, stronger language establishing worksite councils and connecting them to the Local administration; the new constitution met with the approval of the International Union, local staff, and dissident member groups. It was a constitution that, according to Giarrizzo, "was to provide an overall framework and foundation that was radically different from the prior constitution and the practices that had been established through years of history, both good and bad history."[456] With his efforts, Giarrizzo won the support of many member activists, including from CDU.[457]

That same month, Sal Rosselli also declared himself a candidate for President. Rosselli had been broadly associated with the Twomey leadership team, his star rising in the organization after he successfully led Twomey and Ring to a narrow victory over the CDU in 1984. But if the broader administration of the union had by the mid 1980s become rather complacent and ineffective, the East Bay Division then led by Rosselli, Shirley Ware, Ralph Cornejo, and others was seen as an effective, organized component of the union.[458] In 1984, by some measures, it had been the East Bay vote that had kept Twomey and Ring in office. And while Kaiser and the San Francisco hospitals had successfully imposed different forms of two-tier contracts on Local 250 membership, the union had successfully kept two-tier contracts out of the East Bay hospitals. Even some CDU activists, while political opponents of Rosselli's, recognized his relative effectiveness in the union.[459] According to some accounts, Rosselli had been positioning himself for leading Local 250 since before the trusteeship—either with Twomey or Ring, or against them.[460] And by 1988, Rosselli and his running mate Shirley Ware may have attracted sufficient support among Local 250 staff to mount a credible challenge to Giarrizzo. Their longstanding connections to East Bay members, the largest geographically defined membership group in the local, gave them a key organizing edge over the incumbent.[461]

Rosselli's challenge to Giarrizzo alarmed many within the SEIU International Union. While in the early stages of this first public campaign, they avoided cultivating overt anti-international sentiment, there was nevertheless a sense that theirs would be an oppositional administration.[462] Their tight connections to the Twomey old guard and remaining staff, Rosselli's ongoing contentious relationship to the trustees in the first year of the trusteeship, and rumors concerning the insurgent slate's financing kept many deeply suspicious.[463] International officers hired the private investigation firm Goldstein & Denton to examine the sources of campaign financing, as well as to establish a basic biographical profile of Rosselli.[464] More broadly, many perceived Rosselli and his allies as associated with a "business union" approach, and resistant to the more modern, activist model then being developed in the IU Organizing Department under Andy Stern.[465]

By early February, Sweeney had removed Giarrizzo as trustee, extended the trusteeship

through 1989, and installed Mark Splain, an Organizing Director for the IU, as the new trustee. The staff of Local 250 was surprised by the change, and some attributed the shake up to a fight between Giarrizzo and the IU.[466] According to the contemporaneous investigations of SFBG labor reporter Paul Johnston, "Giarrizzo's departure was in fact far from voluntary. He wanted to stay on, wanted to run and was dumped."[467] Splain fired Rosselli, who was at this point the Director of the Hospital division, and replaced him with Jean Quan (who would later become Mayor of Oakland).

The 1988 Affiliated Strike

In 1988, at the height of the political turmoil within Local 250, the union went on strike against Affiliated Hospitals of San Francisco. The strike was profoundly important in three respects. First, it signaled a new approach to fighting employers—one premised not only on the withdrawal of labor as a form of leverage, but also the mobilization of healthcare workers' moral and social claims to legitimacy in the public sphere. And second, it had enormous stakes politically—many perceived that its outcome would largely determine the local elections a few months later, and the future direction of the union. Finally, it also marked one of the first significant strategic coordinations between SEIU and CNA during a strike event.

Affiliated Hospitals was the oldest multi-employer master agreement for hospitals in the nation, and in the fifty years of its existence, Local 250 had never had to strike in order to obtain an agreement. But on the heels of the concessionary bargaining in 1985, the establishment of a two-tier wage structure, and the union's capitulation to Kaiser after a failed strike in 1986, Affiliated hospitals saw an opportunity to obtain more cost controls. This time, in addition to keeping the unequal wage structure, they introduced proposals cutting healthcare benefits and requiring premium copayments for the first time—essentially, they demanded that healthcare workers pay more for healthcare. They also demanded the curtailment of sick days, and a wage freeze for all workers except LVNs.[468]

Karen Henry, the chief negotiator for Affiliated, told the *San Francisco Examiner*: "We're deliberately taking a labor market approach [...] it's no longer the good old days. We'll pay what is competitive for that group of people—no more than that."[469] Some leaders within SEIU perceived that the hospitals wanted a busted union—that they thought they could either force substantial cuts upon the workers, or force a strike and potentially break the union itself. At first, in part because of its financial precarity and vulnerable position, union leaders sought to resolve the Affiliated negotiations without a strike, by working without a contract and applying pressure through corporate campaign mechanisms. This included an effort to "stake out the high ground," establishing the unions and the workers credibility with the general public, through a public relations campaign playing up the irony of hospitals demanding workers pay for healthcare, and community outreach campaign under the banner of "we want to keep working for you."[470]

The union continued its emphasis on public relations, with a broad and relatively successful (given press coverage of the events) effort to blame the strike, and its negative

effects on patient care, on hospital administrators. As with other hospital strikes, the union was keenly concerned with public perceptions of the effect of the action on patient care. In this case, the public representations had to walk a fine line. In relying on a public appeal and counting on public pressure on hospitals to end the strike, the union had to present the strike itself as a costly event that was damaging patient care. While the hospitals maintained the position that "no patients would suffer" during the strike, the union highlighted the ways in which patient care standards were eroding; one newsletter from early in the strike read: "Three open heart surgeries cancelled. Unattended psychiatric patients wandering the streets, potentially dangerous to themselves and others. Elective surgeries cancelled. The incidents will become more frequent, the picture more apparent and the tales more chilling."[471]

At the same time, the union also had to not only present the hospitals as responsible for the strike, but to represent itself as taking great measures to relieve the effects on patients. The union set up a "patient care hotline," to collect public concerns about patient care impacts, and distributed surveys within hospitals to both non-striking workers and patients.[472] They also organized a hearing before the San Francisco Board of Supervisors to evaluate the negative effects of the strike on patient care.

Beyond the press, the union pursued sophisticated community outreach strategies. They established alliances with local gay advocacy organizations and activists who were fighting for increased healthcare support for AIDS patients; the activists walked a gay picket line, led by AIDS activist and CDU member John Mehring. Further, when St. Mary's Hospital threatened to close its psychiatric unit, the Local initiated a ballot measure campaign for an ordinance that would compel hospitals to give 90-day notice to the Health Commissioner before such a closure, and collected 15,000 signatures in support of the measure.[473]

The union was also attempting to hold out until the CNA's contract expired on August first. Bargaining had begun in March, and continued through expiration on May first. According to several accounts, the potential success of a Local 250 strike hinged in large part on whether RNs would honor the picket lines. In terms of hospital operations, as the most numerous occupational group, nurses could maintain production in a hospital during a strike, but operations would be severely hampered if they honored picket lines. The CNA's decision would also be politically consequential, especially important given Local 250's outward-oriented campaign strategy. The Executive Director of the CNA at the time was Irene Agnos, sister of San Francisco Mayor Art Agnos. Affiliated's representative Karen Henry, aware of this potential source of leverage, sought to move the CNA negotiations into third-party arbitration, which would have eliminated this threat of coordination; CNA declined to do so.[474]

On May tenth, Affiliated claimed that bargaining had reached impasse, and moved forward with the implementation of its final offer, including the cuts to health benefits. Local 250, hoping to extend bargaining further into the summer, sought to extend bargaining, refusing to acknowledge that bargaining had reached impasse.[475] Local 250

responded to the unilateral implementation on two fronts. First, it organized members to refuse to authorize payroll deductions, on the theory that if employees signed the authorizations, it would be difficult to reverse.[476] According to McKenna,

> One of the issues that we were really concerned about was they were going to bargain to impasse and then unilaterally implement the premium share. And then once they started taking that out of people's checks, it would become like a fait accompli and people would lose their will to fight on it. So our whole thing was we have to avoid impasse and we have to avoid unilateral implementation."

Organizers aggressively moved the message that employees should sign the authorizations, and then offered to pay the premium share itself while bargaining continued, and when this could not be achieved, to have members pay the premium share in cash rather than through payroll deduction. The union distributed stickers to members for them to affix to the authorization forms, reading: "I hereby choose my health plan option. However, I sign this under protest, duress, and coercion. I do not authorize any premium payment to be deducted from my paycheck. Please provide me with written notice of the amount that is due." In response, employers threatened to terminate health benefits unless workers signed for the deductions.[477] Second, the union sought and obtained an injunction from the US District Court prohibiting Affiliated Hospitals from deducting money from employee's paychecks for the new health plan.[478]

On Tuesday, August second, CNA nurses voted by 96% to authorize a strike. While in the 1986 Kaiser strike, an autonomous group of nurses, associated with dissident factions within the CNA, independently organized to honor Local 250 picket lines, this time it would be possible to bring both organizations out on strike simultaneously. For several weeks, organizers had been circulating petitions among the membership calling for a resolution to the Local 250 strike, and fundraising among RNs to support the strikers. As their contract expired, 2,300 nurses went out on strike from the Affiliated hospitals, as well as from French and St Luke's Hospitals in San Francisco. Together, Local 250 and CNA organized a large rally behind the slogan "United for Justice in Hospitals." Dorothy Christiansen was the mediator with the Federal Mediation and Conciliation Service that supervised the negotiations for both Local 250 and the CNA. "They sorely misjudged the nurses," she recalled, "because in the old days, you could kinda throw money at the nurses and they were happy. And then they figured out there was a lot more than that... In fact, I don't remember what the issue was. But the issue was too burning to give up for money."[479]

Despite their strategic unity, Local 250 and the CNA necessarily approached the strike differently. They were there for different purposes; Local 250 was waging a defensive battle, while the relative nursing shortage had the CNA in a stronger bargaining position. Local 250 was fighting take-aways, with the hospitals' final offer representing a substantial cut; the hospitals' final offer to the CNA included substantial wage increases, but nurses were striking for increased control of work. On the picket line and at rallies, the divergent cultures of the two organizations were apparent to observers. As non-union replacement workers, "scabs," were brought into the hospitals during the strike, local 250

organizers referred to them as "scum;" CNA nurses on the picket lines said of their replacements that they "are not professionals."[480] The confluence of both organizations striking and the large public perceptions of the strike led San Francisco Mayor Art Agnos to pull the parties together to hammer out a resolution.

Local 250 and Affiliated settled after two and a half weeks on strike, and the CNA settled shortly thereafter, after an initial rejection by the membership. Local 250 members remained out of the hospitals until after CNA finalized their agreement. For CNA, the outcome was mixed, and not all supported the use of a strike. The association obtained a wage increase, a weekend differential, improved staffing language, and new language recognizing a broader role for Professional Performance Committees to review staffing changes. Not all nurses saw these gains as sufficient, however. "There's only so much you can get," Kathy Gray, an RN at Mount Zion Hospital, told the *San Francisco Chronicle*. "We haven't made a lot of gains, but at least we haven't fallen behind... [But] It allowed nurses a voice. We have a say. I think nurses are willing to give up some strong gains in order to keep their unity."[481]

For Local 250, the Affiliated strike was also far from the unambiguous loss against Kaiser two years before. In terms of contract language and labor standards, the outcome was mixed. The contract maintained a two-tier wage structure. With regard to healthcare benefits, the contract established a new basic HMO plan that would remain free to employees, though they began charging copayments on more comprehensive indemnity plan coverage. According to Henry, "The employer is very pleased [with the contract]. We had wanted a settlement that over the term, as far as our labor costs, would be either neutral or have cost savings, and we got that." [482]

Evaluations of the outcome of the 1988 Affiliated strike varied according to who spoke of it—predictably, given the politically charged atmosphere in the Local and the upcoming election. Rosselli and his colleagues, preparing to challenge Splain and the International-backed slate in the 1988 elections, presented the strike as a failure, as members lost the full, no-cost indemnity plans. Splain and his colleagues, having run the strike, had an interest in presenting it as a success. After settlement, the local published a large booklet titled "We Won the 1988 Affiliated Hospital Strike," which recounted the innovative strategies they deployed, and compiled the daily strike newsletters. "The strike was about the rebirth of the first health care union in the country, the changing dynamics of the healthcare industry and how hospital workers won the support of San Francisco in the fight against Affiliated Hospitals," the booklet read.[483] But while the material gains of the strike remained limited, one of the legacies of the campaign according to several organizers I spoke to was the strategic, outward-orientation of the strike effort, a step forward from earlier Local 250 strikes that relied on old-fashioned workplace conflict.

After the Affiliated settlement, as the extended trusteeship period drew to a close, Splain announced that he would run for the Presidency of Local 250, and began to establish a slate of candidates under the "Solidarity Slate." Lulu Simmons, a relatively new field representative, would run for the Secretary Treasurer position under the Solidarity Slate.

Also on the Solidarity Slate were several former CDU activists, including Blanche Bebb and John Mehring. The CDU activists argued that Rosselli was "running from his past," as a supporter of the ineffective Twomey administration, and represented more business unionism.[484] They argued that the Solidarity Slate, while closely affiliated with the International Union, was more aggressive, progressive, and prepared to deal with more aggressive employers; the new constitution established under Giarrizzo, further, established greater transparency and mechanisms for member involvement. There was some displeasure at the idea of supporting the International's chosen leadership. But Rosselli's association with the Twomey regime, reinforced by the fact that many former Local 250 staffers were supporting his campaign, was enough to turn many of these earlier rank and file activists against the insurgent slate.

In the end, it was the New Leadership Team that won the major elected offices, installing Sal Rosselli as President and Shirley Ware as Secretary Treasurer. It was a bitter election, which left many bruises, many fired staff, and a starkly divided leadership. While Splain and Simmons departed, other members of the Solidarity Slate remained on the Executive Board, including the former CDU contingent. The months around the election saw numerous charges filed against the incoming administration, both internally through the SEIU administrative process, as well as externally, through the Equal Employment Opportunity Commission. Charlie Ridgell, an organizer in Local 250 and a longtime ally of Rosselli's, recalled the logistical difficulty of governing with a split board:

> So the board that was elected in November of '88 was 50-50. Literally Shirley Ware had to break the tie. If any of our people missed, then they could pass their motions. So nobody missed meetings in those days. Many of the motions were 50-50 and Shirley Ware had to break the tie because the way that the local was structured, we had, like I said, we had Contra Costa, Alameda, Santa Clara, Santa Cruz and Monterey, but they had everything else. So the board was literally 50-50.[485]

Reframing Hospital Organizing in the 1990s: A New Collective Project

For several years following the election, Local 250's capacity was constrained both by its crippling debt from the Kaiser and Affiliated strikes that persisted beyond the election, and the relative hostility that persisted between the Local 250 leadership and the International Union. In the first year of the trusteeship, Local 250 held around $1.4 million in debt. Coming out of the trusteeship, the Local's debt stood at over $3 million. The local established a long-term, multi-year repayment schedule with the International, and focused increasing dues and on staff reductions internally to reduce costs. According to the new Secretary Treasurer Ware, the Local cut in half the management positions relative to Trusteeship levels.[486] The debt was eliminated by 1993.

With the ascent of Andy Stern to the Presidency of SEIU, however, the hostility between the International Union and Local 250 began to subside. [We] "made our amends with John Sweeney," Rosselli recalled. "We were the largest healthcare union, the flagship and we needed for somebody to sail it into port so that we could control it. Well, we started

doing good work, good work, good work – so we were in the leadership of the national union and I co-chaired the national healthcare board, so many of these initiatives and campaigns came from us taking them to SEIU."

Stern appointed Rosselli to the International Executive Board, the Healthcare Division Board and the Organizing Committee of the International union; he appointed Shirley Ware to the Public Division Board.[487] In that context, the Rosselli administration fell in line with the new SEIU leadership's aggressive focus on organizing and growth. "So, for the first time in my history we established a budget for new organizing and hired someone to begin a new organizing department," Rosselli recalled. "After those few years we then got folks to understand the importance of getting their employee in contract bargaining to agree to level the playing field."[488]

As the union regained its footing in the late 1980s and early 1990s, it maintained and even intensified its commitment to working-class organization. In 1993, it published a pamphlet entitled *What is a Union?,* which Rosselli called "arguably the most important document in the union's history." The pamphlet, regularly used in internal organizing efforts through the early 1990s, was unabashedly class-conscious, establishing the key function of the union as managing the inherent conflict between employer and employee:

> Why is there a conflict of interest between management and workers? It is Important to understand why this conflict exists in the first place. It does not arise because the bosses are evil and we are good. Somebody goes Into business, buys machinery and materials and then needs one additional thing, workers [...] The fact is that your salary and the boss's profits come out of the same pot of money—therefore, the lower your wages, the higher the boss's profits. Does that apply to non-profit hospitals too? Of course! In a non-profit facility, there are people who make a profit.[489]

But even then, the document pivots to patient care, in discussing the unions orientation to the political field: "Our Unions most important priorities are *to provide and advocate for the highest quality of patient care* and to secure the best possible wages and working conditions for our members."

The union began changing in other ways that signaled its increasing dependence on social legitimacy as a tool of labor control. Beginning with the Kaiser and Affiliated campaigns and in the years that followed, Local 250 worked hard to establish itself as a key voice in the fight for quality patient care, in the context of an increasingly corporate and profit-driven healthcare industry, and worked to insert its voice in the growing national discussions around healthcare policy. The union wrote and publicized numerous pamphlets and white papers about the corporatization of medicine that it then circulated among public officials and allied organizations.[490] One of its most prominent was 1993s "Market Share vs Health Care: The Hospital Council Cartel Helps Create a Crisis." The document advocated a healthcare reform process that reflected "the basic healthcare rights of everyday citizens, and it must safeguard the basic workplace rights of those in the healthcare professions who often serve as the voice of our patient population." The document linked what it called "a healthcare professions bill of rights" with "a healthcare

bill of rights for everyday citizens."

The new tactics were also used in Local 250s hospital negotiations, though their success was mixed in these early days. As part of the Kaiser campaign, they attempted to mount a corporate campaign that leveraged the legitimacy of Kaiser workers, and their role as care givers, as they targeted Kaiser managers and business associations and attempted to disrupt the company's expansion plans in California. They also worked to get large Kaiser purchasers to withdraw their Kaiser contracts, though by most accounts these efforts were unsuccessful. They also sought to "crack the lack of doctor contact and put together a group inside of more senior doctors," and worked to craft a letter to Kaiser management from these doctors (unsure how successful this effort was).[491]

Local 250's move toward emphasizing patient care was more than a rhetorical cudgel for leverage in the public sphere, however. Union leaders also used the claim to legitimate concern over patient care to assert increasing power within the workplace, claiming greater control over work. Within the otherwise failing 1986 Kaiser agreement, the union negotiated language establishing a Joint Conference on Service Related Issues, which the union claimed "was negotiated in 1986 to improve our members voice in the delivery of quality care."[492] The 1986 contract stated:

> ... the Employer, at the request of the Union, will sponsor a region-wide Employer-employee conference on service related issues. The purpose of this conference will be to provide the Employer and employees with the opportunity to exchange views on enhancing the professionalism of employees in classifications covered by this Agreement and the contribution of all employees to the provision of services to Health Plan members.

The structure closely resembled the Patient Care Committees and Professional Performance Committees that the CNA had used as its primary workplace structure since the 1960s. The union moved to elect 13 worker representatives to the Joint Conference, and circulated surveys on patient accessibility to services. At the first meeting of the Joint Conference, Kaiser representatives opened the discussion with presentations on the economic conditions of the HMO and the increasing competition it faced. The Local 250 representatives, however, quickly turned the discussion toward steps that could be taken to improve patient care, proposing a series of measures including patient chart availability improvements and appointment evaluations. They also brought a recommendation to launch a Local 250-Management patient care and service committee in Kaiser facilities that would meet quarterly, though this proposal was not implemented in the early days of the Joint Conference.[493]

The Crisis of Collective Bargaining: SEIU Local 399

Similar pressures emerging from the crisis of collective bargaining would create political turmoil in Local 399 just a few years later, also in relation to bargaining with Kaiser. In 1992, Kaiser was facing increasing competition from fast-growing HMOs and preferred provider organizations (PPOs), leading the organization to focus on cutbacks in labor

costs. Kaiser had experienced a membership loss of 33,000 that year.[494] Organizers perceived that Kaiser was afraid that its position was eroding. It was still upwards of 3 times larger than its closest competitors, in terms of overall size—but that was, in fact, a decline from its even more commanding position some decades earlier. This concern over increased competition drove Kaiser's aggressive approach to Local 399's bargaining strategy that year. "Our price in the marketplace is still too high," wrote Sally Newton, Kaiser's VP of Human Relations, in a March 1993 letter to staff. "In order to regain our competitive advantage and remain the successful organization that we have been, our cost structure must be reduced."[495] The letter noted clearly that while Kaiser's wages and benefits in Southern California were lower than in the North, they were still well above their competition in the south. This was, in large part, because of the industry's low union density in the South—still, according to the union's own estimates, about 7% in LA County. "Kaiser workers were like a union island in a sea of non-union healthcare providers."[496]

Leading into negotiations, the bargaining team recognized this difficulty. Kaiser was "concerned that it maintain its share of the Southern California Healthcare market," Said Local 399's Research Director Paul Worthman, who worried that the increased competition was leading to aggressive speed-up in bedside work. "Our people are telling us that they are stressed out, overworked and feeling harassed. People tied up in these knots are hard-put to provide quality care."[497]

As they bargained for a new contract in the early months of 1993, Local 399 again confronted road blocks in the negotiation process. The union had agreed to incorporate the principles of "interest based bargaining," a "problem solving approach" to bargaining that focused on bringing "bargaining objectives," rather than "positions," to the bargaining table.[498] Kaiser brought what union leaders perceived to be take-back demands totaling almost $12 million in benefit cuts. In response, Local 399 withdrew from a series of non-contractual labor-management committees active at the time. Shortly thereafter, when Kaiser made a final offer that included a two-tier benefits plan, Local 399 bargainers went out on a series of brief, one-day system-wide strikes in April of 1993.

They struck with the explicit support of strategists from the International Union; IU President John Sweeney himself attended the first day of the strike events at the Kaiser Bellflower Medical Center, where he called the strike, and the effort to regain the union's footing with Kaiser, "the single most important labor action in America."[499] According to one organizer, "the international poured in all kinds of money to support us during the lead – buildup to the strike, during the strike."

Local leaders also ran a substantial public relations campaign, much like Local 250 had run in 1986, geared toward putting a dent in Kaiser's pro-worker public image. "Kaiser had this image in Southern California," said IU Bargaining Director Sandy Polasky, "of being a benign, pro-labor, pro-worker employer. It was clear we had to cut into this image if we were to get any movement at all from them at the table."[500]

Kaiser members soundly rejected Kaiser's final, concessionary proposal, but as the initially planned one-day strike stretched to a week, and Kaiser continued to refuse to stand down on its concession demands, members conceded one week later. Two organizers described to me how the prevailing mood among the Kaiser membership—having rejected an offer, struck, and then found themselves forced to accept it—soured in subsequent months, particularly among key activists.

It was in this space that dissident worker organizing began to gain momentum within Local 399. As was the case in Local 250, there had long been dissenting groups active among Kaiser workers, including groups affiliated with the Workers Action Movement and the Progressive Labor Party. According to Dave Stillwell, these groups "tried to generate no votes on every single contract that came up... tried and frustrate anything the 'union bosses' or 'institutional unions,' as they used to call it, would do. And they usually didn't get much traction." But after an earlier failed negotiation in 1990, "People were really pissed off and at the end of their ropes. It was a really fertile field for them [the dissident groups]. Even in places where there wasn't any sort of organized lefty opposition or anything like that, it was just a really grassroots spontaneous thing."

Earlier in 1992, a group of these dissatisfied Kaiser workers decided to run for the Local 399 executive board in 1992. Six filed to run for positions; of these, five were disqualified, and the sixth was soundly defeated.[501] Nevertheless, it was from this group of Kaiser workers that a broader dissident movement within Local 399 would form in the early 1990s. Several respondents I spoke to confirmed that, with the advice and support of some local staff, this initial group of Kaiser workers formed the early basis of later dissident groups, including 'Change 95' and the 'Multiracial Alliance,' that would later present an explicit threat to the leadership of Local 399. According to two organizers I spoke to, many of these dissident workers were upset that the leadership of the Healthcare division of the union was largely complacent in the face of concessionary demands, while the janitorial side of the union was becoming increasingly aggressive and creative through its Justice For Janitors campaign.

In 1994, this group of healthcare workers began making contact with other dissidents from the janitorial side of the union, the "Grupo Reformista," who benefited from much broader public visibility due to the successes of the Justice for Janitors campaign during this period. They thus created Change 95, with the purposes of running a slate to take over the executive board.[502] Some sympathetic staff informed the dissidents that if they challenged President Zellers, they would face a real trusteeship threat from the International Union.[503] They made the strategic decision to run for all Executive Board seats, while leaving Zellers unchallenged.[504]

In 1995, the Executive Board of Local 399 was voted out of office, replaced by the Multiracial Alliance slate, who framed their success as the displacement of the "old white boys' network."[505] David Stillwell—one of the Local 399 officers defeated in the 1995 election—attributed the defeat to a surge in dissatisfaction amongst the healthcare members:

> The slate that took out the union leadership, that was organized primarily by Kaiser members in Kaiser Sunset and then some other locations, but all healthcare – it was mostly a healthcare division revolt. In the past, they had never been – they had never turned out as much for internal union elections as the old original property service division membership. Because the union before – back in the old days... the healthcare membership was always less involved in that. This time, they came out and doubled their usual amount. I mean the turnout was huge and that's what toppled the leadership. Nobody had ever expected or thought it was possible that the healthcare membership would get that well organized, but they did... There was serious opposition in Cedars-Sinai, Hollywood Presbyterian was supporting the opposition slate. There was Kaiser – not just Sunset, but Kaiser Bellflower and I think Kaiser Harbor City was the only one where we sorta – the union leadership had strong support. But all the rest of the Kaisers were either lukewarm or openly hostile and fairly well organized for the opposition.

The success of the Multiracial Alliance was short-lived. Among its first actions was to call for the removal of a number of staff members. However, the authority to hire and fire staff remained with the President, in this case President Zellers, who refused to remove the staff. The new executive board then refused to sign checks, leaving the staff members working unpaid. A number of Multiracial Alliance supporters then adopted some of the high-visibility tactics of the Justice for Janitors campaign, and staged a hunger strike at the union hall. Andrea Carney was one of these strikers:

> A banner said, 'Respect the will of the workers! Let us govern!' I was one of the hunger strikers at the union call. I lasted eleven days. Some of the men stuck it out until the 23rd of August. Some of them had been on hunger strike in their own countries, El Salvador, Guatemala and Honduras.[506]

Following several weeks of what people described as a chaotic, crisis atmosphere in the local, it was placed under trusteeship by the International Union.

Strategic Reconfiguration and the Shift Toward IU-Driven Organizing

Under the trusteeship, Local 399 was radically reorganized. Given the local's inability to organize extensively in the healthcare sector beyond its 8,500 Kaiser Permanente members, International Union leaders sought to create more rigid jurisdictional boundaries; large, multi-industry locals like Local 399 were quickly becoming converted into industry-specific unions. Hearing officers noted that while the Local's janitorial campaigns were energetic and successful, the healthcare division had been unable to build on these energies.[507] The local's janitorial membership was merged into Local 1877, along with its "allied" division covering racetracks and theme parks. The now healthcare-focused local was left with a much smaller footprint, and about 8% union density in Los Angeles. But it was free to innovate.

It was Local 399 that served as the test site for many of the International Union's experiments in corporate campaigning in the 1980s and early 1990s. This openness began early on, as Local 399 President Jim Zellers advocated the introduction of such tactics for

the Local, as they were already having difficulties countering employer assaults in the 1980s. The Local is perhaps most famous for incubating the innovative and highly studied “Justice for Janitors” campaign.[508] In hospitals, however, this strategic focus was slow to gain ground. In 1986, Local 399 leaders were coming up against many roadblocks in bargaining, and looking for solutions. Zellers and Secretary Treasurer Gloria Marigny unsuccessfully appealed to SEIU President John Sweeney for strategic campaign support in hospital organizing. The Local had won four of NLRB elections in hospitals that nevertheless refused to bargain for a first contract. Still others had been refusing to budge on essential union security contract provisions. The Local officers argued that "Local 399 must develop a 'corporate campaign' strategy in order to achieve collective bargaining agreements," but lacked the capacity at the local level to carry these out.[509]

While the strategic campaigns that Zellers and Marigny advocated were not yet applied to acute-care hospital settings, IU organizers had developed some early tools through large scale campaigns in the nursing home sector just a few years earlier. These were some of the earliest corporate campaigns ever run within SEIU. In these early campaigns, the framing of union workers' public authority and voice in patient care issues proved critically important as it began to develop its repertoire of corporate campaign tactics. The first national corporate campaign was coordinated by SEIU in conjunction with the UFCW and the AFL-CIOs Food and Allied Service Trades division, against nursing home giant Beverly Enterprises. Beverly was in large part a product of the 1980s, and reflected the corporate transformation then underway in the nursing home industry. From a base of 69 homes in the late 1970s, it had accumulated 1,125 nursing homes by its peak in 1987, through debt-financed speculative transactions.[510]

When the national campaign was launched, the Hospital Corporation of America (HCA), the largest for-profit hospital chain in the country at the time, owned about 18% of Beverly’s publicly traded shares.[511] Most of its properties were concentrated in California, Texas and Michigan. The campaign took years of experimentation, but it was ultimately able to maintain many of those unionized nursing homes, and expanded organizing to unorganized homes around the country.[512]

Among other key innovations, the Beverly campaign involved an aggressive shareholder-focused campaign, including a sit-in at the company's Pasadena headquarters by Jim Zellers, Gary Shea, corporate campaign innovator Jeff Fielder, and other AFL-CIO officials;[513] it also involved the nomination of Arthur Flemming, a Republican and former US Commissioner on Aging and an elderly rights advocate, to the board of the firm, which the firm successfully fought off.[514] A BusinessWeek story on the Flemming nomination noted that "the AFL-CIO attempt to put a nominee on the board who calls himself a 'consumer' representative marks the debut of a strategy for dealing with companies in general and health-care institutions in particular. By picking a man with no labor ties, the federation is strengthening bonds with civil rights, consumer, and aging groups that it hopes to have at its side in future battles."[515] The firm was an aggressive opponent, driven in part by its tenuous debt situation, its near bankruptcy in 1987, and the

razor-thin margins in the industry. While the union obtained a national organizing agreement with Beverly in 1984, the firm continued to combat organizing drives on a regular basis.[516] The union remained in litigation with Beverly regarding organizing and bargaining well into the 1990s.

While northern California nursing homes had been mostly unionized by Local 250 in the 1960s, southern California many nursing homes remained largely non-union, and an appropriate site for experimentation. In 1992, the International Union began coordinating its large-chain nursing home organizing initiatives across its locals under the label of the "Dignity Campaign." In Local 250, Dignity initiatives focused primarily on bargaining and labor standards improvement. While focused on strategically countering large chains, the language of the Dignity Campaign strongly reflected the union's growing use of "patient-care" framing in its organizing. Corporate nursing home chains, they argued, produced twin indignities--low labor standards, and staffing levels that meant that nursing home workers were "not permitted to take good care of their patients." Since most nursing home revenue came in through Medicaid, the Dignity campaign focused on state-level campaigns for greater long-term care expenditures; in California, this involved extensive alliances with patient advocacy organizations, churches, and other healthcare lobbying groups in Sacramento.[517] From the inception of the Dignity Campaign, there continued to be substantial investment in non-union nursing home organizing through Local 399, until around 1996 when the International Union closed the Dignity Campaign initiative and put nursing home organizing on pause.[518]

While nursing home organizing was long coordinated through the International Union, there was relatively little focus on acute-care hospitals in the 1980s and early 1990s. After the trusteeship, under President Dave Bullock, Local 399 maintained a tight relationship with the International Union. The transition in Local 399 leadership coincided with the ascent of Andy Stern to the Presidency of SEIU. In that context, Local 399 and International Union research staff worked to develop a large-scale organizing initiative in the Southern California Hospital sector, in order to boost the union's representation of hospital workers in the area. The goal for this group, according to those involved, was to develop a "Justice for Janitors style" strategic approach to the hospital sector. Calling the initiative the Health Systems Organizing Project (HSOP), it was the union's first systematic attempt to engage in large-scale acute care hospital organizing since the post-1974 organizing wave under George Hardy. Given that, as the project opened, union officials acknowledged that the union had limited experience successfully organizing hospitals, particularly under the non-NLRB strategy then ascendant in SEIU.[519] (Though it was the case that a different generation of organizers in Local 250, organizing hospitals in the 1950s and 1960s, did indeed organize through non-NLRB channels, including with the use of card-check agreements.)[520] The west coast effort would be driven by International organizers Mary Kay Henry and Eliseo Medina. Early discussions saw the Southern California campaign as an opportunity to experiment and "create an organizing model for the rest of the country."[521]

HSOP began by analyzing the Southern California hospital market, and attempting to

identify not only how the turbulent industry was changing, but also who the likely winners would be as the healthcare industry restructured in the 1990s. Strategically, the idea was to organize the incumbent firms "wall to wall," including the wide range of occupational classifications in the hospitals. Campaign goals would include "affordable coverage for all," "justice for healthcare workers through union-community purchaser alliances," and "justice for healthcare workers through unionization."[522] In this sense, even before targets were selected, the campaign designers envisioned strongly linking the unionization effort to broader efforts to expand access to care, and to ensure high standards for care quality. Indeed, the campaign proposal began with the assumption that "Health Justice," as a broad strategic frame, would be uniquely powerful in mobilizing internal support among members committed to quality care and access, and was a "major part of for social justice in the United States and in California specifically," allowing the campaign to reach a wide public audience and affect public policy discussions.[523] But beyond a simple "frame," converting these principles into potential concrete leverage relative to an employer involved, first and foremost, building alliances with existing health advocacy organizations in Southern California. Part of this community-centered campaign, researchers argued, needed to build upon "a worker voice in establishing quality care," and address widespread concerns in Southern California about the lack of access to healthcare in the community.[524] For organizers, the internal[525] and external mobilization potential of this moral frame distinguished what they were trying to accomplish from other union organizing drives, even other very effective ones. One strategy memo highlighted the distinction between the Health Justice approach and the HERE's successful organizing drive at an MGM casino in Las Vegas, which they saw as an effective campaign: "HERE doesn't want to alter the gambling industry, they simply want workers to get their fair share. We want health care workers to get a fair share and have a voice in the direction which the industry is going for patient care."[526]

Through systematic interviews with market leaders and policy makers, along with analysis of public documents, they dug into the "likely survivors" of the shake up, including the already-organized Kaiser Permanente, for-profit giant Columbia/HCA, and the particularly powerful physicians' groups that were working to control healthcare delivery in the region.[527] The target they ultimately designated was Catholic Healthcare West, a large 37-hospital chain, for which they sought to build a statewide campaign (also including Local 250, organizing CHW hospitals in Sacramento) that could win an organizing agreement by 1998. CHW was a good fit in various SEIU labor markets in California, and researchers assessed that it planned substantial growth in the south. Researchers also felt that the firm's Catholic connections offered an opportunity to build a campaign on a moral plane--one where they thought they could hold the advantage.[528]

Two features of the resultant campaign deserve mention, given their lessons as to how the International Union and their allies envisioned the moral landscape of hospital worker organizing in the 1990s. The first was what organizers called the "suits and nuns" campaign approach. Union strategists identified an important organizational tension within CHW. The firm was rapidly expanding, consolidating multiple existing hospital systems, and in many ways operating more like a profit-driven enterprise than the

charitable organizations it had emerged from. However, it retained a strong Catholic identity, and expressly involved members of Catholic orders among its top leadership. This produced what organizers saw as a division among the leadership that the union could leverage for influence: the "nuns vs. suits" dynamic. This constituted an important component of the framework for the campaign strategy.[529] It was, in part, a challenge, because it was not always clear whether the "suits" or the "nuns" were calling the shots at any given hospital or strategic moment; this would impact who had the ability to settle with the union.[530] But it also provided opportunities for taking advantage of insider divisions. The union could make targeted outreach to "owner orders," or the religious orders affiliated with the specific hospital owners. This outreach would be distinguished from the broader solidarity outreach that unions often conduct during these campaigns, with one strategy memo clarifying: "we will not target activating radical nuns in a region if it is determined that they carry no influence over the owner nun orders. Our primary goal here is find access to and areas of influence over the owner orders." Powerful figures with Order affiliations could be reached, they surmised, by contrasting the "rational elements of the CHW and the campaign against unethical elements of CHW."[531] This owner-centered campaign built on the idea that these Catholic orders would be open to arguments that were grounded in Catholic teaching on labor rights and social justice. "Our campaign," read one early strategy memo, "will deliver messages at multiple levels and in multiple ways to move CHW, and other Health Care employers, to 'partner' with the labor movement and consumers to create a 'just' health care system."[532]

The second key feature concerns the union's conception of "charity care." While non-profit hospitals had long been behaving as profit-driven entities, the union worked to articulate the message the non-profit status, with all of its concomitant tax benefits, meant that "non-profit healthcare corporations [were] bound by a basic social contract with California's residents," with an important social obligation to provide service to the community.[533] Traditionally, in keeping with hospitals' religious and charitable traditions, this service was provided in the form of health care provision to the indigent. In California at the time, there was no law that required non-profit hospitals to provide a specific level of charity care. However, the tradition provided an opportunity to remind the public and the state about the moral obligations of hospitals. The union's first reports concerning charity care were made public in August of 1996, before the public launch of CHW as an organizing target, and before the early set of workplace and house meetings among workers. By 1999, the focus on charity care was directed specifically at CHW, with the union releasing a report entitled "Broken Promises: How Declining Charity Care at Catholic Healthcare West is Costing All Californians."[534] Labeling CHW "California's new healthcare corporate giant," the report outlined how the firm had benefited from substantial public subsidy, while documenting the firms substantial decline in its rate of charity care expenditures over the early 1990s.

Chapter 7. The Crisis of Professionalism

As the 1980s progressed, Registered Nurses were among the best-positioned care workers in acute care hospitals in terms of their bargaining power. While hospitals were concentrating on cutting labor costs, they focused their efforts on the lower tiers of the occupational hierarchy, opting to push more work onto skilled RN labor. LVN employment in hospitals was in decline, while RN employment was growing. This meant that while employers operated with a relatively loose labor market among ancillary care workers, there were substantial RN shortages, handing the CNA significant leverage at the bargaining table relative to their colleagues at SEIU. While nurses also encountered aggressive employers at the bargaining table, they ultimately faced fewer demands for concessions on their wages and benefits.

This did not mean, however, that the hospital restructuring during this period was easy on bedside nurses. Many nurses experienced the restructuring of healthcare delivery, including the transition toward greater reliance on nursing care, as form of work intensification that made their jobs harder, and attenuated their ability to provide the best patient care that they could. Staff nurses were quick to recognize the uptick in acuity levels, as they translated rather directly into work speed up beyond what was registered in existing RN-patient ratios. Following this transition, staff nurses began to push for their contracts to include provisions that accounted for patient acuity levels. CNA, both through bargaining and through legislation, made efforts to introduce staffing regulations that accounted to patient acuity since the early 1980s.[535] In 1980, some collective bargaining agreements began including specific language that gave Professional Performance Committees a role in determining acuity-based staffing requirements.[536] Staffing by acuity had also been a demand of SEIU Local 790, which represented Nurses at SF General, since 1984. Local 790 RNs first obtained patient-staff ratios that accounted for acuity levels in 1989. Local 660, which represented County RNs in Los Angeles, obtained acuity staffing contract provisions in 1991. But for the most part, these efforts failed to produce meaningful controls over acuity-driven work intensification until relatively late in the 1980s.

This period also saw the introduction of new occupational categories, ostensibly for the purpose of relieving shortages in nurse and physician labor, which threatened nurses' occupational practice jurisdictions and their institutional hierarchies.

I argue that this constituted a *crisis of the professional project,* which undermined the legitimacy of elite nurse governance within hospitals and professional associations. As with earlier challenges to nurses' jurisdictions of practice, challenges during the 1980s

were highly gendered. In that context, the CNA was subject to internal challenge in ways that were reminiscent of the staff-nurse insurgencies of the 1960s and 1970s. In the 1980s, however, these insurgencies encountered an insulated organizational home, a product of the Sierra Vista cases examined in Chapter 3. This organizational insulation offered a space for alternative organizational projects to emerge—including the push for staff nurse labor militancy.

The inter-professional challenge

The 1980s was not the first moment in which there was an expansion of occupations working in the hospital. The proliferation of occupational categories in healthcare delivery had an earlier wave, in the 1960s, as the rapidly expanding role of the federal government in healthcare purchasing dramatically drove up demand for healthcare labor of all skill levels, particularly in underserved, rural areas. This growth led to accentuated shortages of physicians and nurses alike, and a corresponding pressure to expand labor supply by recruiting new nurses and physicians, but also by creating new healthcare delivery occupations. One of these new occupations, the Nurse Practitioner, was a Registered Nurse who received some additional training and was subsequently able to operate independent of physician supervision. This development of a new, more autonomous nurse was readily welcomed by organized nursing. On the other hand, perhaps the most threatening of the new occupational classifications was the "physician assistant."

Originating at Duke University Hospital in 1965 and gaining the official approval of the AMA in 1969, the first PAs were former combat medics returning from Korea and Viet Nam. Early advocates saw an opportunity to respond to physician and nurse shortages by employing young men with substantial practical medical experience, while limiting the formal training they would need to receive. In their early incarnations, PAs were expected to have a limited individual responsibility—while their scope of practice was broad (as broad as medicine, as practiced by the physicians that directly supervised them), their individual freedom to practice was limited. Rather, they were defined—as "data gatherers," collecting patient histories and doing routine examinations and tests.[537] These early PAs were not required to have gone to college. Kathleen Andreoli, Educational Director at one of the early PA programs at the University of Alabama and former instructor in the original Duke program, defined the PA as a worker who "aids the physician by being an extension of the physician."[538] The logic of the early programs relied on the desegregation of the practice of medicine into tasks requiring skill, and tasks requiring judgment—physicians would retain control over medical judgment, while PAs could act in their stead to "perform any procedure which requires skill and which is repeated frequently."[539]

Early debates about the propriety of this new healthcare worker, at least as they played out in the pages of the *American Journal of Nursing*, were highly gendered. Physicians wrote in support of the new labor category, lamenting that nurses were no longer as subservient; they were "more interested in concentrating on extending and developing the

unique role of nursing," particularly through expanded education, than they were in acting as an instrument of the physician.[540] Nurses were "women who marry, raise families, and leave professional practice,"[541] and who were unable to meet the grueling, on-call schedules maintained by physicians.[542]

The solution, argued Joseph Stokes, MD, of UC San Diego, was "to train men as assistants;" early physician proponents justified paying PAs more than RNs because while they would not necessarily have more training, they would have more endurance and work longer hours.[543] Dr Eugene Stead, the founder of the first PA Program at Duke, explained his preference for corpsmen, and men, as such:

> Because of the rigidity of the nursing profession, they had to recruit rather passive people, because anybody who was not passive – got out of it. You saw many nurses leave because they did not want to put up with all this "busy work." Also, we knew that we were going to have an unpopular service so I wanted to recruit men for it that would be tough enough. Secondly, I wanted to recruit men because we envisioned using them across a much greater spectrum than nurses were usually used. We expected them to be in the office, emergency clinic, hospital, and nursing home. We expected them to be wherever the doctor was. We thought at the time we started that the freedom to move geographically through the system [of clinical training] was easier for men than for women... For all these reasons we finally decided that at the beginning we would stick with males and generally you had to be a male with experience in the health care field sufficiently to know that you wanted to take care of sick people.[544]

Organized nursing had been warily watching the growth of the PA occupation since the earliest program graduates began entering the labor market in the early 1970s. There was an serious risk in introducing an additional skilled group into the bedside care hierarchy—nurses were inherently susceptible to encroachment because within hospitals, their scope of practice was defined *institutionally*, in terms of the administration and distribution of care in a complex practice setting; their specific scope of practice, however, could not realistically exclude physicians. Nursing thus suffered from what Margaret Levi (1980) referred to as "functional redundancy"—"there is no job nurses perform that is not also performed by some other occupation." This general scope made nurses valuable for hospitals, precisely because they were a particularly malleable occupation: they could, and often did, step into a broad variety of patient care roles. But it also made them vulnerable to pushback from medicine. The introduction of new occupational categories laid bare the "functional redundancy" of nursing. Nurses saw PAs as a threat because they worked under a separate institutional hierarchy, yet their actual work was defined in ways that substantially overlapped with what nurses saw as their professional jurisdiction.

By the mid 1980s, PAs—still a predominantly male workforce at the time, especially relative to the overwhelmingly female nursing workforce—were gaining a foothold throughout the healthcare industry, from primary care settings to acute care hospitals. While PAs at this point still had training comparable to than a Nurse Practitioner, most

PA training programs required clinical experience and some college by the mid 1980s; slightly less than half of new PAs in 1985 had a college degree.[545] The level of training, therefore, was not altogether different from that enjoyed by NPs. The key distinction from nursing, in addition to gender, was the institutional location of worker. Unlike nursing, which by that point had established its own professional hierarchy and maintained relatively self-regulated departments in many hospitals (i.e., staff nurses reported to nurse managers), physician assistants—as implied by their name—were defined at their inception to operate directly under the supervision and control of physicians. Not surprisingly, the PA "movement" (defined as such by supporters and detractors alike) drew the support of both the medical profession and hospital managers. In Northern California, Kaiser Permanente was an early adopter of the PA occupational category. According to David Lawrence, an MD and Kaiser Permanente executive,

> Well, the AMA was in favor of the PA movement. They were also in favor of the nurse practitioner movement until it became independent and operated under the nursing establishment. The doctors saw themselves losing power to the nurses, so they had more antipathy to the nurse practitioners. PAs were under the aegis of the physician. That was how they were trained, that was how they were monitored and licensed or accredited.[546]

The CNA saw the PA movement, perhaps rightfully so, as an assault on their position and livelihood on the part of physicians and managers.[547] Nurses' fears of potential encroachment and loss of control over their scope of practice became very clear in 1986, when the San Francisco Health Commission attempted to create a new occupational category, "mid-level practitioner," that could be filled by both RNs and PAs, primarily at San Francisco General. The move was a response to a 1985 initiative on the part of PAs to expand their access to jobs in the area. In response, the Commission made an assessment that many of the tasks then undertaken by RNs and NPs could also be accomplished by PAs, leading to the creation of the mid-level practitioner classification, which would "work under the supervision of a physician who accepts total responsibility for the care of the patient,"[548] and that the "Department of Public Health will recruit and hire physician assistants and nurse practitioners interchangeably."[549] At the time, San Francisco County did not employ PAs. Nine other California Counties did employ PAs, and for the most part, these enjoyed identical salary ranges as NPs.

CNA and the regional associations all worked hard to distinguish nursing from other direct care occupations, particularly the PA. At its core, they argued, the distinction between the two occupations was rooted in the relationship to the physician, to organized medicine, and to the institutional hierarchy. The Primary Care Nurse Practitioner Interest Group of the Golden Gate Nurses Association, the San Francisco regional association of the CNA, produced a pamphlet in response to these events entitled "Position Statement on Nurse Practitioners and Physician Assistants." "The PA," the pamphlet outlined, "works in a dependent relationship with a supervising physician to provide comprehensive medical care."[550] RNs, in particular Nurse Practitioners (NPs), were distinguished in this sense by their "independent decision-making about the healthcare needs of individuals, families, and groups... In response to the needs and demands of

society, Nurse Practitioners have expanded the boundaries of nursing practice into areas that overlap with medicine and other health professions."[551]

Nurses' efforts to contain the potential encroachment of PAs also reached workplaces themselves. At Kaiser Permanente, according to David Lawrence, nurses within the hospitals attempted to police the boundaries of the profession by containing what PAs could do:

> They tried to turn the PA into a factotum of the physician, you know, sort of a gopher for the physician instead of giving them the broad scope of practice that training suggested they should have. They treated them as non-educated and less elite than the nurses. They felt they should be paid differently. There was a lot of infighting.[552]

PAs remained active in hospitals, but at far lower levels of employment than nurses, and not at levels high enough to address chronic bedside labor shortages. In 1988, the AMA conducted a survey of a random sample of physicians to ascertain the problems with providing adequate bedside care. Many physicians, they found, communicated a shortage of bedside labor, as nurses were seen as in short supply; 30% reported delays in access to care because of a lack of bedside nursing care; 40% reported delays in treatment; 80% reported nurses leaving the bedside because of burnout or concern for quality patient care.[553] That year, in response to this labor shortage, organized medicine made another move to claw back jurisdiction form nursing, this time at the level of immediate bedside care. That year, the AMA began advocating a proposal for a new occupational category, the Registered Care Technologist (RCT—sometimes referred to as the Registered Care Technician), as "as a possible solution to the shortage of care at the bedside."[554] The first trial run RCT project took place at the Parkway Medical Center, a nursing home in Kentucky. The RCT, like the PA, was to be institutionally located outside of the nursing hierarchy and under the direct supervision of physicians, but would carry out tasks commonly undertaken by RNs and LVNs.

According to the CNA, the RCT initiative was the AMA's "solution to the nursing shortage," and the RCTs "would carry out physicians' orders at the bedside."[555] This was a clear affront to nurses, whose purview included the management of bedside care. Speaking to assembled nurses that summer, ANA President Margaretta Styles pointed to this professional encroachment as the key challenge for nursing:

> Presently nursing's scope of practice is under threat by efforts to establish new health care workers, licensed by medical boards and responsible to medicine, with functions clearly overlapping nursing. [...] [W]e must regretfully expose this movement for what it is, an effort less inspired by concern for patients than for the economics of medicine, and thus we must stamp it out wherever it seeks a toehold through funding and/or legal sanction.[556]

As had been the case with the introduction of PAs some two decades prior, nurses understood the RCT initiative as a gendered attack by organized medicine on organized nursing. In terms of framing the issue before the public, ANA leaders explicitly

articulated the RCT conflict as one rooted in the gendered hierarchies of healthcare delivery. Geraldine Ferraro, addressing the 1990 ANA convention in Seattle, picked up on this gendered language, praising the ANA as the David taking on the "Goliath of the AMA," defending against the incursion of RCTs.[557] Nevertheless, they also saw the overwhelmingly female composition of the nursing profession, and the public view of nursing as a women's occupation, as a critical weakness in their campaign to push back against Medicine. CNA leaders specifically saw the view of nursing as a "female profession" as one of the reasons behind the nursing shortage, as it was an obstacle to nurse recruitment in an era where young women were entering a broad variety of work fields; reducing the public perception of nursing as a female profession would help reduce the shortage. The RCT proposal, on the other hand, presented a threat—by allying itself to medicine, the RCT occupation would be more "attractive to men, corpsmen, and minority groups"— thus broadening the pool for bedside workers, but doing so by side-stepping altogether the institutional silos of nursing.[558]

CNA and ANA leaders saw the RCT proposal as not only a danger to RNs' scope of practice, but as an explicit move by medicine to reassert physicians' diminishing control over patient care. In a 1988 AJN editorial titled "Of Tasks, Techs, and Control," Editor Mary Mallison suggested that the program was not about nursing shortages at all, but rather an undervaluing of nurses' care work, and anxieties about physician control of medical care. "Why is it so difficult for these physicians and personnel directors to get beyond the antiquated notion that patient care is only a series of mechanical tasks?" Mallison asked;

> Sure, you can teach most people sets of manual skills. Look at the complex tasks families perform at home. But a family cares desperately and deeply about its patient, who to them is one of a kind. Physicians often don't understand the "tech take- over" phenomenon, even when it occurs under their noses... Or is this whole brouhaha not about the shortage of nurses, but about the shortage of medical control?[559]

For nursing leaders, the RCT initiative was a response to organized nursing's success at removing nurse education from the hospital itself, and the closure of most diploma schools by the 1980s. Organized nursing had largely succeeded in shifting nurse training toward outside institutions, a key goal of the ANA since early in the 20th century; this meant that hospitals could no longer readily rely on the cheap labor of trainee nurses. RCTs, brought in to the hospitals and trained while at work, would constitute a new group that could be brought in to provide bedside care. By their very nature, in the context of a nursing shortage, they constituted a de-skilling of bedside care. The ANA made moves to nip the spread of the RCT in the bud, resisting the implementation of pilot programs, on a state-by-state level.

In California, this took the form of the "Protect Nursing Practice" campaign. CNA leaders adopted a grass-roots approach to the problem, viewing the most potent response to the RCT initiative as one built on organizing and ally mobilization. The consultant they hired for the project, Stanford Hospital nurse Deborah Africa, was titled the Protect

Nursing Practice Campaign Organizer. Funded through direct contributions from regional associations and individuals, the CNA raised almost $70,000 to carry out the organizing project in 1989.[560] The PNP Campaign established a hotline, ran "Empowering Nursing" training workshops for nurses to discuss scope of practice and encroachment issues in their workplaces and with the public. Volunteers focused on reaching out to patient care advocates and consumer groups, women's professional groups, as well as sympathetic physicians, and trained nurses to speak to the media about the key contributions of RNs.[561]

In terms of strategy, the PNP campaign sought to develop a broad, public campaign intended to shame the AMA and isolate the medical profession from common sources of support.[562] This included developing a public relations initiative, including advertisements and media training for nurse activists. They sought to reach out to sympathetic physicians, both to target AMA and CMA leadership, and to build recognition among practicing physicians of nurses' training and usefulness. Regional groups based in the Regional Nurses Associations were encouraged to reach out to consumer and community organizations based in their regions, using a statewide targeting list. Regional groups were encouraged to establish meetings with local leaders, and to arrange to address large gatherings of these potential ally groups.[563] Some of the consumer groups they targeted included groups of "consumers," with an interest in quality patient care, such as senior groups, disability advocacy groups, and disease advocacy groups. They also targeted women's professional groups, who might by sympathetic to the CNA's resistance to an attack by a dominant, male profession.[564]

The message to consumer and allied community groups focused on the importance of nursing practice, and on finding solutions to the nursing shortage that maintained care quality. They produced a brochure targeting consumer groups, "Health Consumers Beware!!" The brochure highlighted the problem of the nursing shortage, arguing that it was a product of the "assaults" faced by nursing and patient care from outside, which sought to replace skilled bedside care provided by RNs with cheaper, less-skilled care provided by other groups.[565] They framed the shortage as a product of increased demand for nursing care, a result of the increasing acuity levels in hospital wards, as well as advances in medical technology. In that context, they argued, nurses were being increasingly distanced from the bedside, replaced with less-skilled practitioners, whose focus was on technical protocols, rather than the "blend of knowledge, skill and compassion" unique to nursing care. "The RCT is task oriented," argued CNA material targeting consumer groups. "The Registered Nurse is patient-oriented... The RCT is accountable to the physician; the Registered Nurse is accountable to the patient."[566] They also focused, importantly, on creating alarm over the level of hospital-based preparation that the RCTs would have. RCTs, they argued, would come in to the hospital with as little as 2-9 months of on-the-job training.[567]

Over the course of 1989, these campaigns proved remarkably effective. Supporters of the AMA and the RCT program idea began to drop their support. In January of 1989, US Department of Health and Human Services Secretary Otis Bowen appointed a national

Commission to address the issue of nurse recruitment and retention. The Commission's report concluded that there was a serious nursing shortage in the nation's hospitals, which constituted a threat to patient care. According to the CNA, the commission report explicitly rejected the RCT approach to the problem. "Carolyne Davis, the chair of the commission, said the technologists' training and job description would be almost identical to those of the 125,00 nurse aides and licensed practical nurses whose jobs were cut between 1983 and 1986. "Simply calling nurse aides something else will not solve the problem," she said."[568] In February, CNA President Marilyn Rodgers and Executive Director Barbara Nichols attended the meeting of the California Medical Association, to argue against support for the RCT program at the state level. At the meeting, the CMA declined to support the RCT program, instead passing a resolution stating "that the CMA support the nursing profession in its efforts to educate and recruit more nurses to care for our patients, and to increase the income to proper levels, and to improve working conditions of nurses."[569]

Most of the RCT pilot projects were derailed by organizing initiatives like this one, and the AMA Abandoned the RCT proposal in 1990. By most accounts, the Protect Nursing Practice mobilization was broadly successful, and organized nursing had defended against the incursion of organized medicine, to a degree it had not been able to decades prior. But the campaign also showed nurses that the professional boundaries that the organization had worked so hard to build were far from impermeable, and were subject to collapse amidst industrial and organizational turbulence.

Social Closure and the Internal Tensions of Nursing

Beyond this explicit organizing, one of the key strategies that the ANA, and the CNA along with it, pursued to combat this perceived crisis of professionalism was the reintroduction of the educational requirement debates, essentially doubling down on social closure and status attainment strategies. Establishing baccalaureate and masters-level degree requirements would increase barriers to entry, protecting the status of the nurse within a rapidly restructuring industry.[570]

1985 was an important symbolic year for this effort, independent of the contemporary transformation of healthcare delivery. The controversial 1965 proposal to impose the Bachelor of Science in Nursing (BSN) as the requirement for entry into nursing practice projected a two-decade timeline for implementation. Baccalaureate requirements had been debated within the ranks of nurses for over a decade at this point, and they remained controversial. In a 1970 survey of the readers of the *American Journal of Nursing*, the editors found that

> The majority [of surveyed nurses] believe ANA speaks for the elite groups in nursing, i.e., degree-holding administrators and educators [...] Ironically, that underrepresented majority tends to be those nurses closest to patients.[571]

While the discontent among rank and file staff nurses in the 1960s around the issue had pushed the BSN to the back burner in terms of the association's rhetoric, it remained an

important goal for many within the ANA and the CNA. For the 1985 ANA House of Delegates meeting, the CNA Board of Directors advanced a position paper on nursing education, much as they had done two decades prior. The document advanced what they saw as the consensus behind a two-tiered system, whereby BSN graduates could practice with the title "Registered Nurse," while those with Associates Degree preparation would practice as "Registered Technical Nurse." In preparation for debate at the ANA House and after numerous forums on the matter, the CNA advanced its own position on the matter that summer as well, calling for similar entry requirements, and included the achievement of the BSN requirement among its key goals in its 1987 strategic plan.[572] To counter remaining staff nurse resistance, both positions advocated grandfather clauses to allow existing diploma-graduate nurses to retain the RN title. Nevertheless, the position remained unpopular with some working nurses; as Dolan (1979) pointed out, "Rank-and-file nurses have repeatedly resisted a proposal that is, after all, premised on their own incompetence."[573]

Challenging the Legitimacy of the Professional Project

The CNA continued to be dominated by professionalizers in the 1980s, seeking to enhance nursing through expanding educational requirements and the public image of the nurse as expert and authority—even more so, perhaps, than in the 1970s. In 1981, the CNA reviewed the organization's bylaws, listing the Association's goals and objectives—ten goals in total were enumerated, while only one—"to promote and protect the economic and general welfare of nurses"—referred even obliquely to collective bargaining or to working conditions for staff nurses.[574]

The role of the Commission on Economic and General Welfare, during this period, remained contradictory. According to internal orientation documents, the CNA defined the CEGW with relatively little authority, with Commissioners' role defined primarily as conduits of information concerning work issues between the regional memberships and councils and the state body. Commissioners were to "collaborate" with the Director of the collective bargaining program, "adopt rules of procedure and guidelines for the program in accordance with the philosophy of the CNA," and establish educational programs concerning work issues and contract maintenance.[575] Formally, however, the CEGW remained distinct from other structural units in the organization. The Commission was accountable to the House of Delegates, rather than directly to the Board. The CEGW was authorized to establish its own operational policy, unlike other commissions, which only had the authority to recommend policy to the Board of Directors.[576] As established in the previous chapter, the autonomy of the Commission within the broader CNA organizational structure was intended to ensure compliance with federal labor law and maintaining the organization's eligibility as a labor organization. Absent this insulation, the NLRB could find that the organization was subject to domination by nurses defined as statutory supervisors under Taft Hartley.[577]

By the mid 1980s, a group of RNs from Kaiser and Children's Hospital in Oakland began meeting to form the *Staff Nurse Action Project*, or SNAP, following contract negotiations

in 1983. The group quickly branched out to other East Bay hospitals from there. While SNAP was organized as a rank-and-file group of staff nurses concerned primarily with workplace issues, its efforts extended beyond the activities of the EGWC; SNAP members began to agitate within the organization to increase support for staff nurse issues. The group published several in-hospital newsletters, in Kaiser Oakland, Providence, and Alta Bates Hospitals. In 1984, activists produced *The Staff Nurse Guide to CNA*, with the support of the EGWC, which outlined ways for staff nurses to exercise power both at work and within the association.[578] *The Staff Nurse Guide* clearly laid out the structure of the association, including a summary of its governance structures and opportunities for staff nurses to become involved and leverage different parts of the organization for their purposes. It outlined the budget of the organization, showing how much of the revenues came from staff nurse dues, and how much was spent on a variety of programming concerns. The booklet also laid out an understanding of the CNA as riven with the class divisions that had driven decades of conflict and innovation, but also presenting great potential:

> A staff nurse, engaged in the strenuous tasks of bedside nursing, demands more aggressive action of her/his representatives at the bargaining table and in the grievance arena. Working beside other, non-nursing, health care employees, she/he expects CNA to exercise the kind of forcefulness seen in other unions. On the other hand, the nurse administrator/educator balks at identifying with an organization that may endorse and sanction a strike on behalf on its bargaining unit members. They insist that this is somehow "unprofessional." However, there is common ground.[...] All nurses share the same goal. Whether we practice in an acute care setting or in an academic/administrative environment, promoting the delivery of the highest quality nursing care is our concern. To that end we must apply all the practical means of our combined knowledge, experience, and commitment.[579]

In its early years, SNAP was coordinated by Rindi Campbell, Mori Costantino, Martha Kuhl, Kurt Laumann, Carolyn Levy, and Judy Martin-Holland—many of whom would go on to become key activists in the later restructuring of the CNA.[580] RNs running for positions at the statewide and regional elections in 1985, as well as for the ANA House, began identifying as SNAP activists in their elections material. Moori Costantino, a SNAP co-chair, was elected to the Board of Directors in 1985.

In meeting minutes, convention proceedings, and the pages of the *California Nurse,* SNAP activities were presented as in line with the professional goals of the association. But given the increased autonomy of the of the CEGW coming out of the Sierra Vista litigation in the early 1980s, SNAP facilitated the self-organization of staff RNs within an organizational structure already insulated from the control of nurse managers and professionalizers. While continuing to work within the structure of the broader professional organization, SNAP activists nevertheless conceptualized the their purview as an increasingly autonomous organizational space. The visibility of the *Staff Nurse Guide* and the workplace newsletters connected this autonomous group to other staff nurses facing workplace issues, which in turn led to autonomous cross-hospital

coordination. As one nurse recalled,

> What happened was that first, the independents got together and formed an ad hoc group called SNAP, staff nurse action project. We got a telephone call from nurses need to be in there. We were asked if we would meet with them, and we did meet at the Association building here in Oakland. It was the first time that the Kaiser nurses met nurses from San Jose to Sacramento.[581]

SNAP members also organized a contingent of nurses to establish a presence at CNA Conventions, and began to regularly attend CNA board meetings. Within a few years, this group was able to elect staff nurse Marilynne Kennewick to the association board.

A second, more strictly autonomous organization of staff nurses, "RNs for Quality Care," emerged in 1986, initially at Kaiser Oakland. During the 1986 Local 250 Kaiser strike, CNA RNs were under contract and CNA was, as an organization, prohibited from striking in solidarity. Kaiser had gone to the courts to ensure enforcement of picket limitations, and the continued functioning of the hospitals;[582] shortly thereafter, the NLRB warned the CNA that it would be legally responsible for work stoppages by its Kaiser members after individual nurses began to exercise their individual right to honor the line.[583] Individual nurses, however, continued to stay out. At Kaiser Oakland, upwards of 65% of RNs engaged in sympathy walkouts, though this proportion was lower in other facilities.[584] This led Kaiser to obtain an injunction to prevent the CNA from encouraging nurses to honor the strike. Kaiser Oakland nurses at this point formed "RNs for Quality Care," in order to continue organizing RNs in support of the strike.[585]

In naming their ad-hoc organization as they did, RNs for Quality Care activists were explicitly associating the CNA's patient care message with an explicitly labor-centered goal—one focused on solidarity with other unions, no less. Coming out of the strike, the organization became, according to some, a "Kaiser staff nurse caucus" within the broader association.[586] Whether RNs for Quality Care was in fact fully autonomous, or whether organizational links remained to the Commission for Economic and General Welfare, remains unclear. While there were individuals identified as participating in RNs for Quality Care who also worked with SNAP and the Commission, formally, the organization needed to maintain its independence. Spokesperson Jean Stumph said at the time of its founding that

> The registered nurses' movement to honor Local 250's picket lines was an independent action from the start… The action of the registered nurses was not initiated or sanctioned by the CNA, and the temporary restraining order only shows the limited view that Kaiser holds of nurses.[587]

These efforts of rank and file staff nurses reflected the organizing of the earlier wave of dissident nurses who had organized in the late 1970s, discussed in the previous chapter. However, the goals of the two waves were distinguished by the changing organizational context. The earlier dissidents faced a disempowered Commission, and a bureaucratic structure that offered them very few avenues for pushing their project forward within the CNA structure. This led the earlier wave to seek to take the collective bargaining units

out of the CNA altogether, through an alliance with the SEIU, an effort that ultimately failed. By the mid 1980s, however, the situation had changed. The continued organizational reforms following the resolution of the Sierra Vista case in 1982 generated growing autonomy for the Commission and new opportunities for self-organization among staff nurses. Hospital employers' growing push to cut costs and speed up nursing work, combined with the escalating drama faced by Local 250 in its crisis bargaining and concessionary contracts, created an impetus for organizing within the CNA structure, including its broader professional orientation at the time. "We don't want to be seen as dissidents," SNAP's Costantino told the *California Nurse*. "We're working with CNA *and* with the staff nurse. The two should not be mutually exclusive. What we really want is the democratization of CNA."[588]

This new activist orientation may have also found a more welcome reception in the leadership of the EGW program within the CNA in the 1980s than earlier activists encountered in the 1970s. This difference was arguably more a product of organizational differences than leadership ideology. Sam Bottone, the Director of the Economic and General Welfare program during the earlier waves of rank and file dissent, was himself a progressive and his writings show him to have been a believer in the staff nurse cause, even if some activist staff nurses at the time did not always perceive him that way. His obituary described him as a "socialist activist," and he had been a member of the Young Socialist League, and had written for the socialist publications *Anvil, Labor Action,* and *The New International,* and the served on the editorial board of *New Politics*. He had held union organizing positions with the Steelworkers, the ILGWU, and the AFT. But he was also the partner of then-CNA President Toni Propotnik, since 1974. Furthermore, he led the EGW program during a time in which it was relatively insulated from the commission and from rank and file nurses.

When the later wave of staff nurse dissident organizing began to take off in the early 1990s, Rose Ann DeMoro, who also had progressive, labor-centered bona fides, led the EGW program. A former UC Santa Barbara labor sociologist, she defined herself as both a Marxist and a feminist. After entering a supermarket workplace to conduct a labor process ethnography in the 1970s, she became a union organizer, gaining experience organizing with UFCW, AFSCME, and the Teamsters.[589] In many respects, DeMoro and the CEGW staff cultivated this staff nurse insurgency. But it was also the self-organized staff nurses themselves who pushed DeMoro into increasingly confrontational positions vis-à-vis the hospitals, and the CNA administration. Dorothy Christiansen, the FMCS Federal Mediator, recalled the dynamic between DeMoro and staff nurses during a strike at Children's Hospital in Oakland in the early 1990s:

> She came up here and she met – she said, “Would it be okay with you if I met privately with the administrator of the hospital?” I said, “Sure. Anything you can do to help this, do it.” Within two hours, those nurses, the committee gave her a vote of no confidence. They were the toughest group I ever saw. But they do the toughest job, too. Oh my god, they do tough jobs.[590]

Both the Commission and the EGW Program under DeMoro continued to push for

greater autonomy for the collective bargaining components of the organization, and advocated expanded self-governance and insulation from other CNA bodies; these positions provoked significant controversy within the organization. In 1989, the Commission proposed a series of bylaw changes intended to reinforce the Commission's autonomy. In response, the Board of Directors commissioned a large-scale survey to ascertain the preferences of Association membership regarding organizational structure. The survey found that while a slim majority of members expressed approval of the existing structure, upwards of a quarter were dissatisfied; the membership was characterized, the authors found, by a majority of relatively content and/or poorly informed members, with significant minorities in polarized camps split on the basis of support for bargaining: “To be sure, a small number of members believe that CNA is too lenient in negotiating with hospital administrators. An equally small number believes that nurses are professionals who shouldn't be involved in union activities. These two extremes balance each other out.”[591]

In 1991, the Commission changed its name to the Economic and General Welfare *Congress* (or Congress of Economic and General Welfare), a change intended to reflect the body's "policymaking authority for the conduct of collective bargaining." The Congress, rather than electing representatives at the regional body level (which were established by the broader association and included regions with management-dominated boards), elected representatives from 15 "caucuses" established based on the distribution of nurses represented under collective bargaining agreements (what were called "category 1 members"), with caucus membership determined by workplace rather than by regional membership.[592] By 1992, the CEGW had implemented "substantive collective bargaining policies such as supporting joint organizing and bargaining with other unions," establishing as the policy of the CEGW to collaborate with unions when they shared bargaining interests.[593]

Tensions between the CNA administration and the increasingly restive CEGW reached a boiling point in 1992, during negotiations with Summit Medical Center, a new, large hospital formed that March out of the mergers of the "Pill Hill" hospitals in downtown Oakland: Merritt-Peralta and Providence Hospitals. That May, 1700 workers at Summit Medical Center, represented by CNA, Local 250, ILWU Local 6, HERE Local 28, and OPEIU Local 29, began what would become a seven-week long strike. The unions were confronting the "corporatization of care," occurring amongst what they called "a hastily created medical factory and a management team more interested in profits than patient care, more interested in spending money on a senseless strike than to improve healthcare."[594]

While Summit had agreed to reasonable economic packages with all involved unions, as bargaining progressed, the hospital continued to insist that all unions give up the right to respect each other’s picket lines. All unions refused, working without a contract for three months, and continuing to push to maintain the right to honor each other’s concerted actions. For the union coalition, the picket line language was the cornerstone of union solidarity. But given the context of the merger and the perceived corporate approach to

care, the union coalition worked to frame the right to strike together as about more than economic leverage: it represented healthcare workers' resistance to corporatization. "For employees who have dedicated their lives to providing quality care for their patients and for their community," they wrote in a public pamphlet, "having a contract that protected our rights to speak out on behalf of patients became critical... without power, workers surrender their input into patient care and mortgage their future."[595] All unions agreed to strike to protect this important point of leverage over the employer, and the broad principle of worker solidarity. The strike was highly visible, attracting an offer of mediation from the Rev Jesse Jackson (Summit refused), bringing then Presidential candidate Jerry Brown to the picket lines, and provoking a Congressional hearing. In the end, the hospital relented, prompting a front-page story in the Oakland tribune with the headline reading "Union Power," and a photo of DeMoro embracing Local 250s President Sal Rosselli.[596]

But despite this victory on the part of CNA and the other unions, it appears that according to the leaders of CNA, it attracted the wrong sort of attention, and sent the wrong kind of message about what the CNA stood for as a representative of nurses and nursing. According to DeMoro, CNA leadership opposed the strike, and had strongly pressured her to settle before they had achieved their goals of protecting the right to picket.[597] Some staff RNs claimed that a prominent Vice President of the CNA was among those nurses who had crossed the picket line.[598] As DeMoro recounted,

> Barbara Nichols was very upset. She would call me constantly, wanting to know why we were involved, and when the strike was going to end. She let me know the CNA board was very upset about the strike and with CNA's involvement with the unions. They refused to run a front-page story on the strike or even show photos of nurses carrying picket signs in *Cal Nurse* [CNA's publication]. This was at a time the strike was on the front page of the *Tribune* and every other local newspaper. And while other unions were sending all kinds of support to the strikers, the ANA [American Nurses Association] only sent a telegram of support, and they sent it to management by mistake.[599]

On December 20, 1992, CNA Executive Director Barbara Nichols terminated Rose Ann DeMoro, along with thirteen other staff of the EGW program. She appointed Peggy Graham, a vocal proponent of the professional model and an opponent of the CEGW's recent direction, to replace DeMoro. Nichols and Foley denied that the firings were a product of the Summit Strike itself, claiming instead that there were active efforts to split the CEGW off from the CNA as a whole.[600] A few days later, Nichols wrote to CNA members that

> This decision was made because these employees were not effectively representing the interests of CNA's membership and were, in fact, aggressively working to transform CNA into a single-focus trade union organization. These efforts were an assault on the integrity, independence and survival of CNA.[601]

Elsewhere, Nichols pointed to the CEGW's increasing isolation, including the erection of barriers to contact between the Commission and other segments of the CNA. CNA

President Mary Foley, backing up Nichols' decision, characterized the organizational project that DeMoro and the Commission leaders were advocating as contrary to the broader, "multi-purpose" professional mission that the CNA had maintained:

> Seeing the work of a nurse boiled down to contract language that would ignore what nursing has said about the profession or advancement of the profession or doing non- nursing work, there was definitely a philosophical conflict that would have ended up really being very difficult to manage... [This] is exactly why these actions were taken, because we did not want to be in the image of or affiliated with other unions. And in the short run, the image of other unions was being proposed to us...[602]

The firings produced a swift backlash from the leadership of the EGWC, which declared that it was the autonomous body with the authority to hire staff, and demanded that hospitals recognize it, and not the association board, as the collective bargaining representative for staff nurses. CEGW Chair Kit Costello wrote to hospitals to establish the Commission as the legitimate bargaining agent, and to request that dues deductions from member payrolls be sent directly to the Commission rather than the CNA, or alternatively, to place the dues in escrow.[603] The four elected leaders of the Congress were then suspended. According to Kit Costello, the Chair of the Congress and among those leaders suspended, the firings and suspensions were a product of the class divisions within the association, which were being brought to the fore by conflict over hospital restructuring and cost constraints. "Part of the division," Costello told the Sacramento Bee, "is you have managers who belong to the association who make or break their careers on whether they can come in under budget. It's the pivotal issue for nurses' associations right not. It's where the front-line nurses and nurse managers can't agree... If we're a union, we have to act like one."[604]

Three months later, a federal court order compelled the reinstatement of the elected officers and the reappointment of the fired staff, finding that the firings had been provoked by policy differences, and thus violated labor law and the assumed autonomy of the EGWC.[605] The logic of the Court's findings rested, appropriately, on the logic underlining the insulation of the EGWC from the CNA Board resultant from the Sierra Vista decisions. Nichols and Foley acted to prevent the excessive "insulation" of the Commission from the Board.[606] Yet it was precisely this insulation, the court found, that undergirded the CEGW's autonomy from managerial domination, and thus its legitimacy as a labor organization:

> In the context of suits by employers to disqualify professional nursing associations such as CNA as collective bargaining representatives under the National Labor Relations Act ("NLRA"), the NLRB has held that such an association must sufficiently insulate its collective bargaining program from "clear and present danger of conflict of interest" because of the participation of supervisors in the association.

The CNA Board of Directors convened a special House of Delegates meeting in April, 1993, to address "the dispute which has arisen over the role of the CNA's structural units

and their relationship to CNA as a whole."[607] They recruited nurses to the meeting under the banner of "UNITY! Not Takeover!"[608] The meeting, President Mary Foley stated, was called with the express purpose of passing a resolution that clarified existing bylaws concerning these bureaucratic relationships; leaders would not entertain new bylaw amendments. At the meeting, the Board offered a resolution that reaffirmed the CNA as a "multi-purpose association," with a mission that spanned the interests of staff nurses and nurse managers and educators. The resolution defined the Congress of Economic and General Welfare as "a deliberative, not an administrative body," which was not entitled to administer the EGW program itself. The resolution passed 215 to 3.[609] Dissenting nurses appear to have boycotted the meeting.

While they remained in exile, DeMoro and her fired colleagues found support and a temporary home in Local 250. They moved into the Local's offices while they mounted their response.[610] DeMoro's husband, Don DeMoro, was hired on as Research Director at Local 250 in 1994, where he stayed through 1996.[611] Rosselli and the leaders of Local 250 were quick to support DeMoro and her fired colleagues before the public and Local 250 members. In an urgent report to Local 250 membership, Rosselli and Ware wrote that the turmoil within CNA

> Jeopardizes the positive working relationship we have tried to build with CNA and which poses serious consequences for <u>all</u> health care workers in California... Barbara Nichols has created an environment in CNA that can only benefit the interests of hospital management. It is our view that CNA staff members were fired precisely because of their strong defense of their members' rights, as best evidenced in the Summit strike, and their willing- ness to work cooperatively with other Unions, especially Local 250. Those positions appear to be at odds with the present leadership of CNA."[612]

These firings, and the turmoil that followed, ultimately triggered what activists have called the ‘staff nurse rebellion,’ when staff nurses ran for and won a slim majority of positions on the CNA board in 1993. For the next two years, the organization was left with a divided board, and riven by continued conflicts. The staff nurse majority on the board dismissed the Interim Executive Director, and hired DeMoro as the Executive Director, a move that angered many "multi-purpose" partisans. The elected President, Linda Sawyer, remained consistently in conflict with the board and the appointed staff.[613] In the summer of 1994, Kurt Laumann, a Kaiser nurse and a founding member of SNAP, who had been elected Vice President, caused substantial upset among CNA members by publishing an article in the *California Nurse* that criticized the American Nurses Association.[614] Sawyer wrote, in that same issue: "The choice for CNA nurses is clear: join your nursing colleagues nationally in shaping the future or continue along the path of conflict and destruction we have embarked on. My spirit has joined our national colleagues."[615] She resigned abruptly in August of 1994, allowing Laumann to become President.

Similarly, relations between the CNA state body and the regional association bodies remained tense. Regional presidents formed an autonomous "Presidents' Committee," and participated in conference calls with ANA officials to coordinate actions.[616] Following the

resignation of Linda Sawyer, many elected leaders of associational bodies resigned over what some saw as a shift toward a "single purpose" model—i.e., a focus on staff nurse concerns. As Margaret Alderman, Nursing Services Commissioner for Golden Gate Nurses Association explained in her resignation,

> The single-minded pursuit of the Economic and General Welfare goals of the organization not only denies our full potential as professionals, but also appears to be severely compromising the fiscal integrity of the organization... If CNA membership wishes to have an organization with a single viewpoint, that is certainly a legitimate pursuit. However, I personally and professionally choose to place my energies and talents in an organization that can speak for the total profession of nursing: its clinicians, educators, managers and administrators."[617]

Anne Becker, another GGNA Nursing Services Commissioner, put it more succinctly:

> There seems to be no resolution of the conflict between professional nursing philosophy and goals and the 'CNA Union staff nurses are the only nurses represented by CNA' ideology.[618]

The new staff-nurse administration, however, continued on its efforts to chart a more confrontational path for the association. In his first statement as President, Laumann laid out a strong anti-corporate-healthcare perspective:

> Remember who the real enemy is: the medical industry. Remember when our opponent was one hospital at a time - that was before the stakes increased from one hospital trying to balance good care and a few million-dollar budget, to multinational companies fighting for the biggest slice of a trillion dollar industry. It is that industry that processes its patients, er - clients, through the greatest private money-making machine in history."[619]

Organizers mounted a sophisticated campaign to identify, for members and the public, the links between hospital restructuring--often presented as profit-driven hospitals shifting care work from RNs to unlicensed technicians--and nurses' capacity to provide the best quality patient care. The EGWC passed a resolution, in July of 1994, calling for the CNA's top priority to be "a rapid and effective public campaign against restructuring and for single payer."[620] Organizers led a series of workshops across the state, geared toward educating RNs about hospital restructuring and the consequent challenges. In the pages of the *California Nurse,* CNA leaders published a series of articles over the course of several months in 1994 and 1995 calling out the effects of restructuring--and in so doing, framing employers as the key object of contention for the organization. Combatting corporate restructuring, the journal argued, would protect nursing practice, protect nurses' job security, and enhance patient care.[621] They organized rallies and marches calling for "quality care and quality jobs," at one point holding a rally at the San Francisco offices of American Practice Management, a consultancy that advised hospitals on cost containment--and whose staff had had some loose affiliations with the ANA.[622] CNA leaders counterposed this aggressive stance toward restructuring and hospital administrations, against what they argued was a more passive, administration-friendly ANA. According to Laumann,

> CNA passed through a religious conflict, a schism of faith. On one side were

> those whose focus is on what nursing models should or could be. They discuss entry into practice, advanced practice, and cooperative existence with the health care industry--the ANA approach. The other side of the division--those with whom I count myself--are those who see CNA and nurses under attack by the healthcare industry, and our patients being transformed into healthcare consumers--the E&GW view.[623]

By the next election, in 1995, the staff nurses had won full control of the board; Kit Costello, a Kaiser Sacramento RN on the DeMoro-allied "Patient Advocate" slate, received 70% of the vote for President.[624] In June of 1995, the new reps attended the ANA House of Delegates meeting, where ANA delegates again reaffirmed the organization's commitment to the Bachelor's requirement for entry into practice, but in the eyes of the CNA delegates, failed to address the problem of restructuring or the effects on staff nurses. The body also passed a series of bylaw changes that, in the eyes of the CNA delegates, would allow the ANA to discipline renegade state associations, and were "clearly aimed at CNA;" they also revised the association's mission statement to deemphasize its commitment to collective bargaining.[625] In an account of the meeting authored by Deborah Bayer and Martha Kuhl, two CNA board members, the key point of distinction between CNA and ANA at the meeting concerned the issue of restructuring, and the organizations' competing visions for the role of staff nurses in an environment of corporate care restructuring. While CNA advocates wanted to keep nurses at the bedside and protect their role in patient care, ANA partisans sought to maintain the leadership role of RNs:

> CNA Treasurer Martha Kuhl proposed amending [a resolution] to declare RNs as the "direct care provider" rather than "essential" providers in all practice settings as currently written. The debate in the industry and the profession is whether nurses should remain providers of direct, hands on care, or become "care coordinators" or "case managers" supervising others, she said. "Essential" is not clear enough, she said, because It could be argued that having an RN supervise lower paid workers meets that test. "The ANA must explicitly oppose the industry trend," Kuhl said. Her proposal aroused vehement opposition, one speaker stating it would "dilute the entire goals of the ANA" and "dilute any attempt for advancement." Another speaker emphasized, "Our co-workers are in supervisory roles." The proposal was overwhelmingly voted down, an example of the policy-differences between ANA and CNA whose elected leadership places our top priority on pre- serving our practice and protecting our jobs. Another example of that difference could be seen in the new ANA brochure, "Staff Nurse Guide to Work Redesign," which was presented at the House. Instead of opposing the premise of work redesign, which is being used to remove RNs from direct care and to lower patient care standards, the ANA brochure- states that RNs should participate as "full partners" in work redesign and "adapt their skills to new or enhanced patient care environments."[626]

Following that meeting, CNA leaders proposed bylaws for its own September 1995 convention, which would strike references to the CNA as an affiliate of the ANA, and

declaring itself "an independent nurses' association dedicated to organizing and representing the interests of registered nurses, and protecting and advocating for patients and health care consumers."[627] Leaders cited the need to devote the resources they had been paying in dues to the ANA toward organizing new nurses and expanding the representation of nurses in the employment sphere. With the disaffiliation, the CNA lost about a third of its membership, but by some accounts had recovered its numbers through organizing within five years.

The transformation of the CNA into one of the most militant and progressive labor organizations in California in the 1990s marked a decisive shift, both in its practices and its orientation to labor control. CNA activists and leaders came to see their principal opponent as not just the professional groups above and below them, but the employer, increasingly oriented toward markets and profits. Nevertheless, in the years after the staff nurses' rebellion, the organization maintained important aspects of its professional orientation. Though it loosely affiliated with unions that represent a broader cross section of hospital workers, the CNA itself retained its focus on representing RNs and still mobilizes around questions of the scope of nursing practice. And while it shifted toward focusing more clearly on collective bargaining and new organizing, the association retained its core conviction that the power of nurses is rooted in public legitimacy, reflecting Shirley Titus' original claim that "The admiration and the respect which the public has for nurses is our strongest instrument." Moving into the 1990s, the CNA positioned itself as one of the principal advocates of patient care, resisting the cost cutting and rationalization of corporate medicine. One nurse who participated in the staff nurse rebellion articulated it thus:

> How do you confront a trillion dollar industry? How do you confront these hospitals and the HMOs, the drug companies, with the billions of dollars of resources they have, and the chokehold they have on the legislative process? The way you do that is by uncompromisingly, fearlessly, representing patients and the public interest.[628]

Conclusion

To say that the projects of the CNA, Local 250, and Local 399 were "convergent," is not to say that they were the same, or that these organizations would come to get along throughout the 1990s. While the CNA became much more of a *union* in the 1990s, it retained its professional focus, limiting membership to RNs, forgoing opportunities to expand this base of workers, even if this had been a goal of earlier generations of dissident collective bargaining advocates in the CNA and the ANA. SEIU, on the other hand, would continue to maintain a broader conception of the care worker in the 1990s, and adopt an organizing and bargaining strategy more akin to the 'industrial union' model. The 1990s were also a period of recurrent conflicts between CNA and SEIU, particularly in Southern California, but also including the occasional souring of the relationship between CNA and Local 250. The organizations competed for nurse

representation in Catholic hospitals, and diverged in their approach to bargaining with Kaiser Permanente (see Kochan et al. 2009).

Nevertheless, each organization arrived at their own version of a new healthcare organizing model, following their own circuitous path. What they discovered was a potent combination of class antagonism—identifying employers, and the market more broadly, as the key object of contention—and patient care advocacy.

Given the recurrent, turbulent restructurings in healthcare delivery in the 1980s and early 1990s, the organizations shifted to a more aggressive posture. They also came to adopt a framework of class antagonism at the center of their diagnosis of the healthcare crisis. By compromising care workers' capacity to provide adequate care, in the eyes of workers and the public, hospital labor restructuring in the mid 1980s spurred a widespread perception of care workers' alienation from their labor. As such, while the neoliberal assault on organized labor was not, of course, limited to the healthcare industry, healthcare workers' reaction was peculiar, and powerful. What was unique about care workers and the hospital setting, I argue, was the set of moral frames and organizing traditions rooted in the moral economy of care.

Conclusion: Can Capital Care?

A great deal of the responsibility for the transformation of hospital workers' labor contention patterns lies with the hospitals themselves. Hospital administrators resisted both traditional unionism and professional unionism in the late 1970s, and in so doing, innovated new ways to weaponize National Labor Relations Board and undermined existing institutional mechanisms of union recognition. This laid the groundwork for the undermining of these earlier forms of labor contention. In the 1980s, it was hospital administrators who undertook the industrial transformations that challenged both care workers' conceptions of their labor's worth, and the legitimacy of incumbent organizational leaders. This turbulence generated the impetus and opportunity for organizational insurgents to articulate new forms of organization and new visions for the future. And if the struggle against the commodification of care would become a key point of leverage for care workers' campaigns to organize and improve labor conditions in hospitals in the 1990s, hospital administrators handed them that tool by commodifying care in the first place.

The narrative of the events in this dissertation suggests that perhaps the key animating force in the transformation of labor contention remains this exogenous cause: the dramatic transformation of the healthcare industry. In this respect, the analysis here exhibits a failure similar to that which Anderson (1980) found in Thompson's *The Making*: of merely finding culture at work in a historical process defined by the dynamics of capital. However, I argue that there is an independent role for culture in the formation of these new modes of organization. The moral framing of care workers' struggle was not simply a universally pragmatic response (though it was certainly used as a tool), or epiphenomenal to an industrial process.

One way we see this is through the timing of key organizational innovations. This is presented most clearly in Part 1. Observing CNA in the post-war decades, we can see the emergence of a class-antagonistic, care-centered model of organizing that emerged well before the dramatic changes of the 1980s, or what Scott et al (2000) call the Era of Market Mechanisms. This transformation was of course bounded by the structural context of the growth of the modern hospital. But the key moments of innovation—the introduction of collective bargaining, the defiance and then the reversal of the strike ban, the development of worksite committees that merged workplace advocacy with professional practice goals—were products of institutional entrepreneurs seeking to reconcile staff nurse demands for economic justice with the moral imperatives of caring and professionalism as they understood them at the time. Though this change was in large part a product of conservative impulses seeking to contain staff nurse insurgency, the tension was nevertheless generative, leading to a fundamental rearticulation of nurses' potential power, at least within some factions of the nurses' associations. While this basic

class-antagonistic conceptualization of the responsibility to care would later emerge as the dominant model in the field in response to industrial changes, its creation was in large part a product of the moral economy of care.

We can also see the independent role of moral frames in the divergent pathways that the CNA and the SEIU Locals took to reach this model. With the opening of organizing opportunities in 1974, both organizations faced a similar structural opportunity, and were compelled to adapt to a common set of institutional rules under the NLRA. But their varying conceptualizations of the appropriate memberships, practices of contention, and opponents led them to develop different strategies for taking advantage of these openings. And while the different organizations would eventually converge toward a common model—while maintaining meaningful organizational differences—their arrival to that point was not inevitable, but rather, the outcome of organizational turbulence and contingent internal political events.

Throughout all of these processes, organizers used preexisting ideas to articulate new organizational forms, new visions for the future, new definitions of allies and opponents. In this sense, they were drawing on ideas that were meaningful to workers, and in a form of 'bricolage' (Clemens 1996), building new models of unionism. For workers in hospitals, the meaning of their work was inextricably tied up in the call to care. And the fundamental cultural idea that these organizers drew upon—the constant in a changing 'moral economy of care'—was the antinomy of the market and the moral obligation to care. How this antinomy related to the moving part of industrial conflict changed dramatically, shifting over fifty years from an injunction against instrumental unionism into a call to arms against uncaring capital. But the antagonism between moral obligation and instrumental action remained at the heart of these different articulations of the moral economy of care.

This brings us back to the original animating question of this dissertation: How should we understand this antinomy of the moral and the economic in the hospital industry? Are they "hostile worlds," or does this idea mask a deeper, underlying interconnection? My answer here is a pragmatic one: The antinomy of the moral and the market was real, and it was real because people *used it,* and got results. Care workers used the antinomy to define themselves relative to others, to articulate common identities and interests, and ultimately, to wield leverage over those who they would see as uncaring. Organizers used these traditional ideas not only to diagnose the problems they faced, but as tools to combat their opponents. Frame became organizational form (Clemens 1996), and the moral economy of care became inscribed in the everyday practices of care workers and their organizations over time. And if organizational forms failed to produce the results they promised, insurgents tapped into the moral economy of care to articulate a new path forward. It was this fundamental antagonism between the moral calling to care and the drive to treat care as a commodity that gave these workers and their unions the tools they needed to become a caring class.

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Notes

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[2] See Kaiser Foundation Health Facts calculations from Occupational Employment Statistics data: http://www.kff.org/other/state-indicator/health-care-employment-as-total/

[3] Interview with Sal Rosselli, March 5, 2015; Interview with David Snapp, June 16, 2015. See also DeMoro, Rose Ann, 1995. "Destabilized Workforce: Restructuring's Bequest." *California Nurse,* Vol 91 No 96, June 1995.

[4] "The Jungle Revisited: NLRB Assumes Jurisdiction over Proprietary Hospitals." Memo by Lawrence Corbett, distributed to members of the California Hospital Association. Dec 8, 1967. Corbett was a partner of the Berkeley law firm Corbett and Weldon, and represented the Associated Hospitals of the East Bay since its inception in 1953. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 18, Folder n/a.

[5] "The Economic Status of Professional Nurses in California." Report submitted by the California State Nurses Association to the Senate Interim Committee on Nurse Problems. September 12, 1950. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 3 folder 19.

[6] According to research by Lincoln Cushing of the Kaiser Permanente Heritage Resources Department, the first nurses to obtain guaranteed 40-hour weeks were Kaiser nurses represented by the CIO-affiliated United Public Workers (Personal Correspondence). Broader Bay Area-wide contracts with the CSNA soon followed.

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[7] Letter from Eleanor Lambertsen, President, American Nurses' Foundation, to Robert K Merton, 04/02/1969. Columbia University Rare Book and Manuscript Library, Robert K. Merton Collection, M.S#1439 box 157, folder 4.

Letter from Jerome P Lynsaught, Director, National Commission for the Study of Nursing and Nursing Education, to Robert K. Merton. May 25, 1972. Columbia University Rare Book and Manuscript Library, Robert K. Merton Collection, M.S#1439 box 171, folder 10.

[8] Anne Zimmerman, Draft speech for 1978 ANA Convention. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 15 folder 400.

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A. Lionne Conta, "Professionalism versus Unionism." Address to the 8th National Congress of the Association of Operating Room Nurses. San Francisco, February 1981. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 9, Folder n/a.

[9] "Suggestions for Seminar discussion of draft Casebook chapters." Memorandum from R.K. Merton and J.W. Goode to University Seminar on the Professions, Columbia University, October 15 1951. Columbia University Rare Book and Manuscript Library, Robert K. Merton Collection, M.S#1439 box 136, folder 14.

[10] Robert K. Merton, 1957. "Some Preliminaries to a Sociology of Medical Education." Pp 3-79 in *The Student Physician: Introductory Studies in the Sociology of Medical Education,* Robert K Merton, George Reader, and Patricia Kendall, eds. Cambridge: Harvard University Press.

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[11] "Clair Lisker: A Voice for Nursing Education, Kaiser Permanente, 1948-1991." Oral History conducted by Judith Dunning, 2002, Bancroft Library, UC Berkeley.

[12] "Clair Lisker: A Voice for Nursing Education, Kaiser Permanente, 1948-1991." Oral History conducted by Judith Dunning, 2002, Bancroft Library, UC Berkeley.

[13] (Reverby 1987)

[14] (Fondiller 1980)

[15] (Carruthers 1990)

[16] Quoted in (Donley and Flaherty 2002)

(Nutting 1927)

[17] American Nurses Association. 1965. "American Nurses' Association's First Position on Education for Nursing." *The American Journal of Nursing* 65(12):106–11. (American Nurses Association 1965)

[18] (Schutt 1971)

[19] Helen C. Hanson, "Supplemental Report," Proceedings of the Forty- second Convention of the American Nurses' Association, May 2-6, 1960 (New York: American Nurses' Association), p. 55, A.N.A. Archive.

(Fondiller 1980)

[20] "Nurse Participation in Hospital Decision-Making: Potential Impact on the Nursing Shortage." Report, Department of Health and Human Services, Office of the Inspector General, Office of Analysis and Inspections, October 1988. In "Support Studies and Background Information, Vol II," Secretary's Commission on Nursing, Dec 1988.

[21] Throughout this period, there was certainly substantial anti-union sentiment among nurse leaders that bordered on the fanatic. As Emma Nichols, Committee member and ANA Treasurer from West Roxbury, MA stated in a 1939 speech against unions in New Orleans, "We must not forget that it was a sit-down strike in Fiat Automobile works in Italy that started Mussolini's black shirts on the march to Rome."

ANA Committee to Study the Question of Unions for Nurses and the Setting up of Policies on the Subject. Meeting Minutes, January 1938. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 203, Folder 6.

[22] Geiger, A. 1939. "In unions there is strength?" *RN*, Dec1939, Vol. 3, Issue 3

[23] "ANA Report on Seminar on Collective Bargaining," May 31 – June 1, 1946. Listing of reports from State Nurses' Associations. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 404, Folder 2.

[24] ANA Committee to Study the Question of Unions for Nurses and the Setting up of Policies on the Subject. Meeting Minutes, May 1946. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 203, Folder 6.

[25] ANA Editorial: "Union Membership? NO!" *The American Journal of Nursing,* Vol. 38, No. 5 (May, 1938), pp. 573-574

[26] ANA Committee to Study the Question of Unions for Nurses and the Setting up of Policies on the Subject. Meeting Minutes, January 1940. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 203, Folder 6.

[27] ANA Committee to Study the Question of Unions for Nurses and the Setting up of Policies on the Subject. Meeting Minutes, September 1938. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 203, Folder 6.

[28] "Objectives of the AHA and ANA to Give Attention to Salaries and Personnel Practices of Nurses in Institutions." Minutes from joint ANA-AHA meeting, September 1944. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 190, Folder 2.

[29] Quote source: "Objectives of the AHA and ANA to Give Attention to Salaries and Personnel Practices of Nurses in Institutions." Minutes from joint ANA-AHA meeting, October. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 190, Folder 2.

These meetings reflected a common rhetorical strategy of association leaders at the time, which was an attempt to justify improved wages and working conditions for nurses by appealing to hospital authorities' fears of unionization. In this sense, it was a clear effort to generate a "radical flank effect" (see Haines 2013), in which more moderate groups take advantage of the mobilization of more radical groups. However, the alliances with hospital administrators, both rhetorical and institutional, were indeed substantial, and consistent with a broader professionalizing strategy.

[30] "Objectives of the AHA and ANA to Give Attention to Salaries and Personnel Practices of Nurses in Institutions." Minutes from joint ANA-AHA meeting, October. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 190, Folder 2.

[31] The CNA's Shirley Titus, who was at the time working to establish a collective bargaining program within the ANA, would later condemn these efforts, alluding to the collusion between ANA administrators and organized hospital employers:

> One of the greatest dangers we stand in in this whole program is this: if there is no greater thought given to some of these matters, there can be the accusation that the state nurse leaders have betrayed the membership through entering into collusive agreements with hospitals. You will have to recognize that face, because the basic principle and all this evolution of the right of the worker to have a vice in the determination of employment conditions rests on the fact that the employee alone has the right to state what he or she wants... The establishment of "joint programs for economic security for nurses by state

nurse associations and state hospital associations" is inconsistent with the principles of the economic security program adopted by the ANA for the following reasons: Currently accepted principles of democratic employee organization and legal rules governing agencies proposing to act as spokesmen and agents of employed persons or groups require that the spokesman or agents maintain a properly responsible relationship with the persons or groups represented and abstain from any collusive relationship with the employer or the representative of the employer or the persons or groups. I don't think I need to explain that. I think you must understand what is meant by that.

Shirley Titus, Speech to the ANA Advisory Council, 36th Convention of the ANA, Chicago IL, May 31-June 4 1948. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 6, Folder na.

[32] "Portrait of a Nurse Leader." *The Bulletin of the California State Nurses' Association*. Vol 52, No 4, April 1956. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 6, Folder n/a.

[33] A. Lionna Conta, "Shirley Titus… Champion of and for Nurses. *The American Journal of Nursing,* Vol. 61, No. 8 (Aug., 1961), pp. 87-89

[34] Shirley C. Titus, "The Head Nurse's Decision." *The American Journal of Nursing,* Vol. 54, No. 3 (Mar., 1954), pp. 314-316

Shirley Titus, "The Health Morale of Student Nurses." *The American Journal of Nursing,* Vol. 22, No. 6 (Mar., 1922), pp. 458-462

Shirley Titus, "The Pre-Professional Education of the Nurse." *The American Journal of Nursing,* Vol. 28, No. 1 (Jan., 1928), pp. 62-66

[35] "Salaries of Nurses." *The Pacific Coast Journal of Nursing,* Vol. 39, No. 6 (Jun., 1943), pp.

[36] Article in *This World,* October 13, 1946. Kaiser Permanente Heritage Resources private collection.

[37] Marian Alford, "The ANA Economic Security Program." Talk given at the meeting of the Chairment of District Institutional Staff Nurses Sections and Chairmen of Regional Personnel Policies Committees, New York State Nurses' Association, May 1948. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 9, Folder n/a.

Shirley Titus, "Analysis of Personnel Needs of CSNA," Memo to CSNA Board, ca 1945. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 2 folder 10.

[38] Shirley Titus, "Analysis of Personnel Needs of CSNA," Memo to CSNA Board, ca 1945. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 2 folder 10.

[39] Letter from Esther Swenseid, Acting Director, CSNA ESP To Wendell French, Associate Professor at the College of Business Administration, University of Washington, May 11, 1960. Howard Gotlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 355, Folder 6.

[40] "Meetings, CSNA Board of Directors. Summary of Minutes, San Francisco, November 14, 1942." In *Pacific Coast Journal of Nursing,* Vol 39 No 2, February 1943.

[41] Marian Alford, "The ANA Economic Security Program." Talk given at the meeting of the Chairmen of District Institutional Staff Nurses Sections and Chairmen of Regional Personnel Policies Committees, New York State Nurses' Association, May 1948. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 9, Folder n/a.

[42] "Economic Security Program." *The Pacific Coast Journal of Nursing,* Vol. 39, No. 10 (Oct., 1943), pp. 343-344

[43] Shirley Titus, "Analysis of Personnel Needs of CSNA," Memo to CSNA Board, ca 1945. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 2 folder 10.

[44] Shirley Titus, "Analysis of Personnel Needs of CSNA," Memo to CSNA Board, ca 1945. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 2 folder 10.

[45] St Sure, J Paul. 1948. "The Meaning of An Economic Security Program." The American Journal of Nursing, Vol. 48, No. 11 (Nov., 1948), pp. 692-693

[46] St Sure elaborated on this approach in the pages of AJN some years later:

> The state associations should endeavor to bargain with the local hospital employers. Announce at the beginning that you do not intend to strike... Next, point out that the state association is the proper professional organization to represent graduate nurses. Having accomplished these preliminaries, ask whether they are willing to bargain with you. If they say yes, go to work with the bargaining process. If they say no, go to the public with your story... In the absence of the threat of economic action, you have many arguments on your side. Primarily, of course, you have the right on your side, but as a practical weapon above all, the state association has the power to say to a hospital management that has refused to bargain with it: "We will not strike, but, unless you are prepared to recognize and deal with us, we have no choice except to withdraw from the field as a representative of nurses. We shall go back to rugged individualism or it may be the nurses will turn to some other type of organization—perhaps an organization that will believe in striking.

St Sure, J Paul. 1948. "The Meaning of An Economic Security Program." The American Journal of Nursing, Vol. 48, No. 11 (Nov., 1948), pp. 692-693

[47] Spector, Frances, 1980. "California Union of Healthcare Professionals: Message from the Organizing Committee." *Stat Pages,* SEIU Local 723 newsletter, Vol 1. No. 2. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 10, Folder n/a.

[48] Shirley Titus, "Analysis of Personnel Needs of CSNA," Memo to CSNA Board, ca 1945. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 2 folder 10.

[49] Nurses' Guild of Alameda County Bylaws, ca March 1946. Howard Gotlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 354, Folder 12.

Memo from Miss Barthe to Mr and Mrs Scott of the ANA. April 25 1947. Howard Gotlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 354, Folder 12.

[50] Letter from Margaret Stack, ANA Secretary, to Edna Behrens, CSNA President. March 4, 1946. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 354, Folder 12.

[51] Shirley Titus, 1943. "Economic Security is Not Too Much to Ask." *The Modern Hospital,* Vol 61 No 3, September 1943, Pp 71.

[52] "Economic Security through the Years." *The Bulletin of the California State Nurses' Association*. Vol 49, No 9, October 1953. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 367, Envelope 1.

[53] Letter from Shirley Titus to Alma Scott, Secretary of the ANA, February 21 1946. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 354, Folder 12.

[54] "Comments by Miss Titus," as dictated to Elizabeth Porter, June 8, 1946. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 404, Folder 1.

[55] "Comments by Miss Titus," as dictated to Elizabeth Porter, June 8, 1946. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 404, Folder 1.

[56] Source: Letter from Goodman Brudney, Regional Director for United Public Workers of America, CIO, to Kathleen Toepke, Alameda County Nurses' Association and Nurses' Guild of Alameda County, Aug 14 1946. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 354, Folder 12.

Brudney described the meeting in this way:

> This meeting was called after Miss Titus had discussed the situation with a member of the CIO. Because of the interest shown by Miss Titus, the meeting was arranged. Miss Titus wanted to know what the CIO Could do to help the CSNA on the economic front and the legislative field. The CIO representatives gave her a complete picture of how the organization functions and what we could do for the nurses. We explained in detail the structure of the union and how nurses could retain their autonomy. Miss Titus expressed the opinion that she thought more of the CIO than the AFL. She said that she was aware of the strong role played by the CIO, both organizationally and by legislative means. Miss Titus also said that she thought that some kind of program could be worked out whereby we could work through her Executive Board, with the perspective of the CSNA eventually moving, as a body, into the CIO. [...] Miss Titus [...] expressed the opinion that it would be better to all concerned if we did not attempt to organize the nurses and wait until the entire CSNA was ready to move as a body

[57] Article in *This World,* October 13, 1946. Kaiser Permanente Heritage Resources private collection.

[58] "Telephone Conversation with Miss Shirley Titus, Dec 3, 1946," memo from Ella Best to file. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 403, Folder 12.

[59] Toepke described the logic of the change in affiliation as follows:

> The CSNA turned to the ANA for a decision, which organization ruled that there were

> not provisions within the bylaws … for the maintenance of a guild within a district. … The ACNA accepted this decision of the ANA without representation, and even though the emergency was great in the district, the guild was dissolved. In other words, the CSNA and ANA would not sanction such a guild as an emergency measure, as a professional association we accepted the ruling and acted accordingly. Now, some members of the ACNA believed in the possibilities of the guild and what it could do for the nurses of Alameda County and believed the guild should be maintained even if it could not be within the ACNA; and so, having the courage of their convictions, they sought to urge the CSNA for recognition of the Guild as an affiliate body of the ACNA. They presented this request by formal resolution addressed to the President of the CSNA. But never received the courtesy of a reply. Financially it was impossible to retain the Guild as an independent unit, so receiving only a rebuff from the CSNA, they turned to other sources for assistance, which subsequently resulted in affiliation with the CIO. The Guild, then, which was formerly within the ACNA is now affiliated with the CIO.

Special Bulletin, ACNA newsletter, Vol 1, No 1, September 1946. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 354, Folder 12.

[60] Alma Stone, notes from orientation trip to California State Nurses Association ESP. April 15-30, 1947. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 333, Folder 6.

[61] Shirley Titus, "Analysis of Personnel Needs of CSNA," Memo to CSNA Board, ca 1945. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 2 folder 10.

[62] Press Release, Nurses' Guild of Alameda County, June 27 1946. Kaiser Permanente Heritage Resources private collection.

[63] Article in *This World,* October 13, 1946. Kaiser Permanente Heritage Resources private collection.

[64] Indeed, despite the CSNA's claims—often since repeated—to have negotiated the first contract for nurses, the Guild's contracts governing nurses at Kaiser Permanente hospitals in Oakland an Richmond appear to predate those contract by several days (though some reports have both sets of contracts announced on the same day).

Article in *This World,* October 13, 1946. Kaiser Permanente Heritage Resources private collection.

[65] "Subversive Control of the United Public Workers of America." Hearings before the Subcommittee to Investigate the Administration of the Internal Security Act and other Internal Security Laws, Committee on the Judiciary, US Senate. April – Dec 1951. United States Government Printing Office, Washington: 1952.

Robert M. Henderson and Robert Lafollette Sucher, "A Study of the National Development of the Unionization of registered Nurses and Hospital Workers." Report for the Building Services International Union and the Registered Nurses and Professional Workers Guild, Local#126. Special Collections, Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU Historical Collection, AC 1924, Box 9, Folder 17.

[66] *Service Employee News*, Newsletter for BSEIU Local 300, September 1946. Special Collections, Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU Publications Collection, AC LR002452, Box 62, Folder 1.

[67] Robert M. Henderson and Robert Lafollette Sucher, "A Study of the National Development of the Unionization of registered Nurses and Hospital Workers." Report for the Building Services International Union and the Registered Nurses and Professional Workers Guild, BSEIU Local #126. Special Collections, Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU Historical Collection, AC 1924, Box 9, Folder 17.

[68] *RN Guild News-Digest*, Newsletter for Registered Nurses, Technicians, and Professional Guild, BSEIU Local #295. Special Collections, Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU Research Department Historical Collection, AC 1542, Box 12, Folder 45.

[69] Shirley Titus, 1943. "Economic Security is Not Too Much to Ask." *The Modern Hospital,* Vol 61 No 3, September 1943, Pp 71.

[70] At the meeting, the House of Delegates passed a resolution stating:

> The American Nurses Association believes that several state and district nurses associations are qualified to act and should act as the exclusive agents of their respective fields of economic security and collective bargaining. The association commends and urges all state and district nurses associations to push such a program vigorously and expeditiously. Since it is the established policy of other groups, including unions, to permit membership in only one collective bargaining group, the Association believes such policy to be sound for state and district nurses associations.

Source: "Major Official Policies Relating to the Economic Security Program." ANA Publication, 1965. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 9, Folder n/a.

[71] A 1967 report on the status of the ANA ESP programs noted:

> It should be noted thatin places where SNA's Initiated an Economic Security Programin advance of ANA, there had previously been attempts to unionize the nurses. The Economic Security Program was an effort of the nursing organization to meet the needs of nurses at their place of employment. The early efforts undoubtedly arose to counter the efforts being made to organize nurses into trade unions as the leaders felt that this was not the professional way to approachthe problems."

"Review of the ANA Economic Security Program by Stanley Rostov: An Appraisal." Ca. January 1967. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 7 folder 162.

[72] One source of opposition was the state associations based in the South, where anti-union sentiment ran high—a few years later, delegates from Georgia and South Carolina claimed that "some industrial nurses in their states were not allowed by their employers to join the American Nurses' Association" because of the Economic Security Program.

"The 1954 ANA Convention." *The American Journal of Nursing*, Vol. 54, No. 6 (Jun., 1954), pp. 698-714

[73] Stanley, Judith. "Florence Nightingale was a Scrapper, too! Militant Nurses and the Abrogation

of the ANA No-Strike Policy." Historical Memo, ca 1989. University of California, San Francisco Special Collections. Accession #MSS-37, Carton 24, Folder 40, Nursing History Committee 1993-1994.

[74] Joseph K. Hart, "Economic Security for Nurses: Through Trade Unionism or --?" *The American Journal of Nursing,* Vol. 38, No. 4, Section 1 (Apr., 1938), pp. 391-395

[75] Letter from Esther Swenseid, Acting Director, CSNA ESP To Wendell French, Associate Professor at the College of Business Administration, University of Washington, May 11, 1960. Howard Gotlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 355, Folder 6.

[76] One exception to the cellular nature of this mobilization was a case of payment refusal in 1946, where the tactic spanned six hospitals.

"A History of CNA Collective Bargaining in the San Francisco Bay Area." Research report by Sherry Minson, CNA Board member and organizer, 1979. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 10, Folder Unsorted.

[77] Letter from Esther Swenseid, Acting Director, CSNA ESP To Wendell French, Associate Professor at the College of Business Administration, University of Washington, May 11, 1960. Howard Gotlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 355, Folder 6.

[78] "A History of CNA Collective Bargaining in the San Francisco Bay Area." Research report by Sherry Minson, CNA Board member and organizer, 1979. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 10, Folder Unsorted.

[79] Letter from Esther Swenseid, Acting Director, CSNA ESP To Wendell French, Associate Professor at the College of Business Administration, University of Washington, May 11, 1960. Howard Gotlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 355, Folder 6.

[80] "Manual for an Economic Security Program." ANA Publication, 1956. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 9, Folder n/a.

[81] "Manual for an Economic Security Program." ANA Publication, 1956. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 9, Folder n/a.

[82] "Manual for an Economic Security Program." ANA Publication, 1956. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 9, Folder n/a.

[83] The structure would be further solidified, and the autonomy of commissions further enhanced, by a series of NLRB decisions in the 1970s and 1980s, which will be discussed in Chapter 3.

[84] Rich and Associates consultants interviewed staff and members of six national nursing associations then in existence: the ANA, the National Association of Colored Graduate Nurses, the American Association of Industrial Nurses, the National League for Nursing Education, the National Organization of Public Health Nursing, and the Association of Collegiate Schools of Nursing.

[85] Most broadly, the Report envisioned an interlocked network of organizations, including the ANA, a new National Academy of Nurses focused on research and accreditation, and a National Nursing Center, which would lead the outreach and advocacy functions of the association, and allow for the integration of non-nurse allies while maintaining the integrity of the professional association itself.

Raymond Rich Associates, "Report on the Structure of Organized Nursing." *The American Journal of Nursing,* Vol. 46, No. 10 (Oct., 1946), pp. 648-661

[86] Beyond these structural reforms, the Report also articulated a series of principles that would undergird later discussions of organizational functions and long term goals. First and foremost, the report called for the unification of the profession, from the staff nurse to the nursing director to the nurse educator. This was in keeping with the longstanding structure of the Association, and also spoke to the anxieties arising from union competition and rank and file mobilization, in California and elsewhere. Second, there was substantial emphasis on enhancing nursing practice, creating homes for clinical specialties. Third, the proposal focused explicitly on making reforms that would enlist the support of allied professionals and the general public. Finally, the report would codify the newly-created Economic and General Welfare program as a key objective of the association, including the sanctioning of a collective bargaining program. Indeed, the report cited California, and the program Titus had created in the CSNA, as the key exemplar of how the national program might be structured:

> Organized nursing must operate effectively in this important field [social and economic welfare] or see it taken over by the labor unions. In our field interviews, we have found that the average nurse, as well as nurse leaders, would prefer to have the professional association represent them in these matters—if it would set up a sound program and be ready soon to operate effectively. But nurses need and want help in this field *now*. The answer must therefore not be too long delayed. They are seeking effective action and they will not be satisfied by anything short of that. Organized representation for collective bargaining has already been instituted by the California State Nurses Association, and a national program for economic security is being considered at the current ANA convention. We recommend, therefore, that organized nursing assume the responsibility for advancing the social and economic security of nursing practitioners, rather than leaving this field to organizations outside the profession. We suggest that such a program be set up on the basis of the experience of the California SNA—which appears to us to be soundly founded—and of others.

Raymond Rich Associates, "Report on the Structure of Organized Nursing." *The American Journal of Nursing,* Vol. 46, No. 10 (Oct., 1946), pp. 648-661

[87] In 1950, a preliminary plan to merge the six into two distinct organizations, the ANA and the new "Nursing League of America," received formal membership endorsements from each organization. In 1952, the National League for Nursing, which would focus on nursing education institutions, formed out of the merger of the National League for Nursing Education, the National Organization for Public Health Nursing, and the Association of Collegiate Schools of Nursing. On the working nurse side, mergers occurred as well, though the ANA remained in roughly the same form. The National Association of Colored Graduate Nurses vote to merge into the ANA in 1951, after the Association took a stand favoring racial integration in hospital workplaces and nursing organizations (not all state associations followed suit at that point). The AAIN, on the other hand, voted to remain independent.[87] Still, throughout the 1950s and 1960s, many, particularly within the ANA, continued to push for a single nurses' association that would

encompass the broad spectrum of the profession. This push was closely tied to many ANA leaders' emphasis on establishing more rigorous educational and certification requirements for entry into the profession, an area that NLN leaders considered their purview. While the two organizations held a series of formal discussions over this period, ultimately, the discussions faltered, and the associations remained separate.

Fondiller, Shirley Hope. 1980. "The National League for Nursing 1952-1972: Response to the Higher Education Movement." Educat.D., Columbia University Teachers College, United States -- New York.

[88] Frances L. A. Powell, "Changing ANA to Meet Changing Needs, Part 1: Appraising the Situation." *The American Journal of Nursing,* Vol. 64, No. 3 (Mar., 1964), pp. 111-113

Frances L. A. Powell, "Changing ANA to Meet Changing Needs, Part 2: Concern with Practice." *The American Journal of Nursing,* Vol. 64, No. 4 (Apr., 1964), pp. 113-116

Frances L. A. Powell, "Changing ANA to Meet Changing Needs, Part 3: Resolving Complex Problems." *The American Journal of Nursing,* Vol. 64, No. 5 (May, 1964), pp. 117-120

[89] "Supplemental Report from the Committee for Economic and General Welfare." Proceedings, House of Delegates, ANA Convention, June 1966. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 151, Folder n/a.

[90] "Supplemental Report from the Committee for Economic and General Welfare." Proceedings, House of Delegates, ANA Convention, June 1966. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 151, Folder n/a.

[91] American Nurses Association. 1965. "American Nurses' Association's First Position on Education for Nursing." *The American Journal of Nursing* 65(12):106–11.

[92] American Nurses Association. 1965. "American Nurses' Association's First Position on Education for Nursing." *The American Journal of Nursing* 65(12):106–11.

[93] American Nurses Association. 1966. "ANA Convention Report: The Profession Prepares for Its Future." *The American Journal of Nursing* 66(7):1548–67.

[94] "Supplemental Report from the Committee for Economic and General Welfare." Proceedings, House of Delegates, ANA Convention, June 1966. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 151, Folder n/a.

[95] "Organizational Nursing: An Assessment." Article by A. Lionne Conta, in *California Nurse*, 1976.

[96] "The Economic Security Program." Talk given by Marian Alford to a meeting of Chairmen of the District Institutional Staff Nurses' Sections and Chairmen of the District Personnel Policies Committees, New York State Nurses' Association, Albany, NY on May 21 1948. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 9, Folder n/a.

[97] Stanley, Judith. "Florence Nightingale was a Scrapper, too! Militant Nurses and the Abrogation of the ANA No-Strike Policy." Historical Memo, ca 1989. University of California, San Francisco Special Collections. Accession #MSS-37, Carton 24, Folder 40, Nursing History Committee 1993-1994.

"A History of CNA Collective Bargaining in the San Francisco Bay Area." Research report by

Sherry Minson, CNA Board member and organizer, 1979. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 10, Folder Unsorted.

[98] Kossoris, Max D. 1967. "The San Francisco Bay Area 1966 Nurses' Negotiations." *Monthly Labor Review*, Volume 1967, Issue 8

[99] "CNA Joint Statements." CNA Publication, 1972. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 6, Folder n/a.

[100] "Organizational Nursing: An Assessment." Article by A. Lionne Conta, in *California Nurse*, 1976.

[101] "A History of CNA Collective Bargaining in the San Francisco Bay Area." Research report by Sherry Minson, CNA Board member and organizer, 1979. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 10, Folder Unsorted.

[102] Stanley, Judith. "Florence Nightingale was a Scrapper, too! Militant Nurses and the Abrogation of the ANA No-Strike Policy." Historical Memo, ca 1989. University of California, San Francisco Special Collections. Accession #MSS-37, Carton 24, Folder 40, Nursing History Committee 1993-1994.

"A History of CNA Collective Bargaining in the San Francisco Bay Area." Research report by Sherry Minson, CNA Board member and organizer, 1979. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 10, Folder Unsorted.

[103] Kossoris, Max D. 1967. "The San Francisco Bay Area 1966 Nurses' Negotiations." *Monthly Labor Review*, Volume 1967, Issue 8

Max Kossoris, a Director at the Bureau of Labor Statistics, wrote in the Monthly Labor Review:

> Despite this display of militancy, CNA apparently accepted its role reluctantly. It appears to have been forced into its position by a militant rank and file. Giving up a long-held philosophy of the proper behavior for a professional organization came hard, and the leadership was by no means certain that the new point of view represented the thinking of a majority of its membership, particularly that of older nurses." Whether the nurses' group really intended to tie up with the teamsters local or whether it intended to push CNA into more militant action is a moot question. The nurses did make clear that if CNA could not resolve their problems and also get a substantial salary increase, they would try some other way

[104] "Bay Nurses to Remain On Jobs." *Oakland Tribune,* August 2, 1966.

"Marathon Last Ditch Talks Resume in Nurses' Dispute." *Oakland Tribune,* August 1, 1966.

"Position Evaluation – General Duty Nurse." Kaiser Permanente Internal Memo, August 23, 1966. Bancroft Library, UC Berkeley, Edgar Kaiser Collection 85-61c, Box 152 Folder 3.

[105] Kossoris, Max D. 1967. "The San Francisco Bay Area 1966 Nurses' Negotiations." *Monthly Labor Review*, Volume 1967, Issue 8

[106] Arda Vonderheid, "From My Historical Perspective." *California Nurse,* Vol 72 No 2, June 1976.

[107] "Mass Meeting: Nurses Storm, but Cancel Walkout." *San Francisco Chronicle,* August 3, 1966.

Kossoris, Max D. 1967. "The San Francisco Bay Area 1966 Nurses' Negotiations." *Monthly Labor Review*, Volume 1967, Issue 8

[108] "A History of CNA Collective Bargaining in the San Francisco Bay Area." Research report by Sherry Minson, CNA Board member and organizer, 1979. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 10, Folder Unsorted.

[109] Pamphlet, Retail Clerks Union Local 770, August 26 1966. Kaiser Permanente Internal Memo, August 23, 1966. Bancroft Library, UC Berkeley, Edgar Kaiser Collection 85-61c, Box 152 Folder 3.

[110] Pamphlet, Retail Clerks Union Local 770, August 26 1966. Kaiser Permanente Internal Memo, August 23, 1966. Bancroft Library, UC Berkeley, Edgar Kaiser Collection 85-61c, Box 152 Folder 3.

[111] Internal Memo, Kaiser Permanente, Author unknown, September 1966. Bancroft Library, UC Berkeley, Edgar Kaiser Collection 85-61c, Box 152 Folder 4.

[112] Internal Memo, Kaiser Permanente, Author unknown, September 1966. Bancroft Library, UC Berkeley, Edgar Kaiser Collection 85-61c, Box 152 Folder 4.

[113] Internal Memo, Kaiser Permanente, Author unknown, September 1966. Bancroft Library, UC Berkeley, Edgar Kaiser Collection 85-61c, Box 152 Folder 4.

[114] Internal Memo, Kaiser Permanente, Author unknown, September 1966. Bancroft Library, UC Berkeley, Edgar Kaiser Collection 85-61c, Box 152 Folder 4.

[115] Internal Memo, Kaiser Permanente, Author unknown, September 1966. Bancroft Library, UC Berkeley, Edgar Kaiser Collection 85-61c, Box 152 Folder 4.

[116] "Memorandum of Understanding," Agreement between parties regarding fact finding panel, July 1966. Bancroft Library, UC Berkeley, Edgar Kaiser Collection 85-61c, Box 152 Folder 3.

[117] "A Solution to the Hospitals-Nurses Dispute." Report produced by Kaiser Permanente, July 1966. Bancroft Library, UC Berkeley, Edgar Kaiser Collection 85-61c, Box 152 Folder 3.

[118] "CNA Hospital Controversy." Memo from Lawrence P. Corbett to Hospitals, July 25 1966. Bancroft Library, UC Berkeley, Edgar Kaiser Collection 85-61c, Box 152 Folder 3.

[119] Kaiser CNA fact finding meeting summaries sep-oct 1966. Bancroft Library, UC Berkeley, Edgar Kaiser Collection 85-61c, Box 152 Folder 4.

[120] Kaiser CNA fact finding meeting summaries sep-oct 1966. Bancroft Library, UC Berkeley, Edgar Kaiser Collection 85-61c, Box 152 Folder 4.

[121] Kaiser CNA fact finding meeting summaries sep-oct 1966. Bancroft Library, UC Berkeley, Edgar Kaiser Collection 85-61c, Box 152 Folder 4.

[122] "Draft – Meeting of the Subcommittee of the ANA Commission on Economic and General Welfare – which continued its pursuit of new approaches to the Economic Security Program." April 29-30, 1967. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 7 folder 162.

[123] "Nurses are Making it Happen." The American Journal of Nursing, Vol. 67, No. 2 (Feb., 1967), pp. 285-289

[124] Kossoris, Max D. 1967. "The San Francisco Bay Area 1966 Nurses' Negotiations." *Monthly*

Labor Review, Volume 1967, Issue 8

[125] Kossoris, Max D. 1967. "The San Francisco Bay Area 1966 Nurses' Negotiations." *Monthly Labor Review*, Volume 1967, Issue 8

[126] "New Statement of Policy of the CNA Board of Directors." Memo from Mary K Stanley, CNA President, to CNA District Association Presidents and Secretaries, August 26, 1966. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 7 folder 159.

[127] "New Statement of Policy of the CNA Board of Directors." Memo from Mary K Stanley, CNA President, to CNA District Association Presidents and Secretaries, August 26, 1966. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 7 folder 159.

[128] "New Statement of Policy of the CNA Board of Directors." Memo from Mary K Stanley, CNA President, to CNA District Association Presidents and Secretaries, August 26, 1966. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 7 folder 159.

[129] "New Statement of Policy of the CNA Board of Directors." Memo from Mary K Stanley, CNA President, to CNA District Association Presidents and Secretaries, August 26, 1966. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 7 folder 159.

[130] "Chronology of Recent Labor Events." *Monthly Labor Review*, Volume 89, No 9 (September 1966).

[131] Meeting Minutes, ANA Commission on Economic and General Welfare, March 6-8 1968. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 8 folder 199.

"ANA Commission on Economic and General Welfare Recommendation Re: ANA No-Strike Policy." May 1968. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 8 folder 203.

"Approval for transmitting to 1968 convention delegates recommendations of the Commission on Economic and General Welfare on a national salary pronouncement, and the 'no-strike' policy." Memo from Judith Whitaker, ANA Executive Director, to the ANA Board of Directors, March 12 1968. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 8 folder 195.

[132] Stanley, Judith. "Florence Nightingale was a Scrapper, too! Militant Nurses and the Abrogation of the ANA No-Strike Policy." Historical Memo, ca 1989. University of California, San Francisco Special Collections. Accession #MSS-37, Carton 24, Folder 40, Nursing History Committee 1993-1994.

[133] Lionne Conta, "She Worked for the Strike Policy. Letter, The American Journal of Nursing, Vol. 68, No. 10 (Oct., 1968), p. 2105

[134] "Draft – Meeting of the Subcommittee of the ANA Commission on Economic and General Welfare – which continued its pursuit of new approaches to the Economic Security Program." April 29-30, 1967. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 7 folder 162.

[135] Conway Johnson, Cathleen E. 1994. "The Troubles with Angels of Mercy: The Mass Resignation of Registered Nurses at DeKalb General Hospital, Decatur, Georgia, January 22, 1969." Ph.D. Dissertation, Emory University.

[136] "Draft – Meeting of the Subcommittee of the ANA Commission on Economic and General Welfare – which continued its pursuit of new approaches to the Economic Security Program." April 29-30, 1967. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 7 folder 162.

[137] "Draft – Meeting of the Subcommittee of the ANA Commission on Economic and General Welfare – which continued its pursuit of new approaches to the Economic Security Program." April 29-30, 1967. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 7 folder 162.

[138] "Draft – Meeting of the Subcommittee of the ANA Commission on Economic and General Welfare – which continued its pursuit of new approaches to the Economic Security Program." April 29-30, 1967. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 7 folder 162.

[139] "Draft – Meeting of the Subcommittee of the ANA Commission on Economic and General Welfare – which continued its pursuit of new approaches to the Economic Security Program." April 29-30, 1967. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 7 folder 162.

[140] In a September 1967 memo to the Board of Directors, Whitaker argued that the New Approach presented numerous dangers, which would undermine the unity and professional focus of the organization. Importantly, she warned that the New Approach's emphasis on worksite organization might undermine existing patterns of organizational governance, unnerving to many nurse managers:

> The proposal […] raises serious questions of the setting of priorities for the Association, now and in the future, both in terms of ANA financial resources and in terms of the emphasis to be given to each of the fundamental concerns of the organization. [...] Would this widespread use of ANA resources for organizing and representing nurses at their places of work imply a commitment to collective bargaining agreements as the primary means of achieving objectives in the other major areas of the ANA's concerns - nursing practice, nursing services, nursing education? Does it portend the development of the local unit in the employment setting as the basic unit of the Association in the future?

"Draft – Meeting of the Subcommittee of the ANA Commission on Economic and General Welfare – which continued its pursuit of new approaches to the Economic Security Program." April 29-30, 1967. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 7 folder 162.

[141]"Memorandum Re: 'A Proposal for a new approach to the Economic Security Program,' ANA Commission on Economic and General Welfare, September, 1967." Sept 6, 1967 Memo from Judith Whitaker, ANA ED to the ANA Board of Directors. . University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 8 folder 188.

[142] ANA Board of Directors Meeting, Executive Session, Sep 13 1967. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 448, Folder n/a.

[143] ANA Board of Directors Meeting, Executive Session, Sep 13 1967. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 448, Folder n/a.

[144] ANA Board of Directors Meeting, Executive Session, Sep 13 1967. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 448, Folder n/a.

[145] Letter from Judith G. Whitaker to Anne L. Zimmerman. February 2, 1968. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 8 folder 193.

[146] Oral History with Elizabeth Cantwell, September 26, 2008. Conducted by Quincey Harrington, Methodist Medical Center Oral History.

[147] "News." *The American Journal of Nursing*, Vol. 70, No. 1 (Jan., 1970),

California Nurses Association Report to the House of Delegates for the years 1969-1970. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 6, Folder n/a.

[148] "Financial Crisis Prompts ANA Appeal for Funds." The American Journal of Nursing, Vol. 70, No. 3 (Mar., 1970)

[149] By the end of 1969, shortly before learning the New Approach would be eliminated, Zimmerman reflected on the effort and suggested that it had never been fully implemented, but rather, it had been thwarted by its opponents in the ANA hierarchy. Arguing that the proposal approved by the Board in September 1967 specifically outlined that the *Commission* would "initiate, lead, and direct an effective program." But through subterfuge from elsewhere in the organization, the Commission was never able to initiate, lead, or direct the program in any substantive sense.

> Nowhere is there any plan to just assign staff to SNAs to work under SNA executives. There is no insulation. No leadership by the Commission. Not sufficient scale to have much impact. […] Has the NA [New Approach] succeeded or failed? It could be stated that it has not been tried. ANA management insisted on controlling and directing and being responsible for results, but has not in fact controlled, directed, lead or tried to be responsible for ensuring results. Scale has not been half of the plan. Budgeted funds have not been augmented with matching SNA funds. Staff has been assigned to work for the SNA. Other staff whose salaries are charged against the NA are doing the work that ES department staff has always done in offering guidance to SNA staff. Where is the New Approach? Will the Commission have to stand up in the House of Delegates and defend its plan from attack based on lack of progress when its plan has not really been followed? ANA asked for the responsibility. What is ANA doing with it?

"New Approach: Plan and Actuality." Letter from Anne Zimmerman, November 3, 1969. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 8 folder 195.

[150] "Suspension of New Approach." Memo from Elizabeth Cantwell, Director, Economic Security Program, to Commission on Economic and General Welfare, December 15 1969. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 9 folder 224.

[151] Conway Johnson, Cathleen E. 1994. "The Troubles with Angels of Mercy: The Mass Resignation of Registered Nurses at DeKalb General Hospital, Decatur, Georgia, January 22, 1969." Ph.D. Dissertation, Emory University.

[152] "Report of the Convention Subcommittee on History, 1991-93." University of California, San

Francisco Special Collections. Accession #MSS-37, Carton 24, Folder 1.

[153] Proceedings: Forum on Professional Performance Committees. Anaheim Convention Center." 1971. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 6, Folder n/a.

[154] "Sequence of Events in Bay Area Staff Nurse Hospital Negotiations." Memo, Ca 1966. University of California, San Francisco Special Collections. Accession #MSS-37, Carton 9, Folder 49.

[155] Arda Vonderheid, "From My Historical Perspective." *California Nurse,* Vol 72 No 2, June 1976.

[156] Unsigned memo, Kaiser Permanente. Bancroft Library, UC Berkeley, Edgar Kaiser Collection 85-61c, Box 152 Folder 4.

[157] "Organizational Nursing: An Assessment." Article by A. Lionne Conta, in *California Nurse*, 1976.

[158] Lionne Conta, "Professional Performance Committees: Basic Concepts." *The American Journal of Nursing,* Vol. 68, No. 12 (Dec, 1968), pp. 2601-2607

[159] "Request for the Commission on Economic and General Welfare to answer certain questions related to the ANA Economic Security Program." Memo from Pauline Fahey, Commission on Nursing Services, to the Commission on Economic and General Welfare, September 7, 1967. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 7 folder 81.

[160] "Request for the Commission on Economic and General Welfare to answer certain questions related to the ANA Economic Security Program." Memo from Pauline Fahey, Commission on Nursing Services, to the Commission on Economic and General Welfare, September 7, 1967. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 7 folder 81.

[161] Lionne Conta, "Professional Performance Committees: Basic Concepts." *The American Journal of Nursing,* Vol. 68, No. 12 (Dec, 1968), pp. 2601-2607

Barbara Schutt. "Collective Action for Professional Security." *The American Journal of Nursing,* Vol. 73,No. 11 (Nov., 1973), pp. 1946-1951

Lionne Conta, "Bargaining by Professionals." *The American Journal of Nursing,* Vol. 72, No. 2 (Feb., 1972), pp. 309-312

[162] Proceedings: Forum on Professional Performance Committees. Anaheim Convention Center." 1971. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 6, Folder n/a.

[163] "Professional Performance Committee Manual." California Nurses Association publication, 1970. San Francisco State

[164] Proceedings: Forum on Professional Performance Committees. Anaheim Convention Center." 1971. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 6, Folder n/a.

[165] "First Friday Night RN Strike Meeting, July 5, 1975." Meeting notes, San Francisco State University, Labor Archives and Resource Center archives. Data Center collection, Box 4, Folder

56.

[166] "Interview with Burton White, Director of Economic and General Welfare, California Nurses Association, by Tom and Carol, August 29 and 30, 1974." San Francisco State University, Labor Archives and Resource Center archives. Data Center collection, Box 2, Folder 10.

[167] "The Staffing Issue." Memo from Arthur Mendelson, Ca. 1974. San Francisco State University, Labor Archives and Resource Center archives. Data Center collection, Box 4, Folder 56.

[168] Sylvia Weinstein, 1974. "Northern California Nurses Unite in Militant Strike. *The Militant,* June 28 1974. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 10, Folder Unsorted.

[169] "ANA Convention '74." *American Journal of Nursing,* Vol. 74, No. 7 (Jul., 1974), pp. 1258-1275

[170] "ANA Convention '74." *American Journal of Nursing,* Vol. 74, No. 7 (Jul., 1974), pp. 1258-1275

[171] Remarks by Irene Pope, CNA President, to the House of Delegates at the 49th Biennial ANA Convention. Howard Gottlieb Archival Research Center, Boston University. American Nurses Association collection N-87, Box 491, Folder 8.

[172] Some groups of staff nurses and their allies remained dissatisfied with the CNA's handling of negotiations throughout. During the strike, some of these nurses met on Friday evenings to share thoughts and strategies on the strike and on dealing with CNA leaders. The meetings were attended by "about 40 people, RNs, LVNs, ward clerks, radical docs, etc." There, they told of activating Professional Performance Committees in the lead up to negotiations. They spoke of sympathy from administrative nurses within the hospitals, who gave them support and fed them information about hospital management even as they picked up significant work during the strike. They found that, relative to other negotiations, CNA leaders were being largely transparent and democratic; one nurse assessed that this was due to an influx of younger staff in the association with experience in the women's movement, as well as an increased threat of union incursion. But they also felt that by the end of bargaining, CNA had closed off avenues for participation.

Meeting notes for "Friday Night RN Strike Meeting," July 5 and 12, 1974. San Francisco State University, Labor Archives and Resource Center archives. Data Center collection, Box 4, Folder 56.

[173] Memo from Burton White, Director, Economic and General Welfare, to CNA Board of Directors, August 28 1974. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 9, Folder n/a.

[174] Memo from Burton White, Director, Economic and General Welfare, to CNA Board of Directors, August 28 1974. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 9, Folder n/a.

[175] Memo from Burton White, Director, Economic and General Welfare, to CNA Board of Directors, August 28 1974. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 9, Folder n/a.

[176] NURSES' NOTES. Newsletter of the North Bay Coastal Region, CNA, 11:2, July 1975. Quoted in Conta, 1976.

[177] "Report of the Hospital and Nursing Home Committee to the 13th General Convention of the Building Service Employees International Union, AFL-CIO." Los Angeles, CA May 4th-7th, 1964. San Francisco State University, Labor Archives and Resource Center archives. larc.ms.1991-056, Box 4, Folder 7.

[178] "Coverage of Nonprofit Hospitals under the National Labor Relations Act." Report from Senator Cranston of the Committee on Labor and Public Welfare. Ordered Printed April 2, 1974. Senate Report No. 93-766.

[179] Taft-Hartley also excluded public employees of wholly-owned federal government enterprises and the Federal Reserve Banks. Other groups of private sector workers, such as agricultural and domestic laborers, had been excluded under the original Wagner Act. Nonprofit hospital care, however, was the only private industry specifically singled out under Taft-Hartley itself.

[180] Legislative History of the Coverage of Nonprofit Hospitals under the National Labor Relations Act, 1974; Public Law 93-360 (S.3203).

[181] Legislative History of the Coverage of Nonprofit Hospitals under the National Labor Relations Act, 1974; Public Law 93-360 (S.3203).

[182] (Zimmerman 1975)

[183] "The Jungle Revisited: NLRB Assumes Jurisdiction over Proprietary Hospitals." Memo by Lawrence Corbett, distributed to members of the California Hospital Association. Dec 8, 1967. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 18, Folder n/a.

[184] "The Jungle Revisited: NLRB Assumes Jurisdiction over Proprietary Hospitals." Memo by Lawrence Corbett, distributed to members of the California Hospital Association. Dec 8, 1967. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 18, Folder n/a.

[185] Legislative History of the Coverage of Nonprofit Hospitals under the National Labor Relations Act, 1974; Public Law 93-360 (S.3203).

[186] "Health Care Law under the NLRA." American Bar Foundation Report. Online at https://www.americanbar.org/content/dam/aba/events/labor_law/basics_papers/nlra/health_care.authcheckdam.pdf. Published December 18, 2012, retrieved August 3, 2017.

[187] (Feheley 1975)

[188] (Feheley 1975)
(Brannon 1988)

[189] "Coverage of Nonprofit Hospitals under the National Labor Relations Act." Report from Senator Cranston of the Committee on Labor and Public Welfare. Ordered Printed April 2, 1974. Senate Report No. 93-766.

[190] Untitled paper presented by Anne Zimmerman at the International Consultative Conference on the Conditions of Work and Life of Health Service Personnel. Convened by the Medical Workers Union of Moscow. October 21-23, 1975. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06.

[191] Quoted in Vinel (2013:202)

[192] Elisburg, Donald E. 1975. "Legislative History of the Amendments: Rationale and Intent." Chapter 4 in *Labor Relations in Hospitals and Health Care Facilities, Proceedings of a Conference Presented by the American Arbitration Association and the Federal Mediation and Conciliation Service*. Washington: Bureau of National Affairs.

[193] Elisburg, Donald E. 1975. "Legislative History of the Amendments: Rationale and Intent." Chapter 4 in *Labor Relations in Hospitals and Health Care Facilities, Proceedings of a Conference Presented by the American Arbitration Association and the Federal Mediation and Conciliation Service*. Washington: Bureau of National Affairs.

[194] "Coverage of Nonprofit Hospitals under the National Labor Relations Act." Report from Senator Cranston of the Committee on Labor and Public Welfare. Ordered Printed April 2, 1974. Senate Report No. 93-766.

[195] "Health Care Law under the NLRA." American Bar Foundation Report. Online at https://www.americanbar.org/content/dam/aba/events/labor_law/basics_papers/nlra/health_care.authcheckdam.pdf. Published December 18, 2012, retrieved August 3, 2017.

"Coverage of Nonprofit Hospitals under the National Labor Relations Act." Report from Senator Cranston of the Committee on Labor and Public Welfare. Ordered Printed April 2, 1974. Senate Report No. 93-766.

[196] "Coverage of Nonprofit Hospitals under the National Labor Relations Act." Report from Senator Cranston of the Committee on Labor and Public Welfare. Ordered Printed April 2, 1974. Senate Report No. 93-766.

[197] Cited in Vinel 2013

"Coverage of Nonprofit Hospitals under the National Labor Relations Act." Report from Senator Cranston of the Committee on Labor and Public Welfare. Ordered Printed April 2, 1974. Senate Report No. 93-766.

[198] (Rosmann 1975)

[199] "Industry Profile for Health Care Industry in Northern California." Report prepared by Commissioner Dorothy Christiansen of the Federal Mediation and Conciliation Service, August 1978. San Francisco State University, Labor Archives and Resource Center archives. Accession #0341, Box 13, Folder 8.

[200] Oral History Interview with Richard Liebes, Conducted by Adah Bakalinsky, 1991. San Francisco State University Labor Archives and Research Center Oral History Collection.

[201] Oral History Interview with Richard Liebes, Conducted by Adah Bakalinsky, 1991. San Francisco State University Labor Archives and Research Center Oral History Collection.

This was not entirely unique to Local 250 or the hospital industry; the War Labor Board broadly shaped bargaining procedures and collective bargaining agreements along these lines in many industries.

[202] Ransom, David. 1980. *So Much to be Done: George Hardy's Life in Organized Labor*.

Washington, D.C.: Service Employees International Union.

[203] The insulation of the west coast locals was solidified by the Hardys' defeat of International President George Scalise in a public confrontation in 1939. Most broadly, the conflict was triggered by Charles Hardy's commitment to local autonomy, and resistance to Scalise' efforts to

centralize authority in the International Union. However, the specific reasons behind the confrontation remain unclear. Scalise accused the Hardy family of stealing dues money, and of irregular book keeping; Charlie Hardy suggested it was primarily a political struggle, a product of his resistance to Scalise' placement of loyalists in his west coast locals. Hardy also alleged that after he had suggested to Scalise that he would request an accounting to locals of the International Union's per capita assessments, to which Scalise had allegedly responded by threatening Hardy's life. This charge was relatively credible, according to the SF Chronicle, because of an earlier incident in which a Chicago union leader had been murdered, allegedly in response to a similar audit demand. Overall, who was telling the truth here remains unclear, and the allegations were not mutually exclusive. Scalise did have extensive ties to organized crime in New York, which would ultimately lead to his own prosecution and imprisonment in 1940. According to contemporaneous reporting, Scalise had also engineered the removal of several union leaders in Chicago and New York. Hardy, on the other hand, is reported to have resisted financial audits from the International.

In December of 1939, Scalise moved to suspend the Hardy family from their positions, charging several financial inconsistencies and missing dues in an audit of Local 87. He also specifically charged Charlie and George with spreading "malicious propaganda" amongst the rank and file, "castigating" officers of the International Union, with the goal of setting up an independent union and affiliating with the CIO. He asked Meyer Lewis, Western Representative of the AFL, to step in and assume management of the western locals. Hardy and his supporters responded by taking the International Union to court, arguing that the International lacked the rights to trustee the local, or to take possession of its financial records, and seeking an injunction preventing their removal from office. Other west coast BSEIU leaders publicly sided with Hardy, and explicitly against Scalise. As the trial dragged on through March, Hardy brought to light Scalise's connections to organized crime, accusing him of multiple murders and of systematic racketeering. And it was this move from private war into the legal arena that pushed the internal dynamics of the union into the public sphere, threatening the image and stability of the union, while also attracting outside intervention. Ultimately, the conflict ended, but not with a conclusion surrounding the Hardys' innocence or guilt; in April the New York Attorney General Thomas Dewey charged Scalise with racketeering and extortion. Scalise tendered his resignation, which was accepted by the subsequent IU convention that May.

See Beadling, Palladino, and Cooper 1980

Palladino, Grace. 1983. “The Fall and Rise of the BSEIU: An Overview of the International’s History, 1937-1949.” Manuscript. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU Historical Collection, AC 1924, Box 02, Folder 17.

[204] Ransom, David. 1980. *So Much to be Done: George Hardy’s Life in Organized Labor*. Washington, D.C.: Service Employees International Union.

[205] Palladino, Grace. 1983. “The Fall and Rise of the BSEIU: An Overview of the International’s History, 1937-1949.” Manuscript. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU Historical Collection, AC 1924, Box 02, Folder 17.

(Beadling, Palladino, and Cooper 1980)

[206] Letter from Laurence Corbett to George Hardy, November 6, 1957. San Francisco State University, Labor Archives and Resource Center archives. Accession #2002.058, Box a22, Folder “Associated 1958.”

[207] Letter from George Hardy to Laurence Corbett, November 14, 1957. San Francisco State University, Labor Archives and Resource Center archives. Accession #2002.058, Box a22, Folder "Associated 1958."

[208] Letter from Laurence Corbett to George Hardy, November 6, 1957. San Francisco State University, Labor Archives and Resource Center archives. Accession #2002.058, Box a22, Folder "Associated 1958."

[209] "The Jungle Revisited: NLRB Assumes Jurisdiction over Proprietary Hospitals." Memo by Lawrence Corbett, distributed to members of the California Hospital Association. Dec 8, 1967. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 18, Folder n/a.

[210] See for example: Eaton and Kriesky 2001; Martin 2008; Voss and Sherman 2000

[211] "The Jungle Revisited: NLRB Assumes Jurisdiction over Proprietary Hospitals." Memo by Lawrence Corbett, distributed to members of the California Hospital Association. Dec 8, 1967. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 18, Folder n/a.

[212] "Industry Profile for Health Care Industry in Northern California." Report prepared by Commissioner Dorothy Christiansen of the Federal Mediation and Conciliation Service, August 1978. San Francisco State University, Labor Archives and Resource Center archives. Accession #0341, Box 13, Folder 8.

[213] Correspondence between Charles Hardy and A.R. Bowles, May 1939. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU Historical Collection, AC 1924, Box 10, Folder 1.

[214] Correspondence between Charles Hardy and A.R. Bowles, May 1939. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU Historical Collection, AC 1924, Box 10, Folder 1.

[215] Oral History Interview with Richard Liebes, Conducted by Adah Bakalinsky, 1991. San Francisco State University Labor Archives and Research Center Oral History Collection.

[216] Local 250, 1970 Annual Report. San Francisco State University, Labor Archives and Resource Center archives. larc.ms.1991-056, Box 4, Folder 3.

[217] Local 250, 1970 Annual Report. San Francisco State University, Labor Archives and Resource Center archives. larc.ms.1991-056, Box 4, Folder 3.

[218] Local 250, 1970 Annual Report. San Francisco State University, Labor Archives and Resource Center archives. larc.ms.1991-056, Box 4, Folder 3.

"The Kaiser Strike: Eight Days on the Bricks." Local 250 publication, 1969. San Francisco State University, Labor Archives and Resource Center archives. larc.ms.1991-056, Box 4, Folder 3.

Local 250, 1969 Annual Report. San Francisco State University, Labor Archives and Resource Center archives. larc.ms.1991-056, Box 4, Folder 3.

[219] "The History of Local 250." Pamphlet from 1987 Local 250 Leadership Conference. San Francisco State University, Labor Archives and Resource Center archives. Accession #0341, Box 1, Folder 3.

"Industry Profile for Health Care Industry in Northern California." Report prepared by

Commissioner Dorothy Christiansen of the Federal Mediation and Conciliation Service, August 1978. San Francisco State University, Labor Archives and Resource Center archives. Accession #0341, Box 13, Folder 8.

[220] Local 250 Membership Meeting Minutes, May 2, 1962. San Francisco State University, Labor Archives and Resource Center archives. Accession #0341, Box 14, Folder 3.

[221] "Industry Profile for Health Care Industry in Northern California." Report prepared by Commissioner Dorothy Christiansen of the Federal Mediation and Conciliation Service, August 1978. San Francisco State University, Labor Archives and Resource Center archives. Accession #0341, Box 13, Folder 8.

[222] Ransom, David. 1980. *So Much to be Done: George Hardy's Life in Organized Labor*. Washington, D.C.: Service Employees International Union.

[223] "History of Local 399," Compiled by Herschell Chubb, August 1960. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU Research Historical Collection, AC 1542, Box 14, Folder 37.

[224] "Local 399 Activities for 1956: Report to the Delegates, 19th Annual Convention, California State Council BSEIU." Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU Research Historical Collection, AC 1542, Box 14, Folder 31.

[225] "History of Local 399," Compiled by Herschell Chubb, August 1960. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU Research Historical Collection, AC 1542, Box 14, Folder 37.

[226] "Local 399 Activities for 1956: Report to the Delegates, 19th Annual Convention, California State Council BSEIU." Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU Research Historical Collection, AC 1542, Box 14, Folder 31.

[227] "Report of the Hospital, Nursing Home Committee to the 13th General Convention of the Building Service Employees Union, AFL-CIO." Los Angeles CA, May 4th-7th 1964. San Francisco State University, Labor Archives and Resource Center archives. Accession #1991-056, Box 4, Folder 7.

[228] "Successful Techniques of Hospital Organizing." Report to the International Convention, BSEIU, May 1968, Washington DC. Submitted by Michael McDermott, Hospital Workers Union Division of BSEIU Local 399. San Francisco State University, Labor Archives and Resource Center archives. Accession #1991-056, Box 4, Folder 12.

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[232] "A study of the National Development of the Unionization of Registered Nurses and Hospital Workers." Report Written by Robert M. Henderson and Robert Lafollette Sucher, for the BSEIU International Union and the Registered Nurses and Professional Workers' Guild, Local 126, of Seattle WA. 1947. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU Historical Collection, AC 1924, Box 9, Folder 17.

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[243] "San Francisco County Nurses Association, Inc. Broadens Nursing Services to the Community." Press Release, Dec 5, 1958. See also meeting minutes, "Regular Meeting of the LVN/PN Nurses' Registry," 1964-66. University of California, San Francisco Special Collections. Accession #MSS-37, Carton 11, Folder 32.

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"Hospital Rebel Group Loses." *SF Examiner,* Thursday, Jan. 14, I960.

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[253] See Brief submitted by Laurence Corbett on Behalf of Doctors' Hospital of Pinole to the National Labor Relations Board Region 20, Case Nos 20-RC-7876 20-RC-7S02 20-RC-7881.

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Decision and Order, National Labor Relations Board Case No. 20-RC-10243, May 1974. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU George Hardy Collection, AC 1542, Box 95, Folder 3.

[254] "Alert No 1," Letter from SEIU President George Hardy to SEIU Hospital Local Unions, May 17, 1974. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU George Hardy Collection, AC 1542, Box 95, Folder 3.

[255] Hardy, to a research training conference in October 1974:

> The International has spent one million dollars for organizing each year since I have been president. During the period from August 26th, I have spent or put into motion actions that will add up to another one million dollars. This is a lot of money and we have to remember that comes from the pocket books of the hard working men and women that are our members.

Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU George Hardy Collection, AC 1542, Box 82, Folder 56.

[256] Interview by the author with David Stillwell, July 9th, 2015.

[257] Comments by Anthony Weinlein to SEIU Healthcare Organizing Conference, January 1974. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU George Hardy Collection, AC 1542, Box 82, Folder 38.

[258] Comments by Anthony Weinlein to SEIU Healthcare Organizing Conference, January 1974. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU George Hardy Collection, AC 1542, Box 82, Folder 38.

[259] Comments by George Hardy to SEIU Healthcare Organizing Conference, January 1974. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU George Hardy Collection, AC 1542, Box 82, Folder 37.

[260] Comments by George Hardy to SEIU Healthcare Organizing Conference, January 1974. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU George Hardy Collection, AC 1542, Box 82, Folder 37.

[261] Comments by John Geagan to SEIU Healthcare Organizing Conference, January 1974. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU George Hardy Collection, AC 1542, Box 82, Folder 37.

[262] Comments by John Geagan to SEIU Healthcare Organizing Conference, January 1974. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU George Hardy Collection, AC 1542, Box 82, Folder 37.

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Letter from David Prosten to George Hardy, March 7 1974. "Non-Profit Hospital Campaign." Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU George Hardy Collection, AC 1542, Box 95, Folder 3.

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[266] "The SEIU Hospital Organizer." International Union Bulletin for SEIU Locals, Summer 1975. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU George Hardy Collection, AC 1542, Box 95, Folder 15.

[267] "Successful Techniques of Hospital Organizing." Report to the International Convention, BSEIU, May 1968, Washington DC. Submitted by Michael McDermott, Hospital Workers Union Division of BSEIU Local 399. San Francisco State University, Labor Archives and Resource Center archives. Accession #1991-056, Box 4, Folder 12.

[268] "Successful Techniques of Hospital Organizing." Report to the International Convention, BSEIU, May 1968, Washington DC. Submitted by Michael McDermott, Hospital Workers Union Division of BSEIU Local 399. San Francisco State University, Labor Archives and Resource Center archives. Accession #1991-056, Box 4, Folder 12.

[269] "Successful Techniques of Hospital Organizing." Report to the International Convention, BSEIU, May 1968, Washington DC. Submitted by Michael McDermott, Hospital Workers Union Division of BSEIU Local 399. San Francisco State University, Labor Archives and Resource Center archives. Accession #1991-056, Box 4, Folder 12.

[270] See periodic Reports from Michael McDermott to George Hardy, August 1974-April 1975. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU George Hardy Collection, AC 1542, Box 95, Folder 5.

[271] (Rosmann 1975)

[272] "A Decade of Progress: 1980 Convention Organizing Report, SEIU." San Francisco State University, Labor Archives and Resource Center archives. Accession #2002.058, Box a9, Folder na.

[273] "SEIU Western Conference Election Results." Report of 1976 and 1977 Election results to Western Conference. San Francisco State University, Labor Archives and Resource Center archives. Accession #1991-056, Box 5, Folder 6.

[274] "Western Conference Organizing Report July 1979." San Francisco State University, Labor Archives and Resource Center archives. Accession #1991-056, Box 5, Folder 4.

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[282] (Kossoris 1967)

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[283] Interview by the author with Kathy Sackman, June 26th, 2015: "And they would say there across the table to you, Kaiser would say, "Well here's some hospital council rates.""

[284] See for instance, Logan, John. 2006. "The Union Avoidance Industry in the United States." *British Journal of Industrial Relations* 44(4):651–75.

[285] (Logan 2006)

[286] Ballman, Catherine S. 1985. "Union Busters." *The American Journal of Nursing* 85(9):963–66. See also Logan (2006)

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[287] "WCIRA Industrial Relations Newsletter, Issue 5. August 15, 1975." San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 8, Folder n/a.

[288] (Getman 2010)

[289] "WCIRA Industrial Relations Newsletter, Issue 5. August 15, 1975." San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 8, Folder n/a.

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[299] "How it is with Nurses Thirty-Two Months After the Taft-Hartley Amendments." Speech by Anne Zimmerman, ANA President, before the American Bar Association Labor Law Institute Seminar on Hospital And Health Care Facilities, April 28 1977. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 13 folder 333.

[300] "How it is with Nurses Thirty-Two Months After the Taft-Hartley Amendments." Speech by Anne Zimmerman, ANA President, before the American Bar Association Labor Law Institute Seminar on Hospital And Health Care Facilities, April 28 1977. University of Illinois at Chicago Special Collections, Anne Zimmerman Papers, MSZimm06, Box 13 folder 333.

[301] "The Jungle Revisited: NLRB Assumes Jurisdiction over Proprietary Hospitals." Memo by Lawrence Corbett, distributed to members of the California Hospital Association. Dec 8, 1967. San Francisco State University, Labor Archives and Resource Center archives. Accession #1988-041, Box 18, Folder n/a.

[302] (Despres 1976)

[303] "Health Care Law under the NLRA." American Bar Foundation Report. Online at https://www.americanbar.org/content/dam/aba/events/labor_law/basics_papers/nlra/health_care.authcheckdam.pdf. Published December 18, 2012, retrieved August 3, 2017.

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[305] Memo from Stella Hedrick, Associate Executive Director, GGNA Region 12, to Board of Directors, GGNA. ND. "Report of Sessions Attended December 7 and 8, 1974, CNA Board of

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[312] Bottone, Sam. 1978. "Repressive Legal Tactics Aimed at Destroying Nurses' Rights." *California Nurse,* Vol 73, No 8, Feb 1978.

[313] Bottone, Sam. 1978. "Repressive Legal Tactics Aimed at Destroying Nurses' Rights." *California Nurse,* Vol 73, No 8, Feb 1978.

[314] Interview by the author with Frances Spector, April 20th, 2016.

[315] Pope, Irene. 1976. "RE: Sierra Vista Decision." *California Nurse,* Vol 72 No 5, Oct 1976. p3.

[316] C Meeting Minutes, CNA E&GW Commission, October 14, 1979. University of California, San Francisco Special Collections. Accession #MSS-37, Carton 26, Folder 6.

[317] Paraphrase by Sam Bottone. Bottone, Sam. 1978. "Repressive Legal Tactics Aimed at Destroying Nurses' Rights." *California Nurse,* Vol 73, No 8, Feb 1978.

[318] During the meeting, nurses expressed that the Board's delays were a product of sexism:

> During the discussion, inferences were made that many of our members consider the NLRB delays to be (perhaps) a product of a "male-dominated" Board operating in a male-dominated "industry" which has little—if any—respect for a predominantly female organization which seeks to provide collective bargaining representation services to its membership.

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[319] "American Federation of Nurses, AFT, AFL-CIO." Memo from Wayne Emerson, ANA Economic and General Welfare Department, to SNA Executive Directors and E&GW Program Staff. December 15, 1978. University of California, San Francisco Special Collections. Accession #MSS-37, Carton 13, Folder 58.

[320] "American Federation of Nurses, AFT, AFL-CIO." Memo from Wayne Emerson, ANA Economic and General Welfare Department, to SNA Executive Directors and E&GW Program Staff. December 15, 1978. University of California, San Francisco Special Collections. Accession #MSS-37, Carton 13, Folder 58.

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[326] Letter from John Paul Jennings to Arda Vonderheid, February 23, 1977. University of California, San Francisco Special Collections. Accession #MSS-37, Carton 25, Folder 58.

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[328] "American Nurses Association: Report of the Committee to Study the Roles and Functions of Various Levels of the Organization." June 1978. University of California, San Francisco Special Collections. Accession #MSS-37, Carton 13, Folder 55.

[329] "Policy Statement on the Relationship of the Regional Nurse Advocate to the California Nurses Association and the Regions." University of California, San Francisco Special Collections. Accession #MSS-37, Carton 13, Folder 12.

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[333] "Economic and General Welfare: A Program for Achieving Professional & Economic Standards." Golden Gate Nurses Association, Ca. July 1976. University of California, San Francisco Special Collections. Accession #MSS-37, Carton 12, Folder 70.

[334] Policy Statement on the Relationship of the Regional Nurse Advocate to the California Nurses Association and the Regions." University of California, San Francisco Special Collections. Accession #MSS-37, Carton 13, Folder 12.

[335] Interview by the author with Kathy Sackman, June 26th, 2015

[336] (Ballman 1985)

[337] National Labor Relations Board Decision and Order, St Francis Hospital, August 31 1982.

[338] Ultimately, while the Board found against the hospital, Modern Management was not held liable due to its role as a legal advisor.

[339] (Fink and Greenberg 1989)

[340] "Unions Intensify Organizing Efforts Among Nurses, AJN Survey Reports." *American Journal of Nursing,* Vol 80 No 2, Feb 1980.

[341] Memo from Sam Bottone to CNA State and Regional EGW Staff. January 19, 1979. University of California, San Francisco Special Collections. Accession #MSS-37, Carton 13, Folder 59.

Organizing Report, December 1979. SEIU Organizing Department. San Francisco State University, Labor Archives and Resource Center archives. Accession #1991-056, Box 5, Folder 3.

[342] Letter from Sandra Hesterly, CNA Associate Executive Director, and Sam Bottone, E&GW Program Director, to all CNA staff, February 14, 1979. University of California, San Francisco Special Collections. Accession #MSS-37, Carton 13, Folder 61.

[343] Interview by the author with Sherry Minson, October 25, 2016.

[344] "The Multi-Purpose Organization." *California Nurse,* Vol 74 No 10, May 1979.

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[348] Interview by the author with Frances Spector, April 20th, 2016.

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[354] "Hearing officer rejects nurse unit," *California Nurse,* March/April 1982

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[356] "Changes in the Healthcare Industry." SEIU Local 250 Report for Local Leadership Conference, 1987. San Francisco State University, Labor Archives and Resource Center archives. Accession #0341, Box 1, Folder 3.

[357] "Nursing Shortage in the Hospital Sector, 1982-87." Report, Department of Health and Human Services, Office of the Inspector General, Office of Analysis and Inspections, October 1988. Authored by Rosanna M. Coffey, Dean E. Farley, Keith Lind, and Renate, Wilson. In "Support Studies and Background Information, Vol II," Secretary's Commission on Nursing, Dec 1988.

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[362] "The Conditions of Labor in the Hospital Industry." Report of the California Assembly Interim Committee on Industrial Relations, 1965-1967. San Francisco State University, Labor Archives and Resource Center archives. Accession #01988-041, Box 7, Folder na.

[363] Speech by Stan Wisniewski, SEIU Healthcare Conference, October 31 1978. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU Historical Collection, AC 1924, Box 3, Folder 25.

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[370] "LVN ALERT." Local 250 pamphlet, Ca. 1987. San Francisco State University, Labor Archives and Resource Center archives. Accession #0392, Box 2, Folder 30.

[371] "Local 250 LVNs Testify in Capitol," *Local 250 Worker,* Fall 1987

"LVN ALERT." Local 250 pamphlet, Ca. 1987. San Francisco State University, Labor Archives and Resource Center archives. Accession #0392, Box 2, Folder 30.

[372] Within the CNA, the professional organization began taking steps that would, if successful, technically eliminate the LVN altogether. At the ANA's 1985 House of Delegates meeting, the national Association rekindled the debate on nursing education, reviving the call from two decades earlier to shift nursing education out of the hospital and into higher education settings. The Delegates moved to establish the BSN as the minimum educational requirement for obtaining the legal title of Registered Nurse, and creating an "Associate Nurse" title for those nurses trained in two-year associates programs. Both groups would be licensed by a common board, and members of a common association. The ANA called for state associations to pursue these goals at the state level, and in 1986, CNA members participated in a series of organized discussions at the Regional level to determine the CNA's position on the matter. In these discussions, association members called attention to the risks of further fracturing the membership of the Association, integrating a broader variety of hierarchical levels into the vertically-bounded occupational demarcation of nursing; some projected that the groups would end up "competing economically, politically, clinically." Others cautioned against the potential loss of leadership control over the association with the integration of new groups.

"Who will be the Future ANA Member?" Memo, Golden Gate Nurses' Association, October 1986. University of California, San Francisco Special Collections. Accession #MSS-37, Carton 18, Folder 55.

[373] See (Brannon 1988)

[374] According to Local 250 organizer Charlie Ridgell, much of the responsibility behind this move of LVNs into subacute settings was due to the CNA's advocacy of RN-only care in hospitals:

> The registered nurse, the licensed vocational nurse, and the nursing assistant were like a career ladder. You can start out as a nursing assistant, achieve the LVN, which was within your reach as a working class person to get a three-year degree or whatever, to become an LVN, make a little more money and then a couple of years later become an RN… every now and then some hospital in the 80s would say, "We're eliminating all the LVNs. We have to march the LVNs to the board meeting and say the LVN is a valued team." But by the mid-90s the CNA had basically relegated the LVN to the nursing homes. There's very few hospital LVNs anymore.

[375] "Hospital Best Practices in Nurse Recruitment and Retention." Report, Department of Health and Human Services, Office of the Inspector General, Office of Analysis and Inspections, October 1988. In "Support Studies and Background Information, Vol II," Secretary's

Commission on Nursing, Dec 1988.

[376] "Hospital Best Practices in Nurse Recruitment and Retention." Report, Department of Health and Human Services, Office of the Inspector General, Office of Analysis and Inspections, October 1988. In "Support Studies and Background Information, Vol II," Secretary's Commission on Nursing, Dec 1988.

[377] "Nurse Participation in Hospital Decision-Making: Potential Impact on the Nursing Shortage." Report, Department of Health and Human Services, Office of the Inspector General, Office of Analysis and Inspections, October 1988. In "Support Studies and Background Information, Vol II," Secretary's Commission on Nursing, Dec 1988.

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[379] Letter from Tim Twomey, Wray Jacobs, and Jerome Klein to George Hardy, May 19 1975. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. Hardy Collection, AC 1542, Box 25, Folder 39.

"Minutes of the General Membership Meeting of the Hospital and Institutional Workers Union, Local 250, SEIU." February 4. 1967. San Francisco State University, Labor Archives and Resource Center archives. Accession #0341, Box 14, Folder 6.

[380] Letter from Tim Twomey, Wray Jacobs, and Jerome Klein to George Hardy, May 19 1975. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. Hardy Collection, AC 1542, Box 25, Folder 39.

[381] Issues of *The Scalpel* from 1974 to 1980 are: San Francisco State University, Labor Archives and Resource Center archives. Accession #0392, Box 1, Folder 10.

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[382] Letter from Tim Twomey, Wray Jacobs, and Jerome Klein to George Hardy, May 19 1975. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. Hardy Collection, AC 1542, Box 25, Folder 39.

[383] Letter from Tim Twomey, Wray Jacobs, and Jerome Klein to George Hardy, May 19 1975. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. Hardy Collection, AC 1542, Box 25, Folder 39.

[384] Comments from George Hardy to SEIU Researchers training, October 1974. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. Hardy Collection, AC 1542, Box 25, Folder 41.

[385] Letter from Tim Twomey, Wray Jacobs, and Jerome Klein to George Hardy, May 19 1975. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. Hardy Collection, AC 1542, Box 25, Folder 39.

[386] "Local 250 SEIU Background Narrative." Retrospective account of Kathy Labriola. Available at San Francisco State University, Labor Archives and Resource Center archives.

"Helen Lima, Presente! By MARGY WILKINSON Special to the Planet. Category: Features from The Berkeley Daily Planet."

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[388] Letter from Helen Lima to Rank and File Slate supporters, July 7, 1976. San Francisco State University, Labor Archives and Resource Center archives. Accession #0392, Box 1, Folder 11.

[389] Phillips, Esther. 1986. "On Strike at Kaiser: The New Unionism Confronts Corporate Health Care." *The North Star,* No. 5.

[390] See files from Local 250 South Africa Committee, 1978-1990. San Francisco State University, Labor Archives and Resource Center archives. Accession #0392, Box 2, Folder 19.

[391] See files from Local 250 South Africa Committee, 1978-1990. San Francisco State University, Labor Archives and Resource Center archives. Accession #0392, Box 2, Folder 19.

"Local 250 Southern Africal Solidarity Committee History." Retrospective account of Kathy Labriola. Available at San Francisco State University, Labor Archives and Resource Center archives.

[392] "Local 250 Southern Africal Solidarity Committee History." Retrospective account of Kathy Labriola. Available at San Francisco State University, Labor Archives and Resource Center archives.

[393] (Mehring 1990)

"Local 250 AIDS Education Committee Narrative." Retrospective account of Kathy Labriola. Available at San Francisco State University, Labor Archives and Resource Center archives.

[394] Carlsen, William. Peggy Ferro Obituary. *SFGate*. Nov 12, 1998.

[395] According to Committee member Kathy Labriola,

> The union was much more surprised than we were when their office phones started ringing off the hook with requests for the pamphlet from local unions all over the state and later all around the country, as well as from management of many hospitals and Directors of Nursing from numerous hospitals. Within a year, our International Union in Washington, DC, SEIU, was asking us to write a much longer and more comprehensive version of the pamphlet, and John Mehring became the primary author of what would be titled "The AIDS Book: Information for Workers," which was directed not just to health care workers but at all types of workers who might be concerned about coming into contact with people with AIDS in the course of their work and needed accurate information.

[396] Phillips, Esther. 1986. "On Strike at Kaiser: The New Unionism Confronts Corporate Health Care." *The North Star,* No. 5.

[397] "Them and Us (Or, why you should vote for CDU)." CDU Campaign leaflet, 1984. San Francisco State University, Labor Archives and Resource Center archives. Accession #0392, Box 3, Folder 13.

[398] "Are you coming to the next CDU meeting?" CDU Campaign leaflet, 1984. San Francisco State University, Labor Archives and Resource Center archives. Accession #0392, Box 3, Folder 13.

[399] See Local 250 membership meeting minutes, 1975-1982. San Francisco State University, Labor Archives and Resource Center archives. Accession #0341, Box 14, Folders 6-7.

[400] "Vote for your future: Vote CDU, a hospital union run by hospital workers." CDU campaign pamphlet, 1984. San Francisco State University, Labor Archives and Resource Center archives. Accession #0392, Box 1, Folder 10.

[401] CDU Fundraising letter from Amy Grossman, 1984. San Francisco State University, Labor Archives and Resource Center archives. Accession #0392, Box 1, Folder 10.

[402] "Local 250 SEIU Background Narrative." Retrospective account of Kathy Labriola. Available at San Francisco State University, Labor Archives and Resource Center archives.

"Local 250 Service Employees International Union. In the Matter of the Charges Filed Against John Ring, President and Timothy J Twomey, Executive Secretary Treasurer. Decision and Recommendations of Ophelia McFadden, Hearing Officer." February 1986. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. Hardy Collection, AC 1542, Box 25, Folder 39.

[403] "Local 250 SEIU Background Narrative." Retrospective account of Kathy Labriola. Available at San Francisco State University, Labor Archives and Resource Center archives.

[404] "Why did John Ring and Tim Twomey fire Les Kuykendal?" CDU Leaflet, ca. 1986. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. Sweeney Collection, Box 34, Folder 2.

[405] "Local 250 Service Employees International Union. In the Matter of the Charges Filed Against John Ring, President and Timothy J Twomey, Executive Secretary Treasurer. Decision and Recommendations of Ophelia McFadden, Hearing Officer." February 1986. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. Hardy Collection, AC 1542, Box 25, Folder 39.

[406] Charge letters against John Ring and Tim Twomey, Sep 1985. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. Sweeney Collection, Box 34, Folder 1.

[407] Interview by the author with Beverly Griffith, May 19th, 2015

Interview by the author with Paul McKenna, April 4th, 2015

[408] Interview by the author with Paul McKenna, April 4th, 2015

[409] "Local 250 SEIU Background Narrative." Retrospective account of Kathy Labriola. Available at San Francisco State University, Labor Archives and Resource Center archives.

[410] "Interview with Burton White, Director of Economic and General Welfare, California Nurses Association, by Tom and Carol, August 29 and 30, 1974." San Francisco State University, Labor Archives and Resource Center archives. Data Center collection, Box 2, Folder 10.

[411] "Preliminary Report to Service Employees International Union on 1985 San Francisco Bay Area Hospital Negotiations." Report by Paul McKenna, Senior Field Representative, SEIU. July 22, 1985. San Francisco State University, Labor Archives and Resource Center archives.

[412] "Preliminary Report to Service Employees International Union on 1985 San Francisco Bay Area Hospital Negotiations." Report by Paul McKenna, Senior Field Representative, SEIU. July 22, 1985. San Francisco State University, Labor Archives and Resource Center archives.

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[423] "Issues to Consider When and if Planning the Kaiser Corporate Issues Campaign." Memo from Cathy Schoen to Bob Muscat, Gerry Shea, Andy Stern and Ray Abernathy, 1986. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. Research Department Collection, Box 22, Folder 19.

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[428] "Statement by Andrew L. Stern." Statement submitted by Andrew Stern, then Assistant to the President for Organizing at SEIU, later SEIU President, 1995-2009, during Local 250 trusteeship hearing. Special Collections, Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU Executive Office Collection, Box 34, Folder 9.

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[430] "Kaiser Works Because We Do." Local 250 white paper, November 1, 1988. Special Collections, Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU Public Relations Collection, Box 1, Folder 44.

[431] "Recommendations for Local 250 Kaiser Campaign." 1987 memo from Paul McKenna. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. Research Department Collection, Box 22, Folder 3.

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[447] Letter from John Mehring to Richard Cordtz, December 18 1986. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU Executive Office Collection, Box 34, Folder 5.

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[449] "Report of Findings and Recommendations of Hearing Officer In Regard to Local 250 of the SEIU, AFL-CIO/CLC, Pursuant to the December 30, 1986 Appointment of Hearing Officer and Notice of Hearing by International Union President John Sweeney." Report submitted by S.E. (Ted) Roscoe, February 23 1987. Walter P. Reuther Library of Labor and Urban Affairs, Wayne State University. SEIU Healthcare Division Collection, Box 1, Folder 1.

[450] Remarks by Gerald M. Shea ad Local 250 Trusteeship Hearing, June 6, 1988. Walter P.

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[457] "Additional Recommendations for Inclusion in the Revised Constitution and Bylaws." Submission to Local 250 Convention by Phil Giarrizzo, October 16, 1987. San Francisco State University, Labor Archives and Resource Center. larc.ms.0341, Box 6, folder 3.

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