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This dissertation could not have been completed without the support of many persons and institutions.

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Special thanks go to Howard Pinderhughes, my graduate adviser, dissertation chair, and colleague. Working closely with Howard since 1996 has been an invaluable experience for me. Howard is an extraordinary mentor, teacher, and colleague. For the dissertation, Howard patiently read innumerable memos and chapter drafts, and provided timely and helpful critiques. His consistently attentive and guiding presence allowed me to meet my research objectives and self-imposed deadlines.

Special thanks go to Charlene Harrington. Charlene's commitment to producing research that aims to improve social conditions has formally resonated with my own academic orientation, and has informed the dissertation's character and power. She provided useful and timely feedback, and consistently challenged me to improve my work. Her encouragement over the years has been invaluable.

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Teresa Scherzer

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Abstract

Division of labor, or labor divided?:
Health care workers, health care work, and labor-management relations

Teresa Scherzer

This dissertation is a case study of the changing nature of health care labor at Kaiser Permanente Northern California in the 1990s, focusing on the acute-care hospital and outpatient clinic in one city. This study explores the under-examined consequences of the 1990s transformation of the nation's health care by examining three major areas: 1) how health care delivery is constructed and restructured by a health care corporation, health care workers, and labor unions; 2) how this process is mediated by race, gender, and class; and 3) how the workers assigned to the most physically and mentally taxing work of health care experience and interpret the changes. The study also explores how the changes in labor process inform inter-group relations and stratification of the Kaiser non-physician health care workforce.

This study builds on feminist theories that examine the intersectionality of race, gender, class, and other markers of social position, in order to examine the structures and processes that reproduce inequality and oppression. Workers' experiences are central to this analysis, and are the site in which we can theorize how intersecting inequalities are reproduced, structuring exploitative relations in health care and perpetuating divisions within the workforce.

In-depth interviews were conducted with three union officials and 23 health care workers, drawn from the workforce historically assigned to the caregiving and dirty work – a predominantly female workforce stratified by race-ethnicity, class, and occupation.

Interview transcripts were systematically coded for prominent themes and social processes. Interview data were also analyzed within a historical narrative of Kaiser's labor relations, and demographic trends of health care workforce composition.

The data suggest that Kaiser's restructuring entrenches exploitation of and divisions within a workforce organized by intersecting inequalities of race, gender, and class. Based on workers' accounts, Kaiser's restructuring exploited the workforce and degraded the quality of patient care through reorganizing and intensifying the health care labor process. Despite workers' shared concerns, solidarity was consistently undermined by a confluence of historical and locally-specific factors, which reproduced racialized and gendered structures and processes of exploitation, stratification and conflict among the Kaiser workforce.

Howard Gadlin, Dissertation Committee Chair

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Chapter 1
Introduction

Statement of the Problem

With the institutionalization of managed care in the 1990s, market forces and the cost-cutting imperative dominate the health care environment. This has led to the increased public perception that health care is increasingly rationed, restricted, or denied because of health care organizations' preoccupation with cost. Within this cost-cutting environment, health care workers and their unions argue that corporate restructuring jeopardizes patient safety – and workers' anxieties about job security, working conditions, and the impact of restructuring on patient care mobilize workers against management. These anxieties, however, can also just as easily fuel conflict between different groups of workers, as organizations seek to reduce labor costs by downsizing and reconfiguring the workforce into a more cost-effective entity through eliminating positions, increasing workloads, and replacing higher-skilled and licensed staff with lower-skilled and unlicensed staff.

In order to better understand the faultlines within the labor force, and the implications for contemporary labor solidarity and patient/public advocacy, it is imperative to understand the historical legacy of gender, race, and class stratification, conflict, and exploitation within health care labor. In terms of the responses to managed care among the different groups comprising the health care labor force, the specific forms their dissatisfaction, accommodation, or resistance take are still unfolding. Two important questions are 1) how these groups relate to one another as their labor is reorganized by health care organizations, and 2) how inequalities between capital and labor, and within

the labor force, are reinforced or reduced. This study aims to illuminate structures and processes of contemporary health care delivery that inform and organize hierarchies and inter-group relations within the non-physician health care labor force.

Background

To the public and the health care workers on the frontlines of health care delivery, the contemporary health care environment is infused with a focus on cost rather than care. The changes stemming from managed care mean staff reductions and overall erosion of wages, benefits, and working conditions – and represent health care organizations' emphasis on profit or cost containment over worker or patient well-being. Due to these real and perceived changes, an increasing backlash against managed care has developed on the part of consumer advocates, public officials, physicians, nurses, other health care workers, and the public. Numerous proposals seeking to protect health care consumers by demanding more accountability of HMOs have been circulating in state and federal legislatures. These include a "Patient's Bill of Rights" that would protect health care consumers against possible abuses by health care corporations, and legislation mandating nurse to patient staffing ratios. Labor unions have become particularly outspoken about the potential risks to patient care, claiming in particular that downsizing health care staff is injurious to both patients and workers.

Health care labor conflict: linking workers' and patients' wellbeing

The discourse of collective bargaining and labor conflict in 1990s health care increasingly focuses upon the policies of health care organizations that allegedly jeopardize patient care through organizational restructuring – a prominent dimension of which is the restructuring of the health care labor process. To cut labor costs, health care

administrators enact staffing redesigns that increasingly substitute lower-waged workers for higher-skilled and higher-paid professionals. In the current environment, Registered Nurses are the major target of this substitution, since they were the primary caregiver in hospitals for the last 20 years, but all staff are given added responsibilities without commensurate authority or compensation, and witness the erosion of both their working conditions and patient care. In response, much of the health care labor force has vigorously protested these consequences of the restructuring. Organized labor representing health care workers has organized mass rallies, pickets, strikes, and lawsuits alleging corporate health care's interest in profits over patient care.

To mobilize worker and community support for their struggles, unions deploy concepts and rhetoric such as "safe staffing" and "health care workers are patient advocates" that are grounded in an "us/them" framework. This framework links the fates of patients/the public and workers, and constructs the union as their protector against corporate greed and negligence. This framework also suggests that workers are united in their position against corporate greed. However, complicating an allegedly generic model of labor-management conflict is the legacy of race, gender, and class inequality and conflict that has historically informed divisions and alliances among working people.

Intersecting inequalities and worker solidarity in the health care workforce

Historically, racial dynamics have shaped divisions and alliances between and within occupational groups in health care (Fink and Greenberg 1989; Glazer 1991; Glenn 1991, 1992; Hine 1989; Michel 1996; Sacks 1988), and have shaped not only the organization of health care labor but also the organization and strategies of collective bargaining in health care. Previous studies of labor organizing and labor conflict in health

care have paid particular attention to the racial stratification and to the racial dynamics of inter-group relations, and illustrate how race and class were prominent forces that served to unify and divide different groups (Fink and Greenberg 1989; Michel 1996; Sacks 1988). These studies, however, occurred before the current historical period dominated by the turbulent environment of managed care and its impacts on health care organizations' provision of health care and restructuring of the health care labor process.

Health care labor's response to the restructuring provides an opportunity to investigate how the dynamics of race, gender, and class interact with the changes in health care in the 1990s. Groups that have been historically divided based on race, gender, or class, have also united when they share grievances at a health care institution (Fink and Greenberg 1989; Michel 1996; Sacks 1988), but have done so within a health care system organized very differently than the current system. The current health care environment offers an opportunity for a new look at race, gender, and class dynamics – and conversely, race, gender, and class offer a new theoretical lens through which to understand the restructuring of U.S. health care. Building on the earlier studies, this study analyzes intersecting inequalities in contemporary arrangements of labor and conflict in health care. I explore how conflict and solidarity are structured between different groups – in terms of the stratification of the health care labor force and the reorganization of the health care labor process.

The study setting

This study examines the 1990s restructuring of health care labor at Kaiser Permanente in Northern California. Kaiser Permanente is the "grandfather" of Health Maintenance Organizations (HMOs), whose unique structure of integrated health care

delivery has dominated the California health care market during the second half of the last century. Kaiser is also arguably one of the most socially conscious HMOs, with historically close ties to organized labor and a unionized workforce.

This study begins in the mid-1990s, when Kaiser's unquestioned dominance in the health care environment began to be challenged. Competition from other hospital systems and HMOs drove Kaiser to begin a series of cost-cutting measures in order to maintain fiscal viability and recover market share. A prominent feature was restructuring hospital nursing labor, by downsizing all staff and lowering the skill mix in nursing – reducing the number of Registered Nurses and increasing the use of unlicensed workers in direct patient care.

In Northern California, Kaiser's two largest unions chose radically different strategies to address Kaiser's restructuring and mitigate the likely damage to workers and patients. The California Nurses Association (CNA) (an independent professional association and labor union representing Registered Nurses) fought back against Kaiser's attempt to reduce the presence and power of the RN workforce – the primary caregivers in Kaiser hospitals and clinics by the mid-1990s. During 1997-1998, the CNA engaged Kaiser in a bitter 14 month contract dispute, and organized a highly visible multi-pronged campaign against Kaiser's proposed contract concessions and continued job losses for RNs, arguing that Kaiser's planned reduction of numbers of RNs jeopardized patient safety. The other major union in Northern California is Health Care Workers Union, Local 250, Services Employees International Union (an AFL-CIO local representing Licensed Vocational Nurses, Nursing Aides/Assistants, allied health care workers, and nonclinical support and clerical staff). Local 250 joined a national AFL-CIO/Kaiser

labor-management partnership that sought to protect workers and patient care by working in a cooperative relationship with a relatively labor-friendly organization rather than remaining in the traditional adversarial role of organized labor.

Nursing labor is the dominant labor process in health care, and its periodic reengineering historically has been a site of conflict (and cooperation) among groups with divergent interests (Brannon 1994, 1996). It is also a prominent example of the intersections of race, gender, and class inequalities and conflict, where inequalities have been reproduced and entrenched. At Kaiser in Northern California, this conflict is intensified because the two major unions represent very different occupational and race/class segments of the predominantly female health care labor force, which historically have had conflicting interests over status, autonomy, and the nursing division of labor.

The contemporary reengineering of nursing labor is one of the most salient dimensions of the restructuring of the nation's health care, and at Kaiser, it represents the site in which processes of labor-management conflict and cooperation take new forms, with important implications for patient care and inequalities among different actors in the health care landscape. It is also a site in which shared interests and experiences due to restructuring, across occupation and union affiliation, may challenge the legacy of workers regarding one another as opponents or competitors.

Objectives of the study

This study focuses on the under-examined consequences of the transformation of the nation's health care by examining three major areas: 1) how health care delivery is constructed and restructured by a health care corporation, labor unions, and health care

workers; 2) how this process is mediated by social forces of race, gender, and class; and 3) how the workers assigned to the most physically and mentally taxing work of health care experience and interpret the changes. The study focuses on the workers historically assigned to the caregiving and dirty work of health care – a predominantly female workforce stratified by race, ethnicity, class, education, and occupation. These workers, of course, differ from one another in terms of race, ethnicity, class, education, age, and numerous other markers of social position, and experience different relations of status and power within the health care hierarchy. The study explores how the changes in labor process inform inter-group relations and stratification of the Kaiser non-physician health care workforce in one Northern California city, interviewing workers at the acute-care hospital and outpatient clinic.

The study's overall objective is to analyze workers' experiences, feelings, and understandings of the restructuring of the health care labor process. Their narratives are situated within the contexts of a changing health care labor process, different union ideologies and positions towards Kaiser, the historical race, gender, and class divisions within the health care labor force, and the changing racial, gender, and class composition of the workers in the health care labor process.

The data for this dissertation are drawn from historical and archival documents (newspapers, trade publications, academic journals, and publications and websites of Kaiser, AFL-CIO, Local 250, and the CNA), and from in-depth interviews with three union leaders and 23 health care workers represented by either the CNA or Local 250. While a major concern is the nature of work and its transformation, the primary focus is on the changing division of labor and its impact on a predominantly female workforce

traditionally stratified by race and class. This study does not aim to be representative of all health care workers' experiences, but does aim to represent the range of experiences and perceptions expressed by a diverse group of Registered Nurses, allied health care workers, and unlicensed support staff.

The importance of workers' experiences

Workers' experiences are essential to understand the qualitative changes of work and the perceived consequences for patient care and workers' wellbeing. The experiences, feelings, and understandings of frontline workers illuminate what restructuring means to the women and men who do the most physically and emotionally taxing work of health care. Workers' narratives describe how restructuring has impacted the conditions of work and the social relations of health care, and how workers negotiate, accommodate, and resist the changes imposed upon them. By centering workers' experiences, we can learn how they negotiate increasing demands with fewer resources, how they construct group identity and group position in a restructured health care labor process, and how they negotiate relations of status and power with less- and more-powerful others in the health care hierarchy.

While social theory helps to set up the overall context for workers' experiences, the main theoretical work begins from workers' different standpoints. Based on workers' narratives of their experiences, feelings, and understandings of the work and the social relations of health care, I will develop social theory that attempts to explain how intersecting inequalities structure exploitative relations in health care and perpetuate divisions within the workforce. Workers' experiences of restructuring will be the site in which we can theorize how inequalities are reproduced. This kind of intellectual project

is part of the larger movement for social justice, that seeks to ultimately dismantle structures and processes of intersecting oppressions, and replace them with the foundation for a truly democratic society.

Significance of the study

This study is significant in two major respects. First, it contributes to the ongoing analysis of the linkages between health policy and practice, by focusing on an under-examined dimension of the consequences of the transformation of the U.S. health care – how restructuring the health care labor process impacts the primarily female and racial-ethnic minority workforce. This study explores how the health care labor process is constructed and restructured as a site of negotiation and struggle by a health care corporation, labor unions, and workers. By focusing on the structural and subjective conditions of restructuring labor, this study explores the material and ideological consequences of health policy, which inform unions' strategies and health care workers' responses towards health care capital, and workers' relations with one another.

Second, this study contributes to the development of sociological theory. A major theoretical concern is the reproduction of intersecting inequalities, particularly how intersecting inequalities structure exploitation of and conflict between working people. The underlying questions driving this study are: What are the structures and processes that divide working people? What binds them together in coalition? While these questions are hardly new, I seek answers in a relatively new arena – the contemporary health care arena, where actors with conflicting and converging interests struggle and negotiate over the division of labor, and position in the health care occupational hierarchy.

Organization of the Dissertation

This dissertation is organized in eight chapters. I begin with a historical overview of the changes in the health care environment in the 1990s, and the major actors and their relationships in Northern California (Chapter 2). Chapter 3 provides background on the legacy of race, class, and gender stratification and conflict within the health care labor force, focusing on nursing. Chapter 4 discusses theoretical frameworks and key concepts that are especially relevant to an understanding of the changes in health care labor and the relationships among workers as their labor is restructured. Chapter 5 focuses on the methodology. Chapters 6 and 7 focus on workers' experiences of restructuring. These chapters illuminate workers' perceptions of the changes in their work environments, the labor process and occupational structure, their experiences of new roles and responsibilities, and their relations with other actors at work. These chapters also illuminate the interaction between the "mechanics" of restructuring the labor process and the social relations of labor, and explore how Kaiser's restructuring has impacted inter-group relations and hierarchies of race, gender, and class. Chapter 8, the conclusion, situates workers' experiences within the context of the larger changes in health care, using the theoretical frameworks that can help us to understand the different social processes of inequalities at work.

Chapter 2
Background I: National and local contexts of restructuring health care in the 1990s

This chapter will first present an overview of the restructuring of the United States' health care environment in the 1990s and the consequences for health care delivery, especially in acute care hospitals. I then turn to the situation of Kaiser Permanente. After I briefly introduce Kaiser, I explore the impact of the changing health care environment and Kaiser's responses to the unprecedented challenges it faced. I then focus on the labor relations between Kaiser and the two major unions representing the Kaiser non-physician workforce. I provide background on the unions, their relations with Kaiser, and their relationships with one another. I conclude with a summary of the costs of Kaiser's survival strategies in the late 1990s.

The increasing crescendo of "crisis" of health care expenditures

The skyrocketing cost of health care was the major impetus behind the movement for change in U.S. health care in the early 1990s (Lee, Soffel, and Luft 1992), but was a trend that began in the decades before. In the 1960s, the expansion of the health care industry was fueled by Medicare and Medicaid, and facilitated the growth of the "new medical industrial complex" (Estes, Harrington, and Davis 1992; Relman 1980; 1991; Salmon 1990; Whiteis and Salmon 1990). In the 1970s, health care expenditures increased at twice the rate of general inflation, and a "crisis" in health care due to spiraling costs propelled the creation of the HMO Act of 1974 and the establishment of the Prospective Payment System in the early 1980s, through which Diagnostic Related

Groups (DRGs) became the mechanism to control costs. Health care expenditures were not a major concern for employers until the 1980s, when the annual inflation rate for health insurance reached nearly 20%, and an unsteady economy propelled employers to seek ways to reduce their costs for health insurance (Bodenheimer and Sullivan 1998). In the 1990s, national health care expenditures (NHE) reached previously unimaginable totals, constituting 14% of the total Gross Domestic Product (GDP), with increases projected for subsequent years (Burner and Waldo 1995). In 1996, NHE totaled $1.035 trillion, a 4.4% increase from 1995 (Levit et al. 1997). Projections for 1995-2005 showed an increasing rate: in year 2000, NHE's total was estimated to reach $1.5 trillion, or 15.9% of GDP; and in 2005, $2.2 trillion, or 17.9% of GDP (Burner and Waldo 1995).

The rising costs of health care have coincided with the corporatization[1] of health care. Rising health care costs have been also attributed to factors such as general inflation, population growth, and medical care price inflation (Levit et al. 1997). Other factors include: excess capacity and oversupply of physicians (Lee et al. 1992; O'Neil 1998; Rivo and Kindig 1996), excessive and unnecessary interventions (Leape 1994; Lee et al. 1992), administrative overhead (Hellander et al. 1994), advertising (Levit et al. 1997), and advances in medical technology and pharmaceuticals, both of which have been documented as a rapidly growing influence on medical care costs (Lee et al. 1992; Levit et al. 1997).[2] As early as 1980, Relman warned his physician colleagues about the

[1] This term refers to the increasing presence of multinational corporations in diverse arenas of the health care industry, from medical manufacturing to ownership of medical facilities (McKinlay and Stoeckle 1988; Whiteis and Salmon 1990).

[2] Moreover, fee-for-service, the dominant arrangement in health insurance, contributed to medical care price inflation through the relative autonomy of physicians to confer diagnoses, conduct interventions and treatment regimes, and charge third-party payers for fees.

impending crisis posed by the "new medical industrial complex"[3] (Relman 1980), and the transformation of medicine into a for-profit industry.

Other scholars (Estes et al. 1992), have detailed the factors leading to the growth of for-profit health care enterprises, including the ideology and substantial changes wrought by the "new federalism" of the Reagan administration, legislative changes permitting state subsidy of for-profit enterprises, and entry into the equity market. The growth of the new medical-industrial-complex has resulted in an increasingly complex network of interlocking health care organizations and related companies and services whose major concern is profit. However, the imposition of market ideology on the health care industry has not succeeded in cutting costs and improving access to care (Estes et al. 1992; Relman 1991).

The 1990s

In the 1990s, a renewed imperative to control health care costs resulted in a high-profile campaign led by the President and Hilary Clinton. After the Clinton's attempt at health care reform failed in 1994, market forces have become the dominant influence on the U.S. health care system (Bond and Weissman 1997; Harrington and Estes 1997; Kassirer 1996; PEW Health Professions Commission 1995; Wunderlich et al. 1996). This market-based restructuring of U.S. health care has emphasized competition, efficiency, and cost-containment, and as O'Neil (1998) and Bodenheimer and Sullivan (1998) have argued, health care exists in a market-oriented system set up to respond first

[3] This term, coined by Relman in 1980, refers to the vastly diverse and interlocking enterprises that constitute the health care industry, including: social services, pharmaceuticals, direct medical care, medical supply, and insurance/financing (see Estes et al. 1992).

to the needs of organized purchasers, namely by lowering their costs.[4] The trend through 1996 has been for managed care insurers to offer lower premium prices (Levit et al. 1997) but this began to change in the late 1990s due to these managed care corporations' increasing costs and decreasing profits (Casey 2000; Freudenheim 1998).

The drive to cut the costs of health care has transformed the U.S. health care landscape. O'Neil (1998) has written that the U.S. health care system is experiencing "the most significant transformation of this century" (O'Neil 1998:3) in terms of financial, structural, and service arrangements. Several inter-related dimensions of this restructuring include: 1) mergers and acquisitions, resulting in fewer and larger organizations; 2) integrated corporations (payer and provider); and 3) organizational conversion of nonproft to for-profit status (Bond and Weissman 1997; O'Neil 1998). The new "new medical industrial complex" is dominated by for-profit enterprises (Estes et al. 1992), changing the organizational landscape by squeezing out smaller health care organizations by forcing the buyout or taking advantage of the increasingly precarious financial states of nonprofit or smaller hospitals or organizations (PEW Health Professions Commission 1995; Wunderlich et al. 1996). An unprecedented wave of mergers and acquisitions has created huge hospital and nursing home "chains" and complex configurations of HMOs, insurance companies, and other health-related businesses (Bond and Weissman 1997; Wunderlich et al. 1996).

Health care in the United States now takes place in a landscape dominated by larger and fewer entities, both for-profit and nonprofit, tax-exempt organizations. There has been an exponential increase in the number of managed care plans, most of which are

[4] The overall concern behind health care delivery has emphasized cost containment, although the shift from "fee-for-service" to the dominance of managed care has been unevenly distributed across the country.

private, publicly-traded enterprises (Wunderlich et al. 1996). A study sponsored by the Kaiser Family Foundation (unrelated to Kaiser Permanente or Kaiser Industries) found that approximately 75% of all HMOs are for-profit, increasing their share of the market from 18% in 1981 (Levitt, Lundy, and Srinivasan 1998:46). Moreover, of the ten largest HMOs in the U.S., nine are for-profit (Bodenheimer 1997). The hospital sector remains dominated by tax-exempt organizations, but for-profits have increased their presence – as between 1980 and 1996, they increased their share of beds from 9% to 13% (Levitt et al. 1998:46). Distinctions have blurred between tax-exempt (nonprofits) and proprietary or investor-owned organizations as the primary focus of both types of organizations has become the cost containment and net revenue in an increasingly competitive market (Wunderlich et al. 1996). In this environment, medical care has become more focused on cost-effectiveness and the efficacy of interventions (O'Neil 1998).

Seeking "cost-effective" ways of delivering health care

The restructuring of the U.S. health care system has changed health care delivery in two major ways: 1) the shift from hospital-based care to out-patient settings; and 2) the restructuring of health care labor process through changing staffing patterns for patient care. Restructuring into integrated systems of care has been a prominent strategy in the 1990s for health care organizations, mostly driven by the mandate to cut costs by eliminating excess beds, staff, and services (Sherer 1994; Wunderlich et al. 1996). Patient care is shifting from in-patient units in hospitals to out-patient settings and there has been a steady decline of hospital admissions, in-patient days, and beds staffed by clinicians (Levit et al. 1997; Miller and Luft 1994; Wunderlich et al. 1996). Thus hospitalized patients are generally sicker and older (Wunderlich et al. 1996), and the trend is towards

higher levels of patient acuity, resulting in the need for more intensive care during a shorter length of stay.

Health care organizations seeking a more "cost-effective" workforce implement changes in staffing patterns, primarily through reducing the size of the workforce and redistributing paraprofessional and professional personnel. Across health care organizations, labor costs comprise a major segment of the budget (Szasz 1990; Wunderlich et al. 1996), and current changes in staffing patterns rely on manipulating the labor process through deskilling and job consolidation. The desired outcome is for the same work to be done at a lower cost, through directing that "lower skilled" tasks be removed from professionals' jobs and redirected to subordinate workers (Brannon 1996; Sherer 1994; Vanselow 1996; Wunderlich et al. 1996). This occurs between RNs and unlicensed assistive personnel (UAP) (Sherer 1994; Wunderlich et al. 1996), and between physicians and Nurse Practitioners, especially in high managed care states (Buerhaus and Staiger 1997).

Beginning in the late 1980s and early 1990s, hospitals have increasingly adopted staffing models – primarily "Patient Focused Care" – that use "interdisciplinary" teams of staff with different skill levels, with the aim of eliminating "waste" or "inefficiency" in hospital medical care (Lathrop 1991; Ruzek et al. 1999; Vogel 1993; Wunderlich et al. 1996). As the dominant labor process in health care, the nursing labor process is increasingly rationalized, and an increasingly stratified workforce of workers in traditional and nontraditional job classifications is organized and re-organized to deliver patient care at a lower cost (Brannon 1996; Ruzek et al. 1999).

Health care organizations increasingly have channeled Registered Nurses (RNs) into supervisory roles and away from direct, hands-on patient care, preferring to use them for "higher skilled" tasks such as administering medications and supervising other workers. For the bulk of direct, hands-on patient care, organizations increasingly employ paraprofessional nursing staff – Licensed Practical/Vocational (LPNs/LVNs), and Nursing Assistants (NAs)[5] – as well as unlicensed nonclinical workers, whose jobs are restructured to take on "routine" patient care duties along with their traditional job duties (Brannon 1996; Ruzek et al. 1999; Wunderlich et al. 1996). Unlicensed workers are increasingly channeled into new job classifications that consolidate former jobs (or duties of former job classifications), and are "cross-trained" to perform tasks across occupational lines (Brannon 1996; Ruzek et al. 1999; Wunderlich et al. 1996).

While these staffing changes promise cost savings, Patient Focused Care has not been very successful (Ruzek et al. 1999). Limited hospitalizations, sicker patients, increased medical specialization, and sophisticated technology result in a more complex, intense and stressful hospital nursing labor process.

Concerns about the consequences of restructuring: job security and patient care

Restructuring has resulted in workers' increased concern about job security (especially for licensed professionals) and the adequacy of patient care. Nursing is a major target for cost cutting for several reasons: 1) RNs and LVNs are the first and second largest group of licensed health care workers (Wunderlich et al. 1996); 2) RNs' salaries have steadily increased in real dollars and more rapidly than other occupations (Himmelstein, Lewontin, and Woolhandler 1996; Wunderlich et al. 1996; Yordy 1996),

[5] In the 1970s and 1980s, LPNs/LVNs and NAs were displaced by RNs under the previous industry model

even in high-managed care states (Buerhaus and Staiger 1996); and 3) the shift of care to non-hospital settings (Yordy 1996). However, even in high-managed care states such as California, nursing labor is only 16% of an average hospital budget (Spetz 1996).

Restructuring health care labor has serious implications for patient care. As health care labor is increasingly rationalized, the actual labor is based solely on constructions of skill levels, and is divorced from the broader medical context. Moreover, licensing mechanisms that maintain work jurisdiction are under attack from health care administrators who seek to eliminate these "obstacles" so that unlicensed, uncertified workers may be cross-trained to perform a wide variety of routine tasks (Brannon 1996). These market driven practices result in questionable patient safety (Vanselow 1996). Because strategies for work redesign focus on the most efficient and cost-effective way to care for hospitalized patients, they have often focused on staffing reductions without considering other alternatives that may be more beneficial to the organization and the patients (Aiken, Sochalski, and Anderson 1996; Szasz 1990; Wunderlich et al. 1996).

Hospitals have historically employed approximately two-thirds of RNs (Aiken and Salmon 1994; Vanselow 1996; Wunderlich et al. 1996) and continue to do so (Moses 1996). The trends of decreasing number of hospitals (and the implied loss of RN jobs), the declining hospital employment of LPNs (Wunderlich et al. 1996), and higher level of acuity of hospitalized patients with fewer professional nursing staff, has contributed to Registered Nurses' rising anxiety about job security and adequacy of patient care — leading to an Institute of Medicine (IOM) Committee investigation of the "adequacy of nurse staffing" in health care institutions (Aiken et al. 1996; Wunderlich et al. 1996).

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of hospital nursing.

The IOM committee concluded that unlicensed assistive personnel (UAP), under RN supervision, were assuming increased responsibilities for direct patient care without adequate training. However, the committee also found the number of RNs increased, and the number of UAPs was stable (Wunderlich et al. 1996). Echoing the IOM's findings, Aiken and colleagues (1996) stated that nurse employment in hospitals has kept pace with patient acuity. However, health care analysts continued to disagree whether there will be adequate future employment for RNs (Aiken et al. 1996; Buerhaus and Staiger 1996; Hadley 1996/1997; Himmelstein et al. 1996; Spetz 1996; Wunderlich et al. 1996; Yordy 1996).

Cycles of the health care labor market and the looming shortage of RNs and other health care workers

The labor market for nursing personnel has been closely linked to health care labor as either an integrated or all-RN structure. However, current labor market issues, while a product of the recent restructuring of U.S. health care, are also inextricably tied to the cyclical behavior of the U.S. economy. The health care labor market varies dramatically with the cycles of the economy (Buerhaus 1994, 1995; Feldstein 1996). When the economy is healthy, there is a labor shortage. There are basically more jobs than workers to fill them, and workers have more options for employment. Conversely, when the economy is sluggish, there is a labor surplus. Unemployment is higher and there is increased competition for fewer jobs. The attractiveness of different economic sectors, the relative wages, and the supply of jobs and workers informs the health care labor market, and whether there is a shortage or surplus of workers (Feldstein 1996).

Cycles of shortage or surplus for nursing labor, therefore, may be explained by the variation in the economy (Buerhaus 1995; Feldstein 1996), as well as job

opportunities in different sectors, and working conditions – including pay and staffing levels (Brannon 1994). This is also true for nonclinical health care workers. As analysts debated RNs role in the changing health care landscape, an RN shortage began emerging in the late 1990s, largely due to RNs "burning out" on increasingly stressful work environments (Carpenter 2000; Greene and Nordhaus-Bike 1998). The future looks even more grim as a more severe nursing shortage is predicted for the coming decades, as there is a predicted increased demand for RNs, and a supply that cannot meet this demand (primarily due to the aging of the RN workforce and the decreased enrollment in nursing programs) (Billingsley 1999; Buerhaus 1998; Kilborn 1999; Marquis 1998).

In light of the U.S. economy's continuing emphasis on service occupations (Bureau of Labor Statistics 1997b), especially in health care, the labor market for low-wage workers is currently experiencing a shortage to fill the jobs in home health care and nursing homes, sectors that pay less than the hospital sector and whose jobs are disproportionately filled by people of color and women (Harrington 1996; Himmelstein et al. 1996). By the late 1990s, hospitals were also hard pressed to find workers – in all occupations – in a tight labor market. To meet the demand for workers, numerous hospitals have begun collaborating with community based organizations in "welfare to work" projects that recruit and train employees for housekeeping, food service and laundry jobs (Carpenter 2000). Kaiser and Local 250, with a $2 million grant from the U.S. Dept. of Labor, are engaged in such a project to meet an increasing demand for nursing personnel (Kirby 2000).

Kaiser in the 1990s: Facing unprecedented challenges

Profile of Kaiser Permanente

Kaiser is the United States' largest and California's second largest pre-paid group practice Health Maintenance Organization (Kaiser Permanente 1999b). Nationally, it is the third largest HMO and the largest nonprofit HMO (Famighetti 1999; InterStudy 2000:48). By 1999, Kaiser had nine million members in 18 states and the District of Columbia. Its largest division is California, with over five million members, and 50,000 fulltime workers (7000 of whom are physicians) (Kaiser Permanente 1999a).

Kaiser was the first HMO and continues to be unique because of its integrated, three-component organization: the Kaiser Foundation Health Plans, Kaiser Foundation Hospitals, and the Permanente Medical Groups. (Kaiser also is affiliated with Group Health Cooperative in Washington State and Community Health Plan of NY.) The first two components are non profit tax exempt corporations that respectively: 1) contract with individuals and groups for medical and hospital services, and 2) own and operate hospitals and outpatient facilities in California, Oregon, and Hawaii. The Permanente Medical Groups are for-profit partnerships or professional corporations of physicians that have the full responsibility for providing and arranging medical care in each Kaiser Permanente Division. The three components contract with one another to provide comprehensive medical care to members; decision making power is shared between physicians and administrators. Kaiser is organized into regional divisions that organize medical care through the three components. Because of its primarily nonprofit status, any net income is committed to patient care and physical facilities. Kaiser claims that 1) over 94% of members' dues are channeled back into medical care, and 2) its administrative costs of 3% are much lower than the average 12% costs at other nonprofit HMOs and

14% at for-profit HMOs (N.d., California Medical Association survey of 35 California HMOs, cited in Kaiser Permanente 1999a).

Kaiser (called the Permanente Health Plan until 1952) was founded in late 1945 as a nonprofit group practice HMO. It evolved from pre-paid health plans for Kaiser industry workers and their families in construction, shipyard, and steel mills during the late 1930s and 1940s. The Kaiser model began with the collaboration of medical entrepreneur Sidney Garfield, who established a pre-paid health plan for water reclamation workers in Desert Center in 1933, and industrialist Henry J. Kaiser. Kaiser recruited Garfield to implement a pre-paid health plan (paid by Kaiser) at the Grand Coulee Dam project in 1938. Garfield recruited a group of physicians and began a pre-paid group practice, with a focus on illness prevention and comprehensive health care. In 1942, Garfield established a pre-paid group health plan for the thousands of Kaiser industry shipyard and steel mill workers in the San Francisco Bay Area. After WWII ended, the health plan was opened to public enrollment on Oct. 1, 1945; by the end of the year, it had 14,500 members. In 1946, the plan extended to cover civilian workers at the Hunters Point Naval Shipyard in San Francisco (Hendricks 1993). By 1953, approximately one in ten San Franciscans was covered by Kaiser. By 1955, membership in the Permanente Health Plan totaled 500,000, of which about 300,000 were in Northern California. That year, Kaiser restructured to become the three component organization based on a physician-management partnership and decentralized management by geographic regions. Over the next decades, membership expanded geographically and numerically, reaching two million by the late 1960s. In 1977, the six Kaiser regions

became federally qualified HMOs under the Knox-Keene Act. By the early 1980s, membership totaled four million; by 1990, that total was 6.5 million (Hendricks 1993).

The membership growth was largely due to the support of labor unions, especially the International Longshoremen's and United Steel Workers of America, whose collective bargaining agreements added thousands of new members. Labor unions (International Longshoremen and Warehouse Union, and Retail Clerks in particular) were also largely responsible for the Plan's expansion to Southern California. Labor unions were prominent actors in Kaiser's expansion to other geographic and public markets, in an unusual mutually beneficial relationship between one of the most ardent capitalists and often militant organized labor unions (Hendricks 1993).

The hallmarks of the Kaiser Permanente model can be summarized as follows: its integrated organization, its success due to historical and ongoing support of organized labor, its mission to provide preventive and comprehensive health care. Kaiser consistently argues that unlike contemporary health maintenance organizations, its health care is based on physician decisions. Its core philosophy is based on health promotion and prevention, not just treatment of illness; and providing affordable, quality health care through an integrated system. Also unlike contemporary health care organizations, Kaiser's workforce has been historically unionized. Despite this generally positive picture, Kaiser has had to fight for respect from other physicians and the public (Hendricks 1993). Kaiser's image has been of a second-rate health care organization – most likely due to its size, its formerly impersonal health care delivery, and its largely working-class membership base (Taravella 1992). While Kaiser's image has arguably improved in the 1990s, the legacy of its earlier image has not been completely erased.

Impact of the larger changes in health care and Kaiser's responses

Kaiser began the 1990s virtually unchallenged as the largest health care provider in California and the United States. Its operations were primarily located in the Western and Pacific Northwest states, but also scattered throughout other regions of the continental U.S. and Hawaii. By 1992 membership totaled 6.6 million, 4.6 of whom were in California, and slightly more than half of these were in Northern California. Northern California, where Kaiser was founded and where it has corporate headquarters, was a stronghold of the corporation – at least one in three persons was a Kaiser member, and Northern California's revenue was more than one-third of Kaiser's entire revenue (Taravella 1992).

Early in the 1990s, however, a seemingly unrelenting pace of mergers and acquisitions of hospitals and HMOs resulted in an unprecedented challenge to Kaiser's dominance in the California health care market. The failure of the Clinton health care reforms in 1994 and the resulting proliferation of new for-profit health maintenance organizations also began to make inroads in Kaiser's traditional market, with more options and competitive premiums that offered attractive alternatives to Kaiser (Anders 1994; Azevedo 1995; Taravella 1992). In California, PacifiCare and Health Net (and later, Blue Shield and Blue Cross) were the major HMO competitors (Table 1). In Northern California, particularly in the San Francisco Bay Area, hospital systems such as Catholic Healthcare Systems (CHS) began acquiring independent hospitals. From 1991 through 1994, although Kaiser remained the dominant HMO in California, its membership was flat as competitors gained on its lead.

Table 1. Dominant California HMOs, by enrollment

Name	Total California enrollment, period ending…			
	12/31/1991	12/31/1994	9/30/1996	9/30/1997
Blue Cross of Cal.				4,095,000
Blue Shield of Cal. (nonprofit)	73,000	279,305	352,286	1,628,844
CaliforniaCare	373,880	697,982	982,891	Missing
CIGNA	410,450	656,619	449,095	651,152
FHP, Inc.	349,757	875,000	929,381	Incl. in PacifiCare
Foundation Health	301,874	Missing	754,635	772,529
Health Net	854,334	1,243,533	1,328,739	1,411,867
Kaiser Permanente (nonprofit)	4,694,370	4,616,503	4,821,196	5,340,871
PacifiCare	674,984	918,361	1,425,514	2,296,791

Notes: Blue Cross and Blue Shield include PPO member organizations regulated by the California Dept. of Corporations; Foundation Health owned by PacifiCare by September 1997.

Sources: (California Association of Health Plans 1998; California Association of HMOs 1993, 1995, 1997)

To recover market share and maintain its increasingly threatened dominance in the health care market, Kaiser tried to keep rates competitive and annual increases below those of rival HMOs, and hired management consultants to recommend changes in Kaiser's operations. In 1995, a new high-level executive, Jim Williams, was hired specifically to develop and implement a new business strategy that entailed a major overhaul of Kaiser (Appleby 1998). This include downsizing the hospital and physician component, eliminating management strata and converting certain inpatient surgeries to outpatient procedures and massive staffing redesign (Anders 1994; 1995a; Kertesz 1995b). At the same time, Kaiser executives insisted on Kaiser's uniqueness and superiority as a nonprofit, integrated HMO with a social mission (Iglehart 1994).

By 1994, Kaiser's unique three-component structure of integrated health care delivery began to be viewed as a liability rather than an asset by health care industry

analysts. While in previous decades its structure helped keep costs down and premiums low, in the turbulent 1990s it prevented Kaiser from maneuvering in the health care market like its competitors which were "stand alone" HMOs without physician or hospital components, and which could take advantage of changes in the market and depress prices to purchasers (Anders 1994). Many of these competitors were for profit enterprises that had greater access to capital than Kaiser, and unlike Kaiser, did not have capital tied up in "bricks and mortar" investments. Group model HMOs, such as Kaiser, comprised only a small minority of all models, at 5% in the early to mid-1990s (California Association of Health Plans 1998; California Association of HMOs 1993, 1994, 1995, 1996, 1997).

Along with its structure, Kaiser's social mission as a nonprofit health care corporation also seemed to hamper its "flexibility" in the market. Industry analysts questioned whether the Kaiser model would eventually become Kaiser's downfall, a "flawed construct" in the current health care market – especially since Kaiser did not have the entrepreneurial culture of its competitors (Kertesz 1995b). In April 1995, Moody's Investor Services downgraded Kaiser's unsecured debt because of "impediments" to adapt to a changing health care market, particularly the trend of consolidation within health care (Kertesz 1995c). This meant that Kaiser's access to capital would be more difficult, as its "reliability" for repaying loans was downgraded. Citing Kaiser's "flat membership growth in its core California markets and by the expectation that Kaiser will face greater challenges to maintaining its market share as a result of industry consolidation," Moody's report pointed to the need to repair "inefficiencies," rethink organizational structure, and re-evaluate the "cost" of having a

social mission – and emphasized that the social mission of a "not-for-profit" health plan is less of a priority than efficiency and cost.

In California, though, nonprofit HMOs had a more sizeable presence than nationally, averaging about 40% of all HMOs compared to 30% nationally; moreover, the percentage of for-profit HMOs in California declined from 64% in 1992 to 54% in 1997(California Association of Health Plans 1998; California Association of HMOs 1993, 1994, 1995, 1996, 1997). However, of the California HMOs with the greatest market share, only Kaiser and Blue Shield were nonprofits (Table 1). Kaiser's major hospital-based competitors, chiefly Catholic Health Systems and Sutter Health, were also nonprofit, but did not share Kaiser's historically labor friendly orientation. The "flexibility" to adjust to the changing health care environment, then, was not simply about tax-exempt status, but also in terms of Kaiser's social mission and its image as health care for working people, and its relatively positive labor management relations. Kaiser's highly unionized workforce had won wage and benefit packages superior to Kaiser's largely non-union competitors.

By mid-1995, while Moody's and other industry analysts suggested that Kaiser should change its corporate culture in order to regain market share, CEO David Lawrence strongly disagreed, stating that necessary changes were being made (Kertesz 1995b). Under the guidance of management consultants and new executives, Kaiser began an aggressive marketing campaign, expanding into new geographic regions, acquiring pre-paid group practice plans and introducing new "products" (health care plan options), and more dramatically "refining" its integrated delivery system (Moore Jr. 1995a). Kaiser also began actively marketing to increase enrollment, and in 1995, after lowering

premiums 7.2%, experienced rapid growth for the first time since 1991, composed largely of new Medicare enrollees. The trade press portrayed Kaiser as an "awakening giant" that "retools to fight for lost ground" (Kertesz 1995b).

To gain market share, Kaiser aggressively expanded nonhospital operations to gain membership across the U.S. and internationally, acquiring and partnering with several health care organizations and launching an international consulting firm (Hagland 1996; Kertesz 1997b). Kaiser moved into Eastern and Southern states, and entered into partnership with the nonprofit Group Health Cooperative in Washington state. In October 1996, the corporation launched "Kaiser Permanente International" as a consulting enterprise (Kertesz 1997b). In 1996, membership grew by 800,000 – the largest annual increase in its entire history – thanks to recent acquisitions and Medicare enrollment, and Kaiser's year-end economic gain totaled $265 million (Kaiser Permanente 1996).

Kaiser's "refining" of its integrated delivery system focused on exploring options to reducing its hospital services, by planning for hospital closures and contracting with its competitors for hospital services for Kaiser patients. Based on projected costs and benefits, Kaiser gradually began to disengage from hospital services. Earlier, expensive capital investments in new hospitals in Southern and Northern California appeared to backfire when Kaiser decided to not open them as acute care hospitals due to reduced need for inpatient care; the estimated costs of seismic upgrades added to executives' reluctance to invest more money in the hospital component. In late 1995, Kaiser executives even re-evaluated the very foundation of the Kaiser model as a three component organization, and considered eliminating the hospital component entirely (Rauber 1995).

The 1995 Strategic Plan

Perhaps the most egregious symbol of Kaiser's response to the changing health care environment is the 1995 Strategic Plan for Kaiser's Southern California Division. The Plan – although never implemented as planned (personal communication, Jim Ryder interview) – may be viewed as a symbol of Kaiser's direction towards reinventing itself as an organization increasingly similar to its competitors, in order to maintain fiscal viability and succeed in a health care environment dominated by these types of organizations. The Plan was a course of action that followed industry trends of health care delivery and labor relations, and aimed at cutting more than $680 million over the following five years. The goal was for Kaiser to have a rate advantage over its HMO competitors by 1997, accomplished by reducing per-enrollee costs by approximately 25%. The plan detailed a range of tactics that both reflected larger changes in health care while marking a radical departure from traditional health care delivery at Kaiser. The plan's cost-cutting strategy spanned hospitalization, employee compensation, and job redesign:

> Kaiser will shift more services from inpatient to outpatient care, slash hospital utilization and prescription drug costs, tie more of its medical group and salaried staff's compensation to performance targets, reduce staff in surgical and primary-care specialties, and redesign jobs to employ more lower-skilled workers" (Kertesz 1995a).

This plan also detailed major changes in labor relations, as reported by the CNA member publication (Bayer and McVay 1995):

> "Future contracts with labor unions [sic] employees," the Business Plan states, "will seek to decrease the costs associated with certain health care positions (salary, benefits, staffing ratios, etc.)."
>
> The document goes on to say that… "the new breed of health care workers are non-union employees and may replace many traditional union positions. The need to employ less expensive, multi-skilled and non-union workers will weaken the membership base and the power of the labor unions."

Kaiser expects "stiff opposition" from the unions over these issues, but hopes to "mitigate any potential harmful actions on the part of the labor unions" by developing "strong relationships with influential government and opinion leaders" and also by continuing to develop "strong relationships with its union leadership."

This apparent drastic change of direction undoubtedly stems from the unprecedented challenges Kaiser faced in the 1990s. As Kaiser sought to survive in the ever-competitive environment, its plans and cost-cutting tactics elicited a range of responses from organized labor.

Labor relations

Kaiser's relationships with labor unions historically have been far more positive that those in other health care organizations. Kaiser is the most unionized health care organization, across occupations and geographic regions. In California, one of the more politically active regions of the United States, Kaiser's relationship with organized labor is based in a national labor management partnership with the AFL-CIO. The partnership does not replace collective bargaining, and provides a structure for "united bargaining" whereby the interests of 60,000 workers are represented collectively – these interests include job security, and front line workers' involvement in staffing, business, and patient care issues. Kaiser agrees to not oppose any union organizing efforts and to recognize unions on card check (a more expedited process than requiring elections). The unions agree to promote Kaiser as the preferred insurer for their members, who comprise over two million of the nearly eight million Kaiser enrollees (Swoboda 1997).

The labor-management partnership was initiated by the top leaders of organized labor, who regard it as the most strategic way to protect joint interests of labor and management. As a historically pro-union employer, Kaiser is seen as the "least offensive" of the health care organizations. The AFL-CIO unions see it as the key to ensuring

quality of working conditions and patient care because labor has a legitimate place at the decision making table. Of the 26 union locals, Local 250 is the largest local and represents approximately 16,000 workers. By securing labor relations at Kaiser, the unions can allocate resources to organizing workers at less labor-friendly employers.

In Northern California, however, the CNA, representing Kaiser RNs, has refused to endorse the partnership and has publicly condemned what it considers a sell-out of patient care by the partnership unions and Kaiser. Consistent with its militant and confrontational approach to fighting health care corporations' restructuring, it has alleged that Kaiser's restructuring and the labor management partnership threaten patient safety and promote degradation of working conditions for RNs and other workers. The CNA engaged Kaiser in a bitter 14 month battle over nurse staffing, wages, and benefits by attacking Kaiser's credibility and accusing it of sacrificing quality patient care in order to preserve profits for administrators and managers. The CNA views the partnership as a vehicle whereby Kaiser gets labor's consent to proceed with the restructuring, and unions benefit by increasing their membership through expedited organizing procedures and the creation of new jobs consistent with the deskilling part of restructuring health care.

Based on this situation, Northern California Kaiser labor relations are on the one hand relatively antagonistic with the CNA, and on the other, relatively amicable relations with partnership unions. Before the situation came to be as it stands currently, relations among these three actors were informed by their historical roots and the tremendous changes in health care in the 1990s.

Union profiles

Health Care Workers Union, Local 250

Health Care Workers Union, Local 250, Service Employees International Union, AFL-CIO, is the largest union local in California and the second largest health care workers union in the United States. It represents approximately 46,000 workers at 300 Northern California public and private facilities, including RNs, allied health care workers (e.g., LVNs, dietary workers, paramedics, etc.), physicians, pharmacists, and clerical workers. There are six functional divisions: Kaiser Permanente, Hospital Division, Convalescent Care, Home Care, Physicians (MDs in residency programs), and Emergency Medical Services. There are eleven geographic divisions in Northern California – from the California-Oregon border south to the Salinas and Central Valleys. The Local owns the building housing its headquarters in downtown Oakland, and has offices in San Francisco, Sacramento, San Jose, and Fresno.

Local 250 identifies as

> an action-oriented union [whose] staff and members are involved in extensive labor organizing drives, campaigns to preserve and to promote quality patient care and other issues of social and political significance that can improve the lives of our members, our families, and the community. (SEIU Local 250 N.d.-c)

It is involved in social, economic, and political issues that include and extend beyond typical health care issues. Its labor organizing is infused with a social justice imperative that links quality patient care with social and economic issues. It has been involved in several legislative proposals for single payer universal health care in California (Proposition 186 in 1994) and one of two competing "patient care" initiatives in 1996 (Proposition 214) (the other proposition, Proposition 216, was supported by the California Nurses Association). Along with a coalition of social justice and other health

care groups, the union helped organize massive public actions for health care and economic and social rights in 1995 and 1997.

Local 250 was the first union in the U.S. to represent health care workers, and began with a group of service workers at San Francisco General Hospital in 1934, following the San Francisco general strike in 1934, and pre-dating the National Labor Relations Act in 1935.[6] Beginning in the 1950, Local 250 became a prominent and effective force for labor in the San Francisco Bay Area, organizing and representing health care workers in both public and private sectors. The union's emphasis is on organizing unrepresented and/or low-wage workers in hospitals, nursing homes, and home health care organizations – in both national chains and public sector organizations (SEIU Local 250 N.d.-a).

In 1986 the union was reconstituted, when the International union took control of the Local and organized a strike against Kaiser during stalled contract negotiations, from October to December. The Local was put under Trusteeship by the International in 1987 to rebuild its financial stability. In 1988 a new constitution was adopted, and the Local was released from Trusteeship when a new slate of elected leaders took office – Sal Rosselli as president and the late Shirley Ware as Secretary-Treasurer. Since then, there has been a concerted effort to become a more militant and democratic union fighting against corporate greed in health care, and for social and economic justice for its predominantly working-class and racial-ethnic minority membership. By the fall of 1998,

[6] The emergent union was chartered by the American Federation of Labor in September 1934 as a national union, since there were no national unions representing hospital workers. The union then began organizing workers at SF's private "voluntary" hospitals. In 1938 Local 250 received a new charter from the Building Service Employees International Union (renamed Service Employees International Union in 1970) (SEIU Local 250 N.d.-a).

the "10th year of the New Local 250" the union was on solid financial and political ground (Ware 1998).

Relations with Kaiser

Local 250's hospital membership base historically has been largely Kaiser workers. The union currently represents approximately 16,000 workers in over 180 job classifications at Kaiser hospitals and outpatient facilities. In contrast, the Hospital Division represents 9,500 workers at 130 sites (45 of which are acute care hospitals) (SEIU Local 250 N.d.-b, c). The union has had historically favorable relations with Kaiser compared to other organizations. Local 250's first strike against Kaiser was an eight-day walkout in December 1968, resolved by the personal intervention of Edgar Kaiser, the head of the Kaiser industrial empire.[7] This period marked a turning point for the union:

> With consolidation of our presence and strength at Kaiser and at public and private hospitals, Local 250 turned more attention to organizing low-paid, exploited workers in nursing homes and convalescent hospitals. In pursuit of justice for scandalously mistreated workers, the union often stood toe-to-toe with some of the most rabidly anti-worker and profit-hungry corporations in the country. (SEIU Local 250 N.d.-a)

The union's strategy and tactics against corporate chains is markedly different than its Kaiser approach. Regarding the former, the union is aggressive and militant in attacking corporate greed that jeopardizes workers and patients through inadequate staffing and poor working conditions. The union's treatment of Kaiser, in union publications and through informant interviews, is still tough-talking but without the characterization of corporate greed ("profits before workers and patients") that identify the other types of organizations.

[7] This period preceded Kaiser Permanente's establishment as a federally recognized HMO in 1977, separating the health care organization from Kaiser Industries.

In Northern California, relations between Kaiser and Local 250 have been much less antagonistic than Local 250's relations with other health care corporations that are perceived as less union-friendly and more profit-oriented, especially Catholic Healthcare West and Sutter Health, where Local 250 has engaged in long-running contract disputes in which they attack the organizations' deteriorating working conditions and quality of patient care. These two organizations, moreover, are two of Kaiser's biggest competitors in Northern California, and have been much less friendly to SEIU organizing. Local 250 has still called Kaiser to task on staffing and patient care issues, but its approach to Kaiser is cooperative and collaborative. The union is the largest "labor partner" in the national AFL-CIO/Kaiser labor management partnership.

Kaiser-Local 250 labor management collaboration predates the AFL-CIO/Kaiser partnership by at least ten years. The February-March 1999 issue of *Unity*, Local 250's bimonthly newspaper, celebrates the ten year anniversary of the Local 250-Kaiser "Joint Conference" – a labor-management structure whose purpose is to "build better relations between union and management," and which is credited with providing "one of the main models leading to the creation of the National AFL-CIO/Kaiser Partnership (SEIU Local 250 1999a). Subsequent to the signing of the partnership, these labor-management endeavors focus not only on education and training around terms of the collective bargaining agreement (including trainings for new stewards), but also how labor and management can "work together" to improve health care delivery and patient care at Kaiser (SEIU Local 250 1999a).

Local 250-Kaiser relations were tested during impasses in contract negotiations in May 1995 for SEIU California Locals 250, 399, and 535. The Locals planned a one day

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strike at Kaiser clinics throughout California. Echoing the rhetoric of the International and the AFL-CIO, Local 250 president Sal Rosselli stated: "Kaiser has joined an ugly race to compete for market share by offering the cheapest health care instead of the highest quality care possible… Health care workers are the advocates for patients in today's health care environment – and on May 30, that will mean going on strike" (Chiu 1996). Shortly after giving the ten-day notice, the local unions, beginning with Local 250, postponed the strike and returned to the bargaining table, each settling independently with Kaiser. This short-term adversarial stance appears to be the union's last typically "hardline" actions against Kaiser, and Local 250 has approached labor management relations through a negotiated rather than adversarial position, structured through its membership in the national AFL-CIO/Kaiser partnership.

California Nurses Association (CNA)

The CNA is an independent professional association and labor union that represents approximately 30,000 Registered Nurses (RNs) in approximately 100 hospitals, clinics, and home health agencies in California.[8] It is not affiliated with the AFL-CIO, nor with the American Nurses Association (ANA), the major national professional association for Registered Nurses. Until 1995, the CNA was the state affiliate of the ANA, when it seceded to form a more militant association that more aggressively challenged the restructuring of health care, claiming negative impacts on nursing and patient care. The union is organized into eleven regions and has offices in Oakland (Executive office), Sacramento, Santa Clara, Santa Monica, Fresno, and San Diego. Nearly all workers represented by CNA are RNs, but some bargaining units

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include other workers (Staff Nurse Action Project and California Nurses Association Board of Directors 1998). In Northern California, CNA represents approximately 75% of eligible RNs (personal communication, Jim Ryder, Oct. 1999). At Kaiser, CNA represents approximately 8000 RNs in Northern California.

The purpose of the CNA links economic justice and patients rights, RNs' welfare with the public's health care services. "The purpose of the CNA shall be to foster high standards of Nursing practice, promote the professional and educational advancement of nurses, and promote the welfare of nurses to the end that all people may have better health care services" (CNA Bylaws, Article II, cited in *The Staff Nurse Guide* 1998). There are three program areas: Economic and General Welfare, Nursing Practice, and Government Relations. These programs are constructed as essential dimensions of fulfilling one's ethical and legal obligations of being an RN, and this works to resolve the historical ambivalence of many nurses towards unions.

> Collective action in the overlapping arenas of Nursing practice, Government Relations and collective bargaining results in a strong profession in the workplace. The most professional thing a nurse can do is join collectively to advocate for patients and his or herself. CNA is a multi-purpose organization – our strength lies in our ability to coordinate our collective bargaining, legislative, and nursing practice strategies on behalf of all members. (emphasis added) (Staff Nurse Action Project and California Nurses Association Board of Directors 1998:4)

The CNA's core mission is to protect RN practice and patient care by fighting the corporate restructuring of health care, and this is framed through RNs' ethical, professional, and legal obligation to advocate for patients, even in situations that put them at odds with their employer. The CNA puts patient care and nursing practice as the

[8] CNA represents 30,000 of the approximately 250,000 RNs in California. Another 25,000 RNs are represented by AFL-CIO affiliates and small independent unions; another 175,000 are not organized but eligible (personal communication, Jim Ryder, October 1999).

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inextricably linked priority, and encourages members to report situations they consider unsafe to patients, focusing on work assignments and personnel that the RN considers inappropriate or unsafe. In its publication *The Staff Nurse Guide* (Staff Nurse Action Project and California Nurses Association Board of Directors 1998), directions and contact information are provided for different oversight agencies and their jurisdictions (California Dept. of Health Services, California Dept. of Corporations, and Bureau of Registered Nursing).

In 1994, the CNA also instituted a "Patient Watch" program – a public relations ad campaign to alert the public to dangers of health care restructuring. When the new leadership and organizational structure was established in 1995, the CNA began leading "a war against the industry" (personal communication, Jim Ryder, October 1999). As part of its fight against restructuring and the corporate focus on cost rather than care, the CNA has actively lobbied for patient care legislation. This activism includes the initiative for single payer universal health care in California in 1994 (Proposition 186), and one of two competing measures for "patient care" in 1996 (Proposition 216) (the other, Proposition 214, was sponsored by Local 250). Most recently, the union pushed for AB394, the "safe staffing bill" in California that mandates the California Department of Health Services to define and enforce safe nurse-patient ratios. The CNA has also organized mass public demonstrations and lobbying of public officials regarding the dangers of restructuring health care.

The CNA was founded in 1903 as one of the first professional organizations representing RNs. Its publications foreground its leadership in struggles for Registered Nurses' rights and improved pay, benefits, and working conditions. In 1945 CNA became

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eligible (personal communication, Jim Ryder, October 1999).

the first state nursing association to represent RNs in collective bargaining. The next year the American Nurses Association, previously resistant to RNs' collective bargaining, approved the California model for the other states. In 1950 the ANA adopted a "no strike" policy, which CNA adhered to until 1966. Up to that time, CNA began engaging in increasingly militant tactics just short of striking, the most effective one being mass resignations, which achieved the same goals as strikes: better pay, benefits, and work conditions. In 1966 the CNA Board of Directors repealed the no strike pledge. Nurses represented by the union struck successfully through the 1980s, gaining improved working conditions for nurses. In 1992 the union adopted a policy to work with other labor unions in concerns of shared interest, institutionalizing a policy of labor solidarity. That summer, the CNA and four other unions (SEIU Local 250, ILWU Local 6, OPEIU Local 29, and HERE 28) waged a successful seven week strike at Summit Medical Center in Oakland over the right to honor one another's picket lines.

In 1995 the CNA's elected governing body voted to secede from the ANA and become an independent professional nursing association. This was fueled by the conviction of a group of politically radical CNA leaders and nurses that the ANA was not adequately confronting the threat to patient care and to staff nurses posed by the restructuring of health care and the increasing corporatization of the industry. This split reflected, and deepened, a growing rift between more conservative RNs historically associated with the CNA and ANA, and more politically progressive new leaders (some of whom are not RNs) and members who were staff RNs. The "insurgents" wanted a more representative leadership, and more aggressive advocacy for patient care and nurses' rights. Since the union's reconstitution, its Board of Directors are rank and file

nurses (i.e., staff RNs, not managers or academics); its Executive Director and several key staff leaders are not RNs.

Relations with Kaiser

Relations between the new CNA leadership and Kaiser Permanente were strained in the 1990s primarily because of the cost-cutting strategies of Kaiser to reduce the numbers and change the roles of RNs. CNA leaders claim that Kaiser eliminated over 1,400 RN jobs between 1994 and 1997 in order to cut staffing costs (Moore Jr. 1997a) and that Kaiser had planned further RN reductions for the 1997 contract proposal (personal communication, Jim Ryder, Oct. 1999).

The CNA has represented Kaiser RNs for approximately 40 years, but has done so for most of this time as the state affiliate of the ANA, not with the militant labor politics of the current leadership. Their last strike against Kaiser prior to the conflict in the 1990s was in 1974 (Ferraro 1997), occurring during a similarly aggressive cost-cutting atmosphere but with a very different leadership of the CNA. As an independent professional association (before and after its revolution/reconstitution in 1995), the CNA has not participated in the common organizational umbrella and union ideology of the AFL-CIO, unlike the other unions representing Kaiser workers. While several of the new leaders come from the mainstream labor movement and share this ideology, the union culture as a whole has retained an RN-centric focus as it blends RN interests with progressive labor politics.

However, there is no shared bond with other RN unions at Kaiser. Many of the other RN unions have agreed to Kaiser's cost-cutting strategies and actively participate in the AFL-CIO partnership, which the CNA staunchly opposes. While the CNA has

publicly attacked the partnership and Kaiser's restructuring as endangering patient care and selling out workers, representatives of the RN partner unions are often quoted in AFL-CIO publications to demonstrate the success of the partnership, especially the power of the unions and grassroots members to work successfully in collaboration with Kaiser. In California, Kaiser's membership base, the Southern California RNs are represented by an AFL-CIO affiliate that attempted to dislodge the new leadership in the early period of its revolution (personal communication, Jim Ryder, Oct. 1999). The CNA, then, faces a fight on two fronts: against Kaiser's desire to reduce the RN budget, and against isolation by the labor-management partners (both Kaiser and the partner unions, each with their own interests).

Inter-group relations over Kaiser's restructuring

Throughout California and its other regions, as Kaiser began restructuring its health care delivery, its strategy and tactics elicited major protests from organized labor and consumer groups, who claimed that Kaiser was abandoning its traditional structure and social mission, while Kaiser still insisted that these were still core components of the organization (Kertesz 1997b; Russell and Hall 1996). In California, in early May 1996, a coalition of health care labor unions, consumer advocates, and political leaders called for state intervention by the California Dept. of Corporations, to investigate the potential impacts of Kaiser's restructuring (Bay Area Report 1996). Due to Kaiser's size and historical prominence in the health care industry, any changes would likely represent the new standards for the industry in terms of health care delivery and staffing models – these changes would have major implications for health care delivery throughout California and the United States.

Beginning in the 1990s, Kaiser-union relations have been more frequently and more intensely critical over Kaiser's planned restructuring and the negative implications for worker and patient well-being. The CNA and AFL-CIO unions have shared common interests in protecting workers' gains and patient care against job reduction and deskilling of professionals, and vocally supported one another against Kaiser's proposed cutbacks or takeaways through 1997, despite their later disagreements about the merits of the partnership. John Sweeney, President of the AFL-CIO called for organized labor to "renovate the HMO that labor built" (Hall 1996; Moore Jr. 1996c; Russell and Hall 1996). The Southern California Strategic Plan was leaked to a Southern California consumer group, Consumers for Quality Care, which characterized the plan as a "secret HMO business plan" and made it available to the trade magazine *Modern Healthcare* and the CNA's monthly newspaper *California Nurse*.[9] The CNA denied that Kaiser's restructuring was due to financial problems, and accused Kaiser of selling out patients and workers to increase its "tremendous profitability" (Bayer and McVay 1995).

During stalled contract negotiations in mid-late 1995 and early 1996, AFL-CIO affiliate unions faced dramatic takeaways as Kaiser sought to slash labor costs. The AFL-CIO, SEIU, and CNA leadership lambasted Kaiser for the likely negative impacts of Kaiser's restructuring. The leaders criticized the HMO for jeopardizing patient care and eroding working conditions through cost-cutting measures, and demanded input into

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[9] *California Nurse* was more specific than *Modern Healthcare* in quoting the plan extensively to demonstrate the major implications of the plan for union workers and quality of patient care – the replacement of non-union, non-licensed, and less-expensive employees for skilled union jobs – and the subsequent erosion of unions' membership base and power. Most damaging for Kaiser was the authors' assertion that Kaiser directly admitted in this plan to be cognizant of the effects of "drastic altering" of patient care sites and services, and possible "dangerous repercussions among the communities [Kaiser] serves." The authors also quoted from the document that Kaiser's strategy to neutralize "potential harmful actions" by the labor unions was the formation of "strong relationships with influential government and opinion leaders" and "strong relationships with its union leadership" (Bayer and McVay 1995).

Kaiser's restructuring (Moore Jr. 1996b, c). In February 1996, Kaiser CEO David Lawrence demanded that the AFL-CIO stop publicly attacking Kaiser's quality of care (Olmas 1996) while AFL-CIO president John Sweeney argued that Kaiser's long history of close labor relations placed it under special obligation to resist following the quality-cutting model set forth by the majority of the HMOs and health care organizations (Hall 1996). Lawrence acknowledged that these changes would impact employees, but emphasized that if Kaiser was faced with a "choice of serving our members, or serving our employees, our obligation is to serve the members" (Russell and Hall 1996).

The AFL-CIO and the CNA chose different approaches to deal with Kaiser's restructuring. The AFL-CIO decided to take a more negotiated, less adversarial approach with Kaiser as long as Kaiser demonstrated good faith in sharing decision making over restructuring plans. The CNA, which felt that RNs were particularly under attack, and patients by extension, remained committed to an adversarial and militant approach; for RNs, there was nothing to gain by joining forces with the institution that had been downsizing RN jobs and seemed intent on continuing the trend. The AFL-CIO constructed Kaiser as qualitatively different and better than the other health care corporations because of its nonprofit status and long history of positive labor relations, and because union members have historically comprised the majority of Kaiser members. The CNA constructed Kaiser as a greedy and negligent corporation prioritizing profit over quality care – similar if not worse than the rest of the HMOs, because Kaiser was abandoning its original mission of providing quality care through downsizing and deskilling. Both unions demanded a voice in Kaiser's plans but due to their different orientations chose radically different ways to make their voice heard. While the CNA

chose to engage in a 14 month conflict that foregrounded their claims that Kaiser's restructuring endangered patients and the community through downsizing facilities and the RN workforce, AFL-CIO leaders steadily negotiated an arrangement that aimed to meet the joint interests of its members, the unions, and Kaiser itself.

The national AFL-CIO/Kaiser labor management partnership

The national AFL-CIO/Kaiser labor management partnership stems from top-level union leadership ideas about new directions for labor. John Sweeney, formerly president of the SEIU, was elected the new president of the AFL-CIO on Oct. 25, 1995. In an interview with a reporter from the trade magazine *Modern Healthcare* prior to the election, Sweeney elaborated his views on the current health care situation and tactics for labor in the future (Moore Jr. 1995b). This interview previews the AFL-CIO's current stance towards the health care industry and strategic approaches of organized labor in terms of meeting social justice goals. He criticized the corporate entities that dominate health care industry and place profits before patients, citing the massive numbers of persons under- or uninsured, the "merger mania" and "relentless employer cost cutting" that all results in degraded patient care and job security for workers, with "the bottom line of it all is how it affects patient care and workers' concern for care of their patients" (Moore Jr. 1995b).

In this interview, Sweeney elaborated his plans if elected president of the AFL-CIO. He first cited that he would prioritize a campaign for national health care reform. In response to the interviewer's query about increasing the political and economic power of unionized health care workers, Sweeney replied that "coordinated bargaining" – successful in other industries – was a likely strategy for health care, and one that is

currently being approached at Kaiser regarding improving quality of work and patient care. Then the interviewer asked about "fresh ideas" for labor – perhaps a partnership? Sweeney responded that if it's a "real partnership" with a "level playing field" this can be very productive; but if "the playing field is not going to be level, then confrontation will be necessary. There is too much greed" (Moore Jr. 1995b:48).

According to the publication representing the AFL-CIO partnership unions, the national AFL-CIO/Kaiser labor management partnership resulted from a union-initiative beginning Fall 1996, when numerous contracts were still open in California. AFL-CIO leaders contacted David Lawrence with a proposal that involved Kaiser's "serious commitment to giving employees a voice and to creating a better place to work and receive care," and in exchange, "the labor movement will then agree to make Kaiser a 'union label' health plan." (Coalition of Kaiser Permanente Unions 1998a). Other sources (Moore Jr. 1996c; Rauber 1996) report that in late 1995 Sweeney initiated a meeting with Lawrence, and the two met in early 1996 to begin exploring a possible labor management partnership that would have "placed a moratorium on concessions and restructuring issues." When Lawrence initially refused, Sweeney resumed militant union rhetoric:

> Kaiser has decided to compete in healthcare marketplace by cutting costs at the expense of quality patient care, and by denying decent wages, benefits and working conditions to its employees... Now they seem to want to lead the race to bottom of the HMO industry by putting patients into the hands of lower-skilled workers without adequate training by eliminating highly trained professionals, closing more hospitals altogether and contracting out vital services to the lowest bidders. (Moore Jr. 1996c)

This statement links quality of care, jobs and working conditions, and accountability of health care providers. At that time, the AFL-CIO's Industrial Union Department was planning to help coordinate bargaining of the unions representing Kaiser workers.

According to the AFL-CIO partnership's publication *Inside/Out* ("the newsletter that tracks the Kaiser partnership"), in the Spring of 1997 Kaiser "agrees to work with the unions" and after a partnership is constructed, it is "introduced to rank and file union leadership through a nationwide satellite meeting with John Sweeney and Kaiser COO & President Dick Barnaby." In May and June 1997, union members ratify the partnership by a "90% 'yes' vote." For the next year, labor management committees implement trainings in consensus-based decision-making, and develop an "evolving road map" in preparation for the eventual partnership-sponsored projects at several hospitals and call centers. These projects "are experiments in hospital design. Doctors, managers, and workers consult each other about patient care and make joint decision that affect patients and workers" (Coalition of Kaiser Permanente Unions 1998a).

The partnership is based on acknowledging joint interests between labor and management, as articulated in the article "The partnership: finding common ground" from the inaugural issue of *Inside/Out* (1998b):

> Kaiser partnership unions and Kaiser Permanente management have agreed to recognize our common purpose, and to work together through the partnership to effectively deliver the best health care we can.
>
> We have agreed that we want to:
>
> Improve the quality of health care for Kaiser Permanente members and the communities we serve;
>
> Provide Kaiser Permanente employees with the maximum possible employment security within Kaiser Permanente;
>
> Involve employees and their unions in decisions;
>
> Assist Kaiser Permanente in achieving and maintaining market leading competitive performance;
>
> Make Kaiser Permanente a better place to work;
>
> Expand Kaiser Permanente's membership in current and new markets, including designation as a provider of choice for all labor organizations in the areas we serve.

An early example of the power dynamics of the partnership in action is provided in the second issue of *Inside/Out*, describing labor management negotiations over the Hospital Operations Improvement project (HOIP) that seeks to identify and implement "best practices" of patient care and staffing issues (Coalition of Kaiser Permanente Unions 1999):

> After HOIP had been underway for a few months, it became apparent that Kaiser had launched this project without input from its employees. Kathy Sackman, UNAC [United Nurses Association of California, Southern California RNs' union] president, says the union leaders were outraged. "We asked, 'How can you look at best practices in a hospital without including our members at the early stages? They will be the most affected by changes in the hospital systems – they can't just be brought in as 'yes' people after all the key decisions have been made."
>
> To Kaiser's credit, it agreed to operate the project in partnership from then on.
>
> When union members got involved in the work groups to evaluate the hospital practices, they saw that Kaiser wanted to pick the best practices that cost the least, said LVN Bea Bell, SEIU Local 250... "We said, 'No way.' We wanted to pick the best practices that had the highest quality."
>
> Each side – the managers and physicians, and the union members and staff – "had started out politely, like the lion circling the Christian," said Bell. "And then we finally collaborated, and came to consensus as a group that quality was job number one here, not cost, which was so surprising from where we started. The union members really made a difference in the outcome of workgroups."

The article then credits union power and Kaiser good sense for making subsequent projects have union participation from the start. The article concludes with a quote from another RN that links union employer with quality health care, and gives a "realistic" assessment of power dynamics in the Kaiser partnership.

> No one wants to see Kaiser narrow best practices down to the cheapest. "It's really important to keep quality in our patient care and in our organization, so it doesn't get bought out by one of these non-union companies like Catholic Healthcare West where the quality has just gone down, said [Nelly Garcia, RN, President of UNAC]. "If you don't have a union, management won't listen to you. It's not always easy to get our voice heard here either, but it's fair to say progress has been made. Through the Partnership, we have the opportunity to make employee concerns and know-how part of Kaiser's planning process." (Coalition of Kaiser Permanente Unions 1999)

Local 250 as union partner

Twenty of the 26 local unions are based in Northern California, and Local 250 is the largest partnership local with 16,000 members. Local 250 benefits greatly from the arrangement. By having cooperative labor management negotiations at Kaiser, it can focus its resources on its conflicts with less union-friendly enterprises, such as Catholic Healthcare West and Sutter Health (Abate 1999). President Rosselli states the union position: "Kaiser isn't perfect, but it's the least offensive… They've done one big thing no other health care employer has done – include the rank and file people who provide health care at the same table, in equal numbers, with physicians and managers to make decisions about how care should be done."

In its bimonthly publication *Unity*, Local 250 describes the partnership as "designed, in part, to improve quality care by giving workers a larger voice in management decisions affecting their jobs and patients" (SEIU Local 250 1998b). Early examples of partnership achievements focus on workers and management discussing and reaching agreement on performance evaluation tools, dress code, resource scheduling, work area environment (personal items on display in shared work spaces), and new call center trainings (SEIU Local 250 1998a). Regarding achievements for patient care and staffing decisions, the April/May *Unity* mentions the Hospital Operations Improvement Project (HOIP), in which teams of Local 250 members and Kaiser management personnel were charged with "reviewing, evaluating, and making recommendations for adopting best practices while maintaining quality" of nursing care[10] (SEIU Local 250 1999b).

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[10] In this article, "nursing" is alluded to without a specific reference. The text makes no direct linkage to "nursing," and no mention was made of the CNA or RNs lack of participation in HOIP.

Regarding the CNA's and staff RNs' lack of participation in HOIP or other partnership committee, I heard different explanations from union activists and others as to why this was so – moreover, when I mentioned to informants that I was hearing different explanations, most of these informants insisted that their explanation was the "truth." Several informants stated that Kaiser "doesn't allow" CNA to participate, as a "punitive" measure for not joining the partnership. Several others – including a Kaiser manager who was not formally interviewed – stated that Local 250 doesn't allow CNA to participate (as a "punitive" measure for not joining the partnership). Several RNs said that they think that CNA leadership decided not to participate in the meetings, and that "if it's about cutting nurses, then we don't want to participate." Still another informant, represented by Local 250, said that CNA leadership doesn't allow RNs to participate in the partnership, and because they are not in the partnership, they cannot participate in partnership committees.

Local 250's perspectives of Kaiser are informed by its membership in the national partnership. Union leaders are neither "yes-people" nor adversaries. Identifying problems at Kaiser is situated in the overall analysis of the increasing competition in health care in California, where Kaiser's response to this increased competition has been to cut back staffing and services, eroding working conditions, downsizing staff, and ultimately putting patients at risk. Several activists/leaders emphasized that the union's priority is to make sure workers get the training necessary to work in the new occupational structure, and to ensure quality patient care. They said that overall the health care industry, including Kaiser, has fallen short on the training, and that this is a severe problem. However, they emphasized that working conditions and patient care are far better at

Kaiser than the competition, and despite its shortcomings, Kaiser is worth working with, instead of fighting against, in order to protect workers and patients. Rank and file worker informants displayed different perspectives on restructuring at Kaiser – it was unilateral, engineered by Kaiser alone, and then "responded to" by the union, or through a cooperative process involving labor and management working together.

At the time of data collection, the partnership was still in an emergent state. It was conceived of, and implemented beginning at top labor-management levels, and was gradually working "down" to middle management, and stewards and workers. One activist emphasized that currently, not all sectors of management were "on board" – but where they were on board, things worked enormously better in terms of improved morale, reduced sick-outs, and overall work flow. Because the partnership formally structures cooperation between labor and management, Local 250 leaders and activists continue to express a great deal of faith in Kaiser that it "will do the right thing" in terms of staffing and patient care once financial stability is secured. However, these leaders still express concern in terms of the partnership's success. President Rosselli expressed concern over possible management recalcitrance in November 1998 (Rauber 1998). In the December 1998 issue of *Unity*, Kaiser Division Director and Local 250 Secretary/Treasurer Joan Emslie sums up the official union approach:

> The partnership presents a large challenge for all us of – union and management – because we have to 'unlearn' the ways we thought about solving problems and tackling issues important to workers. We've accomplished a lot, but we have a long way to go. Our Local 250 members and management partners are committed, and this is a powerful combination. (SEIU Local 250 1998a).

Kaiser and the CNA

In the 1990s, as Kaiser sought to cut costs through RN layoffs and downsizing of Kaiser hospitals, the CNA fought back hard. It regarded Kaiser's proposed contract in

early 1997 as a "provocation" to strike by the massive scope of the takeaways and job losses. The CNA claimed that Kaiser had eliminated over 1,400 RN jobs in the past three years in order to cut staffing costs (Moore Jr. 1997a) and was aiming to continue this trend (Ryder interview), proposing a massive replacement of RNs by unlicensed staff, a reduction of between 25-60% RNs in direct patient care (Bartel 1994). Kaiser argued that these moves were necessary to bring RN wages "in line" with market rates, especially outside the San Francisco Bay Area. CNA's Executive Director Rose Anne DeMoro accused Kaiser of eliminating RN jobs to save money at the expense of patient care, and of trying to provoke a strike by the union.

> "We were expecting horrible proposals, but they went beyond being horrible...Kaiser is absolutely trying to provoke a strike. They would like to be able to drag anyone off the street and pay them minimum wage and call them a 'patient care Whatever.' But more importantly, they are trying to silence the registered nurses who have taken the lead in speaking out on behalf of patient care and the public." (DeBare 1997)

Thus in 1996, while the AFL-CIO and its union locals were moving in the direction of a partnership, CNA-Kaiser relations became increasingly strained, and the RN union framed the emerging conflict over quality of care. The CNA criticized Kaiser's restructuring of RN staffing and proposed closing of hospitals as a strategy to preserve administrators' salaries and perks, at the expense of workers and patients. The CNA foregrounded the linkage of RNs' and patients' well-being and expanded the linkage to "quality patient care" in hospitals and in the larger community. In terms of the developing labor management partnership, the CNA claimed that Kaiser's proposed contract contained so many takeaways and job losses that it would not consider joining forces with an organization who could seriously propose such changes. However, earlier that year, the Southern California RN union (an AFL-CIO affiliate) had agreed to a

contract with many of the same conditions proposed in Northern California – wage and benefit reductions, tying wages to "performance goals" – ostensibly to be offset by shared decision-making over staffing and job security (Moore Jr. 1996a). When in 1997 the AFL-CIO leadership managed to work out a labor-management partnership outline that seemed to meet both Kaiser and union objectives, the CNA refused to endorse this move and asserted they would not "sell out" or "compromise" their position towards Kaiser on the basis of RNs' legal mandate as patient advocate.

Kaiser's proposed contract and the eventual presence of the partnership in Northern California threatened CNA's and staff RNs' central presence and influence in direct patient care. CNA began a multi-pronged attack on Kaiser's credibility by demanding that patient care data be included as part of the bargaining process in order to demonstrate the negative impacts of downsizing RN workforce. Along with staffing issues, CNA criticized Kaiser for its proposed closures of several East Bay hospitals that serve predominantly working-poor and minority communities, in what the union called "medical redlining." Early in the conflict, the union also focused on Kaiser's possible divestiture of its hospital component, and threatened to strike any other hospital that entered into a short-or long-term alliance with Kaiser to take its hospitalized patients (Rauber 1997).

The very idea of a labor management partnership was an anathema to the CNA, especially after seeing the scope and degree of the proposed RN cutbacks and takeaways. In a point by point rebuttal of the partnership (California Nurses Association 1997b), CNA explained its opposition, based on its obligation to remain patient advocates by speaking out and taking action against Kaiser staffing, proposed hospital closures, and

not entering into a relationship whereby the Kaiser's interests are placed before the patients' interests. It viewed the partnership as an illusion of sharing decision making power at Kaiser – specifically, it was a vehicle whereby labor benefited with limited, short term gains at the cost of not opposing management's decisions regarding business or patient care issues – "to Kaiser a 'partnership' means dominated by Kaiser, not a relationship based upon equality" (California Nurses Association 1997b).

> WHAT PARTNERSHIP [sic] WOULD MEAN TO CNA
> CNA believes this "partnership" would
> - Undermine CNA's credibility with patients and consumers by creating a conflict of interest between RNs' role as patient advocates, and a requirement that RNs promote Kaiser Permanente while concealing information which could demonstrate quality problems.
> - Force CNA into a conflict of interest by requiring CNA to promote Kaiser even while Kaiser is reducing the quality of care; and by preventing CNA from revealing information which might show Kaiser in a bad light.
> - Limit rank and file membership participation by creating a "Senior Partnership Committee" whose members are removed from the work place.
> - Erode Union solidarity with other Kaiser employees by creating artificial barriers through gag rules and confidentiality agreements during bargaining with different Unions. (California Nurses Association 1997b)

1997: Conflict over care

Early 1997 was a crucial turning point in Northern California labor relations among Kaiser, the CNA, and the AFL-CIO unions, including Local 250. Several important events took place within months of one another. In the first quarter of the year, Kaiser began implementing its staffing redesign at selected units in hospitals and clinics in Northern California. This occurred as tension increased between CNA and Kaiser over the proposed contract and the announcement of CNA's first of a series of one- and two day strikes in mid-April. During this same period, the AFL-CIO leadership and Kaiser agreed upon the terms of the labor-management partnership, and participating locals began encouraging their members to vote in favor of the project. As Local 250 joined

other AFL-CIO unions in the partnership in order to protect member interests and quality of patient care, CNA aggressively fought back against Kaiser to protect its members' interests and quality of patient care by foregrounding Kaiser's restructuring as dangerous to workers, patients, and the community at large. CNA opposed the partnership on grounds that it allegedly condoned the reduction of RNs and increasing use of unlicensed providers ("swapping RNs jobs for Local 250 jobs"), undermined labor's ability to criticize patient care at Kaiser, and implied that Kaiser had an adequate quality assurance system in place.

Kaiser's alleged lack of commitment to quality and safe patient care – through access and staffing – became the central theme of CNA's position against Kaiser. In a press release dated September 18, 1997, the CNA states that based on public data that Kaiser reported to California's Department of Corporations, Kaiser's administration expenses rose by nearly 260% in Northern California since 1993, while Kaiser reduced patient services during a time of record membership growth ("up 250,000 the past two years") (California Nurses Association 1997a).

> "Kaiser has become very accomplished at cutting costs for patient care, but opens the bank when it comes to administrative expenditures," said Kit Costello, RN, [CNA president]. What these numbers demonstrate is a shift in resources from patients and caregivers to corporate overhead and management consultants. RNs, other caregivers, and many patients see the effects of these tragically misguided priorities every day."
>
> In fact, an internal Kaiser e-mail message obtained by CNA this week showed Kaiser executives conceding a rapid fall in their own membership satisfaction surveys.

For 14 months the CNA waged a highly visible, multi-pronged campaign against Kaiser, holding a series of one- and two- day strikes, demonstrations at the Kaiser hospitals slated for closure, a highly visible "horror story" campaign (where actual

patients' stories of mistreatment, denial of care, or medical errors are used), ads, editorials and articles in local and national periodicals, and legal actions at the state level that aimed at holding Kaiser accountable for its alleged risks to patient care. The union also filed labor complaints that Kaiser was not bargaining in good faith. The whole campaign was based on "alerting" the public and lawmakers to the "crisis of care" at Kaiser. These claims were bolstered by a series of private lawsuits against Kaiser, and investigations by state agencies into alleged violations at several East Bay facilities that resulted in patient deaths, and gross mismanagement and negligence in Kaiser's Texas operation. Moreover, at a Berkeley, California press conference called by a Southern California organization Consumers for Quality Care, consumer advocate Ralph Nader blasted Kaiser's reduction of RN staffing and released a letter to the California Department of Corporations calling for "an immediate scrutiny and intervention of state health authorities" which Kaiser called "a disgraceful bid for publicity" by the CNA (Moore Jr. 1997b).

As the conflict escalated, both sides called on respective "experts" to bolster their position and discredit the other in an increasingly antagonistic and bitter dispute, with neither side compromising, but rather digging in their heels. Kaiser fought back with ads, letters to the editors, and op-ed pieces in newspapers and claims that RNs were using their contract dispute with Kaiser for the purpose of furthering a larger, national health care agenda, and that CNA's demands were "unreasonable" in terms of the direction of health care and market rate salaries for nurses (Lawrence 1997; Sherer 1998). However, CNA definitely was the actor most likely to gain public sympathy, due to nurses' favorable public image and through the union's centering of risk to patients as the

primary reason for its conflict with Kaiser. The union was able to frame the contract dispute (and larger patient care issues) as nurses fighting back against the large and powerful health care corporation that endangers patients through greed, negligence and indifference (Hall 1998c). Moreover, a nursing shortage throughout the industry seemed to validate the CNA's claims that corporate restructuring reduces nursing staff, results in impossible workloads and increased stress, and ultimately drives RNs from health care; the RN shortage impacts patients who need the skill and education of RNs.

However, after nearly a year of holding onto the moral high ground as virtually the last protectors of patients from corporate health care, CNA's credibility was challenged by several events in the early part of 1998. In January 1998, the CNA planned a two-day strike at the end of the month. This coincided with a flu epidemic in the greater San Francisco Bay Area. Hospitals were already near full capacity due to the flu epidemic and the trends in the industry to downsize inpatient services. In two East Bay counties, public officials declared states of emergency because the hospitals and clinics were full; San Francisco public health officials ordered hospitals to take all critically ill patients, even if the hospital was full. Numerous politicians and representatives from Bay Area hospitals called on the CNA and Kaiser to resolve their issues, appealing to CNA to postpone the strike because of the risk to patients. CNA replied that it would do so if Kaiser postponed closing one of its emergency rooms in the East Bay, which Kaiser refused. The AFL-CIO publicly admonished CNA and said that it was now time for the CNA "to consider an alternative way to address their concerns" with Kaiser by joining the national labor management partnership and working with other unions; Local 250 was "advising" its members to not "recognize" the RNs strike (Brazil 1998a).

Fending off criticism from these different groups, CNA blamed the crisis in nursing and hospitals beds on the industry's cost-cutting emphasis, and stated that the nurses would work in non-Kaiser hospitals in an emergency (Rubin 1998). CNA went ahead with the strike and took out a full page ad in the national edition of the *New York Times* defending its position:

> **WHAT THE KAISER DISPUTE REALLY MEANS:**
>
> Nurses are the last line of protection for patients against the giant corporations that have taken over health care. Nurses strike as the last resort to protect you and your family from worse to come. We all know how much health care has changed.
>
> "Managed care" manages to deliver less care to patients and higher profits to health corporations.
>
> **In fact, the less they care, the more they make.** Kaiser spends hundreds of millions of dollars on consultants to learn how to cut back on care.
>
> ***
>
> That's why registered nurses have gone on strike against Kaiser. If you'd seen what we've seen, you'd know we have no other choice.
>
> ***
>
> We must take a stand to stop the care-cutting which is irresponsible and immoral. (California Nurses Association 1998) (emphasis in original)

The CNA's credibility was further challenged by news reports citing research on nursing both at Kaiser and all Northern California hospitals that refuted the CNA's claim of patient endangerment at Kaiser due to cost-cutting strategies. An article in the *San Francisco Chronicle* stated that the CNA's claims were not supported by an administrator from the Health Care Financing Agency, that had previously investigated Kaiser for alleged violations (Hall 1998a). This article elicited several letters to the editor protesting the author's "bias" and defending the CNA's and RNs' position.

> [The associate regional administrator for HCFA] said she knew of no "live evidence" of any continuing quality crisis anywhere in Kaiser's Northern California region.
>
> Past problems have "all been fixed," she said, suggesting that the CNA has distorted the financing administration's reports to further its contract campaign.
>
> "They read a lot more into (the deficiency findings) than is really there. We're kind of pawns in the middle of their ongoing dispute," she said.
>
> No independent experts could be found to verify the CNA's strongest claims, that people are dying because of cost-cutting.... The CNA's [representative] said that's because all but a handful of experts have been "bought off by the industry." (Hall 1998a)

In this same news story, Local 250 president Sal Rosselli distinguishes Kaiser's behavior from the corporate greed characteristic of other large health care corporations.

> [Rosselli] said it comes down to who is the real villain.
>
> "It's not Kaiser," he said. "The difference between us and CNA is that in our experience, Kaiser is the least offensive of all these people in the (managed care) industry."
>
> "Kaiser is not leading this race to the bottom in health care," he said. "Wall Street's leading it. Because the health care system has changed so dramatically, Kaiser is reacting to maintain its competitive edge. That's still a problem, but at least Kaiser is talking to us." (Hall 1998a)

What was true for Local 250 then, however, was not so for the CNA, as both Kaiser and the CNA accused one another of stonewalling the negotiations. By late March 1998, approaching a planned seventh strike by CNA, Kaiser and CNA began bargaining more earnestly to resolve their differences, with three federal mediators, one of whom was central in resolving the two-week UPS-Teamsters strike in 1997 (Kilborn 1998). Kaiser had been spending $10 million a day for each strike, and had recently posted its first-ever loss of $270 million for 1997. The RN shortage was also very likely pressuring Kaiser to secure stable relationships with its labor force.

On March 17, Kaiser and Local 250 settled their contract smoothly, with Kaiser retracting proposed wage and benefit takeaways; both sides attributed the unprecedented ease in bargaining to the partnership. One week later, Kaiser and the CNA settled. Kaiser basically conceded the battle to CNA – it removed nearly all the wage and benefit takeaways, softened its two-tier wage proposal for non-Bay Area RNs so that both CNA and Kaiser would agree on the eventual structure, and in a major victory for CNA, agreed to create 18 new "Quality Liaison" positions that would be staffed by RNs or Nurse Practitioners nominated by the union and selected by Kaiser. Both sides celebrated the resolution and numerous commentators hailed the Quality Liaison component as a groundbreaking victory for nursing (Brazil 1998b; Ferraro 1998; Kilborn 1998).

CNA Director DeMoro said that the Quality Liaison job category of RNs

> ... is a major step forward for the nursing profession. "This is the first time you see quality liaisons that weren't management. The first time in history the union actually has control over quality liaison positions... Essentially, [the CNA] will have its own internal monitors to reverse bad decisions and reinforce good practices. It's an independent voice to represent nurses and patients." (Brazil 1998b)

Following the settlement, the *New York Times* quoted C. Richard Barnes, deputy director of the federal mediation team, about the importance of the Quality Liaison position:

> "...these are life-and-death issues, which are as important to the U.S. as any economic issue. Nurses will play a greater role in the design of patient care. Now that's done primarily by management. We think this language will be a model for other health care negotiations across the country." (Kilborn 1998)

The *Times* also quoted Karen Donelan, a senior research associate at the Harvard School of Public Health, who reaffirmed RNs' traditional role of patient advocate through this victory: "People want some assurance that they can get the care they need when they need it. And they've always trusted the nurse at the bedside to be their advocate" (Kilborn 1998).

Numerous commentators – in unions and in the news media – debate whether Kaiser's concession was due to CNA's militancy or the partnership unions urging them to settle (Abate 1999; Moore Jr. 1998). The partnership remains a serious problem to the CNA and pro-union RNs because for them it represents labor's supposed collusion with management in order to protect union jobs, wages, and benefits at the expense of patient care. CNA sees the partnership as a mechanism by which Kaiser effectively stifles dissent from unions and maintains power over patient care and staffing decisions, while providing the illusion of power-sharing with its labor "partners." The CNA continued to picket Kaiser and condemn the partnership after ratifying the contact.

Relations between Local 250 and the CNA

Relations between Local 250 and the CNA had been rocky in the 1970s and 1980s due to conflicts over jobs and work jurisdiction, and not honoring one another's strikes.[11] However from the mid-1980s to early- to mid-1990s, the leadership of both unions had been very close on both personal and organizing levels – each leadership had assisted the other in its "revolution" in late 1980s and mid-1990s, and worked closely during major strikes (e.g., Summit Medical Center in Oakland, where in summer 1992, the CNA, Local 250 and three other unions (ILWU Local 6, OPEIU Local 29, and HERE 28) waged a successful seven week strike over the right to honor one another's picket lines.) There were close personal friendships along with trusting relationships on cross-labor solidarity. However, a growing rift developed between the two unions not long after Local 250

[11] In Brannon's (1994) case study of nursing labor at a San Francisco Bay Area hospital during the 1970s and 1980s, SEIU Local 250 and the CNA represented nursing workers. He found that the two unions did not have a trusting relationship; they previously had not honored one another's strikes in the 1970s; and their constituents' interests of jobs and wages were at odds in terms of the structure of the nursing labor process.

leaders helped the CNA "insurgents" organize in 1995.[12] This growing rift was played out in each union's struggles over contract negotiations with Kaiser beginning in 1997, when both contracts were up. Both unions actively encouraged support of the other's struggles through the better part of 1997.

Labor relations were sorely tested when Local 250 joined the partnership on the eve of the first CNA strike, and CNA saw this as an act of betrayal – as unions siding with management against RNs and patients. Over the 14 months of CNA-Kaiser conflict, Local 250 (and AFL-CIO) support for the CNA's position gradually diminished, as they perceived the CNA to be sabotaging labor solidarity in its approach to Kaiser and the partnership unions – especially since in Southern California, RNs had elected to join the partnership. However, both unions recognized that Kaiser's proposed cutbacks to one union would eventually be applied to the others, and leadership supported one another's contract negotiations at Kaiser, while still demanding accountability for labor solidarity outside Kaiser. The CNA, moreover, while congratulating Local 250 on contract negotiations and for worker solidarity during the CNA strikes, also criticized Kaiser for a "divide and conquer" strategy that split labor at the expense of patient care.

Outside their relations at Kaiser, CNA and Local 250 competed over unrepresented workers and failed to honor one another's strikes at non-Kaiser hospitals and facilities owned by CHW and Sutter Health. Moreover, in 1998 CNA and CHW and Sutter Health signed contracts in relatively amicable negotiations – nearly the opposite of CNA's approach to Kaiser, and Local 250's approach to these same corporations. These factors undoubtedly helped to exacerbate the tensions and negative feelings between the

[12] CNA insurgents – staff of the Economic and General Welfare branch – were fired by the CNA leadership in Dec. 1992. Local 250 gave them office space, phones, and other support so they could

two unions. While conflict between Local 250 and the CNA pre-dated the AFL-CIO/Kaiser partnership, it was exacerbated by the partnership, by conflicts over organizing jurisdiction, and by CNA's positive labor management relations and contract negotiations with CHW and Sutter. As a non-AFL-CIO union and as virtually the only Kaiser union actively rejecting the partnership and Kaiser's directions for restructuring, CNA became increasingly isolated in the organized labor community in Northern California. The CNA is far from defeated, however, and continues to criticize corporate restructuring at Kaiser and the entire concept of labor management partnership. Local 250 and the partnership unions continue to work on implementing the partnership into the rank and file and middle management levels of the organization.

Kaiser: Facing the costs of its survival strategies

CEO David Lawrence characterized 1997 as "one of the most challenging and eventful [years] in the 52-year history of Kaiser Permanente" (Kaiser Permanente 1997:2) and it seems hard to disagree. That year Kaiser faced unprecedented attacks on its reputation (largely due to the CNA's media campaign) because of its plans to close hospitals in low-income regions and several high-profile patient deaths or mishaps that elicited State investigations. However, Kaiser also received high honors from national rating systems (Kaiser Permanente 1997). Kaiser began implementing staffing redesign with more unlicensed workers, but rehired hundreds of RNs by the last quarter of the year (Kertesz 1998). Reversing the trends of flat growth and sizeable net economic gains of the first part of the decade, in 1997 Kaiser experienced massive membership growth

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organize membership and legal strategy to gain elected leadership of the CNA.

beyond its projections and its first-ever financial loss – due in part to the unanticipated demand.

Kaiser continued implementing the cost-cutting tactics it hoped would provide the savings necessary to regain financial stability, while maintaining that Kaiser remained unique in the health care environment because of its social mission and nonprofit status. Emphasizing the qualitative difference between nonprofit and for-profit health care, in September 1997, Kaiser joined two other large nonprofit HMOs in calling for government regulation of managed health care, citing that nonprofit quality could not compete economically with the for-profit enterprises who placed less emphasis on quality patient care (Pear 1997).[13] Kaiser also pledged $100 million over five years to subsidize health care for uninsured California children (Kertesz 1997a). However, to the CNA and consumer advocates, as Kaiser moved forward with changes in staffing and hospital downsizing, Kaiser seemed to follow the example set by for-profits HMOs in terms of placing cost-cutting as the organizational priority – not for financial viability, as Kaiser and its labor union partners asserted, but for maintaining executive salaries and perks (Kertesz 1997b).

By the end of 1997, Kaiser was dealing with a massive number of unanticipated expenses partly due to the protracted labor conflict with the CNA (Kaiser admitted each strike cost $10 million a day), State investigations, union and patient lawsuits, and staffing problems (as well as having to counter the terrible publicity about its quality of care largely due to the CNA's efforts). Staffing problems occurred as Kaiser reversed its plan for RN downsizing and began hiring hundreds of nurses in the last quarter of 1997

[13] The two nonprofits were HIP Health Insurance Plans, based in New York, and Group Health Cooperative of Puget Sound.

(Kertesz 1998), as an RN shortage was developing across the country and particularly in Northern California (Marquis 1998; Russell and DeBare 1997). Highly publicized patient deaths and lawsuits in Northern California and in Kaiser's Texas HMO suggested serious flaws in Kaiser's handling of the "downsized" hospitalized services and the subsequent erosion of patient safety. Investigations over patients death occurred in Texas, where the Attorney General threatened to sue Kaiser, and in California, where the Department of Corporations threatened to disqualify Kaiser's Medicare contract.

While dealing with all of these issues, Kaiser experienced both massive growth and its first-ever annual loss for 1997. A 20% surge in enrollment that surpassed Kaiser's estimates brought in nearly 1.5 million new members. That year also marked Kaiser's first-ever annual loss of $266 million – mirroring losses throughout the industry, primarily in for-profits (Kertesz 1998). Much of the loss was attributed to the unanticipated growth in membership (and demand for services), combined with the downsizing of its own hospital services while purchasing these services from other hospitals. Kaiser's downsized hospital operations and projected budget for contracting services were not sufficient to meet the massive increase in membership, and the amount of contracted hospital services it purchased exceeded its planned budget. Kaiser executives cited several other reasons for the loss: increased prescription drug costs, losses outside the California market, and pre-set prices of annual premiums (Anders 1998; Hall 1998b; Kaiser Permanente 1997; Kertesz 1998). CEO David Lawrence announced that Kaiser was formulating a "detailed plan to return to financial health" over the next two years (Anders 1998).

In 1998 Kaiser began an official "economic turnaround" and ultimately decided that better relations with its labor unions were necessary in order to move forward with economic recovery, and settled with Local 250 and the CNA in March. The labor-management partnership continued moving forward as staff and management began negotiating directly over patient care and staffing issues. The CNA continues to refuse to participate in the partnership, and continues to condemn Kaiser's restructuring.

At the time of data collection (Fall 1999 through Summer 2000), staffing redesign had been implemented in different units throughout Northern California. In the interviews with Kaiser workers, all staff complained of a continued focus on cost-cutting, and of understaffing of both unlicensed and licensed workers. Kaiser's 1998 economic picture was another bleak one at year's end – enrollment decreased by approximately 300,000, and the corporation experienced an annual loss of $288 million. This number, however, reflected an offset from investment income that softened the "true" losses of $434 million – of which $350 million was in the California division (Rauber 1999).

Chapter 3
Background II: The race, gender, and class of health care labor

Under heightened economic pressures in the current health care market, health care organizations are reconfiguring their labor force to meet organizational goals of cost containment. This dissertation focuses on nursing labor, the dominant labor process in health care. Nursing has been historically a site of conflict between capital and labor, and among different groups in a race- and class-stratified domain of "women's work." The intersection of the changes in health care delivery and changes in the race/gender makeup of care provision are prominent forces that impact relations among different groups of workers. I explore the different influences on the construction of (and conflict over) the health care labor process and the implications for the production and reproduction of intersecting inequalities in the health care labor force.

I first discuss race, gender, and class stratification in the occupational hierarchy of the health care labor force in general, and then focus on hospital nursing in particular. This chapter also examines the historical race, gender, and class ideologies and structures that created and maintained a stratified hospital nursing workforce, and informed the nursing labor process and inter-group relations. The legacy of oppression and the reproduction of inequalities within hospital nursing continues to inform how nursing labor is perceived and organized by health care industry elites, nursing educators and leaders of professional nursing organizations, and different ranks of nursing personnel, and has important implications for labor solidarity and patient advocacy.[1]

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[1] Since we are all patients at one time or another, I believe health care workers' advocacy is essentially advocacy for the public good.

Race gender, and class in the health occupations

Race, gender, and occupation continue to be prominent divisions within the health care labor force (American Medical Association 1996; Butter et al. 1985, 1987; Coffman et al. 1997; Himmelstein et al. 1996; Moses 1996; Navarro 1993), with whites and males over-represented at the top of the occupational hierarchy, and women and people of color in the middle and at the bottom. While structures of stratification and inter-group relations in health care occur in different configurations in different historical periods, certain patterns persist over time. One of the most salient patterns is a racial division of labor within gendered occupations — domains occupied by a predominantly female workforce (Glazer 1991; Glenn 1991, 1992; Hine 1989).

Within health care occupations, the gender/race imbalance is replicated, especially for physicians and different strata of nursing personnel. Outside the top occupational tiers, women and people of color are heavily represented in the health occupations. For example, women hold 78% of all medical care jobs, and women and African Americans are disproportionately represented in medical care, mainly in hospitals and nursing homes, and mainly in lower-paid, non-medical, non-professional occupations (Himmelstein et al. 1996; Navarro 1993). Moreover, there are large disparities in wages and benefits across health care sites as well as occupational tiers, with nursing homes offering the least compensation for Registered Nurses (RNs) and paraprofessional and nonprofessional staff (Harrington 1996; Himmelstein et al. 1996).

A gender-based division of labor characterizes the health care industry, and women occupy subordinate occupational and economic status in the health care workforce (Butter et al. 1987). Moreover, women's employment opportunities in the health sector diverge along lines of race and profession. In the physician and Registered

Nurse labor force, whites are over-represented compared to the general population (Coffman et al. 1997; Moses 1996). Women constitute 20% of the physician workforce, and approximately 95% of the over two million RNs in the USA (Moses 1996). In 1996, 7.6% of RNs were advanced practice nurses (nurse practitioners). Within nursing, women of color disproportionately occupy lower-status jobs. For example, 30% of Nurse Assistants or Nursing Aides are African American, compared to 19% of Licensed Practical Nurses (LPNs) and 10% of RNs (Wunderlich et al. 1996). The race/gender composition of physicians and nursing occupations over time illustrates the gender and racial hierarchies (Table 2). While occupational segregation by race and gender has declined to a certain degree, women of color remain marginalized and over-represented in lower-status occupations.

Table 2. Percentage of racial-ethnic minorities and women employed in selected health occupations, 1983-1999

Physicians	**1983**	**1990**	**1993**	**1995**	**1997**	**1999**
Black	3.2	3	3.7	4.9	4.2	5.7
Hispanic origin	4.5	4.5	4.6	4.3	4.8	4.8
"other" race	10	10.4%	10.6%	11.0%	14.4%	16.9%
all women	15.8	19.3	21.8	24.4	26.2	24.5
white women	12.5%	16.2%	17.4%	19.0%	19.9%	17.5%
Black women	0.4%	0.5%	1.3%	1.9%	1.5%	2.1%
Hispanic women	0.6%	0.5%	1.2%	0.7%	1.2%	1.3%
"other" race women	2.9%	2.6%	3.1%	3.5%	4.8%	5.0%

Registered Nurses	**1983**	**1990**	**1993**	**1995**	**1997**	**1999**
Black	6.7	7.4	8.4	8.4	8.3	9.6
Hispanic origin	1.8	2.5	3.2	2.6	2.9	3.1
"other" race	5.0%	5.7%	5.2%	5.0%	6.2%	6.3%
all women	95.8	94.5	94.4	93.1	93.5	92.9
white women	84.8%	82.3%	81.5%	80.9%	79.8%	78.3%
Black women	6.3%	6.9%	7.9%	7.6%	7.9%	8.9%
Hispanic women	1.6%	2.3%	2.7%	2.1%	2.5%	2.9%
"other" race women	4.7%	5.4%	4.9%	4.6%	5.8%	5.7%

Licensed Practical/ Vocational Nurses	**1983**	**1990**	**1993**	**1995**	**1997**	**1999**
Black	17.7	17.6	17.2	19.6	15.4	18.4
Hispanic origin	3.1	3.8	3.4	3.7	5.6	5.8
"other" race	2.7%	2.7%	1.9%	3.3%	2.5%	3.4%
all women	97	96.3	94.6	95.4	94.1	95.1
white women	77.1%	76.7%	76.5%	73.7%	77.5%	74.2%
Black women	17.3%	16.9%	16.5%	19.0%	14.0%	17.6%
Hispanic women	2.7%	3.4%	3.1%	3.5%	5.1%	4.2%
"other" race women	2.2%	2.7%	1.6%	2.5%	2.7%	3.1%

Nursing aides, orderlies, attendants	**1983**	**1990**	**1993**	**1995**	**1997**	**1999**
Black	27.3	30.7	30.7	30.4	34.5	35.6
Hispanic origin	4.7	6.5	7.9	8.4	9.5	9.8
"other" race	2.9%	2.8%	3.2%	4.8%	3.9%	4.4%
all women	88.7	90.8	87.9	89.4	89.4	89.9
white women	62.3%	60.5%	58.1%	57.9%	54.7%	54.3%
Black women	24.0%	27.8%	27.2%	27.4%	31.2%	31.9%
Hispanic women	3.9%	5.6%	6.3%	7.2%	8.2%	9.0%
"other" race women	2.5%	2.6%	2.6%	4.1%	3.5%	3.7%

Source: (Bureau of Labor Statistics 1983, 1990, 1993, 1995, 1997a, 1999)

There are severe disparities of wages and benefits between health occupations which coincide with race and gender divisions. In the nearly exclusive female domain of nursing, while Registered Nurses' (RNs) wages rose more rapidly than the inflation rate, para- and non-professional health care workers faced low wages and no benefits, a situation that continues to entrap many in poverty and at risk for compromised health (Harrington 1996; Himmelstein et al. 1996). In addition, race impacts wages within occupational tiers, as demonstrated by a national study (Hirsch and Schumacher 1995) that compared wages of nursing personnel to comparable non-nursing occupations in the general workforce between 1985-1993. This study, moreover, found that Black RNs were paid 10.3% lower than white RNs, a greater difference than in the general economy.

Navarro (1993) writes that the income disparity within the U. S. health care industry is greater than in any other advanced capitalist nation. Of all medical workers, 10.5% made less than $5 per hour; these were 19% of African Americans in the health sector, and 24% of nursing home workers (Himmelstein et al. 1996); wages in nursing homes are much lower than comparable jobs in hospitals (Harrington 1996; Himmelstein et al. 1996; Hirsch and Schumacher 1995). Moreover, in 1993, 11.7% of all medical care workers had no health insurance, and 5.2% had family incomes below the federal poverty line (mostly African Americans and nursing home workers) (Himmelstein et al. 1996).

There is also considerable variance among occupational tiers in health care regarding rates of unionization. In 1994, approximately 14% of all health care workers were union members (Himmelstein et al. 1996). However, only about 10% of nursing home aides were unionized, and 1% of home health care workers (Close et al. 1994;

Wunderlich et al. 1996). The most rapid increase of unionization has occurred among RNs, approximately 20% of whom were unionized in 1994 (Himmelstein et al. 1996).

In sum, the health care labor force is organized in hierarchies of race, gender, and class that mirror and reinforce larger social structures of inequality. Like the labor force in general, the health care labor force is not segregated neatly by race, class, or gender, but it is undeniably organized so that those who perform the "dirty work" of health care (that is, the hazardous, demeaning, dead-end, and low-wage labor) are disproportionately poor, lower-educated, people of color, and women.

Intersecting inequalities and worker solidarity

The discourse of collective bargaining and labor conflict in 1990s health care increasingly focuses upon the policies of corporate health care[2] that allegedly jeopardize patient care through organizational restructuring – a prominent dimension of which is the restructuring of the health care labor process. To cut labor costs, health care administrators reduce the size of the workforce and substitute lower-waged workers for higher-skilled and higher-paid professionals. In the current environment, Registered Nurses are the major target of this substitution, since they were the primary caregiver in hospitals for the last 20 years. Across occupations, however, many workers are given added responsibility without commensurate authority or compensation, and they witness the erosion of both their working conditions and patient care. In response, much of the health care labor force has vigorously protested these consequences of the restructuring. In particular, organized labor representing health care workers has organized mass rallies,

[2] Corporate health care refers to health care that is owned, financed, managed, or delivered by corporations.

pickets, strikes, work-stoppages and lawsuits alleging corporate health care's interest in profits over patient care.

Historically, racial dynamics have shaped divisions and alliances between and within occupational groups in health care (Fink and Greenberg 1989; Glazer 1991; Glenn 1991, 1992; Hine 1989; Michel 1996; Sacks 1988), and have shaped not only the organization of health care labor but also the organization and strategies of collective bargaining in health care. Previous studies of labor organizing and labor conflict in health care have paid particular attention to the racial stratification and to the racial dynamics of inter-group relations, and illustrate how race and class were prominent forces that served to unify and divide different groups (Fink and Greenberg 1989; Michel 1996; Sacks 1988). Some of the salient, and still relevant, issues raised by these studies include: the articulation (or avoidance) of racial, gender, or class dynamics as a dimension of labor struggle; the tactics of labor unions and institutions with regard to these dynamics; the negotiations between labor unions and the workers they represent; the construction of a "moral foundation" to galvanize support among workers and the community in labor conflict; and the influence of race, gender, and class stratification, alliances, or antagonisms on labor organizing – even if some or all of these dynamics were omitted from the discourse. These studies, however, occurred before the current historical period dominated by market forces and their impact on health care organizations, leading to the restructuring of the nursing labor process.

Race, gender, and class of nursing labor: History's legacy for the occupational structure and labor process of hospital nursing

This section traces the historical processes and structures that inform the current occupational structure of nursing, the nursing labor process, and inter-group relations

between the occupational groups. I examine race, gender, and class social ideologies and structures that created and maintained a stratified nursing workforce and informed the contemporary restructuring of the nursing labor process in hospitals. This legacy continues to inform how nursing labor is perceived and organized by health care industry elites, RN educators and leaders of professional nursing organizations, and different ranks of nursing workers. The analysis begins in the 1930s, when the beginnings of the contemporary nursing labor process and occupational structure were forged through conflict and cooperation between nursing educators and leaders of professional nursing organizations, hospital administrators and other health care elites, and rank and file workers who do the work of nursing.

Social historians of nursing have demonstrated that nursing has been a highly gendered, devalued and exploited occupation, and one in which the priorities and objectives of nursing educators and leaders of professional nursing organizations often conflicted with those of the workers (Melosh 1982; Reverby 1987). Nursing educators' strategies to improve the education, training, working conditions, and status of nurses were informed by the often exploitative conditions under which nurses labored. The professionalization of nursing aimed to elevate the occupation and the women who did the work to a position of equal respect, authority and autonomy to medicine. However, across different historical moments, the strategies nursing elites chose and the tactics they employed were informed by and subsequently reinforced racial and class ideologies that upgraded one group – a minority of educated, relatively privileged working-class and lower middle class white women – at the expense of the majority of lesser-educated, lower working class, and racial-ethnic minority women. Specifically, the history of

upgrading or professionalizing nursing was based on a strategy of exclusion grounded in race, class, and gender ideologies that shaped the occupational hierarchy of nursing and the different models of nursing labor.

Upgrading nursing to a profession relied on creating separate tiers of work and separate groups of workers that coincided with a racial division of labor. This was accomplished through the linkages between race and class ideologies and separate and unequal training programs that officially (through licensure, racial segregation, and other formal structures) and unofficially (through racial ideology and defacto segregation) justified professional (white) nurses' superiority over "auxiliary" nursing workers (women from lower classes and racial-ethnic minorities). Nursing educators argued that highly-educated "professional" or "trained" nurses delivered a higher quality of care – through a superior "character" and more extensive education and training – than that offered by the other occupations and the women who did those jobs.

This strategy, however, produced a "catch 22" for RN associations and staff RNs. Upgrading "professional" nursing relied on creating separate and subordinate quasi-nursing occupations. While this defined "professional" nurses as superior, this also put RNs at risk of displacement by the lower-waged workers. Processes of conflict, cooperation, accommodation, and identifying mutually beneficial outcomes among hospitals/health care elites, nursing educators/leaders, and the women who do nursing work shaped different models of nursing labor and eventually determined the three-tiered occupational hierarchy that has characterized nursing since the 1930s.

The "great transformation" of nursing labor: hospital-based nursing

Nursing labor in the 1930s experienced a critical turning point. Hospitals became nurses' primary place of employment, and began using a stratified nursing workforce to carry out nursing labor. The history of nursing and hospitals are deeply intertwined (Hine 1989; Melosh 1982; Reverby 1987). The hospital expansion and transformation from charitable to business enterprise, and the increase in medical specialization and more sophisticated technology and procedures demanded a more numerous, higher-skilled, yet "cost-effective" nursing workforce (Melosh 1982; Reverby 1987). These years saw an "explosive expansion" of graduate nurses working as staff nurses in hospitals, which constitutes nursing's "great transformation" (Reverby 1987). By the end of the 1930s, hospitals had moved from a primarily student nursing workforce to a mixture of graduate nurses, subsidiary workers, and nursing students (Melosh 1982; Reverby 1987). By 1940, almost half of all nurses worked as hospital staff nurses; by the end of WWII the hospital had become nurses' primary employer (Melosh 1982).

Prior to the 1930s, hospitals had previously utilized a workforce comprised nearly entirely of nursing students; graduate nurses left the hospital after training and moved into "private duty," which was their only viable employment option. However, during the Great Depression, the lack of private duty jobs, the number of nursing schools declined (as did the nursing student workforce), and the increasing numbers of hospital patients basically pushed hospitals and graduate nurses into employment relationships, despite strong reluctance by each side (Melosh 1982; Reverby 1987).

Although hospitals did not have the essentially "free" labor of student nurses, they continued to benefit by exploiting a vulnerable nursing labor force through low (or no) wages to the graduate and student nurses, increasing the work demands and hours to be

worked, and authoritative and arbitrary supervision. Graduate nurses, locked into hospital nursing work as the only viable venue of nursing, resented but remained vulnerable to management's exploitation and the threat of replacement by lower-wage workers. Hospitals took advantage of the labor market and paid the graduate nurses lower wages than office workers engaged in far less strenuous and taxing work (Reverby 1987:192). The subsidiary workers, lower in the occupational hierarchy and assigned to the "unskilled" work of nursing and housekeeping, were likely paid even less for their labor.

Given hospitals' demand for the cheapest way to staff nursing, and nursing leaders' quest for professional status of nursing, the 1930s compromise was to increase the hospital employment of lower-waged subsidiary nursing and housekeeping staff. Leaders of professional nursing organizations advocated employment of graduate nurses and suggested that "subsidiary workers and maids" be hired to do the routine non-nursing work, freeing the graduate nurses for skilled nursing care (Reverby 1987:189). Nurses gradually moved from doing primarily bedside care to supervisory positions to deal with the increased complexity of health care, and directed subsidiary workers (referred to interchangeably as "practical nurses," "hospital helpers," "nurse's aides," and "aides") to accomplish the routine patient care tasks (Reverby 1987).

This joint solution, moreover, had a definite racial dimension. Racial-ethnic minority women were systematically excluded from the vast majority of nursing education, training, and employment opportunities – even during nursing shortages of WWI, the postwar influenza epidemic, WWII, and the postwar years (Glenn 1992; Hine 1989). Unless they chose to attend the few accredited nursing schools and training programs for African Americans, Black women were instead channeled into Nursing

Aide (NA) and Licensed Practical Nurse (LPN) training programs. New Deal programs targeted a labor pool of these workers excluded from higher paying and higher status opportunities despite the recognized need for more trained nurses (Glenn 1992; Melosh 1982; Reverby 1987).[3]

Creating a race- and class-stratified nursing workforce

Leaders of professional nursing organizations historically fought the creation of more than one kind of "trained" nurse, even during the nursing shortages of WWI and the postwar influenza epidemic. This stance conflicted with the needs of capital and the State for a large and low-waged workforce. Nursing educators and leaders of professional nursing organizations opposed State- and private-sector sponsored "manpower development programs" that sought to train a labor force of working-class and racial-ethnic minority women into nursing workers that were of lower occupational standing (and whose training and wages were significantly less than graduate nurses) and who could be incorporated into health care during periods of acute labor shortages. When it became clear that the professional associations could not prevent these programs and the creation of other categories of nursing workers, leaders of professional nursing organizations changed their tactics to controlling and circumscribing the new workforce's education, training and work jurisdictions (Glazer 1990; Glenn 1992; Melosh 1982; Reverby 1987). They focused on distinguishing between "nursing" and "non-nursing" labor, and maintaining a racial divide between the two categories. For example, nursing elites were successful in restricting Black nurses from integrating into civilian and

[3] African American women were disproportionately incorporated into the health care labor force as lower-status and lower-waged workers through American Red Cross training programs for hospital nurses aides; trainings began in the 1930s, the numbers employed doubled between 1940 and 1950 (Cannings and Lazonik 1975: 200-201, cited in Glenn 1992).

military service during and after WWI, and nearly successful in maintaining segregation through WWII – despite the massive shortages of trained nurses (Hine 1989).

Some nursing leaders supported the employment of these workers for "non-nursing" functions as a way to upgrade "nurses." This division would ultimately serve to construct graduate nurses as professionals whose education and skill set them apart from the other workers (Glazer 1990; Glenn 1992; Melosh 1982; Reverby 1987). Thus as nursing educators and leaders of nursing professional organizations sought to upgrade the occupation and control the nursing labor process, their strategy and tactics were built upon limiting the opportunities and devaluing the labor of women workers they deemed less "appropriate" for professional nursing. This occurred through blatant tactics of race- and class-exclusion, and through impersonal assessment of "qualifications" or "ability."

Women's potential to be "upgraded" was based on their ascribed aptitude for knowledge, discipline, skill, and degree of "character" – assumptions that were undoubtedly informed by the prevailing racial and class ideologies. While Black women have long been thought of and employed as "unskilled" caregivers in subordinate roles to whites, Black women as highly educated and trained "professionals" who would be peers (or supervisors) of white women would have disrupted the racial order of white superiority and domination. Racist ideology and cultural images of Black and other racial-ethnic minority women's inferiority were invoked by leaders of professional nursing organizations to justify the official or defacto whites-only educational or employment policies (Glenn 1992; Hine 1989).

While blatant racial segregation excluded racial-ethnic minority women, they were also excluded through bureaucratic means. Nursing professional associations –

already virtually racially segregated – imposed increasingly restrictive entry into the profession as they tried to exclude lower-class and racial-ethnic minority women and graduates of lower-grade institutions (Hine 1989; Melosh 1982; Reverby 1987). Black nursing leaders created their own professional associations to foster professionalization and community service (Hine 1989).

The goals and methods of achieving nursing professionalization put forth by white nursing educators, leaders of professional nursing organizations, and hospital administrators were often at odds – especially with staff nurses (Melosh 1982; Reverby 1987) – but these groups' interests converged in terms of the emergent racial division of nursing labor. Hospital administrators promised leaders of professional nursing organizations that the subsidiary workers would be restricted to "non-nursing" tasks (defined by nursing elites), be paid less than graduate nurses, and be constantly reminded that their occupation was not "nurse" (Reverby 1987:194). The racial division of nursing labor – through racial segregation and subordination in education, training, and employment – whether blatantly racist or couched in terms lacking "qualifications" – resonated with the primarily white female RNs, who "closed rank" to protect their interests against lower-class, racial-ethnic minority "others." As Glenn (1992) points out:

> Hospital administrators took advantage of race and class divisions and RNs' anxieties about their status to further their own agenda. Their strategy of co-opting part of the work force (RNs) and restricting the mobility and wages of another part (LPNs and NAs) undermined solidarity among groups that might otherwise have united around common interests. (Glenn 1992:28)

Racial ideologies and segregation in the larger society defined the nature of the different nursing occupations and reinforced prevailing racial ideology about "appropriate" division of labor. Race and gender defined both the jobs and the women who were employed in these jobs. That is, a job's characterization as "skilled" or

"unskilled" informed and was informed by the race and gender characteristics of the women who did the job. However, the social construction of skill often was at odds with the actual work the women did, and the reality of the understaffed hospital often dissolved the boundaries between nurses and subsidiary workers, as the latter often ended up doing "nurses' work" (Brannon 1994; Melosh 1982; Reverby 1987). Subsidiary workers, however frequently they engaged in "higher-level" nursing work, had virtually no upward mobility, and remained defined by their subordinate occupational title. Even if a Nursing Aide competently carried out a "higher level" task, she needed to assume the demeanor of an "unskilled" worker in order to preserve the prevailing racial ideology that defined the "appropriate" division of labor (Glenn 1992; Reverby 1987).

Auxiliary workers soon began to resent the restrictions confining them to the routine and dirty work, and the demeaning attitudes directed at them by workers higher up in the occupational hierarchy (Melosh 1982; Reverby 1987). Hospital administrators and health care elites agreed that these workers had to be convinced to limit their upwardly mobile aspirations and be satisfied with their circumscribed and lowly place in the hospital hierarchy. However, the "fiction of divisions" (Reverby 1987) thus placed greater emphasis on hierarchy and status based on licensure rather than the actual division of labor, and set up the potential for conflict between different groups of workers. As a status enforcing device, it fueled antagonism between the two occupational groups, as RNs sought to distance themselves from the auxiliary workers, and the auxiliary workers sought to demonstrate they were of similar qualifications and character as the RNs, except for the latter's more extensive education and training (Brannon 1994; Hughes, Hughes, and Deutscher 1958). The differences also could be ignored during

understaffed shifts or if a nurse wanted to share her knowledge and experience with an Aide (Reverby 1987). Infusing these dynamics were racial ideologies that reinforced hierarchies and divisions, and maintained a relative degree of privilege for some white working class women at the expense of the majority of less-educated, lower working class, and racial-ethnic minority women.

By the late 1930s, and more so during WWII and the postwar years, nursing labor in hospitals was accomplished through a stratified nursing workforce and a rationalized labor process. Nurses' roles became more bureaucratic and less involved with direct patient care except for specialized procedures. They often delegated routine patient care tasks to Aides, and spent most of their time coordinating patients and subsidiary workers, filling out paperwork, and directing the overall organization of work. Subsidiary workers carried out most patient care tasks, directed by the nurses (Melosh 1982; Reverby 1987).

Institutionalizing a stratified nursing workforce: "Team Nursing"

While hospitals in the 1930s had relied on an informal division of labor in nursing, this became formalized in the 1940s. During WWII and the postwar years, the nursing oversupply of the 1920s and 1930s turned into a nursing shortage. To meet the labor demand, hospitals began to employ increasing numbers of "auxiliary workers" along with RNs in a rationalized nursing labor process. What is different in the 1940s is the creation of distinct and ranked occupational categories based on licensure and credentialling. This model of nursing labor, called "Team Nursing" relied on the creation of a nursing occupational hierarchy with specified work jurisdictions, and licensure and credentialling. "Practical nurses" and nursing assistants did the majority of patient care tasks except for those tasks that required RN skill and education. The "professional"

nurse supervised the staff and was responsible for delegating tasks and the nursing care as a whole. Team Nursing crested in the 1960s; RNs comprised approximately one-third of hospital nursing staff, and the "auxiliaries" comprised approximately two-thirds of hospital nursing staff.

Team Nursing grew from the demand for nursing labor during and after WWII, fueled further by the 1947 Hill-Burton Act that funded hospital expansion. Many nurses took better-paying war industry jobs, married and left the labor market, or became part of the thousands of white women employed in wartime but forced from the labor market at war's end. Nurses also left nursing because of the poor working conditions in the hospital, and their dissatisfaction with a labor process that positioned them in positions where they were not primarily caregivers, but rather supervisors of LPNs and Aides who did most of the patient care work. The nursing shortage put pressure on leaders of professional nursing organizations to endorse the increasing use of auxiliaries, and they eventually did so, despite the protests by the staff nurses who resented the sudden and top-down expansion of who could be called a "nurse."

During these years, nursing educators and leaders of professional nursing organizations formalized the division of nursing labor. Workers were ranked according to education and credentialling/licensure. This shift, with more restrictive licensing for RNs, reinforced the racial stratification in nursing by restricting upward mobility for the mainly racial-ethnic minority LPNs and Aides, while white RNs, can move up a career ladder from staff nurse to nursing supervisor or director of nursing (Glenn 1992:23-24).

The racial hierarchy in nursing was produced and maintained through ideologies of white supremacy and structures and processes of racial segregation. This segregation is

visible in the fact despite the nursing labor shortage, most federal training programs for health care workers were mainly for subsidiary nursing occupations rather than professional nursing education (Melosh 1982), and these nursing Aide training programs targeted the reserve labor pool of African American women denied opportunities in nursing (Glenn 1992). For the majority of Black and other racial-ethnic minority women who hoped to become nurses (or who wanted employment other than domestic service), the LPN or other subsidiary health care occupation was the most accessible entry point. Black nurses eventually succeeded in removing formal policies of racial segregation in the armed forces near the end of WWII and civilian public health nursing, but remained largely excluded from hospital employment (Hine 1989).

The 1948 Brown Report ("Nursing for the Future") firmly endorsed stratification within registered nursing based on education, distinguishing between the superior "professional" nurse with a baccalaureate degree (BSN) who would supervise the less-educated "technical" nurse who had a diploma. The report recommended that the baccalaureate degree in nursing be a prerequisite for RN licensure, and called for the elimination of diploma programs. These changes prevented different groups' upward mobility and fomented conflict in the racially and class-stratified female workforce. The so-called "technical" nurses deeply resented the nursing elites' decision and felt their caregiving work was devalued. They in turn devalued the work of the LPNs and attempted to circumscribe and control the subsidiary workers on the hospital floor, just as nursing elites had tried to regulate them through setting up the tiered system (Melosh 1982). Moreover, while the emphasis on increased educational requirements for licensure most likely helped some white RNs, it served to downgrade those with diplomas or with

training at hospitals below the requisite size for application for the RN license. This disproportionately affected Black nurses by further limiting their already-restricted employment opportunities due to official and defacto racial segregation (Hine 1989).

Brannon (1994) argues that Team Nursing was a result of shared interests between nursing and health care industry elites. In the wake of the health care industry's (especially hospital) expansion in the post WWII years, nursing and health care industry elites wanted to meet labor shortages by improving working conditions, and once met, to then effectively "manage" the expanding and diverse work force. Due largely to a somewhat disorganized approach to nursing labor in the hospital wards, there was much tension and conflict between RNs and the "auxiliaries." To remediate these difficulties while professionalizing nursing, leaders of professional nursing organizations developed a model of nursing care based on an occupational hierarchy with clearly marked differences in training and credentialling/licensing, in which graduate or professional nurses controlled the organization of work and supervised the "auxiliaries" in a team approach. RN educators wanted nursing to achieve higher status within the health care occupational hierarchy and labor process – Team Nursing formally distanced the professional nurse from menial work and redirected her to work that demanded higher skill and knowledge. This model was embraced by hospital administrators and health care industry elites as well because it promised a cost-effective method for organizing an increasingly complex health care labor process.

Brannon (1994) argues that as nursing labor was rationalized, Team Nursing facilitated and constrained nurses in terms of their quest for professional advancement.

> Team Nursing was a complex organization of work that combined aspects of both professional upgrading and proletarianization. Scientific management principles[4] were applied to subdivide work, yet nurses were not deskilled. Rather, tasks were upgraded and RNs assigned overall responsibility for nursing care and the supervision of routine work delegated to practical nurses and nurses' aides. At the same time, RNs remained semiprofessional wage labor subject to exploitation and domination by administrators and physicians. (Brannon 1994:94)

Occupational differentiation and conflict over the division of labor

The occupational differentiation between RNs and nonprofessional nurses was reinforced as RNs upgraded their tasks and delegated the dirty and routine work to subordinate workers. In the 1950s, Everett Hughes et al. (1958) conducted a series of studies sponsored by the American Nurses Association (ANA) to document the division of labor in nursing; they found that the rationalization was consonant with the original plans. In the emergent division of labor, they found RNs spending less time in bedside care, and the auxiliaries spending more time doing routine bedside care. However, they also found there were in practice no fixed boundaries of work jurisdictions within or across the hospitals they studied, and there were frequent "jurisdictional disputes" regarding the overlap of functions among workers in the nursing hierarchy. Moreover, as occupational roles were restructured, workers often resented the changes – RNs were often reluctant to give up bedside care, and LPNs and nursing Aides were often resentful about carrying out most of the hands-on "dirty work" of patient care (Brannon 1994; Hughes et al. 1958). Hughes et al. (1958) concluded that

> Study after study corroborates the chief point: that today not one but several categories of nurse attend the sick and run the hospitals and that the frontiers of each one's work are all changing at once. Thus, the work has expanded, the number and the kinds of personnel who divide it between them also have grown, and no one has as yet settled just what is the best division. (Hughes et al. 1958:143-144)

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[4] "Scientific management" or "Taylorism" was initiated by Frederick Winslow Taylor in the 1880s and 1890s, and focused upon increasing productivity through increased fragmentation of the division of labor and increased management direction regarding the specifics of how labor is actually carried out.

Thus, while occupational distinction in nursing became institutionalized, the actual division of labor often was fuzzy and lacked firm boundaries. What developed was an overlap of, disagreement about, and competition over perceived jurisdiction and work responsibilities (Hughes et al. 1958).

Hughes et al. (1958) also found that race and class stratification in nursing was clearly visible and entrenched by the mid-1950s. Practical nurses were comprised disproportionately of racial-ethnic minority women from lower-class backgrounds; diploma nurses were predominantly white lower-middle class; baccalaureate nurses were white and of higher socioeconomic status than diploma nurses, while of a lower class than other university students. Given the larger society's segregated culture, racial ideology, and class-based organization, it is likely that race and class tensions informed the "jurisdictional disputes" between different nursing personnel.

There is a difference between occupational division of labor and the division of labor as practiced (Brannon 1994, 1996; Glenn 1992; Melosh 1982; Reverby 1987). This becomes visible through several interrelated contradictions of Team Nursing. The differentiation of nursing work divided workers in terms of licensure and credentialling, but without "clear functional differences." Tasks overlapped between occupations and the auxiliaries could "effectively substitute" for RNs in a demanding and short-staffed work situation. Despite hospital rules dividing nursing tasks, nursing personnel's work jurisdictions were not clearly delineated and often rules were violated because of the pressure to do the work. These two factors worked to undermine Registered Nurses' authority to control the labor process and the auxiliary workers, despite her leadership position and authority in the occupational hierarchy. Furthermore, the auxiliaries were

doing the bulk of the direct patient care, and this increased their feeling of responsibility for nursing labor that often competed with the staff RNs' ideas about the appropriate division of labor and responsibilities (Brannon 1994; Hughes et al. 1958).

The legacy of Team Nursing

Despite occupational distinctions becoming more rigid (at least in name and status), by the late 1960s, the actual work jurisdictions were fluid – nurses, LPNs and Aides often did each other's work. Aides provided most of the bedside care, RNs and LPNs did the tasks requiring higher education and skill. The conflict over work jurisdiction using a stratified nursing labor force ("Team Nursing"), the decreasing wage differential between RNs and LPNs, and other factors contributed to a shift from stratified workforce of Team Nursing to a nursing model dominated by RNs ("Primary Nursing") in the 1970s.

Team Nursing may have initially satisfied health care elites' demand for a cost-effective and "flexible" nursing workforce, but it failed to professionalize nurses as RN leaders had intended. RNs were still subordinate to physicians and remained vulnerable to exploitation; moreover the creation of a team in which workers often did one another's work left RNs in the position of possibly being displaced by lower-waged and lower-skilled workers. These auxiliary workers were assigned the menial and dirty work, their labor devalued by higher-educated and higher-status members of the health care occupational hierarchy. Even as they might perform "skilled" labor, their occupation characterized their labor (and them) as "less" than the invisible and unrecognized skills they brought to successfully accomplish their work. Team Nursing's real legacy was the creation of a stratified nursing workforce that reflected race and class ideologies and

hierarchies of the larger societies, and which reinforced class and racial tensions among the predominantly female workforce, making class or gender solidarity highly unlikely.

In the late 1950s and 1960s the professional associations responded, if belatedly, to staff nurses' critiques of rationalization. The concept of "total patient care" (TPC) was introduced in nursing journals and textbooks as a solution to the increasing bureaucracy of the hospital and the distance of RNs from bedside care (Melosh 1982). The nursing labor process gradually moved back into craft organization of work, through TPC and "Primary Nursing" models that emphasized RN dominance in all aspects of nursing.

Moving towards an all-RN workforce: "Primary Nursing"

The movement towards an all-RN staff and models of "Primary Nursing" began in the late 1960s and early 1970s. Primary Nursing refers to the restructuring of the nursing labor process that involves a reunification of nursing tasks and the installation of RNs as dominant bedside caregivers, to eventually comprise a majority of nursing staff in hospitals. Primary Nursing was implemented in the 1970s and 1980s; by the late 1980s, RNs comprised 63% of nursing staff, up from 33% in the 1960s (Brannon 1994). Nursing Aides were displaced to non-nursing jobs; LPNs were sometimes kept on and assigned their own patients (although this contradicted the objectives of Primary Nursing to establish RN dominance in patient care).

Primary Nursing is another example of the joint interests between leaders of professional nursing organizations, hospital management, and staff RNs (Brannon 1994, 1996). Nursing elites pushed for Primary Nursing as a strategy for RNs' increased professionalization and job security, as these objectives were not reached by Team

Nursing. Nursing elites believed that returning to the individual nurse-patient relationship would help upgrade RN status to physicians' peers, and

> advocated an organization of practice in which RNs would no longer supervise teams of auxiliaries but replace them at the bedside. Primary Nursing would establish what contemporary nursing leaders now considered the most important features of professional nursing: an unmediated relationship between the RN and the patient, complete responsibility for patient care through reunified work tasks, and occupational autonomy within the hospital. (Brannon 1994:126)

During this time, the health care industry increasingly focused on cutting costs in an increasingly corporatized health care environment. Nursing labor was the primary patient care labor process and most obvious target to cut costs. Hospital administrators had an incentive to implement Primary Nursing because an all-RN staff promised cost savings and higher productivity than stratified nursing workforce, as the wage differential between RNs, LPNs and Nursing Aides was relatively small compared to the benefits of RNs broader education and skill base (Brannon 1994).

Staff RNs' interests often conflicted with those of leaders of professional nursing organizations, but in the case of Primary Nursing, their interests definitely converged. Primary Nursing appealed to staff RNs for multiple reasons that all hinged on the displacement of the auxiliaries by RNs in direct patient care. First, the reunification of tasks brought RNs back to the center of direct patient care. Primary Nursing promised more autonomy in planning and executing patient care. Second, the model appealed to staff RNs because it promised to get rid of the negative aspects of Team Nursing that were inherent in the model: inter-occupational tensions, the threat to RNs' privileged status of caregiver, and the legal responsibility for someone else's work. Lastly, the racial dimension of securing jobs and privilege for the mainly white female RN workforce surely must have informed staff RNs' enthusiasm.

RNs had higher job satisfaction, lower turnover and absenteeism, and reported a high quality of patient care (Brannon 1994). However, Primary Nursing ultimately intensified RNs labor, through changes in occupational structure and labor process, and through the intensity of the nursing care needed by the patients. First, RNs work jurisdiction was expanded to include tasks formerly delegated to auxiliaries, and included "dirty" work as well as emotional labor. This expansion was accompanied by an intensification of the work, due to rising patient acuity due to delayed admissions, early discharges and returning in more severe condition. RNs' labor was also intensified because management was cutting back in the support departments – this produced more work for both RNs and support workers, and increased the potential for tension between these groups due to short staffing and demands of the job. While RNs were frustrated by all these factors, they still preferred Primary Nursing over Team Nursing (Brannon 1994).

Primary Nursing has numerous contradictions and consequences relevant to nursing status and job security. First, Primary Nursing simultaneously exploited RNs and made them indispensable to hospitals. Despite installing RNs as patients' primary care providers, RNs failed to attain "professional" status and remained subordinate to physicians in the health care labor process. RNs were also increasingly accountable for patient care – to patients, physicians, and hospital management – because of the flattened nursing occupational hierarchy.[5]

RNs' responsibility for planning and carrying out patient care was a near-impossible task, and resulted in RNs structuring their work into tasks, and prioritizing the "higher level" tasks over the routine tasks and emotional work. To manage the work, RNs

tried to contract their work jurisdiction in what approached their previous jurisdiction under Team Nursing. They frequently limited their engagement in "lower-level" tasks and the emotional labor – shifting this work to patients and their families. Third, RNs displacement of allied nursing personnel made them less vulnerable to being replaced by these workers, and RNs gained a near-monopoly on nursing jobs in the hospital. This subsequently created RN shortages in the 1980s, and gave RNs the leverage to pressure hospitals for increased pay, improved benefits, and more influence in staffing decisions and patient care issues. RNs' work under Primary Nursing may have reflected the Team Nursing scope of work, but without the interpersonal and inter-group tensions that characterized the "team" approach. By marginalizing non-RN workers, the predominantly white female workforce was able to secure "nursing" for themselves and minimize competition and friction in the health care labor process.

These benefits, however, eventually set up a backlash by hospital administrators and health care elites. As cost-cutting measures in the 1980s and 1990s impacted many different areas of health care labor, many workers found their work intensified just as RNs did. But any foundation for labor solidarity, already unlikely during Team Nursing, was further eroded by Primary Nursing. After Primary Nursing displaced auxiliary workers with RNs, the two groups had distant and tense relations due to the displacement and overall work intensification (Brannon 1994). The fractured nursing workforce – historically divided by class and race, and by an occupational hierarchy that mirrored these divisions – was set up for a "divide and conquer" strategy by health care elites in the latest round of restructuring the health care labor process.

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[5] However, Brannon (1994) found that staff RNs sense of professionalism is grounded in commitment and responsibility to caregiving – not attainment of "professional" status and distance from the physical, hands-

Nursing labor in the 1990s

The nursing shortage of the 1980s gave RNs greater leverage to advance their interests and benefit both economically and in terms of influence in patient care decision. As RNs gained better wages, benefits, and working conditions in the hospital, they became the largest line-item in hospital budgets, and one of the first targets of cost-cutting strategies. The new wave of cost-cutting in the 1990s involves countering RNs' accumulated power and numbers by increasingly employing a stratified nursing workforce. As discussed in Chapter 2, health care organizations and health care policy institutes followed the lead of industry outside health care to create a "cost-effective" labor process using a "flexible" workforce of licensed and unlicensed workers, using new health care models such as "Patient Focused Care" (Ruzek et al. 1999).

"Patient-focused care" (PFC) refers to rationalized health care delivery that emphasizes restructuring the health care labor process into a more "efficient" process by focusing on the labor process itself, rather than the behavior of individual workers (Lathrop 1991; Vogel 1993). The concept was developed in the late 1980s by the management consulting firm Booz-Allen and Hamilton, whose research on hospitals concluded that a great deal of "inefficiency" (and its concomitant cost) in health care was driven by "fragmentation" in health care delivery. They determined that for every personnel dollar spent, only 16 cents went to direct patient care. The rest went to scheduling (14 cents), paperwork (29 cents) and "structural idle time" of workers (20 cents) (Lathrop 1991). PFC was thus sold to hospitals as a way to improve the "efficiency" and "quality" of patient care. In practical terms, this means radical work redesign through downsizing and reconfiguring the workforce, creating new job

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on work.

categories and eliminating old ones through outsourcing and consolidation, and distributing the work among fewer workers. Licensed workers are deskilled, and unlicensed workers are cross-trained in different tasks in a highly rationalized labor process based on an industrial model of production.

As in Team Nursing, RNs are redirected into quasi-supervisory positions directing subsidiary workers assigned to routine tasks in the health care labor process; RNs' direct patient care is limited to specific tasks restricted to licensed workers. Unlike Team Nursing, however, the occupational hierarchy and theoretical division of labor of RNs, LPNs and Nursing Aides are disrupted by the addition of new job categories designed by health care elites in their quest to eliminate "unnecessary" personnel and job categories (Ruzek et al. 1999). As licensed workers are deskilled, certain paraprofessional and nonprofessional jobs are eliminated, and the responsibilities are redistributed among unlicensed, uncertified, low-waged workers, many of whom have been nonclinical support staff (e.g., housekeeper). The new jobs are redesigned to assume "semi-skilled" and "unskilled" tasks formerly done by RNs under Primary Nursing, such as bathing or feeding patients (Ruzek et al. 1999). These unlicensed and "multi-skilled" workers carry out responsibilities of often multiple jobs that have been consolidated as the health care labor process is restructured to be "leaner" and more "efficient."

These changes may promise the upgrading of health care workers across the board, and the opportunity to gain status and increased skills. However as the numbers of staff are reduced by increasing their "efficiency," the reality in the hospital is increased responsibility without the licensure, authority or compensation commensurate with earlier occupational orders. Health care workers face a "speedup" – expansion of work

jurisdiction and/or intensified workload. Despite added workload and expanded work jurisdiction, all workers experience little or no increase in compensation (Ruzek et al. 1999). Tensions and conflict over "appropriate" division of labor for direct patient care may be exacerbated as the skilled and largely white and middle class workforce is downsized while a fast growing group of workers is drawn from socially and economically marginalized communities.

Through deskilling and job consolidation, a new occupational structure for nursing labor emerges that is organized around "skill" and "training" rather than education and licensure/credentialling. This coexists – and often collides – with the legal constraints that structure the use of unlicensed personnel for certain procedures. One prominent collision involves RNs' responsibility by licensure for patient care, and the legal obligation to act in patients' best interests. RNs in these new "quasi-supervisory" positions are put in the position of having to be responsible for patient care that unlicensed workers do, without the authority of a supervisor. Moreover, as a "quasi-supervisor" RNs face threats to their collective bargaining rights (Brannon 1996). Registered Nurses' legal obligations and ambiguous occupational status as neither supervisors nor peers of the unlicensed workers effectively isolates them in a contradictory class position informed by gender and race, and sets them up for conflict with management and physicians, and with "subordinate" co-workers.

Conclusion

Health care labor is primarily women's work, and nursing is a central labor process within the larger context of health care. As "women's work," nursing has been historically devalued and exploited as largely unskilled labor based on the gendered and

racialized characteristics of the workers. The diverse group of women doing nursing labor has been fragmented along race and class divisions that became formally stratified around education and licensure, producing conflicting interests over occupational status, jobs and work jurisdiction. This stratification is the product of the convergence of interests (and compromise) among white nursing educators and leaders of professional nursing organizations, health care elites, and the mainly white workforce of staff RNs.

As the nursing labor process has been manipulated in the interests of cost-cutting and professionalization, the different models created by nursing and health care elites coincided with and reinforced race, gender, and class hierarchies and processes of exploitation. As RNs were developed into a separate class of nurses focused on increasing status and compensation, their upward mobility was based on emphasizing their distance and difference from the lower-ranked women also doing nursing labor. The nursing elites' strategy of upgrading a minority of white women by downgrading and restricting the upward mobility of racial-ethnic minority and lower-class women had lasting effects on the relations among these different groups. While this strategy was not successful in upgrading RNs to the level of physicians' peers, it was eminently successful in entrenching the divisions between workers and reproducing the exploitation of the primarily female workforce.

Chapter 4
Theoretical frameworks

In this chapter, I discuss the theoretical frameworks I find relevant to explain exploitation of and divisions among workers. My analytic approach emphasizes the interlocking structures of social organization – the intersecting axes of power of race, gender, class, age, national origin, dis/ability, and other markers of social position. I begin by discussing Marxist analyses of capitalist production and key concepts of division of labor and exploitation. I then present theoretical frameworks that argue that intersecting oppressions inform capitalist production through structuring particular labor markets and labor processes. These theories maintain that gender, race, class, and other axes of power must be understood as co-constitutive in constructing collective identities and relations of "othering" and exploitation.

Karl Marx: Production of surplus value

The work of Karl Marx is an essential foundation for a study of labor in the United States. His work emphasizes the fundamentally coercive relations and conflicting interests between workers and capital, and argues that the production of surplus value is key to workers' exploitation. This section will focus on his writings that argue that the social relations of labor are obscured through a range of mechanisms, especially: 1) the commodification of labor into labor-power; 2) the division of labor; and 3) the production of surplus value.

In *Wage Labour and Capital* (1847/1978) and *Capital* (1867/1978), Marx details the fundamental coercion and exploitative nature of the allegedly equal exchange between capitalist and worker. It is in "the meeting in the market" (Marx 1847/1978) that

the exploitative social relations of capitalism are most systematically obscured, through an ostensibly equal exchange of labor power and wages. Marx argues that the social relations of the labor process are those of commodification and consumption of human activity. Workers are basically forced into an exchange that inherently benefits their employers while maintaining their own lives at a minimal level of survival (Marx 1867/1978:357).

The industrial age, and its consequences, the division of labor and the introduction of the factory, have contributed to a radical transformation of social and economic relationships. The division of labor has transformed labor from being one's "life activity" (Marx 1844/1978:75) to a series of repetitious tasks that demean and dehumanize the worker, degrade the workforce as a whole, and increase production (Marx 1867/1978). The workers, however much they enrich the owners of the means of production, are paid barely subsistence wages and are systematically and ruthlessly exploited so that as much profit as possible may be squeezed from their labor. Workers are furthered exploited through the capitalists' manipulation of the working day. As absolute surplus value is produced by extending the working day, relative surplus value is created by increasing workers' productivity: shortening the necessary labor time and thus lengthening the surplus labor time, in which worker is producing exchange values, but is effectively working for free (Marx 1867/1978).

The exploitation of workers through the extraction of surplus value provides a clear example of the contradictory interests of capital and labor, through the structure of capitalist relations of production. Capitalism pits the needs of workers and the objectives of capitalists against each other, and structures the relations between them to

systematically benefit the latter. In singular pursuit of profit, capital will invest only the minimal amount of capital to sustain and reproduce the workforce. The workforce suffers as a result of degraded existence based on subsistence wages, in a position that is structured to remain marginalized and expendable (e.g., Engels 1845/1978).

Underlying Marx's theory of exploitation is an important assumption about the nature of the working class. Marx theorizes that society is divided into two major classes, and does not, for the most part, distinguish variation within each class. His construction of the working class is that of equally exploitable and exploited workers, with distinction given primarily to the cost and quantity of production (that is, the labor of women and children cost less than that of men) (Marx 1867/1978). Marx's conception of a working class consciousness and working class solidarity is a unidimensional phenomenon based on a homogeneity within the working class.

Growth of productive capital results in lower wages, unemployment, and the "industrial reserve army"

In order to achieve greater and greater profits, capitalism keeps driving the price of labor down lower and lower, which results into cyclical crises, and eventually a falling rate of profit, a cycle which creates the very conditions for the most exploited to organize and revolt.[1] Key to this cycle is that production is continually transformed: the drive for cheaper production is a "feverish simultaneous agitation on the whole world market" (Marx 1847/1978:214) resulting in an uninterrupted rationalization of labor, use of machinery, and increasing scale of production.

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[1] This cyclical process is rooted in capital's focus on profit and need to augment itself. Capital increases only by exchanging itself for labor power, and in turn, the increase of capital increases competition between capitalists. Capitalists can gain more market share by producing more cheaply through the use of machinery and a greater division of labor, and depressing wages. When one capitalist undersells

More and more unskilled jobs, and increasing competition for them — despite lower wages, long hours, and unfavorable conditions — are the result of increasing use of technology and machinery to replace skilled workers. Moreover, when these skilled workers find new work, these jobs would necessarily be lower in skill level and pay scale than the ones they were displaced from. Most importantly, the increasing use of technology and the displacement of workers creates a "industrial reserve army" (Marx 1867/1978:423), an available pool of workers who, due to their marginalized status, are more likely to settle for lower wages and worse conditions. This is another way that capitalism structures worker exploitation through the capitalists' drive for accumulation.

> But if a surplus labouring population is a necessary product of accumulation or of the development of wealth on a capitalist basis, this surplus-population becomes, conversely, the lever of capitalistic accumulation, nay, a condition of existence of the capitalist mode of production. It forms a disposable industrial reserve army, that belongs to capital quite as absolutely as if the latter had bred it at its own cost...it creates, for the changing needs of the self-expansion of capital, a mass of human material always ready for exploitation. (Marx 1867/1978:423) (emphasis added)

Braverman: Monopoly capital and the fragmentation of the labor process

In 1974, Harry Braverman's *Labor and Monopoly Capital* provided a fresh examination of the labor process under contemporary capitalism, an analysis which he argued had not occurred since Marx approximately 100 years earlier. Braverman builds on Marx's analysis by examining labor processes in relation to the changing nature of capital, which has become larger, impersonal, and consolidated. He argues that the change in capital has restructured the productive labor process, which in turn has restructured industry, occupations, and the labor force. Braverman's analysis is based upon many of the premises of Marx's theories about capitalism and the exploitation of

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competitors, eventually the competitors will use the same methods, so a commodity's price drops still further. Before long, all the capitalists are back at the beginning of the cycle.

labor, most notably the inherent conflict between capital and labor, while expanding the analysis to account for the changes produced by the difference in the nature of capitalism.

Monopoly capitalism, unlike the individualist capitalism of Marx's era, is characterized by a global centralization and concentration of capital based on the colonization and imperialist domination by western European nations and the United States, beginning in the late 1800s through the present day (Braverman 1974). Monopoly capital produces a new surplus of labor far greater than in Marx's era. This surplus of labor, Braverman argues, is the key to the transformation of the occupational structure and the working class. These transformations occur with the coinciding of several important trends: 1) the increased rationalization of the labor process through the division of labor; 2) the principles of "scientific management" or "Taylorism; " and 3) the "new scientific-technical revolution" (Braverman 1974). These trends will be reviewed following an overview of monopoly capitalism, which I discuss below.

Characteristics of monopoly capitalism

Braverman argues that capitalists' insatiable drive for accumulation both produces and is produced by major social forces that characterize monopoly capitalism. The first is the "modern corporation," which exponentially exceeds the scale of the individualistic capitalist enterprise of Marx's era. The corporation represents depersonalized wealth, as it is located between capital itself and the individual owner(s) of capital. In pursuit of greater profit, corporations grow, and they integrate with other corporations both horizontally and vertically. Management bureaucracies grow in a decentralized structure.[2]

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[2] Thus Braverman argues that the modern corporation has three important dimensions that inform its occupational structure, based on the increased rationalization of labor and the expansion of bureaucracy: 1) "marketing;" 2) "structure of management;" and 3) a social control function within the corporation (1974:265).

The second social force is the growth of the "universal market," which transforms each and every human activity into a commodity. The production and consumption of these commodified activities, relations, and materials, especially in terms of "service employment," furthers the capitalists' goal of accumulation, and leads to the third social force, the rapid and continuing expansion of the service sector. The service sector accrues many benefits for capital. First, since technology and the division of labor produces massive displacement of skilled workers and elimination of jobs requiring skills, a large pool of marginalized workers is available for lower-level, lower-paying "simple labor." The large number of "surplus workers" in turn maintains depressed wages.

Lastly, Braverman writes that the role of the State under monopoly capitalism has an expanded role than Marx's analysis of capitalism in the 19th century. First, the State makes necessary interventions in the private sector in order to deal with economic surplus that is a product of monopoly capitalism. Second, the globalization of capital and capitalism results in international conflict and intra-national conflict (anti-colonialist movements against western-dominated governments). Third, the State needs to ameliorate the damages of capitalism by providing a social control function, mostly through social welfare services, in order to stave off social misery and discontent, and maintain social stability. Lastly, the State prioritizes resources to public education to "cater to the occupational needs of capitalist society" through training for the very service and social control jobs used to address the damages of capitalism (1974:284-287).

The rationalization of the labor process and exploitation of workers

One of the most prominent of Braverman's premises, based on Marx, is that labor-management relations are conflictual and antagonistic, due to the conflicting needs

of capital and labor, accumulation versus meaningful labor. As Marx has described (Marx 1847/1978, 1867/1978), the division of labor is key to achieving the capitalist's goal of accumulation. When capitalists exchange capital for wages to purchase labor power, they invest in order to augment their capital. Braverman makes the important clarification that the labor power purchased to augment capital is "not an agreed amount of labor, but the power to labor over an agreed period of time" (Braverman 1974:54) (emphasis added). Capital attempts to extract the most productivity from this amount of labor power, to gain the greatest amount of surplus value and profit.

Key to extracting the greatest amount of profit is the increased fragmentation or rationalization of the labor process through the detailed division of labor. Braverman attributes the increased rationalization of labor and the development of "modern management" to stem from the principles of "scientific management" initiated by Frederick Winslow Taylor in the 1880s and 1890s. "Scientific management" or "Taylorism" focused upon increasing productivity through increased fragmentation of the division of labor and increased management direction regarding the specifics of how labor is actually carried out. The three major principles of "scientific management" are based on the gathering, classification, and monopolizing of knowledge of productive labor process exclusively by management. This results in the institutionalization of a cleavage between "mental" and "manual" labor, which Marx (1844/1978) argued was the beginning of the division of labor under capitalism. Braverman (1974) in turn argues that scientific management constructed a basic cleavage in modern labor, which in turn produced an occupational structure in which different "types" of workers were needed for different "types" of work.

Due to these changes, the modern workforce has become increasingly bifurcated between "mental" and "manual" workers. The vast majority of workers have experienced a fragmentation and cheapening of labor, as they have been channeled increasingly into jobs entailing "simple labor." A limited number of persons have been permitted special education, training, and knowledge, and this elite is generally relieved of the obligation of engaging in "simple labor" (Braverman 1974:82-83). Braverman asserts that this process of restructuring is so fundamental to modern capitalism that it

> might even be called the general law of the capitalist division of labor. It is not the sole force acting upon the organization of work, but it is certainly the most powerful and general...It shapes not only work, but populations as well, because over the long run it creates that mass of simple labor which is the primary feature of populations in developed capitalist countries. (Braverman 1974:83)

Lastly, Braverman (1974) argues that a wave of scientific advances coincided with the development of scientific management and the fundamental changes in capitalism and the labor force. Science, like labor, became a "social property" transformed into "an adjunct of capital" (Braverman 1974:156). The "new scientific-technical revolution," which began in the late 1880s, was unlike the preceding Industrial Revolution in that science was now framed as a commodity, instead of being characterized by a series of technical innovations. Therefore, Braverman argues that this scientific-technical revolution "must be understood rather in its totality as a mode of production...The key innovation is...in the transformation of science itself into capital" (Braverman 1974:167).

Braverman (1974) asserts that the influence of the scientific-technical revolution on the labor process is informed by capital's need for increased productivity. This revolution has made it possible for management to seek out and obtain control over the entire range of steps in the labor process. Through scientific management, human lives

have been recast as machines, mere instruments in the production process. Divisions among workers help to maintain the status quo, as the elite workers who escape the drudgery of "simple labor" act to defend the division of labor that privileges them, with rationales that promise greater improvement to society due to their freedom to make further advances in science and technology (Braverman 1974). The system in whch they benefit, moreover, has shifted "production" from material goods to commodification of human relationships, and has emphasized the service sector for employment.

Braverman (1974) attributes the rapid grow of service employment in both public and private sectors to several factors, including

> the completion by capital of the conquest of goods-producing activities; the displacement of labor from those industries, corresponding to the accumulation of capital in them, and the juncture of these reserves of labor and capital on the ground of new industries; and the inexorable growth of service needs as the new shape of society destroys the older forms of social, community, and family cooperation and self-aid. (Braverman 1974:359)

According to Braverman, during this era of the "new scientific-technical revolution," service employment is one the fastest-growing sectors of the productive economy because it is one of the most labor-intensive sectors, as the types of labor processes used in labor-intensive sectors are far less influenced by technological advances. Moreover, the shift from producing goods to producing services is accompanied by a change in the gender and race of the worker, as skilled "craftworkers" (predominantly white men) are replaced by "unskilled" workers, who are more likely to be women and people of color.

The labor force is drawn from the reserves of unemployed workers, who have been displaced from skilled and better-paying employment. The masses of workers are relegated to "simple labor," and a few persons, especially those in clerical employment,

are permitted higher education and training for jobs as managers or supervisors. Within this stratum, moreover, are different tiers of position, prestige, and authority. A key point is not simply that "differences" exist among workers, but that alliances to capital are constructed based on self-interest and the benefits one receives by participating in an oppressive social structure.

Composition of the class structure: Review and critique

Braverman pays more attention to differences within the working class than Marx did, but still periodically generalizes across race (Black and white) and gender. With regard to differences within the reserves of surplus labor, Braverman argues —following Marx's formulation — that there are different tiers to the reserves of surplus labor, based on skill and employability. Moreover, reserves exist in "different forms" comprised of different populations (for example, migrant laborers). Braverman is most interested in the least "employable" of these groups, what Marx labeled the "stagnant relative surplus population" — the most marginally employed and impoverished group of workers, ripe for capitalist exploitation (Braverman 1974:387-388). However, he does not specifically say <u>who</u> these people are, implying, but remaining silent on the racial and gendered nature of the most marginalized segments of the population.

Braverman does recognize the disproportionate amount of unemployment of African Americans, and the lower wage scale and limited employment for African American women and men, and white women. In general, though, his discussions of composition of the working class focus more on gender, and there is no such distinction in his analysis of capitalist class members. His analysis of the cleavage of "mental" and "manual" labor and laborers, explicitly locates the "degradation" of labor as coinciding

with a "gender cleavage" in the labor force following World War II. Braverman documents the rising participation of women in the labor force in low-wage, dead-end service jobs as coinciding with the decline of male participation in the labor force and the elimination of skilled, high-wage jobs.

His analysis of women in the service sector economy recognizes inequality structured by class and gender, as the tasks they performed at home are "now in the service of capital which profits from each day's labor" (Braverman 1974:281). Braverman explicitly states that capitalism does not recognize the value of women's work when it is performed at home. However, capitalism assigns a value to women's work when it is performed in the domain of waged labor, because women's labor adds to capital. Moreover, Braverman (1974) asserts that women, irregardless of race, now comprise the main reserves of labor because women's lower pay scale is reinforced by capitalism's strategy of depressing wages when there is a large pool of surplus labor. Despite this recognition, Braverman takes the inequality as a "given," and fails to interrogate gender as a structuring force of exploitation on its own terms. Moreover, by omitting the effects of race on gendered labor, Braverman misses a further stratification of the labor force. Furthermore, unlike other theorists (e.g., Blauner 1972; Bonacich 1972; Cox 1948/1970), Braverman omits any analysis of how race has been used by capital to promote antagonism among working people and depress their wages overall.

Contemporary labor process theory post-Braverman

Braverman has been criticized for his construction of a "labor process" and a "craftworker" as abstract, ahistorical, "generic" entities. The labor process he constructs is a unitary form that exists across different workplaces, geographic settings, and

historical moments. His analysis of the degradation of work is predicated on a deterministic, linear, and unrelenting progression of deskilling, and focuses on an ahistorical and gender- and race-neutral generic "craftworker." He has been critiqued for an over-emphasis on "scientific management" principles of deskilling as having the single largest influence on capitalists' control over workers (Meiksins 1994; Smith 1994; Wardell 1999). Braverman is also critiqued for lack of worker subjectivity – the resistance and consent to changes in work processes (Meiksins 1994; Smith 1994; Wardell 1999). The labor force appears as a plastic entity that does not protest management's transformation of work. Braverman's work suggests capitalists' complete power over workers, permitting a nearly resistance-free implementation of deskilling.

These constructions fail to represent the variations of wage work and the experiences of women and men in different social positions. Feminist theorists argue that Braverman's analysis fails to account for the substantial influence of gender inequality and segregation in the labor market and at work. Much of their critique has focused on his lack of attention to gender as a fundamental structural force of the labor market (Meiksins 1994; Smith 1994; Wardell 1999). While Braverman acknowledged that women are associated with lower-paid and lower-skilled jobs, feminist critiques have pointed to the absence of gender as a social structure of inequality or gender inequality as a "given" or "natural" (Rogers 1999; Smith 1994). His notion of "skill" is not fully explored, and has a restrictive and gendered characterization (Rogers 1999:55; West 1990). Smith (1994) argues that feminist research has demonstrated that gender as a social structure informs the creation and implementation of ideologies of "skill" and occupational sex segregation.

Extending Braverman's work

Contemporary labor process theorists (Kraft 1999; Smith 1994; Wardell 1999) extend Braverman's thesis in several important ways – based primarily in the aforementioned critiques. These theorists argue that workers' agency (through both accommodation and resistance) plays a central role in management's attempts to manipulate the labor process, and that management uses a range of techniques in order to control the workforce and accumulate capital – including cooperative teamwork approaches or "partnerships." Feminist scholars argue that gender inequality is a central organizing principle in restructuring labor.

Vicki Smith (1994) writes that early divergences and extensions of Braverman's work documented the central presence of worker agency and class struggle – specifically, how capitalists and workers in turn devised strategies to resist or implement new forms of control over the labor process. Instead of a unilateral and unidirectional transformation of work, worker resistance and consent to capitalist objectives were causal factors that shaped labor processes as much as managerial strategies of worker control (Smith 1994). These post-Braverman researchers showed that transforming labor was "dynamic, contingent, shaped by various historical, social or cultural circumstances" (Smith 1994:407). Class struggle became increasingly identified as a "causal force" that restructured labor processes. While the introduction of workers' subjectivities and agency added much to understanding labor process transformation, these studies centering class struggle still did not explain why capitalism was not overturned by a unified working class who would implement new modes of production and social relations. A new generation of research focused on more nuanced studies of why and how workers resist

but also accommodate capitalism's objectives. The dialectic of conflict and consent of workers ultimately permits the continued existence of advanced capitalism (Smith 1994).

Smith (1994) writes that the labor process research post-Braverman has expanded his core themes and thesis of deskilling, and in fact has pointed to areas where his work may be inadequate to explain the complexity of the transformation of the labor process.

> Braverman downplayed consent, cooperation, and identity, but a significant number of studies have since persuasively argued that an analysis of labor process transformation is not only partial but, in fact, wrong if it fails to explain how structural change plays on, is limited by, and interacts with subjective experience. Changes in control strategies, skill levels, and autonomy are inextricably connected with workers' compliance and resistance.
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> ... In striking contrast to Braverman's prediction of a great sweeping trend of deskilling...a good many studies have documented a set of genuinely diverse trends in skill levels, autonomy, and worker satisfaction. Not one labor process under monopoly capitalism but many; not the absolute separation of conception and execution but an inability and, increasingly, reluctance to draw a meaningful line between the two; and not a unified working class but a class structure that maintains great multiplicity of experience and status: Contemporary changes seem to suggest that Braverman's project, although raising interesting questions and concepts, has ultimately failed in descriptive and predictive power. (Smith 1994:416)

Despite these inadequacies, Braverman's central thesis is still relevant (Meiksins 1994; Smith 1994). Braverman's work centers class conflict and the inextricable relations of domination and exploitation as informing the nature and restructuring of labor, in which "the pursuit of control is integral to the pursuit of efficiency" (Smith 1994:416), and in which these pursuits in turn inform the conception and execution of labor processes. Deskilling may not produce a workforce of increasingly and systematically "degraded" workers engaged in ever more monotonous "unskilled" labor, but it is nonetheless a widespread phenomena and dominant tendency in capitalist production processes. *Labor and Monopoly Capital* focuses on the <u>continuous restructuring</u> of the workplace, with workers, exploitation, and deskilling at the center of the analysis (Meikins 1994:44-45).

Smith (1994) argues that feminist researchers also extended Braverman's work by arguing that gender is a fundamental social institution that structures social and economic relations of inequality in the labor market and throughout society, and informs ideologies of "skill" and occupational sex segregation. Smith (1994) argues that by foregrounding gender as a social structure embedded in the labor process, Braverman's deskilling thesis is extended in two important ways: 1) labor process transformation is based on capitalists' different control strategies for men and women, and 2) workers' resistance and accommodation may be gender specific. Different bases of collective identity and social relations will likely produce different bases of resistance and accommodation.

New managerial approaches to workforce control

Contemporary labor theorists (Kraft 1999; Smith 1994) note the shift in "demeanor" between capital and labor. In the 1980s and 1990s, there was a shift from the formal relations and agreements of work between management and workers (such as labor unions), towards organizational cultures emphasizing "flexibility" and commitment that avoid formal relations of labor management from earlier times. These new managerial approaches, such as Total Quality Management (TQM), emphasize flexibility and cooperation rather than rigid rules and hierarchies, and obscure the inherently exploitative capital-labor relationship. These approaches, which Kraft (1999) terms "command and control" systems, may be "updated" incarnations of Taylorism or "scientific management" that seek to control the labor process by eliminating "waste" or "defects" in the production process and outcomes (Kraft 1999; Wardell 1999).

> ...the goal of these "quality" and "process" movements is to provide managers with reliable ways to predict and control "outcomes" rather than measure and monitor behavior. Their common formal purpose is to reduce value-adding time, product and process defects, and costs. In this respect, they all owe large and obvious debts to

> Taylorism. TQM and BPR [Business Practice Reengineering] have been enthusiastically adopted by U.S. managers in part precisely because they legitimate and rejuvenate the traditional Taylorist obsession with unnecessary motions and unnecessary people. Taylor's cry of "eliminate waste!" finds an echo in [TQM's] cry of "shrink, shrink, shrink variation!" and [BPR's] command to "obliterate" duplicative and non-value-adding work processes. (Kraft 1999:22-23)

In the new approaches, capital's ultimate objective of producing surplus value is accomplished through building consent among the workforce through participation in the design of the labor process itself, rather than focusing on the behavior and output of individual workers. Kraft (1999:20) terms this shift from conventional Taylorism "from command and control to control and inspire," but emphasizes that a combination of conventional and new management strategies are used together to control the workforce.

Kraft (1999) details major differences between conventional "Taylorist" and process-centered "Control and Inspire" control strategies. Unlike Taylorist models, these new control systems do not separate conception and execution of labor. Where Taylorism is a linear approach to segmenting and rationalizing labor processes, focusing on reducing "waste" and improving "efficiency" of the individual worker, the new control strategies and processes are more fluid and focus on the process of production itself – emphasizing worker input and "team work," and flattening organizational hierarchies. In the new models, occupational structure and labor process clearly move away from Taylorism's explicitly or implicitly clear boundaries between workers and management, types of work, layers of organization, union-management relations, and other dimensions. The "Control and Inspire" strategies emphasize less difference between the interests of management and labor, less difference in types of work and workers, less formal and hierarchical relations between labor and management, and overall warm, fuzzy, and cooperative relationships (Kraft 1999).

However, both Taylorist and the newer approaches are built on top-down organizational structures and have the common goal of maximizing surplus value: "Like Taylorism, all are concerned chiefly with getting fewer workers to produce more in less time and ultimately at lower costs" (Kraft 1999:23). The new approaches restructure the workplace and the workforce through processes of consent to reach (ostensibly) shared goals of labor and management. Workers and employer become stakeholders equally invested in the company's well being. However, a change of management style without a change in the power relations and workers' locations in the labor process keeps management in control.

Kraft (1999) states that there are differences among these new managerial control strategies, ranging from incremental approaches to calls for drastic restructuring of the labor process – and that their "real power" lies in their complementary approaches – they are most effective when used together and their different tactics applied strategically to different levels of labor process and its components. That is, different approaches work together to manipulate labor processes and workforces through focusing on different tiers of control, combining elements of Taylorism for individual tasks with "soft" control strategies that focus on restructuring entire processes and subsequently "managing" the systems and processes of the restructured organization (Kraft 1999).

Key to the new control strategies is the ideology of worker "empowerment." Accomplishing a work culture of "empowerment" is based on two linked tactics: 1) creating a flexible organizational structure that uses teams and limited decision making power; and 2) using ideology as a control mechanism. Examples of the second tactic include changing the recognizable vocabulary of power relations (e.g., "boss" becomes

"coach"), and developing a "win-win" ideology among the workforce. The culture of empowerment and the flattened organizational structure are more cost-effective (profitable) to management than "traditional systems of fragment and flog" (Kraft 1999: 29). These shifts leave workers in a precarious situation, as described by a self-identified "blue-collar worker" who posted the following comments on an Internet TQM discussion list (Kraft 1999):

> I am not stupid... My wife went to work in a new factory about a year ago that opened up under the TQM concept... The workers get half the pay and twice the work that they would get if they were employed by the same company in one of their other non-TQM plants. They work long hours under brutal conditions and have absolutely no input in plant decisions although that is what was preached to them during indoctrination. They have no bosses only "resources" who have more authority and are less responsive to the employees than any boss [they] ever had...I don't have reams of research to offer you. I can only say that TQM sucks. It is a return to the stone age for the working person. It is nothing but stretch out and company unions wiping out worker gains and worker rights for the benefit of management. It is just another tool for manipulation. Nothing new about that. (QUALITY List, quoted in Kraft 1999:23-24).

New role(s) of labor unions

Where and how do labor unions fit into this landscape? Some theorists argue that new management strategies of "team-work" and union representation are not mutually exclusive factors (Shaiken, Lopez, and Mankita 1997; Wardell 1999). In their study comparing team production at Saturn and Chrysler, Shaiken et al. (1997) found that new organization of work processes and labor-management relations rely on greater collaboration between union leadership and management. These collaborations – some of which are termed "partnerships" – result in benefits to both parties, and often represent linkages between labor and management, or workers and the company (Shaiken et al. 1997). The flattened occupational structure has fewer job classifications and less range of

wage scale, reduction in middle management; individual workers have more training, more variety of jobs, more responsibility, commitment, and job satisfaction.

However, as Shaiken et al. (1997) suggest, new roles for unions may simultaneously erode their power as the protector of workers while enhancing this power through shared labor-management decisionmaking (or at least greater influence on management's decisionmaking). The onus of the union's legitimacy in the eyes of the workers, however, falls exclusively on the union leadership, as they try to balance management's goals of productivity with workers' goals of job security, working conditions, and compensation. A major question is whether or not unions should (or can) work cooperatively with management outside traditional adversarial roles and remain independent "enough" to protect rank and file workers.

Marxist analyses of U.S. health care

This section will review the work of contemporary Marxist theorists who analyze the degradation of the health care labor process. A Marxist theoretical approach to health care is exemplified through the work of Vicente Navarro (1986, 1988, 1993, 1994, 1995a, 1995b), John B. McKinlay (1974, 1984) and Howard Waitzkin (1979, 1989/1996, 1994), who assert that social and health crises are to be understood within the structure of capitalism. Moreover, the emergence of monopoly capitalism (Braverman 1974) has exacerbated the conflicts inherent to capitalism through the deskilling of most of the labor force and the eclipse of "individualist capital" by larger, impersonal and aggressive corporations. Monopoly capitalism produces a workforce bifurcated in terms of skill and meaningful labor and has facilitated the exponential growth of a managerial or administrative class, whose control over production (in this case, the practice of

medicine), and whose self-interest protects the structures of private capital at the expense of the labor force (Braverman 1974).

The Marxist literature on health care labor focuses primarily on physicians' labor and their place within the health care division of labor (e.g., McKinlay and Stoeckle 1988; Navarro 1986, 1993), with certain exceptions (Brannon 1996).[3] Although the labor process of physicians is outside the scope of this dissertation, it is useful to review the Marxist analyses of their labor in relation to the changes in the health care system and the medical division of labor in order to address the non-physician labor force and the range of professional and "unskilled" labor included in the diverse body of labor. That said, it is also useful to review how Marxist approaches to the profession of medicine reveal cleavages within the capitalist classes, as many physicians' alliances with monopoly capital in health care are shifting to an oppositional relationship.

Navarro (1986) argues that in capitalist societies, control over medicine is held by the capitalist class, not the physicians. McKinlay and Stoeckle (1988) extend this point to discuss how the "crisis" in health care costs has produced changes in both the management of health care (i.e., prioritizing cost-containment) and the practice of health care (i.e., the labor process of physicians). As physicians' labor process is rationalized and fragmented, some of the tasks may be delegated to these lesser-trained and lower-paid specialists who are trained to perform circumscribed tasks, and hospitals can cut labor costs by using cheaper labor. This degradation of professional health care labor occurs through "proletarianization,"[4] which McKinlay and Stoeckle (1988) define as

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[3] For an in-depth discussion of the nursing labor process, see Brannon (1996).

[4] This theory has generated considerable debate between these authors and Eliot Friedson (1989; 1994), the "truth" of which rests on physicians' maintaining professional dominance in the medical division of labor.

> the process by which an occupational category is divested of control over certain prerogatives relating to the location, content, and essentiality of its task activities, thereby subordinating it to the broader requirements of production under advanced capitalism. (McKinlay and Stoeckle 1988:199)

McKinlay and Stoeckle (1988) argue that the process of proletarianization constricts professional autonomy and privilege, including domains of training, clients, and compensation. Navarro (1988), however, argues that proletarianization fails to accurately represent the power shift in medicine. He argues that the capitalist class, not medical professionals, have historically controlled medicine, and while physicians have lost much of their power, they still maintain "considerable influence" within the production and resources of health care. Furthermore, the medical profession allies itself more with private capital than with the working class (Navarro 1988). Thus in terms of location within the medical division of labor and social position, physicians maintain a professional dominance in relation to the society at large.

Each of these perspectives on the state of the medical profession permits us to see how the potential for conflict in health care labor is situated in the relations between the managers of private capital (health care administrators) and the professional labor force. McKinlay and Stoeckle (1988) as well as other authors (e.g., Budrys 1997; Marcus 1975) have noted the increasing interest among physicians for union or other collective bargaining representation in order to protect their professional interests. The potential for conflict, however, is also situated in the relations between different groups comprising the health care labor force, a situation that could be manipulated by private capital for its own interests, or could just as likely stem from different groups themselves as they seek to attain status and power within a hierarchical division of labor.

Theorizing intersecting oppressions: Race, gender, class, and other markers of group position

Numerous scholars have argued that race, gender, and class are fundamental forces of social organization in general and of the labor market in particular, and have theorized racial and sexual divisions of labor that produce occupational segregation along race and gender lines (e.g., Blauner 1972; Eisenstein 1977/1990), as well as a split or segmented labor market (e.g., Bonacich 1972; Gordon, Edwards, and Reich 1982). These theories have been borne out by empirical works that have demonstrated that at times existing social divisions and antagonisms exacerbate divisions within a work organization, or more generally, serve as divisive and antagonistic forces within the labor force (e.g., Amott and Matthaei 1991; Hartmann 1976/1990, 1981). Many of these studies, however, have regarded race, gender, class, and other markers of "difference" in "additive" models that fail to explain how these markers intersect, and suggest monolithic images of particular groups.

Split labor market theories: occupational segregation by race and ethnicity

There are two basic approaches to racial segregation and labor market segmentation. The first approach is that of theorists who place primary importance of race as a fundamental component in organizing the division of labor through "internal colonialism" and similar models of racial oppression (Blauner 1972). The second approach, which I review here, is one that links racial and class oppression, but ends up privileging class conflict over racial division of labor. Examples of this approach include

Gordon, Edwards, and Reich (1982), and Edna Bonacich (1972), who treat race or ethnicity as important but not fundamental in shaping the labor market.[5]

In contrast to Gordon et al. (1982), who argue that labor market segmentation and segregation are engineered primarily by capital for its own benefit, Bonacich (1972) argues that a split labor market produces conflict within the working class that primarily benefits the white and higher-paid segment of the working class. A split labor market occurs when a price differential for labor exists between at least two groups of workers, with regards to the same work. Bonacich argues that ethnic differences do not always produce a price differential, and that a price differential does not occur solely because of ethnic differences. The major force behind the creation of a split labor market is capital's drive for profit, and ethnic conflict is a "correlate" that occurs as a product of the class conflict (Bonacich 1972).

One of Bonacich's (1972) main points is that conflict in a split labor market occurs among three primary classes: "business, higher paid labor, and cheaper labor." These classes have conflicting interests that lead to inter-ethnic antagonism, but this is based on the price differential of the workers' labor, and the ethnic conflict is a secondary component. The ethnic antagonism occurs in exclusion movements and a caste system (regarding race or ethnicity, or gender), and both strategies benefit higher paid labor, since its interests (jobs and wage scale) are protected. Bonacich's ambivalence towards the importance of race is presented in her conclusion, where she notes that the salient characteristic of societies with high levels of ethnic antagonism is a "powerful white, or more generally higher paid working class" (Bonacich 1972:558).

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[5] Other important theorists who take similar positions, but who explicitly reduce race to class conflict, include Oliver Cox (1948/1970), Steven Steinberg (1989), and William Julius Wilson (1978; 1987).

Dual systems theory: Occupational segregation by sex

Dual systems theory argues that women are structured into the secondary labor market by both capitalists and male workers, in order to serve the interests of both capitalism and patriarchy. It is one of the more important theories to explain job segregation and labor market segmentation because it effectively integrates class and gender oppression. Heidi Hartmann's work (1976/1990, 1981) provides a clear picture of how job segregation by sex benefits both the capitalist class and male workers. Capital benefits by women's lower wages and status as marginal workers. Male workers actively organize and enforce occupational segregation to protect their interests, which include their jobs and the wage scale they are accustomed to. Equally importantly, however, male workers benefit from women's marginal employment because women are structured into a dependency upon men — primarily through marriage, in which men benefit from women's unpaid domestic labor.

Milkman (1987) critiques Hartmann's analysis because Hartmann — like the segmented labor market theorists she criticizes — paints a homogenous picture of male workers and their interests, and fails to consider conflicts among male with <u>different</u> class and gender interests. As Milkman (1987:7) writes, "Hartman correctly identifies the dominant historical pattern of male workers' (and unions') hostility towards women workers. But in some instances, men have actively fought against gender inequality on the basis of self-interest..." That is, men allied with women in order to preserve existing wage and benefits scales. Through Milkman's critique, we can see how both conflict and alliances may be produced within and across boundaries of gender and class.

Glenn (1991, 1992) and Sacks (1989) have also critiqued earlier theories linking class and gender, including: 1) dual systems theory; 2) domestic (reproductive) labor as

the primary exploitation of women; 3) capital's manipulation of wage labor based on women's marginal status in the labor force. All three models fail to address racial domination (Glenn 1985; Sacks 1989). In particular, Glenn (1985) argues that dual systems theory, which asserts that women are seen as "women" first, and "workers" second, is flawed because it is based on only white women's experiences in the labor force. Glenn asserts that women of color were always involved in production, and so have been defined primarily as laborers, not as some "ideal" woman as constructed by the cult of domesticity (Glenn 1985:102).[6] Most importantly, however, this double standard of womanhood was unequivocally based on race, and permitted the development and reification of a supposedly natural racial division of labor that relegated women of color to performing demeaning, arduous work — a structure that simultaneously relieved white women of these tasks, and that compromised family ties of women of color while enhancing those ties of white families (Glenn 1991, 1992).

Additive versus intersectional approaches

Spelman (1988) discusses the implications of dominant ways of conceptualizing "difference" and oppression. In particular, she focuses upon the problems of "additive" analyses, which conceptualize different oppressions as unrelated phenomena:

> How one form of oppression is experienced is influenced by and influences how another form is experienced. An additive analysis treats the oppression of a Black woman in a society that is racist as well as sexist as if it were a further burden when, in fact, it is a different burden... to ignore the difference is to deny the particular reality of the Black woman's experience. (Spelman 1988:123) (emphasis added)

Additive approaches suggest that a woman's racial identity can be somehow "subtracted" from her combined sexual and racial identity to the common ground of some

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[6] This definition of womanhood was based in bourgeois social beliefs that held that "women's sphere" was the home and family, and "men's sphere" was the world of work and politics.

essential "woman-ness," obscuring the heterogeneity of members of the group called "women." Spelman argues that such an analysis distorts Black women's experiences of oppression by failing to note important differences between the contexts in which Black women and white women experience sexism. When gender is studied in isolation it produces and reproduces the "totalizing" tendency (Higginbotham 1992) of gender, and it obscures the ways race, gender, and class inform each other.

From additive to intersectional thinking: subjectivities informed by intersecting oppressions

In contrast to theories grounded in additive approaches, the body of "race, gender, and class" scholarship has demonstrated that different axes of social organization or oppression are fundamentally linked. These axes work together to synergistically produce qualitatively different experiences and structural positions for individuals and groups who fall under more than one category of definition (Crenshaw 1991; Sacks 1989; Spelman 1988). This scholarship emphasizes what Brewer terms the "articulation of multiple oppressions" (1993:13). Theoretical concepts such as "intersectionality" or Patricia Hill Collins' (1991, 2000) "matrix of domination" are of key importance for understanding how race, gender, class, and other markers of social location inform each other and structure a vast and complex network of oppressions.

The need for an intersectional analysis of race, gender, and class has been a prominent theme in the theoretical perspectives offered primarily by feminists of color, who have argued that in particular, race and gender have been treated as separate domains by both feminist theory and theories of racial oppression (Glenn 1992; Higginbotham 1992; Hull, Scott, and Smith 1982; Spelman 1988). These scholars offer theoretical models that consider race, gender, and class as simultaneous and intersecting

forces that shape social organization – both structural arrangements and interpersonal interactions. One of the earliest and most prominent examples of this theorizing is the writing of the Combahee River Collective, who explicitly states its focus to be the development of an "integrated analysis and practice based upon the fact that the major systems of oppression are interlocking" (1977/1979:362).[7] There is a "multidimensional nature" of the inequalities facing women of color (García 1997:271).

Analyzing oppression with an integrated vision means looking at the different social and economic positions ascribed to different groups in terms of the organizing axes of race, gender, and class, and the different experiences across and within these groups. As the Combahee River Collective argues (1977/1990:366): "We need to articulate the real class situation of persons who are not merely raceless, sexless workers, but for whom racial and sexual oppression are significant determinants in their working lives." In order to understand class position one must look at the specific material realities of groups, and their racial and gender positions that inform and are informed by class.

Over a decade later, Karen Brodkin Sacks (1989) calls for understanding race, gender, and class as "parts of a unitary system," while maintaining the specificity of different subjectivities based on different social positions. Sacks (1989) argues that the historical dialectic of profit motive and "expendable" workers has at its center the interrelations of race, gender, and class.

> ...capitalism has specifically recruited workers on the basis of race, and of gender and family relations within specific racial-ethnic communities. But this is part of a historical dialectic whose other pole was the age/marital status and gender of those who were "expendable" in a particular culture's division of labor... (1989:541-542)

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[7] Other important early works include: *This Bridge Called My Back: Writings by Radical Women of Color* (Moraga and Anzaldúa 1981), *All the Women Are White, All the Blacks Are Men, But Some of Us Are Brave* (Hull et al. 1982), and *Home Girls: A Black Feminist Anthology* (Smith 1983).

This dialectic, moreover, has been a major force in occupational segregation in the wage labor force where gender hierarchies operate within and alongside racial segregation (Glenn 1985). Sacks (1989) argues that women's struggles to break into formerly exclusive work domains have been matched by the maneuvering of employers, industry, and technology that continues to marginalize and devalue the kinds of work women perform. As women enter an occupation historically dominated by males (often mostly white), the occupation becomes restructured and retyped as "women's work." Thus women's occupational victories are eroded through structural occupational changes such as restructuring and redefining certain domains as less- or unskilled, and assigned lower status and lower pay.

> It is important not to lose sight of women's history of struggles to break through race and gender occupational patterns, but even victories have been eroded through new forms of occupational segregation...when women do win battles, they may still face an "up the down escalator" phenomenon — when women and minorities gain access to a job it is redefined as less skilled, becomes intensely supervised, and, at the same time typed as women's/minority's. (Sacks 1989:542)

Building on the "feminist materialism" called for by Young (1990) and Hartmann (1981), Sacks (1989:534) argues that class is a "gendered and racially specific concept, one that has no race-neutral or gender-neutral 'essence.'" Sacks asserts that old and new forms of job segregation produce a range of "experiences and consciousness of class" along gender and racial boundaries. For Sacks (1989:543), "The big issue is how to go about finding the unities and commonalities of class and class consciousness while being attentive to specificity." This specificity is key to understanding longstanding cracks and fissures among the group conceptualized as "working class," based on different conceptions and identities of one's own group and those conceptualized as "others."

A universal theoretical model and local experiences of domination

The simultaneous acknowledgement of the universal and particular is elaborated by Patricia Hill Collins (2000), in the revised edition of *Black Feminist Thought*, as she distinguishes between the terms of "intersectionality" and "matrix of domination."

> Intersectionality refers to particular forms of intersecting oppressions, for example, intersections of race and gender, or of sexuality and nation. Intersectional paradigms remind us that oppression cannot be reduced to one fundamental type, and that oppressions work together in producing injustice. In contrast, the matrix of domination refers to how these intersecting oppressions are actually organized. Regardless of the particular intersections involved, structural, disciplinary, hegemonic, and interpersonal domains of power reappear across quite different forms of oppression. (Collins 2000:18)
>
> As the particular form assumed by intersecting oppressions in one social location, any matrix of domination can be seen as a historically specific organization of power in which social groups are embedded and which they aim to influence. ...All contexts of domination incorporate some combination of intersecting oppressions, and considerable variability exists from one matrix of domination to the next as to how oppression and activism will be organized... Thus, regardless of how any given matrix is actually organized either across time or from society to society, <u>the concept of a matrix of domination encapsulates the universality of intersecting oppressions as organized through diverse local realities</u>. (Collins 2000:228) (emphasis added)

Intersectionality challenges reductionist ways of thinking about oppression, and offers the opportunity to break away from an analysis that exclusively focuses on "marked" characteristics, and allows for an examination of experiences based on formerly taken-for-granted norms and characteristics (e.g., "white," able-bodied) that are axes of privilege (Frankenberg 1993). The matrix of domination invites new ways of thinking about how oppressions are experienced, and validates the subjectivities of oppressed groups in identifying and exposing "everyday" racism, sexism, and other personal and collective injuries and injustices. It also provides a way to acknowledge both the universality and the specificity of how domination is organized within a particular society, geographic region, or institution.

One particular organization of intersecting oppressions is a racial division of labor within waged "women's work" or "reproductive labor" – the labor of caring for persons rather than production of goods for the market – that has occurred across different historical moments, geographic regions, and local labor markets and the racial/ethnic populations. This has been conceptualized and most extensively elaborated by Evelyn Nakano Glenn (1985, 1991, 1992), and will be discussed in detail below.

Maintaining inequalities: The racial division of "women's work"

Evelyn Nakano Glenn (1985, 1991, 1992) has focused upon developing a theoretical understanding of the intersections of race, gender, and class through her work examining the racial division of labor within the work domains typed as "women's work." One of Glenn's (1991, 1992) major points of emphasis is that within the arena of "women's work" in the paid labor market, there exists a racial division of labor that directly benefits white women (Glenn 1991, 1992). Much of women's work is

> "social reproduction"...labor that maintains people on a daily basis and intergenerationally — work that women traditionally expended in their roles as wives, mothers, and homemakers...This kind of labor, which has historically been women's work, has also historically been divided by race. (Glenn 1991:1339)

Women's social reproduction labor has occurred within one's own home, and has also been transposed to the paid labor market — through the domestic labor of women of color in white women's homes, and through service work in larger enterprises (Glenn 1985:104, 1991). The exploitation of women of color benefits white women by relieving them of the burden of the "dirty work" and allowing them to compete for more desirable jobs in the labor market (Glenn 1985, 1991, 1992). Glenn asserts that white women also benefit because the oppositional "racialized gender constructs" between white and women of color reinforce the "ideal" woman as originally put forth by the cult of

domesticity. Thus, due to the benefits of more attractive economic opportunities, the avoidance of "dirty work" both at home and in the labor market, and the maintenance of superior social status as an "ideal" woman, white women are invested in the racial division of labor on both material and ideological grounds.

The "racial division of reproductive labor" is a matrix of domination (Collins 2000) that explains the pervasive racial divisions within "women's work" across different historical moments, geographic regions, and local labor markets. By using a theoretical lens of intersecting oppressions, Glenn illuminates the contradictory interests among women based on different racial and class positions. She also illustrates how both divisions and alliances among women based on oppression and privilege are structured and experienced as both interpersonal and institutional ways. She has argued further that the racial division of reproductive labor obscures its racial nature through the maintenance of "skilled" versus "unskilled" hierarchies (Glenn 1991, 1992).

Glenn's (1985) theoretical framework stems from her efforts to extensively critique and integrate internal colonialism and Marxist feminist theory (including dual systems theory). Glenn asserts that both internal colonialism theory and Marxist-feminist theories are useful models for understanding oppression and exploitation as they each begin to link race or gender to economic exploitation. Each theory describes a division of labor based on race or gender that exists in a dual labor market where racial minorities or women, respectively, are segregated into the "dirty," low-paid, hazardous work. However, Glenn finds the failure of both frameworks to integrate gender and race, respectively, seriously compromises their adequacy in addressing the situation of women of color. In particular, Glenn argues that the concept of "paid reproductive labor" — with

reproductive labor comprised of the activities devoted to "social reproduction" – is a key link between the two frameworks. The concept of "paid reproductive labor" facilitates the examination of the intersections of the racial and sexual divisions of labor within a coherent framework, through the acknowledgment of the racial division of "women's work" (Glenn 1985, 1991, 1992). As Glenn writes (1992:3):

> In short, the racial division of reproductive labor has been a missing piece of the picture in both literatures. This piece, I would contend, is key to the distinct exploitation of women of color and is a source of both hierarchy and interdependence among white women and women of color. It is thus essential to the development of an integrated model of race and gender, one that treats them as interlocking, rather than additive systems.

Glenn (1991) writes that over the last two decades, employment gaps in occupations and wages shrank between white women and women of color, but three trends continue to produce disparities: 1) new patterns of segregation in "women's work"; 2) continuing wage inequities; and 3) increasing employment in "social reproduction" labor. All three trends contribute to and mask a racial division of labor.

The first point addresses the kinds of jobs, and settings of jobs. Job segregation exists within occupations. White women are in jobs that require more discretion, provide more interaction with clients, and are often supervisory or management positions. "Sectoral segregation" concerns the racial distribution of women's work; that is, more women of color are in government or nonprofit sectors, and more white women are in corporate jobs. The second trend Glenn points to is the shift in the economy to a predominantly service orientation, where people of color suffer more than whites because their standard of living has been based on manufacturing jobs, and is now replaced by lower-paying service sector jobs. White women are buffered due to their relationships with white men, which raises and maintains their standard of living. Third, the

commodification of social reproduction, or service sector work — what Braverman (1974) termed a large part of "the universal market" — is the fastest growing segment of the U.S. economy. As discussed earlier, women, especially women of color, comprise the majority of the labor force in this sector. Here, as well as in the general economy, an obvious racial division of labor exists: white women get higher skilled and higher paying jobs, and women of color get the low-skilled and low-wage work (Glenn 1991, 1992).

Glenn writes that the exploitation in service work is obscured by service work's "impersonal nature" and by its physical segregation and concealment; it is "invisible" and can be ignored by those who benefit from it (Glenn 1991:1352-1353, 1992:32). In addition, these relations of exploitation and privilege are also obscured conceptually. Like Spelman (1988), Glenn (1991) argues when race and gender oppression are considered in an "additive" model of gender, white women can conceptualize gender as unrelated from other oppressions, and can ignore or dismiss important differences among women. In particular, white women can ignore how their race and class privilege rests on the exploitation of women of color.

The movement for "comparable worth" is one example of how race and class dynamics are obscured under the privileging of gender (Glenn 1991). While "comparable worth" combats gendered wage inequities between "male" and "female" jobs, it actually serves to reinforce racialized wage inequities. This occurs because "comparable worth" bases its campaign for equity upon a job hierarchy between "skilled" and "unskilled" labor — constructions that coincide with a racial division of labor (Glenn 1992). A focus exclusively on gender equity obscures an increasing wage disparity among women –

which benefits white, middle- and upper-class women at the expense of women of color, who are primarily located in lower-paying and less desirable jobs.

Glenn makes two more related points that focus on relations among white women and women of color. Glenn argues that the lives of white women and women of color are interdependent, and perhaps even more importantly, "this history of interdependence must be acknowledged as a fundamental source of conflicting interests among women" (Glenn 1992:1344) (emphasis added). That is, the high standard of living white women enjoy is largely based on exploitation of the social reproductive labor of women of color either in private homes or institutional settings. Policies that either uphold or erode the racial division of labor will benefit only one group. Thus Glenn demonstrates the "inseparable unity" (Higginbotham 1992) of race, gender, and class by examining the patterns and dynamics around women and labor while simultaneously illustrating the fundamental structure of race in forging alliances and divisions among women and the utter impracticality of ignoring the impact of race in social and economic relations.

> Given the historic connection between the elevation of White [sic] women and the subordination of women of color, "race blind" solutions may not exist. Instead of seeking universal solutions, we must recognize the contradictory interests of different groups of women, set priorities among their needs, and devise solutions tailored to specific groups. (Glenn 1991:1358) (emphasis added)

This stance is not necessarily a divisive one (although some people may certainly interpret it as such) because it unmasks divisions that already exist and will continue to exist within a system of capitalist production informed by gender and racial hierarchies and antagonisms, which ultimately reinforce structural and interpersonal experiences of oppression and privilege. Acknowledging this important point may be one of the most essential, and perhaps most difficult, steps for developing new theoretical and practical strategies for public policy that is predicated on an equitable distribution of resources.

Intersectionality and the health care labor force

Intersectionality and the racial division of reproductive labor are of crucial importance to understanding the situations of conflict for health care labor, for it synthesizes the important theories presented in this section. The stratification of the labor force and inter-group conflict (and solidarity) are not structured in hierarchies neatly chiseled by monolithic groups such as "men" or "women." This dynamic is clear with regard to both the labor force at large and the health care labor force — divisions and alliances cross-cut boundaries of race, gender, and class (Blauner 1972; Brewer 1993; Hartmann 1976/1990, 1981; Himmelstein et al. 1996; Navarro 1986, 1993). For example, numerous scholars (Glazer 1991; Glenn 1992; Hine 1989) have analyzed internal conflicts within nursing by examining divisions across axes of race and class within the predominantly female occupation. In particular, Glenn (1985, 1991, 1992) clearly illustrates this through her work on the racial division of labor within "women's work."

Intersectional approaches make it possible to reveal how individuals are structured in multiple positions, and thus have the potential to act in ways that uphold or subvert institutional power relations. In health care, this is abundantly practiced by individuals and groups through processes and structures of professionalization and licensure that protect occupational, economic, and personal interests. As Glenn (1992) and Sacks (1989) clearly show, oppression that is distinctly based on race, gender, or class is often obscured by dynamics and structures that maintain and justify exploitation, namely the construction and designation of occupational domains as either "skilled" or "unskilled."

Glenn's (1985, 1991, 1992) examination of the racial division of labor within "women's work" details the structuring of labor market along race and gender lines, and

demonstrates the "inseparable unity" of race and gender (Higginbotham 1992). The stratification and conflict within the health care labor force certainly seem to exemplify her argument that constructions of "skilled" and "unskilled" (or professional and nonprofessional) work and occupations mask a racial division of labor. For example, in nursing, constructs of "skilled" and "unskilled" labor have been used by nursing's white leadership to exclude and limit Black women's entry into professional nursing, constrain their upward mobility, and maintain white dominance both within and beyond the occupation (Glazer 1991; Glenn 1992; Hine 1989). As Glenn (1992:33) notes:

> Racial ideology is not necessary to explain or justify exploitation, not for lack of racism, but because the justification for inequality does not have to be elaborated in specifically racial terms: instead it can be cast in terms of differences in training, skill, or education.

Strategies that obscure racial ideology benefit the gender hierarchy as well as the racial order. White men also benefit from divisions among women as gender conflicts are partially displaced by racial conflicts among women. Glenn (1992) illustrates this dynamic in health care organizations, in which inter-occupational conflict coincides with a racial division of labor within this arena of women's work:

> White men, after all, still dominate in professional and higher management positions where they benefit from the paid and unpaid services of women. And as in domestic service, conflict between men and women is redirected into clashes among women. This displacement is evident in health care organizations. Because physicians and administrators control the work of other health workers, we would expect the main conflict to be between doctors and nurses over work load, allocation of tasks, wages, and working conditions. The racial division of nursing labor allows some of the tension to be redirected so that friction arises between registered nurses and aides over work assignments and supervision.
>
> In both household an institutional settings, white professional and managerial men are the group most insulated from dirty work and contact with those who do it. White women are frequently the mediators who have to negotiate between white male superiors and racial-ethnic subordinates. Thus race and gender dynamics are played out in a three-way relationship involving white men, white women, and women of color. (Glenn 1994:34)

Thus we can see how race, gender, and class inform each other in complex ways. Depending on historical and other situational factors, one or more axes may have "totalizing" (Higginbotham 1992) tendencies and submerge other axes. However, these axes exist in relation to each other. They are relational products — socially produced and interpreted – with material consequences for embodied lives. The most salient concomitants of these relational products are the unequal distribution of resources, the maintenance of systematic inequality, and the maintenance of a complex and changing network of hierarchies where each actor occupies multiple positions.

The few qualitative research studies of labor organizing in health care (Fink and Greenberg 1989; Michel 1996; Sacks 1988) bear out many of these dynamics, providing empirical examples of hospitals whose workforce was deeply stratified by race, gender, and class. These studies center race, gender, and occupation as social structures that both inform individuals' perspectives about their work and about the organizational dynamics as a whole. Sacks (1988) in particular explored how occupational stratification by race, gender and professional status impacted union organizing that attempted to bridge workers across these different boundaries. Importantly, these studies also demonstrate how these different divisions were overcome through shared interests of diverse groups within the health care institutions.

This dissertation centers intersectionality as a crucial theoretical lens through which to explore the fundamental structural forces of race, gender, and class within corporate health care — an empirical domain that has the potential to further fracture or unify diverse groups who have historically been structured into conflict, yet who have also joined forces in struggle. By emphasizing intersecting oppressions and how these are

experienced by health care workers, we can explore how race, gender, and class shape conflict — and solidarity — among groups of workers as their labor is restructured by corporate decisionmakers.

Conclusion

Braverman's (1974) framework of monopoly capitalism and the degradation of labor can be easily applied to explain the restructuring of U.S. health care. Contemporary health care is characterized by an emerging oligopoly of for-profit corporations and the bifurcation of the health care labor force (a minority of "skilled" vs. the masses of "unskilled" labor). Moreover, the transformation of the labor market and labor process in terms of emphasizing service occupations and the routinization of labor depend on the maintenance of a contemporary "industrial reserve army" (Braverman 1974; Marx 1867/1978). The labor of health care, however, is tremendously gendered and racialized, and needs to be explained beyond a class-based approach.

The "racial division of reproductive labor" elaborated by Glenn (1985, 1991, 1992) effectively integrates Marxist labor theories with theories of race- and sex-segregation in the labor market (e.g., Blauner 1972; Hartmann 1976/1990, 1981). This framework helps to explain historical patterns and contemporary dynamics within health care labor, especially the legacy of institutionalizing gendered and racialized occupations whose contradictory interests are fueled by the intersections of race, gender, and class. Constructions of "superior" and "inferior" occupations – and the workers in these occupations – were informed by prevailing gendered-racialized ideologies, which in turn informed strategies of professionalization. The racial division of reproductive labor also helps to explain the different subjectivities of "class" (Sacks 1989) and meanings of

collective or occupational identity for different health care workers. These different constructions are informed by race, ethnicity, and other markers of group position, which work together to nurture or undermine solidarity among working people.

These two theoretical frameworks will help construct an intersectional approach that recognizes the linkages between capital's exploitation of labor, worker resistance or accommodation, and how this relationship is mediated by intersecting inequalities of race, gender, and class. This approach can help answer the following questions: How are the structures of labor processes, relations of exploitation, and characterizations of workers racialized and gendered? How do workers construct their collective identity and sense of group position, and the collective identity of "others"? What do workers see as an acceptable or optimal division of labor? How does this inform conflict or cooperation over the labor process? How does this inform divisions within the workforce? How do workers perceive the workplace environment and what suggestions do they offer for improving patient care and working conditions? How do workers exercise agency (or not) in order to get the work of health care done in ways they deem acceptable?

Chapter 5
Methodology

Objectives of the study and research questions

Overall objective:

The study's overall objective was to analyze workers' experiences of Kaiser's restructuring of the health care labor process. I planned to do this by situating their experiences within the contexts of a changing health care labor process, different union ideologies and positions towards Kaiser, the historical race, gender, and class divisions within the health care labor force, and the changing racial and gender composition of the actors in the health care labor process.

I had two basic aims:

Aim 1: Conduct an in-depth analysis of workers' experiences of the changing health care labor process, processes of labor conflict and cooperation, and the implications for worker exploitation and solidarity at Kaiser Permanente Northern California in the mid to late 1990s.

Aim 2: Develop social theory that focuses on structures and processes that reproduce racialized and gendered exploitation, inequalities, and divisions among different sectors of the health care labor force.

Research questions and interview schedule

My original research questions focused on how the pressures of the health care environment informed labor conflict between the unions, and between each union and Kaiser. I wanted to see how labor conflict at Kaiser in the 1990s altered or reinforced race and gender stratification and inter-group relations of the health care labor force at a

particular Kaiser hospital and clinic. The research questions, however, evolved to focus less on labor-management conflict, and more on workers' experiences of the restructuring of labor processes in health care.

While I had planned to center workers' experiences, I had planned to do this by focusing on labor conflict of the major actors. This process of shifting the emphasis from "labor conflict" to "workers' experiences of restructuring" was a gradual process informed by the initial interviews. My first interview schedule focused on relations of labor conflict between each union and Kaiser, and with one another, and the consequences of labor conflict (see Appendix). While the CNA leaders freely talked about their conflictual relationship, Local 250 leaders focused instead on the cooperative relations between the union and Kaiser. After the first few interviews with union leaders and rank and file activists, I realized that 1) the inter-union dissension was deeper than I'd realized, and 2) Local 250 did not want to talk about (previous) conflict with Kaiser. I also realized, quite quickly, that the questions about labor conflict did not "click" with the rank and file workers, who talked more about their experiences and perspectives on changes to health care labor processes, staffing, and working conditions. I then modified the interview schedule to emphasize questions about the work environment, inter-group relations with coworkers and management, and questions about work jurisdiction and labor processes (see Appendix).

I still wanted to focus on race and gender stratification and inter-group relations, but I began to see that the underlying issues behind labor conflict or cooperation concerned struggles over changes in the health care labor process. I wanted to see how workers' experiences and perspectives were informed, or not, by 1) union ideology of

conflict or cooperation with Kaiser, and 2) historical structures and processes of exploitation and inequalities. I also wanted to explore how these different factors either reinforced or undermined race, gender, or class hierarchies and divisions among workers. My approach to the Kaiser situation and my research questions became more nuanced as I integrated history's legacy of racialized and gendered exploitation and inter-group conflict with the multiple and simultaneous factors of capital's restructuring of the labor process, union ideology, and workers' experiences. Out of this process, the final research questions centered labor process restructuring at Kaiser:

1. What was the health care context of Kaiser Permanente's restructuring in Northern California, in terms of the health care market environment, union backgrounds, and Kaiser labor relations?

2. How has the health care labor process at Kaiser been restructured? How do workers resist or accommodate the changes? How do union positions and ideologies inform workers' experiences? How do race, gender, class, and other markers of social position "matter" – or not?

3. What are the consequences of restructuring for workers? What are the implications of Kaiser's restructuring for the reproduction or erosion of hierarchies and divisions in Kaiser's workforce?

Research design

The dissertation's research design is a retrospective, nested case study of workers' experiences of the transformation of health care labor at one of Kaiser Permanente's most active Northern California hospitals and out-patient clinics. This study focuses on the mid to late 1990s, a period characterized by tremendous change and instability in the national

and local health care environments, and during which Kaiser's labor relations were marked by both intense labor conflict and labor-management cooperation. Orum, Feagin and Sjoberg (1991:2) define a case study as "an in-depth, multifaceted investigation of a single social phenomenon...The study is conducted in great detail and often relies on the use of several data sources."

This dissertation uses primarily qualitative methods. Historical and archival data analysis provide the context and overall narrative, but the heart of the study is workers' experiences of the restructuring, illustrated through in-depth, semi-structured interviews. Qualitative methods are essential for illuminating the structural and subjective meanings of race, gender, and class, especially in terms of the organization of labor in the health care organization (Sacks 1988). Qualitative research focuses on the social processes and the social relations of labor, particularly the strategies for articulating or avoiding issues around race, gender, and class. In addition, the existing qualitative research on health care labor demonstrates that health care, because of its fundamental importance to society, is a special domain for negotiating labor issues (Fink and Greenberg 1989; Michel 1996; Sacks 1988). Most importantly, qualitative methods offer the opportunity to see competing constructions of the health care labor process and labor management relations.

Methods were structured to gather historical and local data on the intersections of race, gender, and class in the restructuring of the health care labor process by Kaiser, the unions, and the workers. I used multiple data sources to gain different perspectives on the restructuring of health care labor at Kaiser Permanente Northern California and the ensuing processes of labor conflict and cooperation. Along with the in-depth interviews, I gathered Census data on race and gender composition of selected health care occupations

to provide a national context of the racial division of reproductive labor (Glenn 1992) and its persistence over time. I gathered historical data on national and local health care environments to develop a historical narrative of the relations among Kaiser, SEIU Local 250, and the California Nurses Association. These data provided a historical context for interviews with health care workers' experiences of restructuring.

Data analysis using multiple data sources and techniques that emphasize constant comparison of the data helped insure that I was not "seeing what I want to see," but rather was rigorously engaging in a search for multiple perspectives and analysis. With this research design I hoped to provide an analysis of the situation in terms that reflect the varied and competing perspectives of different actors, and situate these perspectives within macrosocial trends in health care labor, and the histories of relations among Kaiser, the California Nurses Association, and Local 250.

Rationale for case selection

My selection of Kaiser Permanente Northern California is based on my estimation that it is a case from which I can learn the most about how race, gender, and class structure conflict and alliances. As detailed in Chapter 2, Kaiser Permanente is not one of the typical new managed care corporations that characterize the restructured health care landscape, and it has been profoundly influenced by the shift to market-driven culture of U.S. health care in recent years. In the mid-1990s, as Kaiser began adopting cost-cutting tactics utilized by its corporate, for-profit competitors, it was increasingly criticized for eroding patient care and working conditions by the unions representing the Registered Nurses (the California Nurses Association) and technical, support, and allied workers (SEIU Local 250 and other affiliates of the AFL-CIO).

I chose Kaiser as the targeted case study because of the radically different approaches taken by Local 250 and the CNA in dealing with Kaiser's restructuring, and the widening rift between the two union leaderships. The rift in organized labor has serious implications for the race, gender, and class stratification and exploitation, and for rank and file worker solidarity. The Kaiser labor conflict is intriguing because of the intersection of traditional collective bargaining issues (for example, protecting jobs, working conditions, salaries) with the contested discourse about "quality care."

In particular, the inter-union and union-management conflicts offer opportunities to explore how problems in labor relations are constructed by different groups with different agendas, yet who share a strategy of linking patient care with working conditions. This linkage seemed to be the primary way the definition of the situation was constructed by the CNA and how lines were drawn in the inter-union and union-management conflicts. These lines, moreover, especially in the inter-union conflict, coincide with the race, gender, and class stratification in the health care labor force, and point towards questions about how racial and class antagonism may be submerged beneath other more "acceptable" discourses of skill, training, or "appropriate" staffing (as argued by Glenn 1992). Lastly, because of Kaiser Permanente's historical commitment to labor relations and patient care, the Kaiser Permanente Northern California case seems to be a unique opportunity to explore how the tremendous changes in U.S. health care have impacted health care labor within an environment that has provided more favorable conditions for labor and health.

Rationale to interview Kaiser Permanente employees within one hospital

The CNA labor dispute and AFL-CIO partnership involved all 54 of Kaiser Northern California hospitals and other facilities, from Fresno to the California-Oregon border. I interviewed frontline workers at one hospital and one outpatient clinic in the same city. My methodological decision was based on the trade-off between breadth or depth. That is, for the Kaiser employees I planned to interview, I could either gather sweeping but superficial data across multiple facilities, or collect detailed data about the social relations of labor within a delimited and local context. I decided that the second option offered the opportunity to collect richer data, with the opportunity to contextualize these data within one organizational culture that is part of the larger Kaiser organization. Data are nested in a multi-tiered analysis, in which local data are situated within larger contexts of the Kaiser Northern California market area and general trends in health care.

Kaiser is a relatively labor-friendly organization, and the Northern California city in which I focused is located in a relatively labor-friendly (and labor-strong), politically progressive, and racially, ethnically, and sexually diverse region of the country. My case study is thus an exploration of labor conflict that occurs within more favorable structural conditions for labor, and where inequalities of race, gender, and class may be far less severe than other organizations and geographic regions. By focusing on a more favorable political and social environment, I could explore how race, class, and gender shape alliances and divisions even under relatively progressive conditions.

Data sources and collection

Data collection was accomplished using multiple sources. Since my intent was to conduct an in-depth analysis of the changing health care labor process, labor force composition, and labor relations at Kaiser Permanente Northern California in the mid-

1990s, I gathered both quantitative and qualitative data. I first reviewed historical and archival data on staffing trends in the changing health care market environment, and followed this with in-depth interviews of key informants about the labor conflict. Another data source was informal conversations with workers not formally interviewed. For the qualitative data on how different interest groups frame changes in the labor process, my methodology was structured for gathering variation across and within different groups.

Historical and archival data

I identified and analyzed historical and archival data on trends in health care and the health care labor force, and Kaiser Permanente and its responses to the changing health care environment. First, I constructed a "quantifiable" context in which race- and gender-stratification are institutionalized in the occupations most affected by the changing health care labor process. Using demographic and employment data from the Bureau of the Census, I calculated race/gender composition of selected health care occupations from the early 1980s through the late 1990s (Table 2). I also requested data from Kaiser on its workforce – race and gender composition and full time equivalents (FTEs) of selected health occupations – in order to contrast these figures with national trends, but I never received the information.

To construct a qualitative historical context and narrative of the changing health care environment and background information on Kaiser, Local 250, and the CNA, including their stances regarding changes in the health care labor process, I reviewed both print and electronic media. This included Kaiser publications (e.g., annual reports, biweekly newspapers), published "biographies" of Kaiser, union publications, websites for all three organizations, and articles from trade journals and newspapers.

Articles in the print media were identified using multiple electronic databases: Lexis/Nexis News and Mags, Melvyl ABI/Inform, Melvyl Mags, and Dow Jones Interactive. I limited the Lexis/Nexis search to the five largest national and ten largest California newspapers, and added two additional local business newspapers to the list.[1] The search terms for all databases were title word "Kaiser" and title word "nurs#" or "union#" (# indicates any character, for broadest search). For Melvyl databases, I added title word "labor" to broaden the search without duplicating the results. The search was conducted for the period January 1, 1996 to May 1, 1998, to encompass the time period of open contracts for both the CNA and Local 250. Articles that did not focus on labor conflict or the historical background were excluded. The number of relevant articles was in the hundreds – but many of them were duplicates.

I organized the massive amount of background data by constructing a chronology of events and trends. I selected articles that most succinctly captured the overall pattern of changes in health care environment and labor management relations at Kaiser, as well as media coverage of the labor management partnership and the CNA's labor conflict. These articles form the foundation of the historical background of Chapter Two.

Interviews

I conducted in-depth, semi-structured individual interviews with 26 union leaders and workers, focusing on issues articulated in the research questions. I constructed a purposive sample of workers (n = 23) represented by the CNA and Local 250. While I

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[1] The top five national papers, beginning from the largest: *Wall Street Journal, USA Today, New York Times, Los Angeles Times, Washington Post.* The top ten California papers, beginning from the largest: *Los Angeles Times, San Francisco Chronicle, San Diego Union-Tribune, Orange County Register, San Jose Mercury News, Sacramento Bee, Investors Business Daily, Los Angeles Daily News, Riverside Press-Enterprise, Fresno Bee* (Famighetti 1999). The other two papers added were the *Oakland Business Times* and *California Business Press.*

did not formally interview a representative of Kaiser management, I obtained data on Kaiser's official stance through the historical and archival materials. Interviews took place September 1999 through August 2000; I ended when there was no more variation in informants' perspectives.

Interviewees were asked about their perspectives on the changes at Kaiser San Francisco and in health care generally, what they perceived to be causes of labor conflict, and the consequences and implications of the CNA's labor conflict – and of restructuring in general. After the initial interviews with union leaders and activist workers in which my questions focused on conflict, I realized that the political rift between the unions had polarized the leadership and that a "he said, she said" situation was emerging, which told me more about the antagonism between union leadership and less about workers' experiences. While this information was helpful in assessing the volatility of the political environment, it did not seem to relate directly to workers' experiences of changes of restructuring that were enacted on the "shop floor." In subsequent interviews I began emphasizing questions that focused on changes at work, and I asked workers what they thought about the unions only after they had discussed the daily realities of work. Depending on the interviewee, some interviews were audiotaped and transcribed verbatim, and some interviews were recorded only in detailed field notes.

Sample

I interviewed 23 health care workers represented by either Local 250 or the CNA at Kaiser's acute-care hospital and outpatient clinic in one Northern California city. Ten were RNs (represented by the CNA), five were certified or licensed workers (represented by Local 250), and eight were unlicensed workers (represented by Local 250). I also

interviewed three union leaders, two from the CNA and one from Local 250. Most of the workers had been at Kaiser for many years, and represented a very diverse group in terms of occupation, gender, race/ethnicity, education, union affinity, and labor militancy (see Appendix).

My goal for my sample was two-fold, and reflects the sampling strategy discussed by Johnson (1990), of dual selection criteria that are "theory-driven" and "data driven." The former refers to sampling that is based on one's prior theoretical knowledge — in my case, my intent to construct a sample that reflects: 1) the changing health care labor process; 2) racial, gender, and class diversity of occupations and workers represented by CNA and SEIU Local 250; 3) official perspectives of the CNA and SEIU Local 250; and 4) a diversity of opinion about the issues. I sought out workers who had been working at Kaiser since at least the early 1990s, and whose jobs had changed because of the restructuring in the 1990s.

I first approached union leaders in order to get their official position towards Kaiser and the restructuring, and to ask for referrals to key rank and file informants. In order to recruit key informants who have varying perspectives on labor issues, it was important for me to not be affiliated with any particular group, and so I did not seek letters of support or any kind of formal assistance from either the CNA, SEIU, or Kaiser administration. In general, I identified potential key informants through union leaders and through my social and professional network in health care. To minimize selection bias, I utilized initial contacts who were not related to each other. I asked union contacts and my colleagues to give a written description of the study (that included my name and phone

number) to potential interviewees (frontline workers), and asked them to contact me if they were interested (see Appendix).

Negotiating access to informants

While I had some idea about the level of inter-union disagreement or hostility, it was only when I began interviewing that I realized the depth of the rift between union leaderships, and that getting access to talk to union leaders and rank and file workers would be difficult. I had decided to first contact unions and inform them of my project, ask for interviews to get the official union position, and then ask for referrals to rank and file members. I had talked a little with people in both unions – but my personal connections (friends of friends) were much stronger with the CNA. The people in Local 250 I talked with advised me that this was a touchy subject and that leaders were defensive about getting compared to the CNA and being characterized as the "bad guy" or somehow not on the right side, because the CNA is "so radical."

My first interviews with union leaders demonstrated the deep level of dissension and antagonism between the unions' positions towards Kaiser and one another. Each characterized the other union's leadership as the "problem" – whose stance was "unfair" to its membership, and whose actions sabotaged union solidarity at Kaiser and throughout Northern California. The leaders were very helpful in referring me to labor representatives ("reps") and key rank and file leaders at the Kaiser hospital on which I would focus. I quickly realized that my research would be more fruitful if I centered the research on workers' experiences of restructuring, and how union ideology and position – along with other important factors (such as collective identity and sense of group position) – informed workers' definitions of the situation at Kaiser.

I then proceeded to contact the "reps" and rank and file leaders. The CNA contacts went easily, as nearly everyone I contacted was willing to be interviewed. As I played phone tag with Local 250's union rep, I also tried to interview another Local 250 leader, and he was extremely suspicious of my research and asked whether I had "a certain angle" on the situation. I insisted that I was not interested in taking sides, but wanted to represent different perspectives accurately. Apparently he was not convinced, and left a message on my voice mail telling me that the union decided to not participate any further and he had notified the labor rep.

I then called everyone I knew to try to find someone to vouch for me, so that I could get another chance to explain my project. I was referred to several SEIU and Local 250 members outside the case study's city. Several told me they remembered hearing announcements at stewards' meetings to not talk to me if I contacted them, and several suggested I wait another year to contact Local 250 leaders because the memories were still "like yesterday" and "too hot." In one conversation, when I said that I just wanted to get my foot in the door, to prove that I was not taking sides, the worker said, "Hon, the door was already closed before you even knocked on it."

Meanwhile I was getting interviews with RNs, referred by the CNA leadership and by my RN friends. Some of the RN interviewees referred licensed Local 250 workers to me (whose perspectives on restructuring were similar to the RNs). My sample was becoming lopsided – comprised mainly of RNs and licensed workers who ultimately agreed with the RN union stance towards restructuring the labor process – but there was variation in terms of racial and ethnic background, union affinity, and labor militancy. However, I was increasingly troubled because there were two prominent gaps in the

sample: 1) unlicensed workers whose jobs had been restructured to include patient care duties, and 2) licensed or unlicensed workers with Local 250 who had some degree of union affinity or who agreed with Local 250's stance towards Kaiser. Several informants talked about unlicensed colleagues who they wanted me to talk to, but despite repeated requests, these workers were either unavailable or unwilling to do so. Several workers I talked to informally said they did not want to be formally interviewed because they were afraid of potential retaliation.

Eventually I made contact with workers who referred me to the kinds of people I was lacking in the sample – unlicensed and nonclinical workers restructured into patient care, and Local 250 members who had some degree of affinity for their union. My sample was now relatively balanced in terms of occupation or rank, union affiliation, and perspectives about Kaiser's restructuring and their union position (see Appendix). However the quantity of data remained lopsided in favor of more educated, pro-CNA, anti-partnership workers. RNs and licensed/certified Local 250 workers gave me longer interviews, and allowed me to tape record and quote them. Unlicensed workers gave me shorter interviews, and all but one did not want me to tape the interview or quote them.

Data analysis

Initial data analysis and data collection were conducted in tandem, and focused on the linkages between "micro" and "macro" processes and structures of inequality and exploitation. My aim was to gather different perspectives on restructuring – to examine how workers and their unions resist or accommodate corporate restructuring, what "getting the work done" was like in a restructured environment, and the implications for inequalities and worker solidarity. Informants' perspectives and group position(s) were

identified in the context of local organizational dynamics and more general race/gender stratification in health care. I did not intend to construct a metanarrative of "The Truth" but rather to construct multiple narratives based on different perspectives.

I began data analysis with a focus on my research questions, and I also explored unexpected themes or issues that arose during the interviews or from the archival data (Strauss and Corbin 1990). I systematically coded archival materials and transcripts to identify themes based on my *a priori* research questions and theoretical frameworks, as well as themes that emerged from the data. I wrote memos on codes, processes, and ideas of emerging analytic structures, and constructed categories and subcategories based on the variation within the themes.

Workers' perceptions about the overall changing health care environment were coded as "defining the problem in health care." Within this overall context, I constructed two main categories: "health care labor process" and "inter-group relations." The former category included changes in the work environment, staffing changes, changes in job responsibilities, conditions (and consequences) of "getting the work done"– especially in terms of struggles and negotiation over the division of labor, and perceived implications for quality of patient care that rested on different constructions of "safe" staffing or division of labor. The second category focused on the social relations of health care, including constructions of one's own group identity and "others," sense of group position, and inter-group relations within an increasingly stressful environment.

To further clarify the relationships among the major categories and codes, I diagrammed extensively. The final diagram (see Appendix) centers workers' experiences of restructuring, situating the experiences within larger contexts of race, gender, and class

inequalities and the specific case of Kaiser's restructuring, which inform one another to subsequently inform workers' experiences. The diagram illustrates the relationships between "health care labor process" and "inter-group relations" and presents these categories as overlapping domains. These domains are inextricably linked because the social relations and social organization of health care cannot be extracted from the organization of the labor process. Diagramming these relationships was instrumental in helping me to develop the basic social process based on my analysis of the categories and codes (Strauss and Corbin 1990).

Informed by the research design and questions that ask how a changing labor process is informed by and subsequently impacts race, gender, and class stratification and inter-group dynamics, I constructed the study's basic social process (Strauss and Corbin 1990) – my interpretation of "what is going on" from the multiple data sources. The study's basic social process is the persistent process of reproducing inequalities, exploitation, and divisions of the health care workforce through historically racialized and gendered processes of capitalist production, and through locally specific processes of conflict and cooperation among Kaiser, Local 250, and the CNA regarding the organization of the health care labor process and division of health care labor.

Limitations

The accounts of working conditions, the restructured labor process, and the effects of the transformation of work on patient care are based on the interviewed workers' experiences, and reflect workers' partial and situated knowledges of local work environments. I was unable to get data from Kaiser to confirm or contrast what workers have reported. Moreover, the restructuring occurred at selected Kaiser facilities and units

at these facilities, and may not represent system-wide changes. Although I began recruiting interviewees through unrelated contacts, I still ended up with people who knew one another socially or who worked together. Sometimes their perspectives were very similar, but not always. While this study does not aim to represent the experiences of all Kaiser health care workers, it does aim to accurately reflect the experiences of the interviewed frontline health care workers, whose voices are often ignored in the discussions about staffing, training, and the implications for patient care.

A second major limitation involves a different kind of sample bias that informs what we can conclude after taking the first bias into account. Despite the numerical balance between RNs and Local 250 workers, the amount of data is skewed in favor of licensed/certified workers (especially RNs). RNs and licensed/certified Local 250 workers gave me long interviews, and allowed me to tape record and quote them. Unlicensed workers generally gave me short interviews, and all but one did not want me to tape the interview or quote them. The presentation of different groups' perspectives is also skewed because a group of unlicensed workers are talked about at length by unlicensed and licensed informants, but were not interviewed by me. These "talked about" workers were hired en masse in the 1990s to meet Kaiser's need for more unlicensed workers – they are not the longtime Kaiser unlicensed workers whose jobs had been restructured to include patient care duties. My sampling decision was to interview longtime workers whose jobs have changed during the 1990s, and so the voices and perspectives of these "talked about" workers are absent from this dissertation. This decision, combined with the local circumstances producing differential access to informants, results in a sample bias where data about workers' accounts of the

transformation of work privilege the perspectives and experiences of certified and licensed workers, especially RNs.

These limitations can potentially inform what one can learn about the Kaiser situation. Because the interview data privilege the perspectives and experiences of more educated workers, especially RNs, readers could draw conclusions that basically agree with the CNA's approach to Kaiser, assessment of restructuring and patient care, and the stance about safe staffing patterns. Especially because workers' accounts are about health care and ultimately center patient well being, readers may be inclined to react strongly to what they read, and could draw conclusions about the situation at Kaiser that reproduce dichotomous thinking in terms of "either/or," "right/wrong," and "good/bad." This approach could lead to conclusions about which union position is "right" in terms of Kaiser and restructuring, and the consequences to patient care.

Dichotomous thinking could also reify conceptual or ideological divisions between licensed and unlicensed workers. Readers could conclude that RNs and licensed/certified workers are agentic, reflexive, morally committed to "doing the right thing," and "correct" in terms of their perspectives about restructuring and its impact on patient care. Conversely, readers could conclude that unlicensed workers are non-agentic, unreflexive, powerless "victims" of Kaiser and union policies. This dichotomous, "either/or" approach obscures the complexities within groups and the heterogeneity of perspectives within these groups, and produces a reductionist analysis of the situation. This approach fails to link structure and agency, and constructs "difference" between groups as a function of <u>either</u> the groups themselves <u>or</u> the structures of intersecting oppressions that enable or constrain the groups. One useful tactic to address this

limitation is to consciously employ a "both/and" approach that links structure and agency, and is attentive to the complexity of the situation without losing sight of the overall picture.

Chapter 6
Workers' experiences of Kaiser's restructuring

Introduction

This chapter explores workers' perspectives, experiences, and analyses of Kaiser's restructuring. While I focus especially on those workers who were displaced from their old jobs and repositioned into new roles and responsibilities, my overall aim is to describe workers' experiences of working in a restructured health care environment, as Kaiser sought to contain or reduce the costs of providing health care.

As detailed in Chapter 2, Kaiser Permanente is not one of the typical new managed care corporations or hospital chains that currently characterize the restructured health care landscape, and it was profoundly influenced by the shift to a market-driven culture of health care in the 1990s. In the mid-1990s, as the health care environment became dominated by large HMOs and hospital chains, Kaiser's integrated structure and social mission began to appear as liabilities rather than assets. As Kaiser's previously unquestioned dominance began to be threatened, it began adopting the business strategies of its competitors in order to survive in a health care market environment dominated by monopoly capital.

Kaiser's new direction was symbolized by its 1995 Strategic Plan for restructuring health care delivery and labor relations – emphasizing more outpatient procedures and a restructured workforce comprised mainly of unlicensed, "multi-skilled," and non-unionized workers. This new direction was intensely criticized for eroding patient care and working conditions by the organizations representing the Registered Nurses (the California Nurses Association) and support and allied workers (AFL-CIO

affiliates, including SEIU Local 250). However, neither the original Plan nor united union opposition to Kaiser's restructuring lasted, and by early 1997, Kaiser began restructuring the health care labor process in selected hospitals and clinics in Northern California with the collaboration of AFL-CIO unions via the national AFL-CIO/Kaiser labor management partnership. The restructuring served both Kaiser and union interests by protecting jobs and lowering the cost of providing health care, through utilizing a greater proportion of unlicensed (and unionized) workers in direct patient care, and channeling many licensed professionals, especially RNs, into "skilled" jobs or supervisory roles. The restructuring and union collaboration were bitterly opposed by the California Nurses Association, which denounced Kaiser and the unions for prioritizing Kaiser's financial interests over patient care.

According to workers, Kaiser's restructuring entailed a dual imperative of cutting costs while increasing the amount of health care provided, creating an increasingly stressful environment characterized by reduced hospitalizations and staffing, especially of licensed workers. Workers' accounts described a restructured health care labor process – patient care – that was fragmented into a series of "unskilled" and "skilled" tasks, and accomplished by fewer RNs and more unlicensed workers. All workers emphasized that the changes in labor process and occupational structure – in tandem with reduced staffing overall – created a work environment of chronic stress that produced frustration, demoralization, and conflict among the workforce, and that ultimately resulted in poorer patient care. Based on their accounts, the most profound effects of Kaiser's restructuring were the negative consequences to patient care and workers' well-being, as workers struggled to provide quality care under conditions that seemed to work against them.

Cost-cutting culture: "Everything is budget"

Workers' experiences of restructuring emphasized Kaiser management's constant pressure to cut the costs of providing health care. In every interview, workers described Kaiser's over-riding concern with "budget" as infusing all aspects of care and every aspect of the work environment, from delayed hospital admissions and early discharges, to chronic understaffing. All workers also expressed that the entire health care industry is "run like a business" that prioritizes the bottom line over patient care, and that Kaiser's focus on "budget" reflects the larger environment.

All workers also expressed dismay over Kaiser's increasing focus on cost-cutting. RNs saw Kaiser's restructuring as a quick way to cut labor costs. Many interviewees told me they believed that in order to meet arbitrary budgets on patient care, Kaiser cut staffing, hospitalizations, and other forms of patient care services, to have more money for administrators' and managers' salaries and perks. Workers also expressed frustration that the cost-cutting culture targeted patient care, without looking for other options.

> Bea[1] (RN, CNA activist): ...everything, everything is budget. It's competition. Hospitals are downsizing and from management the quickest way to save money is to cut staff, is to cut nursing staff because they look at RN salaries and benefits, the total package, and they think we're the most expendable, instead of seeing other ways of trying to save money. I mean, I see so much hospital waste. The things that get tossed out that I've taken to Third World countries and patched because it's brand new, sterile things that just gets tossed out. The things that can be reused and why can't some of the money be saved THAT way instead of cutting the direct, hands on people?
>
> ...the bottom line is the budget, that's all they care about. Kaiser's hired, you know, basically bean counters, you know, business people, to come in and decide where to trim the budget, not knowing what it entails, you know. Oh sure, they see the biggest budget as maybe nursing staff. Well, okay, let's cut there then. You can have, you know, two care partners or three care partners for the price of one nurse, there you go.

[1] Pseudonyms were used to protect workers' anonymity.

Workers' analyses of Kaiser's behavior, situated within the larger health care environment, varied considerably. Several workers articulated the belief that Kaiser's pressure to cut costs stemmed from the increasing competition in health care and challenges to Kaiser's dominance in the health care market. They believed that top executives, following the advice of health care consultants ("bean counters"), adopted the cost-cutting tactics of Kaiser's competitors – namely reducing staff and hospitalizations – without anticipating the more serious, longer term negative impacts of these changes on workforce morale and patient care.

CNA leaders and activist RNs saw Kaiser as unquestioningly following high-priced consultants and adopting the strategies of its competitors in order to preserve profit margins and executive salaries and perks. This direction symbolized a "change of heart" as Kaiser abandoned its mission of providing quality health care and instead turned to the practices espoused by health care industry elites, whose restructuring models focused on increasing corporate profit margins and symbolized a direct attack on registered nursing and patient care. A more "sympathetic" view came from Local 250 leaders and activists – who stated that "Kaiser got nervous" about the competition and responded by "cutting, cutting, cutting" staff and patient care. However, Local 250 workers and activists saw restructuring as an exercise of corporate power to cut costs and exploit workers.

Increasing production

Workers reported that while Kaiser sought to cut the costs of providing health care by reducing hospitalizations and staff, it also sought to increase "production" in the least costly way in order to maximize revenue. According to informants, this was accomplished by increasing the number of certain lucrative procedures that required

hospitalization. However, in order to maximize revenue, workers reported, physicians and administrators limited the in-patient stay.

Before examining workers' experiences about increasing "production" at Kaiser, I would first like to step back and reflect on the nature of "production" in health care. Health care – especially at Kaiser, with its historical focus on health management and preventative medicine (Hendricks 1993) – is essentially a process (taking-care-of-people). In this process there are services that are quantifiable (e.g., a check up, a mammogram) and services that are qualitative (e.g., being able to receive information about symptoms, "caring" in relationships with health care providers). What is the effect of using an industrial "production" model in providing these kinds of services? One effect is that the taking-care-of-people is evaluated and constructed solely in quantifiable terms. The social relations of health care – the qualitative part of health care – are not factored in because they are not quantifiable (this is consistent with the historical devaluation of caregiving work that "doesn't count" as "real work"). "Products" are counted as "units of service" (e.g., number of procedures), and elements of the production process are quantified as number of patients per staffing unit, number of days or hours hospitalized in a unit. A major effect is that the cost of providing these services is much more easily calculated – and monitored – when the production process is broken down into units and sub-units, each with its own cost.

I argue that increasing production in health care means adopting an industrial, assembly-line model where "components" and "outcomes" of the process are quantified and objectified. The industrial model of production is geared to producing the most items in the quickest, cheapest, and most efficient way – and it is geared towards producing

inanimate objects. Adopting such a model in health care effectively transforms the process of health care into a "production line" of a series of discrete, mechanical, and routinized tasks – without allowing for the unquantifiable ingredients of human emotions, fallibility, unanticipated patient issues, and other "bugs" that risk disrupting the rationalized plan of care. The components and products are transformed into quantifiable "units" to be manipulated into the most efficient and cost-effective process that meets the financial objectives of management – not the well-being of the "products" (patients).

With this frame, I now return to workers' experiences of increasing "production."

Prioritizing procedures over patient care

The drive to increase production takes place without assuring that there is adequate in-patient bed space. Many interviewees see physicians as callous and concerned only with the production aspect of health care – caring only about "doing their procedures," and having little or no regard for whether there is an available bed or adequate staff to care for the patients on which these procedures were conducted. Several workers described a high-production surgery center, after which the post-operative patients often wait in gurneys in the halls because no inpatient beds are immediately available. These workers also described how "increasing production" often entails shifting hospitalized patients out to lower-acuity settings, or to physical space in the hospital that has been legally reconfigured to accommodate post-operative patients. Their accounts emphasized that patients were not being hospitalized in the appropriate unit and for an appropriate amount of time.

> John (LVN, Local 250 activist): They've also, apparently, got some special dispensation from the state, temporary, to house patients in a recovery room, which is STRICTLY ILLEGAL because that's a STERILE area. So now they house patients down there, they FEED them, they TOILET them. So, in other words, they do surgery when they don't have a bed, and they wait for people to go.

Kris (RN, CNA activist): ...one weekend I remember, ICU [Intensive Care Unit] was completely full. We got couple emergencies -- and this happens ongoing basis -- that need an ICU bed. We say, Where do we put them? there is no ICU bed, not one. Half an hour later there were four ICU beds, because somebody in administration talked to doctors and said, You HAVE to dismiss at least 4 patients. Well NONE of them is fit to go to anywhere, they NEED ICU care. They said, We don't CARE, who LEAST needs ICU care has to GO. So they transfer patients out of the unit BEFORE patient's health is...stable enough, to go to TCU [Transitional Care Unit] or to the floor.

Juan (care partner): Most TCU [Transitional Care Unit] patients are 24-hour post-op, or NOT EVEN 24 hours [they come to TCU 24 hrs. or less after surgery]. They stay in TCU maybe 2 days, they send them home with staples in them. It's nuts! It's dangerous. Then they come back, with infections, because they were sent home too soon. ... We had a staff meeting, they were ignoring the care partner concerns... Kaiser is ignoring us. They send patients wherever [after surgery]. This has been going on for a year. It needs to stop. The co-workers are not happy. The patients are not happy – you can look into their eyes and see that, they're not happy.

Constructing a "flexible" workforce

Workers reported that along with reducing hospitalizations, the most prominent way that Kaiser sought to cut costs was through restructuring and downsizing the workforce. Workers' narratives indicated that Kaiser's restructuring mirrored the trends in the larger health care environment, and sought to cut labor costs by deskilling professionals, "cross-training" unlicensed workers, and intensifying everyone's workloads. Workers reported they heard about job changes from their managers, and that the changes were presented either as an opportunity for upward mobility, or as a flat-out directive. They also said they basically had no choice about getting restructured – they had to go along with the changes, or risk termination.

As the health care labor process was rationalized into a more "efficient" organization of labor, workers were repositioned into job groupings organized around different constructions of "skill," and given increased responsibilities and workloads without commensurate authority or compensation. Many jobs were eliminated and workers were forced to re-bid for the new ones; other jobs retained the same title but with

expanded work jurisdiction and increased clinical responsibilities. In some units, standard job classifications were replaced by new jobs that combined elements of several standard jobs of similar "skill" level; in other units, the standard job classifications remained but with increased workloads.

Displaced and repositioned

Across occupations, there was a pervasive theme of eroding labor-management relations – from friendly and cooperative to impersonal, authoritarian, and retaliatory. Managers were also perceived as absent from the work site, and as unaware, unfamiliar, or incompetent – they are paper-pushers who design the work process, making it inefficient and awkward. Several workers expressed feelings that Kaiser management had changed drastically over the last decade – with fewer nurse managers who came from the ranks of staff RNs (and who were willing to work cooperatively with staff) and more MBAs with an impersonal perspective. As restructuring was implemented and workers displaced and repositioned into more intense work situations with little or no additional compensation, workers increasingly felt treated as "disposable" workers – unappreciated for their seniority, hard work, and loyalty to Kaiser.

Facing unprecedented job losses and contract concessions in Kaiser's proposed contract in early 1997, RNs in particular felt particularly unappreciated, undervalued, and threatened. These RNs had differing perspectives on how management previously valued RNs, but both agreed that Kaiser's construction of RNs as an "excessive" workforce translated into dismissal of their invaluable role in health care, and impending job loss.

> Kris (RN, CNA activist): ...we started [contract negotiations in 1997] SO far apart, that they didn't even sit at the same table. There was not even, that CLOSENESSNESS [sic], which was really surprising, because usually, we did ALL previous years -- even though we have had our differences -- we start, not quite,

maybe CLOSE, but not so that the other party is just sort of, You've GOT to be KIDDING, and turns around and leaves the room… And people who participated in negotiations said there's a really-- there has never been such an ugly, cold atmosphere. … it was complete, you are NUMBERS, INVISIBLE, we don't actually NEED YOU, ANYBODY can do your job. And, and that kind of atmosphere that we first felt ever. …we are completely just... NOTHING. Nothing. Air. And, um, that has been complete change of heart. And I haven't kept up with administration, like how many new faces there, did we get more MBAs instead of somebody who has gone through the old-fashioned promotions, from RN you get your masters degree, you get into administration, then you get jobs there. Or doctors, and even though doctors are not always so sympathetic to nurses, but, so we, I couldn't personally figure it out what had triggered it. And it was even too painful to dig into that, that What is going ON? Did we just get new generation of some new management style?

Susan (RN, CNA activist): And basically, especially in [unit name] with the system of residents, we're making decisions all the time. And you know, the experienced nurses, the residents trust them. In a lot of ways we're doing their jobs for them, you know? We really are. And nurses do, and some of the public is aware of that, especially in teaching hospitals, ICU nurses all the time, you know, and the resident will say, okay what do YOU think? You know, because sometimes these nurses know more than the doctors do. And so I practice my profession knowing that and knowing that, you know, although I don't have the same level of responsibility, I have a very high level of legal responsibility for my patients. And the salary differential is large. It's been the same thing with nurse practitioners providing care and doing almost exactly the same job as the physicians but at quite a different salary range [laughs], so some of the nurse practitioners— but I accept that. I accept that but, even though it's just a WORD of acknowledgement it makes a difference to feel appreciated. …this is basically what the nurses were saying is that, you know, you're just having less and less nurses at the bedside, and <u>we're not getting any type of acknowledgement from management of what we do in terms of providing the product that keeps Kaiser going</u>. We're just hearing that you know, OK less nurses can do that work. Implying that we're sitting around... (emphasis added)

According to informants, as Kaiser sought to eliminate "waste" in labor costs, health care consultants surveyed workers' labor and calculated the time needed for different aspects of the work. The work of RNs, among other licensed occupations, was reconstructed and fragmented into a series of tasks – and not surprisingly, much of these "tasks" were constructed as "unskilled" labor that a lower-paid (usually unlicensed) worker could do for considerably less money. The labor process was manipulated to become "leaner," more "efficient," and more "cost-effective" by eliminating "waste" in

the "production process" and using "cheaper" labor instead of professional labor. In order to actually accomplish this, the "taking care of people" labor process had to be reconstructed as a constellation of primarily "semi-skilled" or "unskilled" tasks in order to distribute these tasks among fewer licensed and more unlicensed (and lower-waged) personnel. A new occupational structure began to emerge as different classifications of unlicensed personnel were created and workers repositioned into the nursing labor process in the outpatient clinic and the hospital.

A new occupational structure

In 1997-1998, certain departments and units in various Kaiser hospitals and clinics in Northern California began implementing a restructured health care labor process – "Member Focused Care" (Kaiser's version of Patient Focused Care) for the hospitals, and similar configurations for the clinics. These changes promised increased efficiency and improved patient care. This excerpt is from a March 1997 article in Kaiser's biweekly local community publication in Northern California (the former "Golden Gate" Service Area) (Wuotila 1997:8):

> Care partners and service partners are positions designed specifically to work with a team of providers. Care partners receive training to perform tests that do not require a license, including phlebotomy, EKG and other direct care activities such as vital signs, baths, and weights.
>
> The service partner works under the direction of the RN. Their primary duties include cleaning rooms and units; transporting patients, specimens and documentation; heating, servicing and collecting meal trays; and providing patient comfort.
>
> Members of the care team work together to provide core comfort care to the patient. For instance, the service partner who delivers the patient's lunch may also escort the patient the next day to go home. The care partner who takes the morning vital signs assists with bathing, and may administer range-of-motion exercises later that afternoon. The RN coordinates the team, develops and implements the care plan with the physician, services as patient educator and advocate, and provides expert clinical nursing services.

> Under the old system, when a patient had complications or the unit staff was busy, the RN would concentrate on the acute patient. According to [the unit manager], patients sometimes felt that their care was fragmented… "From the patient's point of view, if Member Focused Care works, changes in work flows are more likely to be invisible…The staff is learning new ways to work together."

RNs were dislodged from their role as primary caregiver, and traditional nursing occupations (Licensed Vocational Nurses [LVNs] and Nursing Assistants/Aides [NAs]) were also displaced from their roles and repositioned into two new occupations of "semi-" and "un-skilled" labor – "care partners" and "service partners." Instead of using education or credentialling to organize the occupational hierarchy and division of labor, the work was now organized around clusters of tasks that had purportedly similar "skill" levels. LVNs' licenses and NAs' certificates did not "apply" in the new occupational order, where cross-trained unlicensed workers – many with limited or no previous clinical experience – were repositioned into new job classifications that included direct patient care duties (depending on the duties, unlicensed workers attended brief training courses before assuming the new responsibilities).

These two new occupations of care- and service-partner were consolidations of ancillary and support services occupations. In units implementing Member Focused Care, the hospital nursing labor force was organized around three skill tiers: "unskilled" (service partner), "semi-skilled" (care partner), and "skilled" (RNs). In the clinic, unlicensed workers and RNs were also repositioned into new occupations with a similar organization based on "skill" (e.g., cross-trained Medical Assistant, RN-extended role).

The numerous changes in work jurisdictions are illustrated in Table 3, which provides a "before and after" picture based on workers' accounts of their own and others' job responsibilities. These expanded responsibilities are also illustrated in Kaiser job ads posted on Kaiser's website (see Appendix).

Table 3. Restructured job responsibilities, as reported by workers

Orig. job title	original duties	(new) job title	restructured duties
Outpatient Clinic			
Medical Assistant (MA)	room patients, take 'mini history' and vital signs of patients	Medical Assistant	room patients, conduct more extensive patient history, take vital signs, prepare and give injections, asthma treatments, other medications, assist MD and other licensed workers with medical procedures ("be the right hand person"); do ear washes, call in prescription orders to pharmacy, call patients with test results.
Receptionist	front desk, appointmt's	Medical Ass't.	Same as above
Registered Nurse (RN): "Advice Nurse" or Staff Nurse	Answer patient questions and offer advice about illness or symptoms, make appointments with primary care provider(s), call patients with test results	RN in extended role (RNX)	Patient care restricted to complex procedures, assessment, and recommendations for treatment to MD; more areas of specialization; treat minor ailments on urgent care basis; delegate "routine" work to MAs.

Table 3 continued

Orig. job title	original duties	(new) job title	restructured duties
Hospital			
Housekeeper / "Environmental Services" (ES)	clean patient rooms: disinfect, mop floors, change bed linens, empty trash Many ES jobs eliminated, repositioned in new jobs with heavier workloads and less favorable conditions	Service Partner	clean patient rooms, run to/from lab with specimens and results, pass and pick up food trays, transport patients (and corpses), answer call lights, provide patient "comfort" (adjust thermostat, bring water, blankets)
Transporter	transport patients (heavy lifting) Many jobs eliminated; same situation as ES workers	Service Partner	Same as above
Housekeepr/ES		No change	same work, increased workload
Transporter		No change	same work, increased workload
Phlebotomy tech	draw blood, bring to lab	job eliminated	
EKG tech	take EKGs	job eliminated	
Dietary	pass and pick up food trays	job eliminated	
Floor tech	clean and buff floors	job eliminated	

Table 3 continued

Orig. job title	original duties	(new) job title	restructured duties
Hospital (cont'd)			
unit secretary		Care Partner	"RN assistant;" take vital signs, do EKG, phlebotomy ("blood draw"), "in's and out's", pass and pick up food trays; bathe patients, assist patients with "activities of daily living" (ADLs) (e.g. bathing, toileting)
ward clerk		Care Partner	Same as above
other downsized nonclinical occupations		Care Partner	Same as above
Licensed Vocational Nurse (LVN)	total patient care without patient assessment	Care Partner	Same as above
Certified Nursing Assistant (CNA), Nurses' Aide	take vital signs, answer call lights, provide water, blankets, etc. if patient requests	Care Partner or Service Partner	Care partner - Same as above; Service partner - same as description on previous page
Registered Nurse (RN): staff nurse	Total patient care	RN	Supervise and train care and service partners. Patient care reduced to doing IV procedures, medications, patient assessment, and other procedures that only licensed workers can do legally.

Clinic

In the clinic, Medical Assistants (MAs) and receptionists were "cross-trained" and we re given more (and new, respectively) direct patient care responsibilities (extended history, blood pressure, injections – as well as scheduling, reception, patient callbacks, etc.). Nearly all the Registered Nurse (RN) positions were eliminated – primarily RNs serving as Advice Nurses. A new job classification was created to extend the responsibilities of RNs without demanding the advanced degree of Nurse Practitioners. Nurse Practitioner positions remained and workloads intensified. LVNs were either eliminated or "extended." The more "routine" tasks that RNs did were delegated to the MAs. (Most licensed or certified clinic workers I interviewed did not see much change in their own jobs, and talked primarily about the use of unlicensed workers for patient care.)

Hospital

In the hospital, RNs, ancillary, and support personnel saw jobs eliminated, extended, and reconfigured. "Member Focused Care" (MFC) was implemented in several departments, integrating unlicensed assistive personnel (UAP) into patient care through deskilling RNs and eliminating ancillary positions. Other departments retained standard job classifications but workers faced increasing workloads.

With MFC, many ancillary positions were eliminated (dietary, lab, and phlebotomy techs) and these positions' tasks were distributed among new positions called "care partners" and "service partners." These positions are combinations of clinical and nonclinical jobs that have expanded work jurisdiction and intensified workload because the job consolidation is linked to workforce downsizing. For example, former transporters or housekeepers had new jobs ("service partners") that are consolidations of transport, housekeeping, dietary, nursing aide and "go-fer." They remained responsible

for their regular responsibilities (their original work), while also responsible to carry out whatever the RNs directed them to do – routine patient care duties (answering call lights, feeding or delivering food trays, helping patients toilet or bathe), running lab specimens back and forth, or other errands. Some nursing assistants who engaged in a few technical/clinical patient care duties before restructuring (answering call lights, taking vital signs) got additional training to do EKGs, and phlebotomy (blood draw). Since the beginning of MFC, workers told me that unlicensed workers' patient care responsibilities expanded and contracted.

Under MFC, RNs in the hospital train and "supervise" (without the authority of a manager) the new unlicensed patient care workers. RNs were assigned fewer patients for direct patient care because, theoretically, much of the "routine work" ("unskilled" or "semi-skilled" work) was to be done by the care partners and service partners. The restructuring channeled RNs into more specialized duties (restricted to RNs because of education, skill, and licensure) such as patient assessment, medications, and IV procedures. However, RNs as licensed workers remained responsible for all patients under their supervision, and the number increased since more patients may be cared for in these restructured, interdisciplinary units.

According to informants, licensed or certified hospital workers varied in their experience, and several told me that the job duties or workload of RNs in specific units, and of certain technical workers in the clinic, did not change. Respiratory therapists (RTs) were not de-skilled like nursing personnel, but ultimately experienced speedup.[2]

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[2] According to one informant who was an RT, in 1997-1998, management tried to expand their work jurisdiction, but RTs successfully resisted. Then management tried to cut costs by substituting a quicker patient care procedure and increasing patient load since there was ostensibly "less" to do, but subsequently returned to the original and more time-consuming procedure without decreasing the patient load.

LVN positions in hospitals were virtually eliminated in 1997-1998, except in particular departments, and the workers restructured as "care partners." By summer 2000, they were reintroduced as LVNs (as Kaiser modified unlicensed workers' duties).

Unlicensed workers' experiences: Change as opportunity?

Several of the unlicensed clinical workers in the hospital and the outpatient clinic (the care-partners and MAs who may be considered "semi-skilled" workers) liked the additional patient care responsibilities at first. They were enthusiastic about the changes and saw them as an opportunity to gain new skills, provide better patient care, and gain upward mobility and job satisfaction, as articulated by a former hospital nurses' aide:

> Jamie (Medical Assistant, former hospital Nursing Aide): I really missed the patient contact [from working in the hospital] though at that time, I mean for quite a while as far as the actual physical touching and so that was why I was really glad when— 'cause initially when I moved over to [the outpatient clinic] it was, was taking a blood pressure and weighing someone and doing a little mini interview, you know, prior to the – Why are you here today? What medications are you taking? – before the doctor would see them, and so that was why it was really, I really like the fact that when we started doing injections and I was being able to have more hands-on [work]. And so, its really been, um, it's been much more fulfilling since we've started doing that. I am getting a little bit of the hands-on that I had at the hospital, so.

However, the changes were based on increasing production with fewer staff, and workloads steadily increased. The changes that first seemed positive began to appear like blatant cost-cutting measures with no regard for workers' ability to complete the work, and no regard for quality of patient care.

> Juan (care partner): [Kaiser] loves playing games, they love to play games – they say, We're going to train you how to do phlebotomies, EKG, and you'll have 3 or 4 patients. You'll learn to do EKG, the blood draw. We feel, oh good, we'll learn new things. Everyone is happy. We do lots of blood draws, no problems. The patients are happy. After six months, it goes up to FIVE patients. Then – oh my god! – 11 patients, for one care partner and three nurses. It's not good at all. Blood draws – LOTS, especially at night. We also walk the patients, especially the CV [cardiovascular] patients. Now, everyone expects you to do it all... [The RNs are] scared, don't want to speak up. One manager said to a nurse, if you don't like what you're doing, you know what you can do [leave].

The (formerly) nonclinical workers gave a different impression of restructuring that emphasized Kaiser' deception towards them. They told me that in 1997-1998, their managers had encouraged them to apply for new positions that combined regular nonclinical duties with clinical assistant duties – and said workers could return to the old job if they did not like the change. (When I asked what would have happened if they had not voluntarily applied for the new job, they replied that they would have been "let go.") According to these informants, many of the repositioned workers wanted to return to their original jobs, but found that they could not because these jobs had been outsourced. Limited to nonclinical work because of training and experience, these workers were essentially locked into either the new job (which they detested) or the old job classification that had only limited positions. The available jobs, moreover, were far less desirable than the original ones: they were part-time, in the night shift, and required workers to rotate throughout the clinic or hospital.

RNs' experiences: Change as "something taken away"

RNs I interviewed gave mixed accounts of job changes, but many of their accounts described most RNs as unhappy, fearful, and resistant to being displaced as primary caregiver. Their perspectives towards restructuring are based in their experiences of approximately 20 years of Primary Nursing (and at Kaiser, a nearly all-RN staff) in which RN work meant a holistic process of caring for patients in which all aspects of patient care (including the "dirty work") were essential to assess the patient.

RNs were extremely worried about their job status and the quality of patient care that would take place in the restructured Kaiser health care. Numerous RNs and CNA leaders argued that Kaiser's restructuring fragmented the labor process into "skilled" and

"unskilled" tasks, and removed RNs' control over the patient care. The restructured labor process basically limited RNs to "skilled" tasks, increased the number of patients under their care, and introduced the possibility of conflict between RNs and unlicensed workers. They argued that when RNs are at the center of patient care, they can effectively integrate the "skilled" and "unskilled" work to assess the patient's condition and organize the labor process in the patient's best interest.

> Terri (CNA leader): Member Focused Care was the- is the biggest change [in the 1990s] that I'm aware of... And it created a problem for one- well for, on lots of levels. For one thing it fragments the work. Umm, it goes back to the scenario of a nurse only giving medications or only doing the complicated things. Umm, and then of course along with that they figured, well if you're doing fewer things then you can take care of more patients... which creates its own problems. It also created a certain amount of friction between the workers because the nurses saw things as being taken away from them. Duties that they felt were necessary for them to do because there are other components than just doing the task. There's the professional evaluation and umm, like when a nurse gives a bed bath, she isn't just washing and drying. She's looking at the patient's skin, she's feeling the patient's skin, she can use that time to talk to the patient, to discuss other things about their emotional status. Umm, it's not just the task. And of course there are sometimes when maybe the patient just needs that task. And the nurse can delegate that to someone else and do something else that's more complicated. I think one of the problems was that the nurses felt that they weren't being given the option to do that, it was being forced on them from outside. So whether or not they felt they were the one who needed to care for that patient, they weren't being given that option and that was a problem.

One leading CNA activist said the aging Kaiser RN workforce meant that some RNs had more stress and difficulty getting repositioned than others because of what they felt comfortable with and what training they had, but generally the repositioning went fairly well. Other CNA activists and staff RNs reflected that the change was difficult because RNs deeply resented having less direct patient care and the unwanted responsibility for the work of unlicensed staff.

RNs in the clinic: the RN-X option

In the clinic, many RN jobs (primarily as Advice Nurses and in primary care) were eliminated as Kaiser began centralizing the call-centers and rationalizing the patient care to LVNs and Medical Assistants. The clinic RNs, however, were given the opportunity to "upgrade" to a new job classification – the RN in extended role (RN-X) – that extended the RN jurisdiction without an advanced degree.

Two of the RNs I interviewed were former Advice Nurses in the clinic, both long-time Kaiser employees, whose Advice Nurse jobs ended in 1997-1998. One seemed to generally enjoy her new upgraded position, and described her "new job" without expressing any stress of displacement and repositioning. The other RN had a very different experience. She gave an extended account of her displacement and those of other colleagues, and emphasized a lack of management "caring" for these nurses, attributable to new top level administrators who hired these types of managers to do the "dirty work" of firing workers. After accepting the option to be trained for the RN-X position, she became increasingly uncomfortable with the brevity of the training and eventually declined the position.

She and several other RNs (all former Advice Nurses) who also declined RN-X repositioning were not offered any severance or alternative job from Kaiser. This ordeal caused a great deal of stress, and she described the union as unable to help them. Her account emphasized the change in labor-management relations that failed to recognize workers' loyalty and instead treated them as disposable components of "production." This account also echoed the unlicensed workers' perspectives that if workers did not "go along" with the changes, they would be terminated.

RNs in the hospital: The implementation of Member Focused Care

Several hospital RNs I interviewed worked in units where Member Focused Care (MFC) was implemented in 1997-1998. Prior to the implementation, they were told by their managers that the RN staff would have to re-bid for fewer jobs in the unit, and there was no guarantee of anyone's position. They were told that unlicensed personnel would be coming in to "assist" with certain patient care duties, and RNs' new responsibilities would be to teach and supervise the new workers, while maintaining a reduced patient load of their own. Whether in these MFC units or not, RN interviewees described a great deal of anxiety over what the change in skill mix would mean for patient care. The RNs in these units also expressed much stress and fear about job security.

> Kris (RN, CNA activist): I have great, I mean I have great respect all these people [unlicensed workers] and we have lots of hardworking for instance housekeepers. And I love them dearly and I think we NEED ALL these people, whoever it is, secretaries housekeepers engineers. But the thing is, that when Kaiser suggested that we make, we train some kitchen workers and janitors and other housekeepers, and laundry workers and, and orderlies to be CARE partners. And it was like, I got—there was cold stuff going down my spine, it just scared the living daylights out of me. Because I have had, I found this RN and LVN combination is the ONLY thing that can take care of the patient.
>
> Eileen (RN): I remember them telling us that we were going to have to bid for our jobs and that...the options were open to EVERYBODY, and ANYBODY with seniority...would be offered the positions first. ...Lots of nurses got switched. ...some people they were really concerned about the fact that they were going to go from full time to short hours or lesser hours and they weren't going to be able to make their salary, be able to pay their house notes. People were really concerned and STRESSED, STRESSED to the maximum at that time. What I SAW were people who cried just instantaneously over, over little things and NOTHING.

All the RNs were convinced that Kaiser's restructuring was geared to cutting labor costs by substituting lower-paid workers for RNs. Several of the RN activists also saw Kaiser's restructuring as a way to "make nurses feel less powerful," through marginalizing them from the bulk of patient care and using them as quasi-managers

without the authority of managers. The RNs repositioned to quasi-supervisory positions in the hospital made cynical and derogatory comments of how they were "sent to classes" to learn how to "teach" and "supervise" – as well as provide "customer service." They said Kaiser's hype about "training" and repositioning of RNs and unlicensed workers obscures the latest attempt to manipulate nursing labor into a "cheaper" workforce. This perspective on worker exploitation echoes the earlier quote by Juan, one of the restructured unlicensed workers. Unlike Juan, however, this RN emphasized the sentiment expressed by nearly all the RNs – that given the current situation of higher patient acuity and more sophisticated technology used to treat these patients, RNs need to be the central caregivers, not unlicensed workers under RN supervision.

> Susan (RN, CNA activist): Also in general [restructuring] has decreased the MORALE, because it was always felt that when Member Focused Care came in, which was part of the restructuring – Member Focused Care being less nurses, more unlicensed personnel, that was the umbrella term for it – a lot of money was spent, we were sent to classes for like two weeks, just of classes, in order to implement this program. And we were all very, very skeptical and especially people that had been there for many, many years. We've seen TEAM nursing, and PRIMARY nursing, and we've seen all these different MODELS, it goes ONE way, it goes the OTHER way, this won't LAST. And recently as I've heard second-hand from the care partners, that Member Focused Care has been abandoned. So there's a very deep cynicism among the nurses that there's all these grand SCHEMES that are basically another try at trying to save money, when the bottom line is, is that with the level of technology right now, you need, there needs to be skilled nurses at the bedside with the patients. And there's no way to make that any cheaper. [laughs] Really. I mean there really isn't. I mean that's how the nurses feel. It's expensive. But if you're going to have this technology and this level of care you need to have people constantly monitoring the technology otherwise there's no use for it.

This quotation reflects a feeling of confidence expressed by several RNs that Kaiser's restructuring would eventually fail, and that there was ultimately no real threat to their jobs. This account contrasts dramatically with the majority of the others that described RNs' fear and stress from possible job loss.

The upgrade/downgrade of LVNs

The anxiety, anger, and fear experienced by many RNs reflects the overall emotional tenor as workers from different occupational tiers were displaced and repositioned. As RNs were simultaneously marginalized and repositioned into "higher level" jobs, LVNs faced similar situations. RNs and LVNs I interviewed reported that LVNs were displaced from their intermediate position in the nursing labor process and either "demoted" to a lower-level and unlicensed job classification, or "extended" into a quasi-supervisory position. In the clinic, they were demoted to a MA classification, or extended, often as "lead LVN" who picks up some of the RNs responsibilities, including overseeing (and having responsibility for) MA's injections and other work. Like the hospital RNs, they were legally responsible, yet without the supervisor's authority.

In the hospital, LVN positions were virtually eliminated in the 1997-1998 restructuring, and the LVNs repositioned into "care partner" jobs – along with unlicensed patient care workers. This was essentially a "demotion" for LVNs in status and salary. The LVNs interviewed told me that at first Kaiser tried to downgrade their pay as well as their position, but they fought back through the union and maintained their salary level. (However, during data collection in 2000, LVN informants also reported that by summer 2000, Kaiser began reintroducing LVNs back into the hospital.) Even with the pay correction, the "demotion" deeply angered them, as they were restructured into a "lower" occupational category that limited them to the dirty work, without the opportunity to use the knowledge, education and training behind the LVN license. The following quote describes LVNs' resistance to the restructuring:

> Eileen (RN): We went to lots of classes, I think it was a week's worth of classes, three to five days I think it was, where you went and uh, try to go through all the different things that happen to, to make the transition easier. We went with care

> partners or people who were care partners. A lot of times what I found was the people who were care partners who had previously been on an LVN status and now were care- gonna be care partners even though they retained their LVN symbol, they became an LVN but a care partner, they were VERY resentful. And um, I think even more resentful than the RN's EVER were. ...I think they felt it was more DEMEANING to them, that they weren't going to be PAID for what they KNEW. They felt um, that they were going to be dumped upon much more by the RN's than they had been before.

Getting the work done

Speedup

Workers' narratives of getting the work done emphasized a context in which Kaiser's desire to increase "production" coexists with the cost-cutting imperative – through reduced labor costs and reduced hospitalizations. They described their experiences working as part of a restructured and downsized workforce, where everyone has expanded work jurisdictions and/or intensified workloads.

One aspect of restructuring the health care labor process was downsizing the staff by job consolidation, producing a speedup and intensified workload. Downsizing the workforce and increasing production ostensibly was to eliminate "waste" in the labor process and produce more "coordinated" patient care, but the ultimate result was a speedup for licensed and unlicensed workers. All workers reported increasing stress of trying to care for more and sicker patients with fewer staff overall, and fewer licensed staff in particular. Both licensed and unlicensed workers talked about how they were "constantly moving," and reported working harder, faster, with minimal or skipped breaks. The visual picture I often constructed was of a workplace with persons literally running from one place to another, with barely enough time to administer "the basics" of patient care such as giving medications, taking vital signs, or other "tasks," before rushing off to the next patient.

Unlicensed workers' experiences

Based on workers' accounts, care- and service-partners' workloads have been determined based on how much time it takes to do various tasks. Depending on "budget" their labor is often allocated to two or more RNs, or units, or sometimes floors. The "waste" or "slack" of housekeepers or other nonclinical support workers in the production process was supposedly eliminated by an expanded work jurisdiction. "Efficiency" quickly translates into "more work" as unlicensed workers find they have more to do than is physically possible within the eight hour shift. The idea that their time is efficiently budgeted and accounted for does not meet the reality of multiple and simultaneous demands on their time, largely due to the fact that health care is an unpredictable production process. As RN or MD "assistants" or "go-fers," unlicensed workers are directed by more-powerful others to take care of tasks deemed priorities (e.g., patient transport, specimen run to the lab, prepare room for new patient). These designated priorities take precedence over basic nonclinical necessities such as room cleaning, restocking materials, or patient care such as bed baths – and these tasks are left undone until a last-minute crunch.

> Jamie (Medical Assistant, former hospital Nursing Aide): It really became DIFFICULT in the last year [1998] that I worked in the hospital as far as time was concerned because … the lab no longer made rounds, so … in the early 90's I was like doing 4 to 5 patients a day as far as total bedside care, [by 1998] it became 8 to 10 patients a day. Plus… you didn't have EKG technicians anymore, you had to do the EKG the minute [a patient] had chest pain, the minute the doctor got a whim, came around and [ordered a blood draw]…But so whereas you were added on all these extra patients… and you were added on all this other stuff that took so much time especially if someone got a fever, 'cause drawing, drawing blood cultures was a long drawn out procedure and um... I mean it was a great skill to get, you know, I didn't mind getting that, but it was just more added, more work added… And in the last year I couldn't leave at the end of the day feeling like I had really done a good job because the basic things, because the lab draws and EKG's were priorities and at the end of the day you walk out, Well I didn't get this one's bed changed today, or

> This one, I didn't have time to give this one a bath. So I couldn't come home feeling good about the job I'd done, and that really bothered me personally.
>
> Reba (licensed Local 250 worker): I mean they cut back the housekeeping staff dramatically. Before everybody always complained, for crying out loud they're sitting around, they're sleeping, you know, they're not doing much of anything. But that place was CLEAN. [Kaiser] cut them back to like bare bones, next to nobody, you know, borrowing one from another unit area. And [service partners] are saying, I don't have time to – you know, garbage cans overflowing, everybody's emptying the trash themselves. And the place is just filthy. Dust bunnies everywhere, take something off the shelf [coughs, blows imaginary dust away], you know.

Unlicensed workers who did not want to be quoted expressed feelings of pressure and frustration about the short staffing and the reorganization of their priority work. The short staffing means that service partners end up with an impossibly high workload of cleaning, errands, and patient care. What they thought should be an unquestioned work priority – cleaning – was deemed "less important" than the other work they were told to take care of first. They blamed Kaiser for understaffing RNs and piling the RN work onto the unlicensed staff to save money at the expense of patient care.

Rational planning already underestimates what it takes to do the work, but several workers told me that as time went on, they faced increased demands to do more and more work, based on seemingly arbitrary budget cuts. Workers described how their original responsibilities are increased gradually until they face a nearly-impossible workload each shift. They also described working more than calculated because there are often fewer staff actually working (other unlicensed workers are either not at work, or are "sitting on their keesters"). The chronic stress has led to workers frequently calling in sick, further intensifying the workload of the remaining workers, and intensifying their stress. Several unlicensed workers said that this situation sets them up for criticism or discipline by RNs or managers, for not doing their job.

RNs' experiences

Using a similar process of calculating time spent on different "skilled" and "unskilled" patient care tasks, RNs had fewer patients for direct care, since the care- and service-partners were to pick up many of the lower-skilled tasks, but more patients to assess and administer medications. RNs described speeding from one patient to another; and said they felt they had much more work to do now than they can ever remember.

RNs' accounts differ from those of the unlicensed workers in several prominent ways. RNs accounts of the speedup always included a description of the fragmentation of care among "skilled" and "unskilled" labor. These accounts illuminated management's expectation that the planned rationalization resulted in the quantity of work, and the same quality "product." These themes are articulated in the following quotes. The first quote illuminates the fragmentation of RN labor that has RNs focusing only on specific tasks (administering medication), and the near-impossible task of balancing "speed" with "quality." The second quote illuminates the disruption of rationalization due to the work not "counted" into the rationalization, and to RNs picking up "routine tasks" delegated to unlicensed workers because of complications. Both quotes express the overall speedup and intensification of work for RNs due to the changes in the labor process.

> Skip (RN): I know that I feel like I'm busier NOW on the job then I EVER was before. I don't, I remember way back when being able to sit and talk with patients like you and I are talking today. To spend some time to kind of really see WHAT was going on... And NOW, you know, it's like I'm on the train, you get your pill [makes a speeding train noise], you know, [I'm] moving down the line because there's just so many other things going on...I'm like the train. If I stay at this station too long I'm going to be off schedule for my next pickup down the road and then everything gets thrown off.
>
> And hospitals are very much willing for you to stay overtime, but they're very not, they're very much willing NOT to PAY you FOR it. Everything has to be JUSTIFIED, it has to be, you know, OKAY'D, and if you're staying overtime too much you're looked at as somebody that's not able to perform their JOB in a timely fashion when it may be just that, you know, you just can't do your job 'cause there's

too much to DO. Or you're trying to maintain that sense of QUALITY in your job, you know...

Eileen (RN): What happened in post-partum was where you used to have two RNs on, you now had one RN on, two LVN's maybe and MAYBE two aides or one. The RN is now expected to give the reports on ALL the patients on the floor. And have the support, the supportive information to be given. Well nobody took into account all the antibiotics that had to be hung, and the interventions that you had to do because this mom can't feed. And even though you might've had somebody else who was helping her with feeding, when you had really difficult people to feed, it ended up being the RN's responsibility to do that.

Just, it just felt like— people thought that they were REPLACING people but they weren't replacing the SKILLS. And when you don't replace the skills what happens is, then I have to not only ascertain the skills of the person that's there but I have to look at each one of the patients in a much more critical way to make sure that I am able to give them the care that I think they need. And don't forget MY standard of care was very high for what I wanted my patients to have. THEIR [Kaiser's] standard of care, in our [RNs'] opinion, was very LOW for what they wanted the patients to have. And they had things that they thought the patients should get but it's like, when you give it by an, when you give it by an aide versus an RN, some little things, some things in the translation, some things that are an RN's skill could not be given. And so, YES they learned how to breast feed. Did they learn how to breast feed well? Well I don't think so, that's why we had so many people calling. Calling back and uh, two, three days later very upset because they couldn't get their babies to feed and there wasn't anybody really, who really did have the TIME. Because if there's one person doing -- what is there? I think there's fifteen rooms over there. So when you have one RN doing fifteen patients, even though she has the support of all the other people, it still ends up being a lot. It still is a lot. You have patients who are C-sections. It's a LOT just to, to teach those patients how to get up and walk. And I'm not saying that the LVN's can't do that. But I'm just saying that the, the- where it used to be an RN and an LVN helping the patient to do that, you didn't have that.

Eileen's quote speaks for many RNs in terms of the subjective and structural reality of RNs' responsibility for patient care, and the difficulty of "getting the work done" in a division of labor where allegedly routine "tasks" (teaching the birth mothers to feed, teaching the patients to walk) are more complicated than envisioned by rational planners. This contexts informs RNs' perceptions of sharing the work with workers who not only are not licensed or certified, but who are relatively new to doing the patient care

"tasks" to which they've been trained. Both quotes speak to the clash between RNs' and management's ideas about what constitutes "quality" patient care.

Confusion and conflict over the division of labor

A second aspect of restructuring that led to an intensified workload was a new occupational structure and division of labor. Unlike the optimistic prediction of "less fragmented care" under Member Focused Care's "coordinated" interdisciplinary team, the changing occupational structure produced conflict and confusion over the restructured health care labor process, dynamics which were exacerbated by the short staffing and speedup. The major issues all centered around Kaiser's increasing use of unlicensed workers for direct patient care – and emphasized inadequate training and supervision of these workers, the perceived lack of their competency, and the overall risk to patients. Although this issue will be examined again in Chapter 7 (as a factor that informs power relations and hierarchies at work), I introduce it here as an essential component of Kaiser's restructuring that informed how "getting the work done" occurred in an intensified work environment.

Inadequate training

Workers' experiences of their new roles and responsibilities in the restructured health care labor process differ between licensed and certified workers, and unlicensed workers, and largely center around whether training unlicensed workers can effectively produce a competent worker. Across occupations, most workers expressed that Kaiser's training of unlicensed workers for patient care work is inadequate, and reflects Kaiser's priority of cutting labor costs over quality patient care. Many workers, especially licensed and certified workers, link Kaiser's inadequate training with a general lack of screening, training, and supervision of unlicensed workers. However, informants didn't see

problems with their own training – only others' training, characterizing it as inadequate and a risk to patient safety.

Numerous informants – licensed and unlicensed, including union activists on both sides of the Kaiser restructuring debate – claimed that many of the new care partners and MAs were trained through a brief, in-house training, and were dismayed it was so short for workers who had not had previous clinical training or experience. They were very disturbed that many workers started with no or minimal training, and said that Kaiser just wanted to see "bodies" working. Several workers criticized Kaiser for trying to spend as little as possible on training and labor, and speculated that Kaiser expected high turnover, so was not going to invest in workers' training.

RNs argued that training unlicensed workers for specific tasks cannot substitute for the broader knowledge base and skill level of licensed workers, especially RNs – and emphasized that shoddy training increases the likelihood of medical mistakes either unwittingly done, or not noticed and prevented, by unlicensed workers. RNs described many unlicensed workers' discomfort with the training and their avoidance of the new responsibilities, and argued that many of these workers are "unqualified" for the work. (On the other hand, only one RN expressed uncertainty and skepticism about the training to become RN-extended role.)

Like the RNs, Local 250 activists expressed that inadequate training of unlicensed workers risks patient safety, and that this is an ongoing problem. However they argued that the restructured health care labor process can work as long as people are "properly" trained, and units adequately staffed.

Negotiating the new division of labor

Rationalizing the health care labor process did not go as smoothly as planned. The restructured health care labor process and occupational structure was often unclear as to unlicensed workers' roles and responsibilities. The new occupational structure coexists (and collides) with the occupational structure based on certification or licensing, and blurs the boundaries between the RN and the care partner in the hospital, or the RN and Medical Assistant in the clinic. This structural confusion exacerbates many RNs' reluctance to delegate nursing work to unlicensed workers because it disrupts the established order based on education. Most of the licensed workers (of both unions) believe that the new order grants greater participation and nominal autonomy to workers who "don't know what they don't know," ultimately placing patients at risk.

> Int: So, if you had a certified nursing assistant would, would that be easier to work with than a care partner?
>
> Skip (RN): Well, you know, what a certified nursing assistant does is really just kind of cut DOWN on the delineation for what I feel is still nursing responsibility personally, as opposed to what THEY feel that they've been trained to do, okay? ...a certified CNA [certified nursing assistant] does the vital signs, can do the paperwork, but they don't draw blood, they don't put in Foley catheters, you know, that kind of stuff and basically, you know, a real good CNA is somebody that's, you know, done the vital signs and, you know, can kind of keep things up that way. Get some paperwork together, kind of answers the lights, kind of very helpful that way, and anything else that goes on, but NOT into that other REALM where it's like this CONFUSION about what USED to be nursing job responsibilities that's now kind of being moved into by the care partner, and them saying it's THEIR responsibility.
>
> ... when I started, it was this TEAM concept...it was very clear cut. This is what the CNA will do, this is what an LVN can do, this is what the RN can do. What this new confusion [is], the care partner kind of cuts into what an LVN can do, kind of cuts into what the RN used to do... There's just a large disagreement in MY soul about that whole scenario, because those people haven't went to school and learned all the principles behind it is, you know, behind what they do. Things can actually be wrong and, yeah the tube's in, but it's IN, you know, but is it in and working right and is there anything that I could have done when I put it in that might be a potential problem? You know, that kind of stuff is just not within — I can't, you can't even expect them to know it, you know, 'cause they were taught to put the tube in and

> something comes out, that's what it is. And so, and they're not, you know, they just didn't get the education that everyone else got.
>
> And then it just kind of cuts, it's a, it's a DEEP CUT, I think to kind of say that here's somebody we can just take off the street and train them to do some of the things that you can do. SO THERE!, you know. And...having some knowledge about...where the deaths have actually occurred have been in places that have...put in these care partner situations, you know ... it's been kind of proven out, you know, on a mortality/morbidity kind of outcome? That, you know, that's what happens when you reduce nursing, licensed nursing care.

RNs' experiences

RNs may do the tasks assigned to the unlicensed workers because they are already doing something with the patient and feel they can easily do the other tasks. RNs may also do the unlicensed workers' work if 1) they don't want to delegate the work to the unlicensed worker, or 2) the unlicensed worker doesn't want to do it, doesn't do it, or does it incorrectly. These two situations often inform one another and result in RNs' constructing unlicensed workers as not "appropriate" to conduct patient care – because of their lack of skill, professional demeanor, or commitment to patient wellbeing. At the same time, the RNs view the unlicensed workers as "shirking" their new responsibilities if they try to avoid doing the clinical work, even if they say they are uncomfortable.

> Ann (RN): I think a lot of the, the Medical Assistants are, were being asked to do things that they really didn't want to do, because they were uncomfortable with some of the tasks. Whether it was they were embarrassed... You've got, you know, a Black, heterosexual female having to give a testosterone shot, a deep intra-muscular, in the buttocks on a gay man who's HIV positive and it's, you know, that sort of the big thing. First of all they were embarrassed just at the where to do it. They were afraid of using a big needle -- is this in the right--? I mean, it's one thing if you give somebody a flu shot in their arm, but you know, this is a more dangerous part of the body to put a shot in, and so there's kind of two or three things, and some of them were trying to say I'm not going to do it. And, the answer to that was, Well why not? Well, 'cause I'm not confident. Well, then we'll go with you several times until you feel comfortable with it, type of thing. So, they WEREN'T going to get out of it... it was like, Well, okay this is what you guys have to do now, so just, we'll help you though it 'til you're comfortable with it, so...
>
> Int: And who's saying that? Who's saying we'll help you through it?

> Ann: Our manager, yeah, would just sort of say... And sometimes it was even more complicated by the person that was going to go with them was the male LVN. So, here you, you know you don't have one of your little girlfriends that you can sort of, you know, giggle about it...

This quote "proves" that unlicensed workers are not appropriate for patient care because they don't want to do the work, don't take it seriously, and are not "professional" about it. This is underscored by Ann's example of a situation that has the innuendo of "incompatible" images in a taken-for-granted "reality" of appropriate patient care etiquette and skill. Despite the image of a "Black heterosexual female" who "giggles" about a medical procedure as "inappropriate" for the responsibilities assigned to her position, this characterization occurred in an interview where Ann described workers of different racial groups and occupations as getting along very well – and where racial tension was described as only occurring with "problem" people irregardless of background or occupation.

This dynamic occurred in other interviews with licensed workers. Even when they made it a point to emphasize respect for all workers no matter what their status in the health care hierarchy, it was not uncommon for licensed workers' to characterize unlicensed workers as "inappropriate" for direct patient care by imitating a "typical" unlicensed worker as an unthinking, uncaring "dummy." Many RNs expressed the sentiment of "We wish they weren't in these positions doing patient care, but since they are, they better do it right – because otherwise it makes for much more work for everyone else, but especially the RNs."

Unlicensed workers' experiences

Several unlicensed workers described different degrees of conflict with RNs in getting the work done. One said that RNs have said "This is my job! That's your job!"

increasingly over the past few years. He found this offensive, as if RNs were protecting their "turf" or asserting their power over the unlicensed workers, instead of working more cooperatively "side by side" and delineating responsibilities in a less aggressive way. Another unlicensed worker described how understaffing of RNs resulted in more work for the unlicensed workers, because RNs were disorganized, or so overworked they could not attend to patients in a timely way. For example, unlicensed workers had to reassure patients that the RN was coming "soon," or had to clean up after a patient's toileting accident because an RN did not arrive in time to help them. This kind of unplanned, extra work "added on" to the unlicensed workers' already intensified workload, and increased the pressure to get all the work done.

"Inconsistency" and "double work"

RNs consistently characterized the unlicensed workers as "inconsistent" in terms of skill or motivation. Because unlicensed workers did not have the same "baseline" of skill and commitment to patients that exists for licensed or certified personnel, RNs were unsure about their new co-workers. This made it difficult for RNs to allow the unlicensed workers to do their assigned tasks, or to count on them to do their job competently. Some RNs reported they end up doing the unlicensed worker's assigned work because they were unwilling to do it, or the RN perceived them as incompetent to do it themselves. Conflict between RNs and unlicensed workers exacerbated the tension that already existed because of the intensified work environment.

> Ann (RN): You can't just have an MA decide to do an ear wash on somebody. A licensed person needs to look at it to evaluate what's going on and then can pass it down. So now my schedule ends up getting booked with a lot of ear washes. That was sort of a big deal because on another floor the RN there has a carpal tunnel problem, she also has a personality problem, and she would be following the rules, evaluating it and asking the MAs to do it. NO!, we're not going to do that, that's

> your job! back and forth. That's one aspect of it -- it's like she's, one of them saying she sort of treats the MAs as subhuman... Yeah, so, I mean there's, there's several aspects of it. First of all, are they qualified to do it, and sort of, what's the, what's the pecking order here? Technically, I'm supposed to be able to just say, oh, yeah you're full of wax, the MA will do your ear wash. But, you know, I'm a little afraid to do that sometimes with the caliber of, of some of the people I work with, so...They're having people do things that the training isn't that good.

Unlicensed workers also had to address inconsistency in their new roles as "multi-skilled" workers. Unlike the pre-restructuring jobs, the work itself was not consistent – there was no autonomy to organize your work. Workers had to follow the directives of different RNs – in what was characterized as a "Do this now! Don't do that now!" Moreover, working for different RNs was inconsistent because they often had different expectations of how to "correctly" do the work. Conflict was likely when an unlicensed worker did the work according to how she or he thought was correct, often based on previous RNs' directives, only to be criticized or "corrected" by another RN – who may have believed that the unlicensed worker shouldn't even be doing the work at all.

Although corporate planners designated a work jurisdiction to include tasks based on a common construct of "skill," unlicensed workers had different ideas about the different levels of skill needed for different tasks, and what they themselves were qualified for. For example, housekeepers felt qualified to know chemicals and how to clean, but did not feel qualified to move patients – even in supposedly routine tasks, such as helping patients walk to the bathroom. Several unlicensed workers also described inconsistency in terms of having their work jurisdictions expand and contract, seemingly out of the blue, whenever "it suited Kaiser." When I asked them for suggestions on how to improve patient care and working conditions, they immediately said "more staff," and then emphasized the need for consistency in job structure and responsibilities.

Local 250 activists emphasized that the real problem was the inconsistent training, not inconsistency among the unlicensed workers.

> Cheyenne (LVN, activist): If you want to get the best out of folks, you've got to give them the proper training. I mean, you can give somebody a FOUR-hour training class or two-day class for something that normally would take three months. You know. Something's gonna break down with the system when it gets going. So, if they give folks the proper training, I think it's gonna be OK. ... [Training is] totally INCONSISTENT, and like I said, it's not PROPER. Like, our receptionists slash MAs [Medical Assistants]. We have three in our department. They were THROWN into this MA training, which I don't remember how long it lasted, but it was some ridiculous number of days. You know, they had to go in and learn some medical terminology – I mean, they KNEW some of these terminologies, but they didn't really know 'em. They had to learn procedures, you know, just routine blood pressures and stuff. People were extremely UNCOMFORTABLE because they RUSHED them through. And we've had some folks quit, but the majority of them, they do NOT want to work in the back offices, you know, with the doctors because of procedures, because of medications, including injections.

This quote provides a more sympathetic perspective on unlicensed workers' discomfort with the work, compared to RNs' accounts that frame the workers as "inappropriate" for and "shirking" their new responsibilities. Cheyenne is a union activist supporting the Kaiser partnership, and her perspective reflects the position that the restructuring of health care labor is "safe" as long as people get "proper" training. Workers' avoidance of the work, and some workers' decision to quit was an unintended outcome of Kaiser's rationalizing the labor process – which ultimately produced more work for the remaining workers in the unit, as workers' accounts described Kaiser as not replacing workers who leave.

For many RNs, the new roles of unlicensed workers in patient care work, be they competent or not, makes for "double work." Like "inconsistency," "double work" refers to RNs sometimes doing the unlicensed workers' tasks because of the latter's unwillingness to do them. It also refers to RNs doing the tasks delegated to unlicensed

workers because it is more efficient for RNs to just do it themselves, especially because of legal constraints on procedures.

> Eileen (RN): ...You [the RN] had to be right there when the person [the unlicensed worker] drew the bloods 'cause YOU were the one who had to sign for, to sign and say you saw it. So you had to sign the slip, they had to sign the slip, it just seemed to be DOUBLE THINGS that were going on. Um, sometimes it was really nice, some of them were really good... at drawing bloods. Of course what always happened is, you had to draw, do an IV, 'cause if you did an IV, you might as well draw the blood. So that's what would happen, so we would do that.

Bending the rules

As Kaiser focused on increasing production in "cost-effective" ways, the "mechanics" of health care delivery and the power relations of authority and status intersected in ways to reinforce and contest race, gender, and class hierarchies of power. Informants described different tactics of Kaiser to work around legal constraints, and described how workers must often "ad-hoc" to get the work done in a chronically understaffed and pressured work situation. I call this kind of work "bending the rules" because it addresses how bureaucratic and interpersonal relations of power restructure or accommodate the "rules" of health care delivery.

The phrase "bending the rules" seems to accurately describe the disjuncture between the planned rationalization of health care labor and the reality of how health care is practiced. There are two major dimensions: 1) Cutting corners – legally and illegally, and 2) "ad-hoc'ing" or "making do" with limited resources.

Legally bending the rules refers to Kaiser's corporate power to reclassify physical space in order to utilize unlicensed workers for procedures formerly restricted to licensed workers. As detailed by numerous informants, the Medical Office Building (out-patient clinics) was reclassified as private doctors' offices, and the hospital recovery room was reclassified as an overnight facility, even though it is supposed to be a sterile

environment. Workers also told me that certain hospital in-patient units were reclassified as "observation units," so Kaiser could have someone physically in the hospital but in a more "cost-effective" stay.

Illegally bending the rules refers to licensed workers not following the legal protocol for unlicensed workers to carry out certain tasks, or to do something beyond their legal scope of practice. Often this "bending" comes in the form of an occasional request/demand that eventually becomes a normative expectation. Workers in the clinic told me that MDs regularly ask/demand unlicensed workers to do work beyond their scope of practice – such as drawing up and administering injections virtually unsupervised. According to both licensed and unlicensed workers, licensed workers often "sign off" retroactively on unlicensed workers' injections, sometimes without checking to see if the procedure was done, or done correctly. (In the clinic, "signing off" is done by MDs, "lead" LVNs, and RN-Xs or Nurse Practitioners; in the hospital, mostly by RNs).

The burden of deciding to bend the rules is indirectly placed on the less-powerful person – through bureaucratic and interpersonal means. Several unlicensed workers reported that their injection slips are signed retroactively because 1) the MDs don't like to be disturbed when they are with a patient and 2) workers are rushing to get their work done within the context of an increasing patient load and chronic short staffing. According to these workers – and licensed workers who work with them – in order to get the work done by cutting corners illegally, physicians use their status to coerce the MAs to bend the rules. This is accomplished through the unspoken but clearly perceived threat of risking one's job by not "obeying" the physicians, and by the physicians' explicit and paternalistic reassurance that the MAs can indeed bend the rules and will not get into

trouble. Pressure to bend the rules comes through bureaucratically as well. If the MA were to wait for a signature, s/he would quickly have a backlog of injections and other procedures, in an already overloaded schedule.

Bending the rule illegally speaks to the intersection of structural arrangements and work relations informed by race, gender, and class. It refers to being "caught" in responsibility and obligation, and accountability to people in the occupational hierarchy who have power over you. Who is caught? RNs and the unlicensed providers, despite their unequal status in the health care hierarchy. For example, hospital RNs have to address the overload of patients due to physicians' and managers' hyper-production and understaffing. They are legally responsible for more patients because of the increased number of unlicensed workers doing direct patient care under RN supervision. RN informants told me that many RNs often feel compelled to sign off on an unlicensed worker's work they may be unsure of, without thoroughly checking because they are too busy due to the number and the acuity of patients.

MAs in the clinic are "caught" between following physicians' directives and their own misgivings about these directives. According to the MAs interviewed, most MAs bend the rules to get the work done and keep their job. If an MA doesn't go along with how the doctor wants the work to be done, s/he risks being characterized as "insubordinate" or not doing her/his job – "if the doctor wants you to do something, you do it" and "When the doctors want something done NOW [you do it]." Physicians' "reassurance" is also geared to getting MAs to bend the rules. One told me of her amazement and horror when an MD told her "Don't worry – if you kill them I won't fire you" about signing an injection form after the procedure.

The second dimension of bending the rules – ad hoc'ing – refers to "making do" with limited resources in order to get the work done. As discussed earlier, RNs pick up unlicensed workers' assigned tasks because of RNs' reluctance to delegate, or unlicensed workers' refusal to do the work. RNs and LVNs also ad-hoc when support staff are simply not available; the rationalized labor process has created a situation of chronic understaffing, which causes the "inefficient" use of unlicensed and licensed staff.

> John (LVN, Local 250 activist): There's NO REASON why an RN making thirty-five dollars an hour should do phlebotomy and draw labs, or leave the floor and transport a patient down to X-ray. Or, not have a ward clerk here and answer telephones and transcribe physicians' orders. Those are the things that take away nurses from bedside care.
>
> Int: But supposedly those care and service partners are supposed to be doing it?
>
> J: Oh BULLSHIT.
>
> I: Bullshit?
>
> J: Yeah, I'll give you an example here. This unit has eight beds, we don't qualify for eight hours for a unit assistant. [unit name] is next door, it has about ten beds. We're budgeted to SPLIT a service partner and a unit assistant, four hours there, four hours here, or as needed back and forth. But that's the way the budget's set up. If there's something going on over there, they're gone. Patients can't wait for them to get un-busy to be taken out the door, so one of us has to do it. Can't get anybody to run lab specimens, we have to leave the floor and do it. If I run down and take a lab I draw, that leaves the RN up here alone with eight patients. The phone rings off the hook, we're doing dressing changes, I can't stop and answer the phone. They'll start paging overhead... answer the telephone! Which is just UTTERLY ridiculous to me. So I think that profoundly affects a licensed people's ability to do patient care, all this cutting down, especially a WARD CLERK!

Bending the rules stems from Kaiser's cost cutting imperative. Based on workers' accounts, they are pressured into participating in "inefficient" or potentially unsafe situations in order to get the work done. The rationalization that calls for a more "efficient" and "streamlined" labor process seems to backfire as staffing is inadequate to meet the increased demands of production. This eventually results in workers taking on different roles and responsibilities in a labor process characterized not by an "efficient"

use of differently skilled workers, but a frantic "stamping out the brush fires" process. Kaiser's rationalized health care delivery produces a speedup and a situation where numerous rules are "bent" in order to meet the demands of production with fewer and fewer resources. As the rationalization does not go as smoothly as planned, all workers experience intensified workloads in an increasingly stressful environment.

Perceptions of patient care: "Failing" the patients

As detailed above, licensed and unlicensed workers described work environments that were increasingly stressful and chaotic, as they struggled to provide quality patient care under circumstances that seemed to work against this. All workers expressed feelings of frustration and anxiety over what they perceive to be an eroding quality of patient care because of Kaiser's cost-cutting tactics. Workers described Kaiser's over-riding concern with "budget" as infusing all aspects of care and every aspect of the work environment, from delayed admissions and early discharges to chronic understaffing, especially of licensed staff. Every interview emphasized how restructuring – through the dual imperative of increasing production while cutting costs – sabotaged workers' abilities to do the quantity of worked asked of them, with the quality they felt patients deserve.

Reduced hospitalizations

Nearly all workers expressed that Kaiser compromised hospitalized patient care through reduced lengths of stay and staffing changes. Workers perceived that hospitalized patients are sicker – often because of delayed hospitalization and because they are often discharged early, returning in worse condition. Informants described fighting (futilely) against physicians' decisions to admit late and discharge early.

> Bea (RN, activist): We've had eighty year old women who've had mastectomies, with the drain we call a Jackson-Pratt drain, this woman's eighty years old and has had a mastectomy and they send these patients home, just to save money. Everything's to save money. EVERYTHING [laughs] literally everything. And a couple of times I've had to fight, you know, to ask the surgeon, Will you consider keeping her overnight? And the answer was Well, we'll keep her in the recovery room a few hours and THEN send her to the ASU – which is our sister unit, the ambulatory surgical unit – and see how she does there, and if she needs to stay then she can stay. So, this would be four, five, six hours down the road. ...she was sitting in a chair downstairs, then they'll decide, whereas if they had decided immediately, she could have been in a room in a couple hours – in a regular hospital bed, getting some rest. That type of— and we've had to FIGHT...Yes, it was horrible. Eighty year old woman. Honest, honest to God. And the hardest part is trying to fight. Just trying to fight and fight and fight. And then the patients will say, I want to stay. And so we're kind of stuck between a rock and a hard spot. I want them to stay, but the decision is not up to me. I can voice my concern and, and speak up, but ultimately I cannot be the one to admit a patient. It has to be the surgeon or physician.

Short staffing

In addition, the short staffing overall (particularly of licensed workers) led workers to feel like they were "failing" the patients because they were unable to do all their work with the same degree of quality as before restructuring. In the hospital and clinic, care- and service- partners and Medical Assistants described feeling constantly behind, or "on the edge" and periodically overwhelmed. Unlicensed and licensed staff told me that many RNs regularly work massive amounts of overtime (often unpaid) to keep up with charting and other responsibilities that only RNs can do. Several RNs, describing how they rush from patient to patient, emphatically stated that this kind of work is "not nursing! – it's pushing meds!"[3] All staff described patients needing immediate assistance but there are too few RNs to meet their needs on a timely basis.

Most informants, regardless of union affiliation and occupation, agreed that Kaiser's use of more unlicensed workers compromises patient care, especially in the

hospital, where patients are sicker and need more intensive work than in previous times. Unlicensed workers consistently expressed frustration that RN understaffing in the hospital put RNs through tremendous and ongoing stress, and that patients were denied the attention and caring they "deserve" – that only RNs are qualified to provide. All workers emphasized that only RNs have the knowledge and the education to get the whole picture on the patient, to provide information, reassurance, and high-quality care so patients can have a less anxious time while hospitalized.

Most licensed/certified workers emphasized that a patient care workforce of unlicensed workers trained to do "tasks" – without adequate RN supervision and hands-on work – could not substitute for RNs' broader knowledge base, training, and experience and ultimately resulted in poorer care. They believed that licensed workers are essential for patient safety because unlicensed workers do not have the education to recognize potential errors or problems. These workers emphatically stated that unlicensed workers should be restricted to patient "comfort" and nonclinical responsibilities.

> John (LVN, Local 250 activist): And the bedside caregivers, [sighs] it's a BIG problem here. BIG problem. Um, when you're team leading and you're like an RN you sort of have to cover everything, you work with a care partner...But the one's downstairs, the one's that have the eight [patients] for one RN, one nurse's aide, that's where the patients get the shitty bedside care because the RN cannot be in every room supervising everything with eight patients. ... [RNs are] really not free to do a lot of supervision so there's been a big decline in patient care. When it's- I think when a non-licensed person does it particularly. Well THEY'RE overwhelmed, they have eight patients. And they really aren't TRAINED really to do like range of motion, understand the importance of getting someone out of bed after surgery, doing pulmonary, toilet, using tri-flows, you know, all that kind of stuff.
>
> ...I don't think we need more nurses' aides. People are SICKER in the hospital, there are more MACHINES, people don't stay in the hospital for bullshit reasons. They're SICK and they need skilled people and licensed people taking care of them not less licensed and more non-licensed. That's the bottom line.

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[3] Real "nursing," on the other hand, is the holistic taking-care-of-people process in which the physical hands-on care work is inextricably bound to the "thinking work" based on accumulated skill through education and training.

Despite the range of opinion among workers about "safe staffing" and "quality" patient care, there is a clear rift between workers' constructions of "quality" and what they perceived to be management's idea of quality. Licensed and unlicensed workers repeatedly expressed frustration because they did not see patients getting the health care they "deserve" because of short staffing – and especially RN under-staffing. In response to my question, "Do you like your job?" a worker's typical response would first state the commitment to the patients, and then express feelings of exploitation and frustration over the work conditions that compromise the quality of care.

> Int: Do you like your job?
>
> John (LVN, Local 250 activist): When things are going well, yes. But it's become EXTREMELY stressful to me because I really don't have the time to do things the way I [emphasis] think they should be done or I would WANT them to be done to ME, if I was a patient. So I feel really PULLED APART. I mean, there are some nights where I don't get to eat dinner, some nights where I take ten minutes. You know, and that's in the last three or four years that kind of stuff's been happening.

The risk for medication error

Numerous RNs and several unlicensed workers were extremely concerned about an increased likelihood of medication error with unlicensed workers administering injections or calling in orders to the pharmacy – their limited knowledge of medications could easily result in an error, or could prevent them from noticing someone else's error (e.g., on the order form). RNs and one care partner also discussed the risks and occurrences of medication errors due to the chronic stress. Several RNs told me they became intensely self-monitoring, which ultimately added to their stress.

> Eileen (RN): And there's always some nights that are like that [extremely stressful]. There's always SOME nights that are like that, but not EVERY night, and that's what was happening, it got to be EVERY, single, solitary night it got to be like that. And I think that was pushing people to the edge and then uh, and THEN that made you even more aware of uh, the possibility of making errors. So you were even more

> CONTROLLED about what you were, HOW you were documenting, WHAT you were documenting, EXACTLY what happened so that if anything happened that you knew that everything that you were doing was okay. So those things ended up being hard to do. A lot of it might have been stress that you added to yourself but it was for your own protection that you added that.

The care partner talked about how the RNs on her unit were extremely "wound up" by the overwhelming quantity of their work and were often working 14 hour days, which had caused them to make several medication errors. The care partner continued by saying that while this was serious enough, what made it even worse was that it was a continuing problem. Because of the short staffing everywhere, the follow-up occurred weeks later, and the mistake was often repeated.

Consequences of restructuring on workers

Based on workers' narratives, Kaiser's restructuring also had serious consequences for workers. All workers expressed frustration, anxiety, and "burnout" over the conditions of work and patient care. The following quote exemplifies how workers regarded the impact of restructuring's on both workers' and patients' welfare.

> Eileen (RN): I don't think there was enough service partners. I think people UNDERESTIMATE what it takes to clean a room, especially after a labor and delivery patient. They would have, you might have two or three patients deliver at the same time and you might have somebody who also was in a C-section [caesarian delivery]. And this person's expected to do all those rooms and have those rooms ready for the next [patient]. Now you can say that it only means mopping the floor and changing the beds, but there's a lot of blood in that area, so those people have a LOT to do, I think. And if you're doing a C-section it's really something. ... I think people UNDERESTIMATE the NEED for HOUSEKEEPING and the service partners provide a lot of housekeeping. ...I don't know how they can transport and clean those rooms at the same time.
>
> ...there was a point in time when you have ALL these patients coming in, and it felt like, no sooner do I take this patient out of the room-- before I could even take this patient out of the room somebody was coming in and saying to me-- you know, we have a two hour period after delivery until the patient is, is ready to go to her room. In that two hour period, MANY times in an HOUR they were asking you, Can you get this patient out? Can this patient go? No she can't go now but I'll have her

out at the end of her, at her two hours. And AT her two hours they were right there, your charge person was right there saying, Can you move them now, can you move them now? Because you had another patient who's sittin' in the waiting room, or you had another patient that the charge nurse was doing. And um, what happened is the charge nurse was taking SO many patients, the charge nurse was taking patients, people were taking extra just trying to help each other out. Um, I'll put this patient in a room for you, I'll do this, oh you can't- and people were running around to make sure the patients didn't necessarily feel the absence of staff. But what happens is after awhile that becomes too stressful because you know as soon as I finish taking care of this patient I will have another one.

And your break time – What they used to do is if you did, if you labored with a patient and then you recovered the patient and then you took the patient out, you get your break time between that patient and the next one. Uh, because it, a lot of times it took a lot out of you just pushing with the patient. So what they would uh, do is give you a break time. Well it got to the point that when you finished taking that patient, it felt like you were taking that patient out, on your way back you, you needed to take this break. And they're saying, Well can you take ten minutes? Can you take ten minutes, and then I have another patient for you. And it got to be, it got to be really hectic, it got to be really STRESSED during that time. So people had, people had very little DOWN time, and I don't mean down time where you took two hours off, I meant down time where you took twenty minutes off, or a half hour between patients off, you didn't get that often.

And there's always some nights that are like that. There's always SOME nights that are like that, but not EVERY night, and that's what was happening, it got to be EVERY, single, solitary night it got to be like that. And I think that was pushing people to the edge and then uh, and THEN that made you even more aware of uh, the possibility of making errors.

Climate of stress, demoralization, anger and militancy

Speedup, short staffing and increasing job stress were prominent themes in each and every interview, as workers consistently described having to work harder, faster, and often working through breaks. All described their feelings of anger and betrayal by Kaiser, who they believe treats them as disposable "components" instead of loyal and committed workers essential to Kaiser's success. Numerous workers said things to the effect of "Kaiser forgot that they got this big and successful because of its workers" and attributed management's change in attitude towards workers to Kaiser's preoccupation with the bottom line. All workers expressed enormous levels of stress and frustration with

the current situation of patient care, and felt that patients were not getting the care they need and deserve because of the reduced hospitalizations and short staffing. Their detailed and emotionally charged accounts of the stressful work environment left me drained and exhausted, as if I'd worked a shift with them. Nearly all interviews were characterized by expressions of deep-seated anger, frustration, and low morale.

Interviewees' accounts consistently described the chronic short staffing as leading to increased stress, anxiety about patient care, worker demoralization, and emotional and physical strain and injury. Interviewees talked about co-workers calling in sick more frequently – "because there's only so much you can take – and now people call in sick for TWO days at a time!" which resulted in more work and more stress for the workers who show up to work. Interviewees talked about tremendous turnover – of unlicensed workers, RNs (longtime workers and new graduates) that disrupts the daily work because management is slow to fill the vacancies. The reasons given by informants are that longtime workers "don't want to deal with it [the stress and lack of compensation and recognition] any more," the new (unlicensed) workers find the jobs distasteful and demeaning, and the new RN graduates find the jobs exploitative. Several of the unlicensed workers described an increase in co-workers' injury because of the added duties and the pressure to attend to multiple and simultaneous demands – "that's why you see so many care- and service-partners out on workman's comp." When Kaiser did not replace workers, the short staffing was made more acute, resulting in a downward spiral of short staffing, stress, demoralization and/or injury, and turnover.

Many workers expressed feelings of anger and militancy towards Kaiser, and felt that workers needed to stand up to fight for their rights and against Kaiser's cost-cutting

that endangered workers and patients. RN informants in particular felt that union power could (and did) put the brakes on Kaiser's restructuring in terms of the proposed concessions in the RN contract. However, most workers, even union activists who felt positive about the strength of the union, seemed to feel powerless and demoralized by Kaiser's seemingly intractable power to do whatever it wanted to. Many workers felt that the strength of workers and unions could make a difference, but also felt betrayed by Local 250 in its "partnership" deal. They claimed that the only effective long term "brake" on Kaiser and the rest of the managed care corporations was state legislation to enforce accountability.

Some workers' actions towards management became increasing militant as their anger and frustration grew, and as the RN strikes seemed to inspire unlicensed and licensed workers to "stand up" to Kaiser. RN activists told me that formerly apolitical RNs began to take steps that demonstrated their growing politicization and activism against corporate power. These steps were all related to RNs' role as "patient advocate." One tactic was to protest and document potentially "unsafe" situations by filing an Assignment Despite Objection form (ADO). Another tactic was to call the California Department of Health and Department of Corporations to report violations of health and safety. Another step towards politicization was to actually go out on the picket line – several RNs said that they were surprised and happy to see co-workers on the line whom they never previously imagined going out on strike.

Many Local 250 informants told me they increasingly spoke out and challenged their managers' and physicians' decisions about staffing and patient discharges. They told me that although many of their co-workers agreed with them, most were afraid to speak

up – including RNs – because of the potential for retaliation by managers. I talked informally with several unlicensed workers who told me how their consistent "standing up" to managers about patient care issues resulted in increasingly retaliatory work assignment and harassment; because of the threat of further retaliation they ultimately declined to be formally interviewed.

One of the most prominent differences between RNs and Local 250 workers I interviewed was the degree of feeling union "backup" in terms of the restructuring. While most Local 250 informants knew about and utilized traditional union grievance procedures to address work issues, a pervasive feeling of distrust and demoralization characterized their accounts. They believed that the union has only limited influence on Kaiser's staffing and patient care plans. While a minority of informants expressed feelings that the union was totally "in cahoots" with Kaiser, it appeared that this feeling of workers struggling "alone" (without strong union support) against Kaiser's corporate power pervaded the rank and file.

Emotional and physical breakdown

Several times during the data collection phase, several informants excitedly told me that "all" the Local 250 workers "walked out" of a particular unit (although I could not verify this), and several planned interviews with one of the lead stewards were cancelled at the last minute due to threatened walk-outs. One spontaneous walk-out that actually did occur did not appear to be an act of labor militancy, however, according to several informants – one of them a steward who was directly involved with the situation. Based on their accounts, the walk-out was a symptom of "breakdown" caused by the speedup and intensified demands on workers, and the lack of formal recourse to correct

the situation. Considering the overall context of chronic understaffing and intensified labor, this was not a completely unexpected consequence.

According to a prominent Local 250 activist, the way Kaiser was going about the restructuring of health care labor focused on short-term solutions to "train" and "restructure" unlicensed staff into a new production process that could not be sustained in the long run. This activist emphatically stated that Kaiser's lack of investment in the workers – by providing inadequate and "improper" training and support for the changes – was likely to result in an inevitable system breakdown. By summer 2000, this breakdown finally occurred in one unit in the clinic. According to this same informant, the unlicensed workers were so overwhelmed that they experienced a collective emotional breakdown and walked out. All were fired by Kaiser for "abandonment of practice," but eventually were rehired after Local 250 struggled with Kaiser – however, the workers were still "punished" by Kaiser through their subsequent assignments.

> Cheyenne (LVN, Local 250 activist): ... I said guys, you can't do this [leave work]. But if you're THAT stressed out, then you each as individuals need to go see your doctors. And they said OK. Well, at this point they were SO hysterical if you will, they ALL just stopped and went to see one of the Nurse Practitioners on the floor. And this Nurse Practitioner knew the situation where he was with folks' stress levels and everything. I mean, people were actually standing in the hallway crying. That's how stressed ... I must have gotten 15 calls that day, boom boom boom boom boom, one right behind the other. And by the time they got to the Nurse Practitioner, what could he do? These people could NOT go back out on the floor and take care of patients. So he wrote each one of 'em out a slip, and they all left.
>
> Well needless to say the next morning Kaiser management was ready to just fire everybody. And it took about three, three and a half weeks to a month before we got all those folks back to work. We took up money, we went around the clinic and the hospital to take up money to help – you know, a lot of the folks that were out are single parents or, just had financial problems. And [sighs], the majority of them did not go back to that module. They did not. The majority of them took positions in other departments. And that was another morale breaker, is when they DID return, they didn't return them to that module. They floated 'em throughout the clinic. And, you know, that just, I mean, that broke my heart. These DEDICATED people, instead

> of being put back in this module where they were desperately needed, they just floated 'em all over, wherever...
>
> ... the chief PIC [Physician in Charge] and the administrator [said] Well they broke the law and then they did this and they did that. And I said, And do you know WHY they did what they did? In any given situation, these – the poor people didn't have a CHOICE. You know? They were so stressed, it's like, I can't, I can't GO ANY MORE... And we're not talking middle age or UP, we're talking YOUNG folks who are PHYSICALLY, MENTALLY able to do this, they could NOT deal with it any more. So, it was, it was, it was a nightmare. It was a nightmare. Couple of 'em went back but the majority of 'em were hired into other departments.

As a union activist, Cheyenne's orientation is to frame the workers as "victims" of corporate restructuring. However Cheyenne is also a Local 250 partner, so it is also in her union interests to not "bash" Kaiser for the situation apparently caused by its lack of investment in the workers, and the subsequent breakdown (the opposite would be true for the CNA and RN activists, who would see this as "proof" of the failure of restructuring.) Cheyenne is a longtime rank and file union leader, however, and her anxiety about the consequences of restructuring for workers and patient care pervaded the interview. She repeatedly characterized the restructuring in both the global context of the health care environment and the local consequences as "a nightmare" for Kaiser the organization, Kaiser workers, and the patients.

Other consequences of chronic stress and short staffing

When I asked workers how the changes at Kaiser had impacted them or other workers, all replied that the stress and short staffing were the most prominent results of restructuring. Nearly all informants talked extensively about speedup and the increasing stress, but few described the severe emotional or physical "breakdown" as symbolized by the spontaneous walkout above. Many workers described themselves or co-workers (of the same or different occupations) as extremely stressed and overwhelmed by the quantity of work expected of them, and by their commitment to do the work at a standard

they felt was above Kaiser's "bare minimum." All the RNs and many care partners reported how hospital staff RNs (and Nurse Practitioners) consistently worked regular overtime, in order to get the work done and to preserve "quality" in their care. Unlicensed workers described feeling overwhelmed by multiple and simultaneous demands.

While the restructuring has led to different degrees of "breakdown" of workers' health, it has also led to an overall decline in morale. Low morale, like stress, was a prominent theme in nearly every interview, whether or not the term or concept was mentioned explicitly. Eroding morale stemmed from workers feeling they can barely do their job in such a way that patients are adequately and "safely" cared for. Numerous interviewees expressed how the pervasive stress and resulting demoralization had both individual and collective consequences – in terms of individual worker health, work relationships, and also workforce stability.

While a minority of workers described experiences as severe as the collective breakdown described above, nearly all described chronic exhaustion. Several workers also reported chronic and severe headaches, and back and knee injuries. Many informants claimed the restructuring produced a large increase in worker injury and workers' compensation claims. Work relationships suffered as the increasingly stressful work environment placed tremendous strain on individuals, and eroded their work relationships. While most interviewees said that everyone basically gets along, they added that the stress made people "snap" at one another. Workers also saw the decline in morale as producing increased sick-outs and turnover. One RN summed up how the stress has affected individuals and the collective spirit at Kaiser, and the potential harm for patient care.

> Kris (RN, activist): The stress is taking a huge toll on people. It's straining good relationships among co-workers. This is why people are calling in sick, why people are getting injured. Nurses still work mandatory overtime – management finds ways to do this. Truck drivers and pilots have laws restricting how long they can work – we don't have any! Kaiser management has pressured nurses to work two, three shifts in a row. The labor laws are not protective. The pressure is to rush, and it puts patient care at risk. And it increases the chance for costly mistakes. The stress is tearing us apart because we're exhausted.

Conclusion

The transformation of the health care environment into a landscape dominated by monopoly capital challenged Kaiser's dominance and threatened to eventually marginalize the organization. In response, Kaiser adopted the strategies and tactics of monopoly capital, as symbolized by the 1995 Strategic Plan. However, instead of creating a non-union workforce, Kaiser and the AFL-CIO collaborated to restructure the health care labor process in order to protect union jobs and Kaiser's financial interests. According to frontline workers, however, the results had profoundly negative effects for the workforce and patients.

Workers perceived that Kaiser drastically changed its focus from a "caring" to "business" orientation, prioritizing the cost of providing health care over the quality of services. By doing so, it abandoned its commitment to providing high quality patient care and a high quality work environment, and instead adopted an industrial "assembly line" model of care. As the health care labor process was rationalized, workers felt objectified and devalued as Kaiser began changing the workforce into a more "efficient" entity based on principles of Taylorist "Scientific Management" and new management models of job consolidation and workforce downsizing.

Structured by historical and contemporary processes of race, gender, and class stratification and exploitation, workers were displaced from their old jobs and

repositioned – willingly or unwillingly – into new jobs with expanded responsibilities or increased workloads. As the dominant health care labor process, nursing was constructed as largely unskilled "women's work" that "anyone" can be trained to do. As RNs were dislodged from the central place in direct patient care, Kaiser drew upon the "unskilled" surplus labor force to carry out the bulk of direct patient care. This surplus labor force of unlicensed workers came from poor, racial-ethnic minority, and immigrant communities – from both within Kaiser's own ranks of displaced workers, and from historically marginalized communities. All workers were convinced that the changes in staffing and patient care were driven by Kaiser's imperative to cut costs and raise production.

Based on workers' accounts, getting the work done occurred in an increasingly stressful context characterized by the ongoing pressure to increase health care "production" with fewer resources. As workers accommodated or resisted their new roles and responsibilities, they found that getting the work done in a restructured labor process was extremely difficult, inefficient, and exploitative. Licensed and unlicensed workers were exploited through the chronic short staffing, which disrupted the rationalized, preplanned calculations of the division of labor, and placed the burden of completing the unit's work on the remaining workers. Restructuring the health care labor process meant that fewer workers worked harder, faster, and often with minimal or skipped breaks.

Workers felt betrayed by Kaiser, devalued and exploited by management, and increasingly stressed about doing their job well enough to ensure patient safety and quality health care. Workers shared feelings of exploitation as they were given increased responsibilities without increases in compensation or authority, and saw the changes as geared solely for short-term cost savings without anticipating the consequences for

patient care. They repeatedly characterized the work environment as more conflictual and stressful, due to the chronic stress created by the cost-cutting culture, which often fomented conflict among workers in an occupational structure with ambiguous, contradictory, and unreasonable expectations.

Despite the aim of rationalizing health care labor process for a more "efficient" and cost-effective labor process, getting the work done in a restructured environment was a near-impossible task. Workers were set up with near-impossible workloads, and were also set up for conflict with one another in terms of different expectations and ideologies about how health care should be carried out. The short staffing and conflict over division of labor disrupted the planned "efficiency" of rationalized health care labor by pulling workers across assigned work jurisdictions, using "resources" inefficiently, and leading to even more work for an already overstretched workforce.

Restructuring intensified the workloads and obstructed workers' abilities to provide quality health care. The changing division of labor and intensified production process created a climate of chronic stress, and produced conflict and confusion between workers as they tried to get the work done. While workers shared increasing anxiety about working conditions, one another's wellbeing, and quality of patient care, their solidarity was continuously undermined by historical and local factors. The next chapter explores the social relations of restructuring – workers' relationships with one another as their labor was restructured, the different factors that informed their relationships, and the implications for worker solidarity. In particular, I explore how Kaiser's restructuring has eroded or reinforced historical conflicts among health care workers, and the implications for hierarchies and inequalities of race, gender, and class.

Chapter 7
The social relations of restructuring

Introduction

As described in Chapter 6, workers emphasized that Kaiser's restructuring had multiple negative consequences for workers and patients. Kaiser's restructuring meant the intensification of the health care production process with fewer resources, a changing occupational structure and division of labor, and increased workloads for a downsized workforce. Workers were basically in agreement that Kaiser's restructuring prioritized cost over patient care, and as such, exploited workers and denied patients quality care. Despite this potential for workforce solidarity, the workforce was not united at the grassroots level. While workers shared increasing concerns about working conditions and quality of patient care, the chronic stress and restructured labor process strained positive work relationships and fomented conflict between workers.

This chapter focuses on the social relations of workers as they assumed new roles and responsibilities or coped with an intensified workload, with a special interest in the relations between licensed and unlicensed workers. Most importantly, this chapter explores the impact of restructuring on inter-group relations of Kaiser's workforce, especially in terms of how race, gender, and class (and other markers of social position) inform relationships and hierarchies of power. This chapter also aims to identify some reasons behind the fracture among Kaiser workers – particularly the social processes that divide working people and tip the balance of power to capital, maintaining a stratified workforce and hierarchies of exploitation and privilege. I attempt to answer questions such as: How has Kaiser's restructuring impacted relations between workers, especially between licensed and unlicensed workers? Has Kaiser's restructuring increased the

likelihood for worker solidarity, or has it entrenched historical divisions and hierarchies in the workforce (and of capitalist exploitation of the workforce)? Do race, gender, and class "matter" to worker relations?

To begin to answer these questions, I explore different groups' constructions of collective identity and sense of group position at Kaiser. I argue that these identity constructions and experiences of restructuring inform one another and contribute to how workers experienced Kaiser's restructuring and social relationships with "others" in the health care hierarchy. I also argue that these constructions of group identity and sense of group position at Kaiser are informed by the racial division of reproductive labor. The racial division of reproductive labor has informed historical conflicts in health care (as described in Chapter 3) and locally specific structures of racialized and gendered exploitation and conflict under capitalist health care production. Local factors, particularly 1) the nature of Kaiser's restructuring and the structure of labor relations, 2) different union ideologies and orientations towards Kaiser, and 3) workers' affinity (or not) with their union, have also informed workers' experiences of restructuring and perspectives of "safe" staffing and division of labor. All these factors in turn contribute to workers' constructions of "others" in the health care labor process – and have implications for worker solidarity.

Constructions of collective identity and sense of group position

The legacy of the racial division of reproductive labor: Historical constructions of collective identity and a fractured workforce

I argue in Chapter 3 that 1) the health care labor force has historically been stratified by race, class, and gender, and 2) a racial division of labor persists for the "non-physician" predominantly female labor force. Nursing labor in particular has been

characterized by a racial division of reproductive (or caring) labor, accomplished by overt and defacto educational and employment segregation. This overt segregation subsequently informed the official stratification of nursing labor based on education and licensure. The legacy of this history means that race and class continue to inform fractures between different groups of health care workers. I argue that the racial division of reproductive labor retrenches contemporary divisions in and exploitation of this workforce.

The racial division of reproductive labor informed different constructions of collective identity and those of "others." The majority of working-class white RNs regarded themselves as distinct from (and largely superior to) the other health care workers based on their education (despite the range of options) and obligations of licensure. To most RNs, the "others" were racially distinct and lower-class women who did not possess the same skills, aptitude, or commitment. These social ideologies and structures of racial exclusion were internalized by white staff RNs, but rejected by the women in subordinate nursing occupations. These workers had been unjustly excluded from educational (and thus employment) opportunities because of the racial order, and saw little difference between their skill and experience, and those of ostensibly "superior" workers.

Relations between staff RNs and other health care workers were structured for conflict through ideologies of race and class and "appropriate" division of labor. For example, the prevailing racial order structured Black women as nominally "unskilled" caregivers, but prevented their upward mobility into "skilled" caregiving occupations. Conflictual relations were also based in the "catch 22" of professionalizing RNs – their

distinctiveness and status as "skilled professionals" depended on the creation of subordinate "unskilled" others, yet these others could potentially displace RNs in much of direct patient care. These conflictual relations – combined with the frequent understaffing of hospital nursing – involved frequent inter-group disputes over work jurisdiction between RNs and the subordinate nursing workers (Brannon 1994; Hughes et al. 1958).

As RNs and other health care workers constructed different collective identities, the racial division of reproductive labor in health care has also informed the potential for worker solidarity. White RNs' occupational identity was that of professional caregiver who delivered skilled caring labor; and the primary bond was between themselves and patients. Black RNs and other racial-ethnic minority health care workers, and a minority of white RNs, recognized larger social structures of racial and class inequalities and were committed to community service and empowerment as much as professional practice. These workers recognized the need for worker solidarity against health care employers in contract struggles. In the 1970s and 1980s, labor organizing for health care workers emphasized a theme of "racial and economic justice" that galvanized support among racial-ethnic minority workers and their communities. These drives to build worker and community solidarity were also informed by racial and class divisions and tensions, as many white workers were reluctant to join forces with workers of color (Fink and Greenberg 1989; Michel 1996; Sacks 1988).

The 1990s offered new opportunities for health car labor solidarity, as monopoly capital increasingly dominated the health care environment. Riding the public backlash against managed care, labor unions invoked the defense of "patient care" as the moral

foundation for labor's position towards health care capital, linking worker and patient well-being against "corporate greed." Unlike the moral foundation of the earlier struggles, "patient care" did not explicitly reference racial matters, and therefore bypassed that proven obstacle to inter-group worker solidarity. The rhetorical strategy of linking workers and patients offered a conceptual opportunity for a broad-based social movement that could potentially shut down the capitalist health care machine.

Kaiser's restructuring and labor relations

As detailed in Chapter 2, in the mid-1990s, organized labor at Kaiser was united against the proposed direction outlined in the 1995 Strategic Plan. In their public stances toward Kaiser, leaders of the California Nurses Association, the AFL-CIO, and union locals deployed the contemporary moral rhetoric that linked worker and patient well-being. The unions denounced Kaiser for adopting the tactics of monopoly capital ("wanting to lead the race to the bottom") that prioritized cost-cutting over quality patient care. This labor unity, however, dissolved over the AFL-CIO's decisions to quietly initiate and eventually enter into a national labor management partnership with Kaiser in spring 1997. In Northern California, the RNs' union, the California Nurses Association, adamantly opposed the partnership on the grounds that it sacrificed patient care in order to meet Kaiser's financial objectives.

By spring 1997, Kaiser's restructuring had begun in selected hospitals and clinics in Northern California, and the partnership was ratified by AFL-CIO members by early June. The vast majority of Kaiser unions were AFL-CIO affiliates, and began collaborating with Kaiser as labor "partners" rather than in traditional adversarial roles. The collaboration entailed negotiating a restructured health care labor process that both

protected unionized workers' jobs, and served Kaiser's financial interests of cost-cutting and membership growth. The restructuring altered the labor process so that more unlicensed workers and fewer licensed professionals carried out the bulk of direct patient care, and closely resembled the tactics outlined in the 1995 Strategic Plan, except that these unlicensed and "multi-skilled" workers were unionized. In spring and summer 1997, cooperation characterized the relations at the leadership level, but substantive negotiations began slowly on the frontlines.

During this same period, Kaiser's relationship with the CNA was increasingly conflictual due to Kaiser's proposed contract (which contained massive concessions for RNs) and the restructuring in progress. Relations between the CNA and Local 250, already rocky because of disputes over organizing jurisdiction, deteriorated further as each union became increasingly entrenched in their positions towards Kaiser. Deploying the linkage of worker and patient well-being, the organization accused both Kaiser and the partner unions (Local 250 in particular) of sacrificing RN jobs and patient care in order to meet their own objectives of unlicensed worker jobs and Kaiser profits.

In Northern California, organized labor (the California Nurses Association and SEIU Local 250) fractured at the organizational level, as the CNA represented Kaiser staff RNs, and AFL-CIO affiliates (especially SEIU Local 250) represented the other Kaiser workers. Each side argued that their position truly defended workers and patients, and the other side was simply out to protect their own members at the expense of the other union's members. What remained largely unspoken by union leaders was that the fracture in organized labor coincided with the historic racial division of health care labor, particularly among the workers doing nursing labor. RNs, a predominantly white working

class female workforce, were targeted by Kaiser for displacement by unlicensed workers, a predominantly racial-ethnic minority workforce from historically marginalized communities. (This circumstance, however, appeared unique to Northern California, because the CNA was the only RN union at Kaiser so adamantly opposed to the partnership.)

Because of the different union orientations towards Kaiser and the structure of union representation of Kaiser workers, frontline workers were positioned on opposite sides of the partnership agreement. This circumstance, along with Kaiser's proposed contract in 1997 that dramatically reduced the number of RNs in direct patient care, and the beginning of Kaiser's plan to use more unlicensed workers and fewer RNs in direct patient care, helped structure an oppositional relationship between different parts of Kaiser's workforce, particularly among workers doing nursing labor. For the CNA, it created an "either/or" ideology of RN jobs "swapped" for unlicensed worker jobs. For Local 250, the situation was constructed as joining a partnership to protect its workers and patient care from the potential damage caused by an unchecked Kaiser restructuring. However, before I explore the role of union ideology in shaping workers' experiences of restructuring and the potential for worker solidarity, I first turn to workers' constructions of collective identity and sense of group position, in order to situate these constructions within the legacy of the racial division of reproductive labor and the current context of Kaiser's restructuring and labor relations.

RNs' collective identity and sense of group position

RNs regard themselves as the backbone of health care because of their extensive education, their legal authority to assess patients, their commitment to caring, and the

legal responsibility to act in patients' best interests. RNs' accounts emphasized that their licensure, education, and skill gives them the knowledge to assess the patients' conditions and to know what is in the patients' best interests. The RN informants also expressed pride and "ownership" of hands-on, sometimes "dirty work" as part of doing nursing – the holistic process of caregiving that values emotional labor, physical labor, and "technical" expertise. All types of work are geared towards assessing the patients and advocating for their best health care. They emphasized that as patient advocates, RNs cannot compromise patient care by consenting to practices that in their professional judgement, are not in the best interests of the patient. These are essential parts of RNs' professional identity and the legal and ethical obligations inherent to that role.

While RNs' collective identity is that of skilled "professional," many RNs also saw themselves as "worker" because of the "dirty work" of nursing (as one informant said, "How are we professionals when we wipe people's butts?") and because they are vulnerable to physicians' and management's devaluing, deskilling, and downsizing. Several RNs – with different degrees of education, management experience, and union enthusiasm – expressed a lingering ambivalence about RNs "needing" a union, which was based on their image as RNs as professionals. They also acknowledged, however, that RNs lacked professional status relative to physicians and managers, and ultimately did not control their work.

The sense of RNs as "essential" to patient care was reinforced by their elevated status and influence in patient care during the years of Primary Nursing (to the early 1980s), and the attempt by health care corporations to erode RN gains within the cost-cutting of the 1990s. Several informants said Kaiser had a nearly all-RN staff previous to

the 1990s restructuring, and that RNs enjoyed a period of relatively high status and recognition. Kaiser's restructuring focused on reducing RN jobs, and RNs perceived this as an about-face in terms of the respect and value they thought they had secured. The contract proposal in 1997 shocked many RNs and symbolized Kaiser's assessment that RNs were no longer "essential" but "replaceable" – personified by Kaiser's restructuring that integrated unlicensed workers into direct patient care.

Group identity as "subordinate" females

The group identity of RNs is grounded in their professional identity as RNs, and in their gendered identity as "women." Although rarely brought up until I asked, interviewees emphatically acknowledged that the gendered nature of nursing informed its devaluation and exploitation, with statements such as "If there were more men in nursing this bullshit would never be happening." RN informants, regardless of their race or ethnicity, did not see race or ethnicity as informing relations with more powerful others, and repeatedly emphasized RNs' subordinate position as one informed by gender, with class "implications."

However, RNs still acknowledged that as a female workforce, they remained in subordinate and often devalued relations to the predominantly male decisionmakers of physicians and managers. With many male physicians and managers, overt sexism dismissed RNs as skilled, educated professionals and engendered them as "doctor's little honeys" or "bitches."

> Willy (RN, CNA activist): Because, you just can't trust Kaiser because you could be talking to this one person this time, you have a good rapport with them and in two years they're gone. And somebody else comes in with their shit ideas that are totally negative, totally awful – Screw the nurse, she's getting paid too much money, she doesn't deserve all that money, what does she do anyway, let's get rid of the old ones, you know. Even some of the doctors when they had a thing where they had to cut back in the clinic, they go, why can't we get rid of the old nurses and keep the nice

YOUNG ones? [laughs] You know, it's like well why don't we get rid of all the old fart doctors and keep some of the young ones. Get rid of the doctors that are making a quarter of a million dollars a year. So.

Kris (RN, CNA activist): But I found it culturally for me, it's more difficult here [the USA], and people DON'T accept outspoken females the same way they expect that – if you are MALE who speaks up, gosh, you are the better stuff. If you're female who speaks up or stands up for herself, you are a bitch. And it goes very much for nursing, so that, REALLY REALLY REALLY it's a FEMALE profession and females are still supposed to keep they [sic] mouth shut. ...And I have even had nurses, when doctor has a fit, they think it's our job just to take it. And I said, Oh Hell, watch ME, it's NOT. I'm not going to tolerate that kind of behavior here.

Int: What— you mean they get verbally abusive?

K: Yeah, yeah. And, and I said, I don't have to take it, nobody has to take it, and just 'cause he's MD, it doesn't mean that he can do that. But believe me, they do it and they get away with that. And, so that puts nurses in the position that they really just feel very little of themselves. And that's why they are afraid of standing up for themselves too, 'cause they are afraid of consequences. That part, YET, to ME, paying those consequences, which means that I get invited to my boss's office once again, is worth paying, because he CANNOT fire me. And if he has to fire me because I made a nursing error, I live with that. But if I don't speak up, then I can't live with myself, so, but again like I said, it's completely personal matter.

Several RNs also expressed that gender also impacted RNs' power to "get results" in terms of patient care. The male RN Skip reflected on the differences.

Skip (RN): If [staffing is] BAD in the beginning, [I'll] talk to some of these supervisor types and come up with some alternative solutions that you know you best well act on. And I think I get a little bit of respect, but I think it's also my gender, and that I can make my voice low. I mean, I can get, I can turn on to something else that's a little, not, maybe it's intimidating, but it gets it done. When people are sick in the unit and the docs – you know, we work with interns – want to keep them there and watch them? Oh, NO, this patient is going to the ICU, we'll set up the transfer NOW. I mean I don't even give them that little room of indecision. I'll call the supervisor and she may say "We don't..." I say, "You do whatever you got to do, but they're too sick to be in HERE" and you know it gets going. I don't give it, I don't give it a chance to FALTER [laughs]. I, I hate to have to BE that way, but, you know sometimes you DO, and I've just learned how to DO that and I've HAD to on several occasions... And you would think that you could say that and people would, you know, the supervisor would just RESPOND to it, but they often don't, so you kind of have to jump up and down...it can get pretty heated, you know.

> Int: Yeah, yeah I can see, yeah, you know, I think, I think gender DOES have a lot to do with it.
>
> Skip: Yeah, it does 'cause I've seen my colleagues kind of, it's a shouting match, and it's circular and it's, it's not moving, it's not getting the thing done, and, you know, there's a lot of time spent with that when it could have been, you know, you could have had the gurney half way out the door by now, you know [laughs].

In this quote, Skip explicitly attributed gender as a factor that obstructed or facilitated getting the best care for patients. He attributed his ability to "turn on" his masculinity as the primary reason he could avoid the "shouting matches" that constrained his female co-workers. Despite his acknowledgement of gender informing interactions with more powerful others, Skip did not "see" gender as organizing the devaluation of the nursing workforce. He attributed RNs' poor treatment as "workers" to "non-gendered," "generic" relations of capitalist exploitation.

> Skip (RN): So, I've just seen staffing patterns change to where I'm not in agreement with them all the time. You know, I think it's, I don't think it always has to be EXTRA, but I think there's some times where it NEEDS to be extra so, A, you don't BURN people out 'cause I think we're throw away, we're just viewed as throw away people in terms of the hospital scheme of we're, we're the BULK of the working force, you know, and so WHAT if we put it on, and we WRENCH that bolt till the threads strip. GET another BOLT, you know, and that's, and wrench IT until it... and get another BOLT, and that's what happens. That's what's happening in nursing and I think that's why you're seeing a shortage, and people not wanting to DO it.

The militant stance of the CNA and the visible presence of numerous strong female RNs who weren't afraid to challenge their managers or the physicians on patient care issues helped change the self- and collective image of nurse from passive caregiver to "fighter." However, as the CNA became increasingly isolated from Kaiser "partner" unions in its contract dispute against Kaiser beginning in late 1997, RNs resisted being constructed as "unreasonable" women whose demands could then be easily dismissed as

the carryings-on of "prima donnas," through emphasizing patients' support of their position towards Kaiser.

> Bea (RN, CNA activist): I'm so gung-ho in it [the CNA] and I'm TOTALLY supportive of it, you know, because I've worked for places that, that did not have a union and management just decided, you know, this is it and you have no say, and if you don't like it, leave. ...You know, I mean, my main concern [sic] are, are for the patients, but it's real interesting because we had one patient who rode a big, old gold motorcycle and he was a patient and he was probably 70 years old. He was out there every morning striking with us. Every morning. And...most of the patients were totally in support of us. And, so, I felt good about that. And that we weren't just a bunch of prima donnas, you know.

Many RN informants expressed that Kaiser's restructuring aimed both at cutting costs and disempowering and demoralizing RNs – by devaluing their work as "unskilled," assigning it to unlicensed workers, and retaining these workers even if they were incompetent. One activist recounted a "typical" event in which an RN colleague went to her physician and encountered not only the incompetence of the Medical Assistant, but the tolerance of the physician for this incompetence. She believed that despite the "irrationality" of the "double work," the real value of having the MA was to dislodge RNs from their central position in patient care and to erode their sense of entitlement and power for that position.

> Willy (RN, CNA activist): ...when the Medical Assistant [took the blood pressure] ...the blood pressure was HIGH and [Willy's colleague] brought that up to the doctor's attention. And he said, oh don't pay attention to what they do, we'll do it ourselves, and they did it and he said, see your blood pressure's not high. And she goes, what's the whole purpose of having them, the person do this if we have to repeat it.
>
> Int: Right. That's crazy.
>
> W: It is. But part of it again is to give 250 more people working. And to make the nurses feel less powerful. Because at one point if you're all-RN staff and the RNs say, Well screw you we're leaving, we don't make enough money, we're out of here— And it's still that way now, even if it happened now. Even during the strike when it happened, they couldn't get by with just what they had. And you know, they were trying to make the nurses feel that they should be THANKFUL that they have a

job. When it's the other way around, they should be thankful the nurses STAYED. I mean there's two ways to look at it.

RNs' perceived themselves as skilled professionals who were "under siege" at Kaiser, and whose proposed contract and restructuring in progress threatened their jobs and patient care. They rarely mentioned the impact of restructuring on unlicensed workers, mainly referring to them as others who were repositioned into a work process where RNs should be. Through their accounts of restructuring, RNs' group identity was constantly referenced to the RN license and what it represents – that their primary obligations were to their patients. This core of RN identity was historically structured through gender and racial segregation, and ideologies that institutionalized the dominant sphere of nursing as a racially stratified domain of "women's work," in which (white) RNs' caregiving relationships to patients took priority over their relationships with other workers, and over RN or workforce well-being. The legacy of these divisions continued, as RNs stressed their essential place in patient care through expressing their education and legal obligations, and by using "nurse" exclusively for RNs (LVNs and unlicensed workers used the term to refer both to LVNs and RNs).

Local 250 workers' collective identity and sense of group position

Local 250 represents over a hundred job classifications that range in status and occupational identity, and which are located throughout the social and occupational hierarchy. This fact alone makes a cohesive union solidarity more unlikely than in the CNA, which represents basically one occupation. Along with the occupational variation, Local 250's members are extremely diverse in terms of race, gender, class, and nation/immigration status – and have different perspectives of their group position(s) based primarily on their occupation and its "ranking."

Of the licensed and certified workers interviewed, all expressed occupational affiliations as "professionals," while also acknowledging their identity as "workers." The two LVNs interviewed are union activists, and regard themselves as both "workers" and "nurses." Unlike many of the RNs and unlicensed workers, most licensed Local 250 workers did not experience changes in their job and were not directly impacted by restructuring. The exceptions were the two LVNs, of whom one had been "demoted" to an "unlicensed" job classification, and then re-hired as an LVN. Both of the LVNs were union activists closely involved with Kaiser-union negotiations over restructuring. All workers had strong feelings about Kaiser's restructuring that resembled either Local 250's or the CNA's position towards Kaiser. Their perspectives are included in subsequent discussions of union ideology and "safe" staffing.

Unlicensed workers

Unlicensed workers expressed occupational identities and a collective identity as "workers." This collective identity as "worker" was largely due to their expressed acknowledgement of their class position of limited power and lower status in the health care hierarchy. They described their work as often devalued by managers and RNs because their jobs are near or at the bottom of the occupational hierarchy, but they emphasized that everyone has an equally important role in patient care, regardless of differences in skill and education. They expressed a strong identity as "worker" who needs other workers and a strong union to counter Kaiser's exploitative maneuvers.

Unlicensed workers displayed a different orientation to health care labor and occupational identity than RNs or licensed workers, whose more extensive training and education had inculcated professional values and occupational identity. The difference in orientation to the work certainly did not mean that Local 250 interviewees cared any less

about the patients, as each informant expressed a great deal of concern about the impact of Kaiser's restructuring on patient care.

Unlicensed workers described traditional or authoritarian manager-work power relations, and their recourse as workers was to seek union backup. Many expressed that they are expected to do what they're told or risk losing their job, and see the union as essentially ineffective, signing away workers' rights in the contract, and not informing workers that concessions were made. Other workers expressed more entitlement to basic "rights" on the job and used the union as backup for unreasonable or unfair actions or situations. Unlicensed workers felt vulnerable in terms of criticism and "write-up" by RNs and managers, but also felt that their union would counter any unfair treatment. (However, reflecting the power differences between physicians and RNs, the clinic MAs expressed that they had no recourse if physicians ordered them to do work they felt was beyond their legal scope.)

Most unlicensed workers expressed a shared group condition and position of stress and exploitation, and often wanted to be interviewed in groups, or a group chose one worker to be the spokesperson. There seemed to be a shared sense of vulnerability, which was suggested in several ways that were markedly absent in most of my interactions with the RNs or the licensed or certified workers. There were numerous unlicensed workers who were hesitant or who declined to be interviewed, expressing fear of retaliation. Of the unlicensed workers I did interview, all but one did not want the interview tape recorded or for me to quote them, and all chose pseudonyms (several workers chose names traditionally assigned to the "opposite" sex). (Of the four RNs and licensed Local 250 workers who declined to be interviewed, only one did not want to

participate; the other three had demanding family obligations and asked if we could interview over the phone or if they could "write the answers" and mail them to me. All the licensed and certified workers I interviewed were comfortable with the tape recorder and possible quotations; and many of the RNs volunteered to use their real names.)

Intersecting axes of power informed a striking difference in terms of occupational identity, as one unlicensed worker openly distanced himself from the others. Unlike the unlicensed workers I interviewed (and the larger unlicensed workforce described by informants), who were largely working-class people of color unfamiliar with research projects, he was at least 20 years older than the others, had worked as a Nursing Aide for over 30 years, was an out gay man, was white, and had been a "subject" in other qualitative research projects. He expressed difference from the other unlicensed workers also in terms of "needing" union backup – he felt rather that it worked "against" workers by failing to recognize individuals and colluding with Kaiser with the overall speedup of health care. Lastly, he felt different because of his identification as a "nurse" – he spoke of a "calling" to be a nurse, of his extensive skill and experience, and of his primary social bonds with other RNs. The other workers, he felt, were "really young" and did not show the same initiative, same degree of skill, or commitment to patients – to them, it was "just a job." Without explicitly referencing race or gender, his perspectives reflected white and male privilege that informed an individualistic orientation.

There is another sense of group position, but it is not represented directly in the data. It is in characterizations of the new unlicensed workers hired en masse to be integrated into patient care, and are the ones talked about by long-time licensed and unlicensed workers I interviewed. These new workers are consistently characterized as

susceptible to management influence about what they are qualified to do. The gist of commonly heard comments from long-time workers is that the new workers think they can do X because Kaiser says they are trained to do it. These "labor partners" are also characterized as having a sense of entitlement to the job regardless of the quality of their work. This contrasts with the long-time unlicensed workers who consistently expressed a sense that their lower status puts them at risk for management (or other powerful others') indifference or harassment.

Union ideology and member affinity

California Nurses Association and RNs

In the struggle to protect RN jobs, wages, and benefits, the CNA locked onto the RNs' legal role as patient advocate, and constructed a convincing linkage between RNs' and patients' welfare. This resonated with RNs, who on their own, were extremely anxious about the threat to their jobs and the implications for patient care. Although many RNs did not share the CNA's militant approach, they agreed that they are different than other health care workers because of the combination of knowledge and caring.

As described in Chapter 2, the CNA constructs itself as a blend of traditional RN professional association and militant labor union. The union emphasizes RNs' role as patient advocate by linking the wellbeing of RNs with the wellbeing of patients and the community at large; and encourages worker solidarity across occupations – within and beyond health care as part of the militant caring agenda. This blend of traditional nursing issues and labor militancy translates successfully to claims to represent RNs who see themselves as "essential but under siege" at Kaiser. The threat of job losses, while intimidating many RNs, also helped galvanize a growing sense of RNs as workers that

need to stick together – with the constant "education" of the CNA activists. Many RNs thus had a sense of group identity as "nurse" and as "CNA member."

Activist RNs saw the threats to RN jobs as working to galvanize RNs behind the union, and would ultimately fail because of Kaiser's reliance on the RN staff. These activist RNs, however, while expressing this kind of empowerment, described their RN co-workers as much more passive and intimidated by physicians and managers, and needing constant "education" by the pro-union RNs.

> Bea (RN, CNA activist): You know, it's funny, a lot of nurses were just saying, Just be grateful we have jobs – and I told them, NO, no. You know, we're GOOD, we do a wonderful job, we shouldn't just be GRATEFUL that we have JOBS. It's not as if we're BEGGING. Again, you know, I'm single, so I can probably just hop from a different job, but for lots of these people, they've been there for a long time, they have families and they don't want any changes. And, so, a lot of them were just WILLING to just kind of sit back and take what Kaiser GAVE them and, and it just INFURIATED me, you know. And, but, a lot of it is word of mouth and, a lot of nurse reps [stewards] or a lot of people who were pro-union, you know, would be on the floor and, you know, talk with other nurses and by, by word of mouth encourage other nurses to, to BE supportive of the strike and not just take a defeated attitude.

Most RNs I interviewed identified with the CNA at Kaiser because of working conditions, and threats to wages and benefits – many others seemed to identify as "caregivers" or "nurses" who did not want to get involved with conflict. According to informants, these RNs were "educated" by RN activists that standing up for themselves meant standing up for their patients. Encouraged by their pro-union co-workers, many formerly apolitical RNs began to take small steps towards political activism, such as signing a postcard, wearing a button, or going out on strike. The RNs I interviewed also spoke of how RNs were increasingly taking action to document their perceptions that Kaiser is providing "unsafe" care – they documented potentially unsafe care situations by filing Assignment Despite Objection forms (ADOs) and calling up the California

Department of Health or Department of Corporations (which regulates HMOs) to report unsafe staffing or other conditions.

For activist RNs, the ideology of RNs as central caregiver became a highly charged ethical issue, as the AFL-CIO partnership represented labor's switch of allegiance – from workers and patients to Kaiser management. This resulted in the construction of an "us/them" dichotomy, where CNA was on the side of patients, not management. To the CNA and RN activists, Local 250's participation in a partnership ultimately symbolized the antithesis of RNs' most important role, which is to act in patients' best interests. RNs' primary obligation to patients set RNs apart from other health care workers, and made it impossible for them to join a partnership.

> Willy (RN, CNA activist): When a MANAGER doesn't come to work we don't say, oh we got to call a registry to replace them. I said, we HAVE to be there. Somebody has to do hands-on care, and is responsible to take care of the patients for that eight hour period. Um, and that doesn't- in a partnership you can say, okay well we won't give the bed bath today or, don't complain about this, or don't complain about that we're in tough times right now. It's like, Yeah but who's getting compromised? It's not US, it's the patient – and that our job by LICENSE is that we're supposed to protect the PATIENT, not protect Kaiser. So that's, you know, when I try to explain to people WHY we're not in the partnership is because they'd say, Oh we wouldn't compromise care, but in the long run you wouldn't know if they WOULD.

The growing politicization of RNs built on traditional self-image of RNs as caregivers, and at Kaiser, the CNA and activist RNs constructed their group position as on the "side" of patients. This stance also constructed the Local 250 leadership as <u>not</u> on the side of patients, but rather on the side of Kaiser because of the Local 250's participation in the AFL-CIO/Kaiser labor- management partnership. The partner unions were constructed by CNA leaders and activists as accommodating, if not actively colluding with, Kaiser's restructuring by ensuring the job security for unlicensed workers displaced and repositioned into patient care, "replacing" RNs in direct patient care. The

partner unions' accommodation of – and benefits from – Kaiser's restructuring placed patients at risk by having unqualified and inappropriate staffing.

CNA leaders distinguished between Local 250 and other union leadership, and the rank and file workers who were restructured into patient care, and they emphasized that RNs should and did show respect for their Local 250 co-workers. Because RNs' first duty was to the patient, however, union leaders also emphasized that RNs had the legal right and obligation to assess whether or not to delegate work to a Local 250 worker, based on the RN's assessment of that worker's competency. This ideology, while galvanizing RN support behind the union stance towards Kaiser, ultimately set up RNs' constructions of "others" to be Local 250 unionists and frontline workers as the personification of "danger" to patient wellbeing.

Local 250 and its members

RNs affinity for the CNA and the belief in its power to effect positive change at Kaiser contrasted sharply with Local 250 informants' assessments of their union. Local 250 constructs itself as both militant labor union and a labor "partner" at Kaiser. For workers, this is an ambiguous role that represented (and reinforced a belief in) labor's limited influence on Kaiser's corporate power. By assuming a non-traditional, cooperative role towards management, Local 250 was in a new position of having to convince its members it could still advocate on their behalf (see Shaiken et al. 1997).

Local 250 workers expressed ambivalent feelings about their union. Most Local 250 members considered the union useful and effective in terms of regular collective bargaining issues such as wages, benefits, etc. However, they expressed the belief that the union was basically unable to influence (or unwilling to challenge) Kaiser's restructuring

of patient care – especially in terms of staffing issues, reduced hospitalizations, and inadequate training for unlicensed workers.

> Lynn (certified Local 250 worker): And, and I believe in my heart that the unions bought into this, you know, let's be partners with management deal. Sure it's FINE as far as negotiating my salary and benefit type things. But I really feel that they've been CONVINCED, however, that it's OK for all these non-certified or licensed individuals to be delivering health care. ...for whatever reason they've been convinced this is a wonderful idea and they try to sell it to the members.
>
> There's been many occasions where employees have, you know, gone to the union and said, Look they want me to do THIS, I don't want to DO this, we shouldn't be DOING this. And it's, Oh WELL, this is the way health care is and you really don't have any choice here. That's not cool. I mean, it's a sell-out in my opinion. I mean there's certain things of course that can be delegated to someone that's not licensed and I'm not, in any way would object to any of that. I have a hard time having a Medical Assistant who is – the worst of all scenario is the Medical Assistant that is only a Medical Assistant at Kaiser and is not recognized ANYWHERE else as such, being able to draw up meds and give an injection. I just cannot – it doesn't work for me.
>
> ...I think if there's a real, if the legality is strong then depending upon the EMPLOYEE they can get the union to back them. But you have to RIDE the union to do this in a lot of instances...You really have to push your union reps. ...If there are issues that Kaiser has decided are gonna be handled a certain way, then you see the union back down off of that.

At the time of data collection, the partnership was just beginning to be implemented for rank and file, and did not have a visible presence in terms of labor management cooperation in the hospital and clinic on which the study focused. Several workers were overtly hostile to the union leadership, seeing it as effectively selling out workers and patients for its own gain of more jobs, more members, and more member dues. Most Local 250 workers didn't know about the partnership, or cynically said the union was caving in to Kaiser ("crawling into bed with management") that ultimately meant more work for them.

Some rank and file informants described how they actively participated or supported labor-management cooperation, by willingly being "restructured" and taking

on more responsibilities, and helping plan the implementation of Member Focused Care in the hospital. They appeared to internalize and reproduce Kaiser and "partnership" union ideology that constructed the "necessity" of unlicensed workers taking on "nursing" responsibilities because of an RN shortage, and because of Kaiser's need to contain costs to gain financial stability, and thus use staffing dollars more "efficiently." Unlicensed workers said these decisions "made sense" and benefited both workers and Kaiser; licensed workers said that the financial "reality" dictated that Kaiser needed to cut costs by reducing RN staffing and use an integrated workforce.

This cooperation with Kaiser and the partnership, however, led to workers' eventual disappointment, frustration, anger, and demoralization. Workers' expectations of shared decisionmaking power and management responsiveness to worker loyalty collapsed as Kaiser management appeared intractable regarding its concern for the "bottom line" over worker or patient well being. Workers promised a bonus if certain goals were reached were first told they succeeded, and then told that the goals were in fact not reached – and thus no bonus was forthcoming. They then saw their workload substantially increased. Activists involved in joint labor management implementation of restructuring staffing and patient care issues saw Kaiser's corporate power continue to prioritize cost over worker or patient welfare.

While AFL-CIO literature described this struggle as ultimately resulting in the greater power of labor over Kaiser, informants were more skeptical about this outcome. One activist joined a labor management committee to jointly decide how Member Focused Care would be implemented, but quickly found that Kaiser had already made plans based on budget.

John (LVN, Local 250 activist): [Kaiser] had already implemented [Member Focused Care] before they came to the meetings and they already had their bottom line. And they already had, had what they wanted to do set up. I got a sheaf of articles and I saw from reading them what parts they had extracted from Member Focused Care and changed to suit their own needs here.

Int: So do you think Member Focused Care can work? Really?

J: IF they FOLLOW a CERTAIN SPECIFIC MODEL, YES it can work. But you CANNOT DO AWAY with ALL ANCILLARY SERVICES. The Member Focused Care part is good but you cannot— you really, really can't dismantle the whole ancillary services and NOT increase your staff. When it first, when it was first here there was one care partner to one RN on the floors. That, QUICKLY, in a month and a half that was dismantled. So it WAS actually in a way, sort of better staffing. But they've changed everything around to suit their numbers and their budget.

The perception that the union has limited power over Kaiser, and even less so since becoming a "partner," produced in some workers a strong belief that the union cannot or will not protect workers and patients in terms of staffing and patient care issues because of its interest in maintaining good relations with Kaiser (echoing Shaiken et al. 1997). Nearly all the restructured workers in Local 250 felt deceived and exploited by Kaiser and their union. They felt that both organizations benefited from workers' exploitation, and that both Kaiser and the union were indifferent to the perceived decline in patient care. Some workers felt demoralized and powerless, abandoned by both union and Kaiser. Some were angry and militant, expressing the need for workers to stick together and together prod the union to take action on their behalf. Even the Local 250 activists expressed varying degrees of doubt that Kaiser would make the changes called for by workers – while they hoped the labor management partnership would effect substantial change, they also expressed doubt that Kaiser management would actually meet workers halfway.

The legacy of the racial division of reproductive labor and the contemporary situation of Kaiser's restructuring informed differences between workers' constructions

of their own group identity and group positions at Kaiser. Union ideology and worker affinity to their unions also informed workers' experiences of restructuring. All these factors together informed workers' constructions of "others" – and the potential for worker solidarity – through their constructions of "safe" staffing and division of labor in the restructured health care labor process.

"Safe" staffing and division of labor

Workers' sense of group position, union affinity, and union ideology informed different and sometimes competing perspectives on "safe" staffing and division of labor. Workers' accounts of restructuring provide an opportunity to examine where workers agree and disagree.

"Putting all the pieces together": RNs are essential for patient safety

Nearly all RNs agreed with the CNA's position towards Kaiser, but with varying degrees of militancy or enthusiasm. All were concerned about patient safety. All agreed that RN labor is historically devalued. All saw RNs as essential for patient safety because of RN's extensive knowledge, commitment to caring, the legal authority to assess the patient, and the legal responsibility to act in the patient's best interests. All agreed that support staff are essential in the support roles, but risk quality of patient care/safety when they are repositioned to do more patient care.

While many RNs did not share the CNA's militancy regarding the partnership, many felt that RN centrality in health care was necessary because of RNs' higher education and ability to "put all the pieces together," which can alert the RN to an emerging or full-blown problem. Even seemingly routine tasks are important in the overall and ongoing assessment of the patient's well being.

Willy (RN, CNA activist): Well [patient] care involved this, this, this and this, and that might take an extra two hours a day, or two hours a shift... But then Kaiser wanted us to break it down into tasks. So when they did THAT, it was trying to say essentially what a nurse does is she does TASKS all day. And what task does she do that somebody else can do? So that was the whole purpose of breaking it down into tasks.

Int: What do you think of that?

W: It's stupid because when they aren't- it's just like this guy from the hospital association on TV, he's like, Well you don't need a nurse to change the bed. It's like, no you don't need a nurse to change the bed, that's true. But while the nurse is helping this patient, changing the bed while they had their bath -- she got them up out of bed -- she could see, you know, maybe their legs were oozing, that's why the bed needs to be changed because there was something going on. The IV was leaking or SOMETHING. It's not JUST changing a bed.

Many RNs believed that attempts to fragment nursing labor and integrate unlicensed workers ultimately placed patient safety at risk. Even if unlicensed workers had clearly restricted roles, their lack of education would prevent them from identifying a problem. Nearly every RN and licensed or certified worker gave me real-life examples of how RNs' advanced education and training avoided a potential crisis with a patient, or how an unlicensed worker, out of ignorance, unwittingly endangered a patient. These stories, along with the idea that unlicensed workers "don't know what they don't know" is crucial to explaining the construction – expressed primarily by licensed and certified workers – of educated staff as a "protector" of patient safety (and conversely, uneducated staff as risk or danger to patients). Moreover, while education is essential to have an overall assessment of the patient and to identify potential problems, nursing also relies on a "gut feeling" to sense if something's wrong.

Ann (RN-X): So, I think that, that's what's scary in healthcare, and over the years I've heard of things they're doing at Kaiser that are innovative yet you wonder [about] bottom line patient safety type of thing. You know having TRAINED somebody to read a monitor, well, you know, there's a gut feeling besides looking at a monitor. You kind of have to KNOW what's going on physiologically with the patient and be able to sort of run in the room and be able to say, yikes this is really

> happening. We got somebody just trained to sit there and watch the EKG tracing and it just seemed a little scary to have untrained people. Well, they were TRAINED, but they were, they just -- not trained professionally. Don't have the whole picture....
>
> Willy (RN, CNA activist): And even in the hospital bad things can still happen even if you're totally staffed and have an all-RN staff, bad things still happen. You have equipment failure, you have medications that can be labeled wrong, you have the pharmacy send up wrong things that say they're labeled one thing but they're not. You know, there's all kinds of places mistakes can happen. And that's with people that are LICENSED and KNOW what they're doing. You're opening up a whole can of worms when you have people that AREN'T licensed and don't have ANY idea of what they're doing.

Delegating work

Most licensed/certified workers feel that licensed workers are essential for patient safety – even for the "dirty work" – because unlicensed workers don't have the education to recognize potential errors or problems. These workers believe unlicensed workers should be restricted to patient "comfort" and nonclinical responsibilities, but if some patient care duties are delegated, there first needs to be improved screening and training in order to establish a baseline of competency among unlicensed workers, and there needs to be an adequate number of RNs to properly supervise the unlicensed workers.

> Lynn (certified Local 250 worker): ...And the quality of care, at least from my point of view would be that it's being administered by licensed individuals. Or you know, in- they're GUIDING everybody else through this. Not that you shouldn't have non-licensed people working but you need a certain appropriate amount of licensed to you know, be the leader here. [Kaiser is] stripping away these people which means that the public is being left in whose hands here? People that aren't licensed, that don't have the medical knowledge to draw on. They're drawing on their own life experiences or what they may have been exposed to on the job. You know perfectly well you don't stop every time somebody asks you something and ask a doctor, what am I doing? How do I do this? I mean, you know, you just DON'T. You're not TAUGHT these things...So what are you drawing on, you know?
>
> Bea (RN, CNA activist): ...in the most recent years, especially at Kaiser where I work they've offered severance packages [to RNs] because they were saying we were over budgeted, there were too many nurses and that Kaiser could care for the patients with non-licensed personnel... They're wonderful people, but they're not licensed... They mean well, but because they need a job they'll do anything that Kaiser will ask of them. And I like most of these people, but, but if it was my loved one in the hospital, I would truly be afraid because they don't know what they're doing. But

> they don't KNOW that they're NOT capable of doing the job that they're asked to. And, so, it's a vicious cycle. It's scary. If I had a loved one in the hospital on the ward, I would be there with them twenty-four hours because with the way the wards are staffed it's, you know, some patients don't get any care until, you know...

These excerpts demonstrate workers' agreement that Kaiser's "stripping away" licensed staff and using unlicensed workers for clinical tasks are not "safe" or part of an "appropriate" division of labor. However, they also demonstrate differences in how workers constructed the "problem" in staffing. The first comment criticizes Kaiser and then begins to insinuate blame towards the workers Kaiser has assigned to patient care. The second comment likewise criticizes Kaiser but expresses a more sympathetic perspective towards the unlicensed workers.

Licensed and certified workers' perspectives emphasized that when patient care is predominantly organized as a series of discrete "routine" tasks conducted by a workforce of predominantly unlicensed workers, rather than a holistic labor process conducted by RNs, there is far less likelihood that the downsized RN workforce can adequately "put all the pieces together" – and that patients' well-being is at risk. These perspectives reflected the "non-racial" ideology of Primary Nursing (all-RN staffing) that emphasized the RNs' education and licensure as criteria for both "skilled" and "unskilled" labor. This emphasis on education sometimes was equated with intelligence and commitment to care, as several informants characterized unlicensed workers in patient care as unthinking "dummies" who simply did their task and cared about nothing else. Moreover, despite the lack of explicit references to race, race was embedded in the restructuring of the health care labor process due to the changing race, gender, and class and composition of the workforce assigned to the bulk of direct patient care.

Helping the RNs, helping Kaiser

For their part, unlicensed workers saw their role as "helping" the RN and the care partner, not "replacing" RNs. The hospital unlicensed workers consistently expressed dismay that there were not enough RNs to adequately care for the patients – suggesting that they saw clear delineations between "RN work" and "care partner work." Two long-time unlicensed workers, however, said that they had much more conflict with RNs about the division of labor in the last five years (when Kaiser began reducing RNs in direct patient care). The unlicensed workers talked a great deal about inadequate staffing overall – and that it was "unfair" to patients to not have more RN contact and dialogue.

In the clinics, however, the MAs directly said both that they "took over the RN jobs" and that the RN jobs in the clinic were vastly different from the RN roles in the hospital. Hospital and clinic MAs reflected union or Kaiser ideology in that a nursing shortage made it "important" for unlicensed workers to pick up many of the tasks formerly done by RNs. One unlicensed worker said that Kaiser "cooperated" with Local 250 to train the people who were already employed. Clinic MAs expressed that they were helping Kaiser save money by doing what clinic RNs did at a lower pay rate: "Why pay a nurse $40 an hour when you can pay a Medical Assistant $12?" This comment reflects the "typical" RN salary Kaiser propaganda deployed during the labor conflict with CNA, a figure that CNA repeatedly disputed, arguing that actual RN salaries were much lower. (Several CNA activists told me that RNs start at around $24 an hour, and take over 6 years before reaching $30; the CNA contract reflects this).

Several hospital unlicensed workers complained that the RNs had "forgot their jobs" when care and service partners were introduced – and basically dumped a lot of their work onto the care partners, who then would call on the service partner for help, and

both would be continually overwhelmed with work. They saw the majority of RNs as doing only specific tasks and "not enough" of the routine, "dirty" work to help the care- and service partners. One former hospital nursing aide told me that many RNs he knew did not fit the militant profile of the CNA activists, and were happy to have the opportunity to delegate the physical, hands-on work of nursing.

> Jamie (Medical Assistant, former hospital Nursing Aide): Yeah. I can only say for myself ... let's put it this way, I saw a lot of RNs who were damn glad to get rid of these tasks. To not have to do them, to be able to sit and do paperwork, and do nothing else. Were THRILLED. There are some, there are some older RNs who love to have the hands-on [patient care work] and who miss that, but I'd say the majority of them were thrilled that they didn't have to do 'em, the one's that I worked with. And as far as patient care, they were GLAD not to have to do patient care. I mean they talk about, you know you hear about all this stuff, and when they've done their labor stuff about oh, you know all this altruistic stuff about wonderful patient care and everything. That hadn't been my experience. You know, I'd say the majority were thrilled not to have to go in there and give a bath, or you know, were able, were thrilled to... I mean I'd say many of them were glad to, Go do this, Go do that, Go do this, you know.

Jamie distinguished between the "old school" RNs who valued hands-on work and the "new ones" who disdained it. Although none of the RNs I interviewed expressed these sentiments, it is entirely possible that some RNs took advantage of the opportunity to delegate the dirty work to subordinates, mirroring the racial division of reproductive labor that infused the professionalization of nursing. However, it is equally possible that reduced staffing restricted RNs to high-priority tasks. The point, however, is that the workers' interpretation of the changes in work reflected the race- and class-stratification and power relations within nursing, in that relations were assumed to be conflictual or demeaning, rather than cooperative and respectful.

Convergence?

Workers' constructions of safe staffing ultimately agreed that RNs are essential actors in the health care labor process, that RNs should have a central place in direct patient care, and that Kaiser's reduction of RN staffing hurts the RNs and degrades patient care. RN informants were basically united in advocating a return for RNs doing all, or nearly all, of direct patient care – especially those recently delegated tasks formerly restricted to licensed or certified personnel (e.g., injections). The RNs also expressed that other health care workers were absolutely essential to health care delivery, but in support roles to the RN, not in direct patient care.

Local 250 members varied in terms of the type of responsibilities that could be safely delegated, but none suggested that RNs could be replaced by unlicensed workers in the hospital nursing process. (In the clinic, unlicensed workers did express this belief, but emphasized that RN jobs in the clinic were vastly different from RN jobs in the hospital.) Most Local 250 members, while expressing that RNs are central, did see a place for unlicensed workers in more restricted areas of patient care, but differed loosely along occupational lines and union affinity; a "safe" division of labor meant there were adequate numbers of all staff, and of licensed staff to supervise the unlicensed workers. All felt that there should be more RNs, and that RNs should work more "side-by-side" with the unlicensed workers.

RNs and licensed/certified workers couched the implications of RN understaffing as jeopardizing "patient safety." Unlicensed workers' generally spoke about concerns with "patient care." These differences in language may reflect nothing more than differences in education and training, but they also may reflect underlying attitudes towards "others" and the impact on patients as the health care labor process is

restructured. For example, nearly all Local 250 informants argued for increased staffing overall so licensed workers can provide adequate supervision and patient care. Few RNs also argued for this – they argued for more RNs. This is not surprising given that RNs are the main occupation targeted for downsizing and deskilling so that these support workers can be repositioned into patient care.

While the RNs' stance was informed by Kaiser's restructuring and the CNA ideology, it may also reflect the RN-centric occupational vision that has characterized Registered Nursing historically: RNs are the most important and most devalued caregivers, and are regularly targets of cost-cutting schemes by health care elites. Local 250 members have a different orientation – informed by labor union ideology and by the sense of "worker" identity that emphasizes working together to provide quality patient care, and nurturing labor solidarity to resist exploitation.

These different perspectives, moreover, reflect the legacy of the racial division of reproductive labor in which worker "qualifications" for upward mobility were contested between different ranks of workers. Historically, the emphasis that education, training, skill, and licensure was necessary to provide "professional" quality patient care was used to justify defacto racial segregation in employment when overt segregation was outlawed. The competing perspective that RNs are not necessary for all patient care work reflects the resistance of subordinated nursing workers whose actual skill, training, and experience was routinely devalued as justification to maintain the racial division of reproductive labor.

Workers' agreement about safe staffing and division of labor, then, while ultimately reaching the same conclusion, remains riddled with difference based on

constructions of collective identities and sense of group position, informed by the legacy of the racial division of reproductive labor. Workers' perspectives about restructured occupational roles informed and reinforced constructions of "safe" staffing, and the appropriate "places" of different workers in the health care labor process.

Constructions of "others": Do race, gender, and class "matter"?

None of the informants talked about race, gender, and class until I brought it up, and differed widely in how they "saw" (or not) differences in power and status. The most visible markers of status were class and gender. Nearly every woman I interviewed, and a few of the men, saw gender as a prominent force in the devaluation of nursing work and the subservient and passive nature of most RNs. Many say if more men were in nursing, nurses would get the respect and compensation they deserve.

However, when I asked interviewees if race, gender, or class informed worker relationships, nearly everyone said right away that the Northern California city in which this study focused is extremely "different" in terms of more gender and race-ethnic diversity – and that the Kaiser facilities in this city reflected the diversity. Most of the white workers said there were basically "no problems" in terms of race informing interpersonal relations – and that problems occurred when racial issues were created out of nonracial ones. Most white workers didn't "see" racial stratification (or said it's not that visible), and emphasized that Kaiser is diverse and "homogenous" (when I asked what they meant, they said "all mixed up" without one group dominating the others). Most people of color and a few whites saw racial stratification and discrimination in interpersonal (inter-occupational) relations – but emphasized that Kaiser, especially in this geographic region, is much more diverse than other hospitals. The African American

workers said that most whites don't "see" anything that has to do with race—either tension or joking– and that racism in interpersonal interactions was largely due to the white person's lack of awareness or sensitivity, or basic cultural differences in communication between different groups.

While race, gender, and class were "seen" or "not seen" in these ways, they were nonetheless embedded in the organization of work and the stratification of the labor force. They informed how workers described one another, and interpreted the changing division of labor and inter-group relations of the workforce. When I asked interviewees who the RNs were in terms of demographics, workers said "women," and "older women." Several RNs also claimed that many RNs were "married with families." Both RNs and unlicensed workers described RNs as very passive, unwilling to enter into conflict with Kaiser, and intimidated by the physicians and managers; more RNs than unlicensed workers also characterized some RNs as strong and "fighters." Most workers did not elaborate on racial-ethnic diversity until I asked them (sometimes twice) – and then they emphasized that the RNs were NOT a majority-white female workforce – there were "lots" of Filipinas, and "quite a lot" of "men," and "gay men and women," "different types of Asians," and "not so much" Black or Latina RNs (and more women than men). Many workers detailed their RN workforce portrait by describing the different ethnicities of white and Asian RNs.

When I asked interviewees who the unlicensed workers were, they said "a lot of Blacks and Hispanics" or "mostly African Americans," and "Asians" and "Filipinos" and "immigrants" – and a higher percentage of men than in the RN ranks. Many informants did not distinguish between repositioned nonclinical Kaiser workers and the new workers

hired en masse to fill many of the new care partner jobs. The RNs in particular characterized the new workers as people for whom this is their first job – persons who are recently off "welfare," "single mothers," and "young people." Several of the Local 250 workers characterized many of the new workers as "immigrants" who are afraid to speak up, and will do whatever they are told.

While workers described a racial division of labor, they also emphasized that Kaiser's racial and gender diversity did not exactly mirror the white-Black/racial-minority dichotomy that characterized earlier eras, and which persists in less progressive or less diverse regions of the country. From workers' descriptions of who comprised the different ranks in the health care hierarchy, however, the class-race intersection maintained the white-Black "racial binary" (Brodkin 1998) that has characterized the U.S. racial order. As many workers described both more- and less-powerful others as belonging to the same racial-ethnic group (e.g., Filipino), the class-race intersection provided a commonsense organization of the hierarchy.

This racial binary infused workers' different constructions of their own and others' class position in the occupational hierarchy, even if they were not explicit about it, and informed how they conceptualized (or not) worker solidarity. Local 250 workers in general alluded to class and working people's solidarity, and unlicensed workers in particular focused on their devalued status and need for solidarity with other workers, criticizing some RNs (or the CNA) for thinking they were "above" the other workers. RNs' allusions to class focused on the devalued status of nursing, and linked class with gender. When I asked RNs specifically about class they all spoke about the contradictions of RN status – a professional who also "wiped people's butts." Several RNs claimed to

not see any class "difference" between workers despite making several demeaning characterizations of unlicensed workers' allegedly low intelligence and "character" in scenarios in which the unlicensed worker was charged with doing patient care.

Informed by their perspectives on Kaiser's restructuring that reflected either the CNA or Local 250 orientation towards Kaiser, licensed/certified workers constructed unlicensed workers as either on the side of Kaiser or on the side of patients, based largely on how they were perceived to accommodate Kaiser's restructuring that assigned them to provide certain functions of direct patient care. The non-LVN professionals (more sympathetic to the CNA) expressed a sense of "difference" from the unlicensed workers – in terms of education, intelligence, and more awareness and conscience about the quality of patient care. The LVNs (Local 250 union activists) expressed a difference as well, but emphasized an equal commitment to patient care all around.

> Lynn (certified Local 250 worker): When we first started this new way of running our clinic we were training our receptionists to, you know, cross train so that they would be working in back. And in back meaning working with the physician and the patients in patient care. So that the receptionists went to, I believe it was, a six to eight week course, you only went two days a week, given by Kaiser to say, OK you're, you know, capable of being- you're now a Medical Assistant. Well this Medical Assistant title only applies within Kaiser because if they should leave Kaiser and apply at UC [University of California medical center], they are not Medical Assistants. Only in Kaiser's eyes are they Medical Assistants, so that kind of gives you an idea truly of, how intense was this training?
>
> OK. So now these individuals are turned loose and many of them have no idea what to ASK because they don't know, they have nothing to draw on, so they can't ask the questions that, you know, I might ask. Or, you know, someone else might ask, or even question something. You know, where are they getting this from? They're also intimidated by physicians, OK so if a physician tells you, I want you to do X, Y and Z, you don't question it, you simply DO it.

> Cheyenne (LVN, local 250 activist): ...there's so much you can do in 8 hours, with short staffing. And it puts the patients at risk. And this is scary, because a lot of our MAs just started giving injections. And there's either supposed to be an RN, a lead LVN, or one of the docs checking each one of their injections before they give them,

> and, I don't think it's happening. I really don't. I'd say most of them yes, but some of them no. And our MAs are REALLY concerned about this, because they WANT to do the right thing, but there's nobody THERE to double check their work a lot of the time. So. It's scary. And our patients ultimately are the ones that suffer, so, there's got to be some positive changes.

Licensed workers rarely if ever mentioned race as a marker of difference between RNs and unlicensed workers that could contribute to inter-group tension or conflict. Instead, the emphasis on education, often became conflated with intelligence and commitment to care. In several interviews with licensed/certified workers (RNs and others), informants characterized unlicensed workers assigned to patient care as unthinking, uncaring "dummies." Most licensed workers, however, constructed unlicensed workers as low-status workers forced into jobs for which they were not qualified, and who participated in these jobs because of financial necessity or misguided sense of "qualifications." From informants' accounts of their own or others' experiences, racial "othering" at times infused the class construction of unlicensed workers, and contributed to the "us/them" dichotomoy fostered by historical relations and local circumstances.

Along with race, gender, and class, age also appeared as a marker of difference and inter-group conflict. Many workers – both formally interviewed and who talked to me informally – brought up age, specifically "youth" of the new unlicensed workers as a prominent dimension informing inter-group relations – between physicians and Medical Assistants, and among different workers. These new and young workers were consistently characterized as persons who "think they know everything" or "think they're supposed to do certain things" in the division of labor. Longer-term Kaiser workers bristled at the "know it all" attitude, and RNs in particular saw this as jeopardizing patient

safety because of the new workers' lack of education, training, and experience. In particular, several long-time workers pointed out that the new workers as "young girls" were easily manipulated by managers and physicians, through intimidation or flattery. In their work, these new workers relied on the knowledge and experience of the older women workers, but also resented them telling them about what they can or cannot legally do, despite some physicians' assurances it was fine.

Older workers (both Local 250 and CNA) were seen by both licensed and unlicensed workers as "risks" to patient care and to labor solidarity. Several workers (licensed and unlicensed) talked about older RNs who were unable to deal with some of the technology, and thus placed patients at risk. Their passivity towards the physicians meant they were unwilling to "rock the boat" against the doctors' decisions, and were just "biding their time, waiting for retirement." These workers also described the RNs as disorganized and frazzled, which interfered with the work processes of the unlicensed workers and created conflict and more stress since everyone was already stressed out from the intensified workload. Several unlicensed workers saw older workers as unwilling to join in sympathy strikes or other ways of supporting workers, because they were afraid of losing their job and their benefits, especially the retirement benefits.

Relations of health care: Relations of status and power

Getting along under chronic stress

How do people get along on a daily basis? As described in Chapter 6, the stress from short staffing intensified production and strained positive work relationships, and exacerbated inter-personal, inter-occupational, and other tensions stemming from Kaiser's restructuring of the labor process. Everyone was extremely stressed, in large part

because of the imposed pressures of new roles and responsibilities, increased workloads and sicker patients. RNs resented being responsible for the work of people they did not want and did not trust (as a group); the unlicensed workers resented the dirty work, the unreasonable expectations, the lack of autonomy (ability to organize their work) because they were now the RN or physician "go-fers." All workers wanted to return to doing the type of work – with a manageable workload – they were doing before restructuring. Many workers reported that everyone basically gets along, but everyone is so stressed and "burnt" – they often snap at each other. At its worst, the environment is described as intensely competitive, characterized by one RN as a "war zone" where RNs fight each other over scarce resources – hospital beds, support staff – as they try to take care of patients.

> Int: So, what do you think, I mean, workers get affected too [by all the changes].
>
> Bea (RN, activist): Yes. The stress level, yes.
>
> Int: Tell me, tell me about that.
>
> Bea: Okay, okay. I think I'm a very good nurse and, you know, I'll always do my best for a patient. ...I'll try and get a patient to a room if they're to be admitted. And they'll say, Oh, oh bed's not ready. You know, there's still a patient in it. So, I'll keep calling, I'll keep calling, you know, because my patient's asking me, When can I go, when can I go, da da da da da. And so, you know, so even though I know the nurses out on the floor -- they're not lazy, they're not dumb, they're not stupid, they're just OVERWORKED. They're just overworked because of the lack of BEDS, lack of, you know, nursing help, that THEY'RE stretched, and even the [service partners] -- these people who are supposed to be cleaning these rooms when the previous patients gone home -- THESE people are working between two floors apparently, and so this bed could have been probably made a half hour ago, but the [service partner] is on another ward doing something else. And so they'll call, but, but if they're busy doing something else, this bed will have to wait. So, my patient will have to wait in the recovery room. We've actually had our OR [Operating Room] transporters go out and clean the room and make a bed just so we can get our patient into the bed.
>
> ...It's so FRUSTRATING because then, you know -- and I usually have a very good RAPPORT with the people on other units, but because of that, it's this constant-- so in a way the hospital makes-- pits the nurses against the nurses on different units. You know each unit, the ER is always trying to get their patient out of there because they need THEIR space, we try to get our patients to the wards, to the ICU's, but they

> don't have any space, and so the nursing staff, we're all short tempered and that is the most frustrating thing about the job is that. It's not, I love the patients, you know, the patients are NEVER the problem. It's always the constant FIGHTING for beds and with the staff. For whatever reason, bed's not ready...you know, da da da. I say, Well why isn't it ready? And then, they have their reasons, and they're totally valid and legitimate, but it still doesn't, you know, help me because I have patients waiting on my end to go. .. you know, on the outside, everyone is very nice, you know, we all socialize together. But, when once we get in the work environment it becomes a war zone. It really does.

Bea used "war zone" when describing how she tries to get the work done in a situation that "pits" the nurses against one another. While "war zone" was the most extreme characterization used by workers, the climate of stress and conflict appears in numerous interviews, as informants described work as an constant struggle to provide patient care in an understaffed and increasingly stressful environment. RNs and LVNs described fighting managers and physicians so patients would not be discharged and their safety would not be at risk. Several licensed and unlicensed workers also described RNs and unlicensed workers fighting over the delegation (or not) of certain work responsibilities. Other descriptions of stress and conflict highlighted situations in which RNs would brusquely order around unlicensed workers, often because of the pressure of the work speedup, and these workers would resent it because they were already working harder than ever, and felt overloaded and exploited. Despite these pressures, all workers emphasized that "patients are my priority" and that, as Bea said, "the patients are NEVER the problem."

But stress did not always produce a conflict between workers. Several RNs and care- and service- partners talked about co-workers (same or different occupations) who they valued because of their work and cooperative spirit. All workers saw Kaiser's corporate power as being ultimately responsible for their increasing exploitation and

stress. How workers related to one another as they focused on "getting the work done" was informed by how they "see" their own and others' collective identities – informed by race, gender, and class – and the conflicts or convergence between perspectives on "safe" staffing and division of labor.

Workers relationships to one another

Workers' relationships to one another are structured by the legal responsibilities assigned to licensed workers, and the different degrees of authority officially and unofficially assigned to these workers. Licensed workers remained legally responsible for the unlicensed workers' work. RN licensure, for example, mandates that the RN be confident in a worker's competence in order to delegate a particular task (Bureau of Registered Nursing, quoted in SNAP/CNA 1998). In the hospital, RNs are caregivers, and "quasi-supervisors" and teachers of the care partners and service partners assigned to pick up "routine" RN tasks. In the clinic, RNs are moved into an "extended role" in which they deal with more complex work, and much of their former, often routine work is picked up by unlicensed Medical Assistants – whose work with medications or injections are signed off by the lead LVN, the RN-X, or the physician. Status differences and relations of power were both retrenched and undermined by the intersections of race, gender, class, age, and "immigrant" status.

Physicians: Distance and power

Before attending to the relations among workers, it is first important to briefly discuss the position of physicians and their influence on the work environment and co-worker relations. Having responsibility for someone else's work differs greatly between RNs and physicians. While both are legally responsible for the unlicensed workers' care, RNs are at far greater risk for discipline or firing. The main difference in status is because

the physicians are not employees, but owners-managers – and as such, they are insulated from the risks and tensions produced by the restructured labor process.

As described in Chapter 6, physicians were perceived by workers as distant from the daily "caring" of health care through their drive to "do their procedures" with minimal regard for the available resources to care for the patients. They are also insulated by their power and distance provided by their social status (informants described most physicians as male and white, despite a greater "diversity" than at other hospitals and in other regions of the country). The physicians do not get involved with the conflict of daily inter-group relations at work – while their actions individually and collectively contribute to the conditions in which the workers find themselves. They are buffered by their status and power as management partners from the material consequences of their collective decisions.

RNs and unlicensed workers

The relations between RNs and unlicensed workers are informed by the restructured occupational hierarchy and labor process. RNs were already anxious and upset about RN job reduction, difficulty of the work with reduced staffing, and eroding job security. They are legally responsible for patient care and have a strong sense of commitment to acting in patients' best interests. They look at the new workers as unqualified trespassers (willing or forced) into RN work domains – as "shoo-in's" thanks to their seniority at Kaiser and the power of their union. RNs have no authority to hire, discipline, or fire these workers, but were forced into a training and quasi-supervisory role with them, and are responsible for the patient care work they do. (These feelings were directed nearly exclusively towards the unlicensed workers who have little or no clinical experience; RNs expressed trust for "former" LVNs who are now care partners.)

The unlicensed workers were told of new patient care responsibilities to integrate with their old ones, but they have virtually no independence in determining their organization of work due to the unpredictability and exigencies of health care – when the RN or physician calls for help, they have to be there right away. In this sense they became more directly subordinate or subservient in the occupational hierarchy because they have to answer directly to the RN or physician – a role of somebody's "go-fer" instead of a co-worker responsible for a discrete domain of work (e.g., housekeeping, reception). Whether they were confident in doing the patient care work, or uncomfortable and avoidant, their presence was often met with RNs' skepticism about their ability to do the work.

The vast majority of RN accounts concerning their sense of group position in relation to less powerful others focused on ideas about division of labor and patient safety. While RNs' accounts of group position relative to more powerful others highlighted how gender prominently marked RNs as subordinate, RNs' accounts of relations with subordinate others consistently failed to bring up gender as an axis of power, as well as racial or ethnic dynamics.

Most RNs – of different racial or ethnic groups – did not talk about race or class overtly in these relations, and instead emphasized issues such as unlicensed workers' "training," "qualifications," "attitude" and other characterizations that have historically racialized and "othered" subordinate workers. These characterizations served to defend the traditional occupational hierarchy and labor process with RNs at the center. (In contrast, only one RN account of "training" or "qualification" questioned RN competence.) In these constructions of group position vis a vis less powerful others, RNs

were the normative standard against which subordinate workers were "othered" through terms that carry racial connotations of inferiority.

Several white and Black RNs expressed an awareness that RNs' position "over" other workers in combination with the racial stratification in nursing, often produced a "better than/less than" attitude on the part of RNs that informed the working relationship.

> Skip (RN): You know, it's like a BETTER than, LESS than kind of a scenario particularly around people, you know, at least in the health profession... you know, RNs generally have some leadership and, you know, responsibilities are on running the unit and everyone else is underneath, to the level that the folks that are like care providers or janitors, people with those kind of skills, you know, it's almost, you just sense it because often they're either African American or some people of color, you know, maybe not as well educated as they could be, but still, you know, are human beings. And I often see, it's just that, it's almost not like they're not treated like human beings, but it's like they're LESS THAN human beings, and I SEE that.
>
> ... some of the [shift change] reports [between RNs] will be about what this person didn't do – and it's just that DEROGATORY kind of NEGATIVE TONE about what an [unlicensed worker] wouldn't do. You know, "I had told them to go in there and clean up this thing" and, you know, it's just the way its kind of put out and, you know, you just sense that well, maybe if you would have asked, hey, let's go do this together, or it's like there are certain kind of communicated things better. But you just, you can't help but FEEL it and I think being a BLACK man you kind of may be – super-sensitive might be too strong of a word, but definitely SENSITIVE to the fact that, you know, there's probably more to this than just this person being an [unlicensed worker] 'cause they're either Hispanic or Black or Asian Americans, and just, you know, it's not only the tone [of voice], but the facial expression that you kind of witness when people kind of report what, whatever went on...

What was more common, however, was RNs' consistent focus on having to get the work done with co-workers who, as a group, are less "qualified" than RNs. RNs talked about how service- or care-partners are "inconsistent" and "you don't know what you're getting," in that some workers are "excellent" and very helpful, and some are not. This is usually related to a worker's previous experience – those who are certified nursing aides, nursing students, or nurses trained overseas (and not licensed as RNs in the USA) are the "trustworthy" and helpful co-workers. The LVNs, demoted to a job classification

of primarily unlicensed workers, are also in this category. The "problems" are those workers who are neither motivated nor competent to do the work the RNs and other workers expect of them.

For their part, unlicensed workers talked about RNs' ability to do their job "right," their willingness to work cooperatively, or their demeaning attitude and delegation of work towards the unlicensed workers. "Problem" RNs were those with demeaning attitudes towards the unlicensed workers, and who were excessively critical or unwilling to help – or whose own disorganization disrupted the subordinate workers' organization of their work (e.g., by directing them to do tasks where their time is "wasted.") Workers talked about others in their occupation in the same terms as well – several unlicensed workers referred to other unlicensed workers who are "lazy" and unhelpful, and several RNs talked about other RNs who were demeaning to unlicensed workers, were "lazy," or who never pitched in – when possible – to help with the "dirty work" assigned to the unlicensed workers.

Class, and to a lesser extent, race was salient in accounts of unlicensed workers' relations with more powerful others. Several workers (Black, Filipino/a, and Latino/a) discussed how racial prejudice or discrimination by more powerful others put them more at risk of criticism or discipline from superiors – who were either white, Chinese American, Filipina, or Indian/South Asian. While they described their (and other unlicensed workers') relations with managers and physicians as largely authoritarian, they described relations between unlicensed workers and RNs as dependent on the personalities involved. RNs were characterized as respectful and cooperative, or hostile and demeaning. Their descriptions of "personality," moreover, were tied to their

assessment of how hard the RNs worked, and to what degree RNs worked cooperatively (including sharing the "dirty work") with unlicensed co-workers. Many unlicensed workers expressed feelings of concern for what they perceived to be RNs' exploitation, and told me they encouraged the RNs to complain to their union about mistreatment by managers or physicians.

Racial tensions were rarely mentioned as a factor in RN-unlicensed worker relations, despite the perception of many workers that a racial division of labor existed to some degree (RNs were characterized as predominantly "white," "Filipino," and "Asian" women; unlicensed workers were characterized as men and women who were predominantly "Black" or "African American," "Filipino," "Hispanic," and "Asian"). I argue that the historical legacy and contemporary incarnation of the racial division of reproductive labor informed these relationships, where race – with gender, and class, and other axes of power – was embedded in the organization of the labor process, even if it was rarely named as a salient feature of inter-group relationships.

The quality of the relations between unlicensed workers and RNs were informed by the feelings about new roles and responsibilities, by the degree of agreement or conflict over the appropriate division of labor, and by how workers regard the reduction of the RN workforce and the restructuring of labor process and repositioning of unlicensed workers in patient care. RNs saw this as a way for Kaiser to quickly cut labor costs, marginalize RNs and their power/presence, and exploit them; it was a short-sighted scheme that did not consider the risks to patient care. Unlicensed workers saw the changes as opportunities for upward mobility and improving patient care, and better use of Kaiser's limited RN staffing and financial resources (they were told by union and

management that there was an RN shortage, and that Kaiser needed to cut costs in its struggle to compete against other health care organizations). However, as workloads increased to levels where both RNs and unlicensed workers became increasingly worried about quality of patient care, all workers agreed that Kaiser's cost-cutting exploits workers and risks patient safety.

Positive relations involved a shared sense of commitment to the patients and a shared sense of one another's exploitation, stress, and anxiety in the work. Positive relations were also based on a general agreement of the division of labor. Numerous workers referred to others in different occupations as "stretched," "overwhelmed," "wound up," "bugged out," and expressed a great deal of empathy and concern about their well-being. They joked to relieve their shared stress ("Where's my aspirin? Where's my aspirin?"). They saw their situation as caused by corporate decisionmaking to cut costs without thinking through the consequences, and saw one another as "victimized" by the changes. They encouraged one another to take issues to their union representatives and fight back against unfair and unsafe conditions and work assignments.

Negative relations centered around "attitude" and perception of competence, respect, and autonomy in the restructured work process. These conflictual relations were informed by race, gender, and class constructions of group identity, and constructions of "qualified" workers and a "safe" division of labor. Several unlicensed workers described how certain RNs resisted giving up their patient care work, or simply weren't good at their new role as teacher or trainer. However, RNs' perceived and legal "mission" is patient care – and their legal responsibility for patients takes priority on the floor. RNs consistently expressed uncertainty about working with unlicensed workers because they

differed so widely in terms of skill and motivation. RN informants said they are hesitant about trusting unlicensed workers who have minimal clinical training and experience with patient care work, and that they would often do the routine work themselves rather than delegate it. Race and class tensions between the two groups exacerbated the stress of the work environment, as the RNs are largely white women, and the unlicensed workers are largely racial minorities. Unlicensed workers interpreted RNs' lack of "respect" for them as informed by race or gender prejudice; this was usually denied by the white RNs, who claimed that racial "issues" were created out of "non-racial" situations.

The unlicensed workers wanted to do their work and didn't like RN micro-managing them, the feeling of surveillance, or the inconsistency in organization of work. However, some unlicensed workers did not like the work, were acutely uncomfortable and tried to avoid doing it – these efforts were not supported by RNs, who still expected them to do what they were trained to do, and resented their attempts to avoid their new responsibilities. Many of the unlicensed workers felt like job changes were positive for patient care and their job mobility – but as their amount of work increased to near-impossible levels, they resented the impossibly high workload and sometimes saw the RNs at fault for not helping them. They often felt distrust, disrespect, and hostility from RNs, who could devalue their work or blame them if they were unable to complete the multiple and simultaneous demands on their shift.

The RNs, for their part, felt that having a restructured labor process with fewer RNs and more unlicensed workers simply made more work for them – in both the mechanics of the work and the social relations that go along with it. They were already stressed and anxious about patient care because of the reduced RN or skilled nurse

staffing, reduced hospitalizations, and higher patient acuity. They looked at Kaiser's cost-cutting schemes as dangerous to patients, unfair and exploitative to all workers, and an attempt to make RNs "less important" at Kaiser – while also demanding more of RNs. While some RNs criticized Kaiser for the stressful situation, some extended the criticism to Local 250 and the workers themselves for actively taking part in, or otherwise accommodating, the restructuring of health care labor process that "replaces" RNs with unlicensed workers.

"Pecking order": RN authority challenged and responsibility entrenched

RNs' contradictory class position takes a new twist in the restructured health care labor process. Race, gender, and class inform tensions and relations of power. The physician-RN relationships highlight the gender and class dynamics; the physician-Medical Assistant relationships highlight race, gender, and class. Physicians as largely white men are buffered from the physical proximity and close working relationships among RNs, LVNs, and unlicensed workers. In the relations between RNs and unlicensed workers, race and class tensions exacerbated the stress of the speedup and the chronic understaffing. All RNs, regardless of race or ethnicity, expressed concern about RN responsibility for patients without the power over the patient care process – and saw the incorporation of minimally trained staff as potentially jeopardizing patient care.

Responsibility for unlicensed workers' work without any authority "over" the workers themselves put RNs in a position where the traditional occupational hierarchy of nursing was simultaneously subverted and retrenched. They had to deal with varying degrees of motivation or "attitude," competence, and cooperation or insubordination. This was expressed across race or ethnicity of RNs; however, it was more likely that RNs

who were people of color would extend the analysis to seeing the unlicensed workers' side of things and not insinuate blame. RNs were reluctant to write up and call for discipline of unlicensed workers, and often dealt with "difficult" unlicensed workers by not confronting them, and asking others to pick up the slack. RNs' resistance to having unlicensed workers varied, but they agreed that the unlicensed workers should competently do the work they are supposedly trained to do – and make the labor process "work" for everyone.

The historically conflictual inter-group relations between unlicensed workers and RNs over the division of labor now occurred in a restructured health care labor process where RNs' traditional authority was no longer recognized. The RN-Aide or RN-LVN conflicts that characterized Team Nursing were eliminated by Primary Nursing, as subordinate workers were displaced from patient care. Now, in the restructured Kaiser units, these conflicts resurfaced, but without RNs' authority to "manage" it. In an account that typifies many of the RN-unlicensed worker conflicts, Ann regarded the conflict as primarily class-based, "diluting" the possibility for racial tension by alluding to Northern California Kaiser's diverse workforce.

> Ann (RN-X): Well, the Medical Assistants feel like the nurses are over-paid and that we don't do anything. That type of thing. And some nurses sort of do treat the Medical Assistants as sort of, you know, kind of know-nothings and underlings and that, that's a problem with one of the nurses that has the same position I do on another floor, and she has a lot of problems with that floor. But, I think that's kind of part of it, and I think a lot of the MAs resent some of our, we don't really have any AUTHORITY over them per se, but they just well, they think they're, they just know everything and blah, blah, blah, blah, blah...
>
> So, I don't know if it's, if it's a racist type of thing 'cause some of them, there's sort of ALL different nationalities. I don't know much about the Chinese [Adult Primary Care] module. I never worked down there, but I, part-time when I was doing this mentoring for my position, I was on the Spanish floor [Latino module], and I could see what was going on there, what they would refuse to do. And the nurse who was hired as the, you know, the Spanish RN-Extended Role ended up LEAVING

> before she even, her position even came into fruition because she was new to Kaiser, and she just couldn't handle the way these Medical Assistants were sort of refusing to do things, or telling HER how to do HER job, and that type of thing.

As the RNs expressed skepticism or concern about the dubious skills, motivation, and aptitude of the new patient care workers, they also articulated a concern that their own knowledge and abilities were not respected by Kaiser management or these co-workers, which ends up altering the traditional "pecking order" of nursing staff and the effectiveness and safety of patient care. Several RNs described situations where their direction was not followed by the unlicensed worker, and that management did not "back up" the RN.

> Willy (RN, activist): ... I had a nurse that was a charge nurse in the clinic on the weekends, I had to go sit in a meeting with her and um, she just worked in this clinic on the weekends and some other area during the week. And there were two Medical Assistants there that I guess during the week had their run of things and the manager let them do whatever they want and the other nurses I guess never paid attention. Well on the weekends, she said, Well you both can't go to lunch at the same time because that only leaves ME here, so we have to rotate. And she had told one the doctor wants this done to this patient, and she told the other one, well you go to lunch. Well when she came back the doctor was complaining, she went to see other patients the doctor said well that patient never got that, whatever they needed done, done. And she went out to go find her and they were both gone. And they came back from lunch, and there were patients out in the front, and so she said come here, and she pulled them back in the med room and closed the door so people out there couldn't hear her talking to them.
>
> ...And she said, You KNOW, I TOLD you, and she went through the thing I told you not to do this and I told you not to go to lunch together. And the [MA] goes, Well you know, we can do whatever we want. She goes, but I TOLD you you COULDN'T, you just left ME here doing all this and I can't do it all by myself. Well the one person said that she KIDNAPPED them and locked them in the med room, and that she berated them and pointed her finger at them [laughs], and that she didn't like being treated that way. And so [management] took their side, and the nurse was just like beside herself saying, well I don't know what I'm supposed to do. I'm supposed to be in CHARGE and make sure everything runs SMOOTHLY but yet you're letting them do what they want to do, and nothing's happening to them. ...But she just said, you know, this is ridiculous.
>
> And the management people [said]...don't touch the [MAs], don't touch them any more, you can't touch them. And gave her a warning, gave the nurse a warning,

> instead of telling— because we wanted to know, what happened to THEM for leaving and not doing what the doctor's thing. And we never found out. They said, Oh that, you don't need to know that, it's been taken care of. Because it's almost like they cause the friction because they're not dealing with it. They're not saying, this is your job, this is your job, you need to do what this person tells you.
>
> Int: What do you think's up with that?
>
> W: I don't know. I just think they're trying to keep everybody happy. [laughs]

Willy's story echoes many RNs who described the situation of being responsible for the work of unlicensed workers without the authority in the occupational order. This story also is about Kaiser's "protection" of clearly insubordinate workers and management's indifference to RNs' ability to do their job, and to their feelings about the interpersonal conflict. Strikingly, Willy's comment that "it's almost like [management] causes the friction because they're not dealing with it" was repeated throughout nearly every interview, regardless of occupation or union affiliation. Workers constructed managers as extremely hands-off, letting the workers struggle on their own – or if managers are present, they are constructed as money-focused and indifferent to the anxieties and stress of the staff. The "pecking order" among RNs, allied workers, and unlicensed providers is up for grabs, and there is no constructive leadership. Moreover, managers' and physicians' tolerance for insubordinate or incompetent workers ultimately obstructs the restructured health care labor process and places the burden of getting the work done on the RNs.

Numerous RNs – formally interviewed and in informal conversations – expressed outrage that the restructured "pecking order" in outpatient settings at times positioned Medical Assistants, not RNs, as unit supervisors. Ann described the implications of this change in the "pecking order" for health care.

Ann (RN-X): It's even harder now 'cause our manager is away, and then I hear she's not coming back. She's going to take another position, and the person who's been taking her place is a Medical Assistant. She's, I think she, she could possibly be out of the union now, but she's sort of like interim manager, and so she's got a real history with all these other [Local] 250 people and she's kind of one of the gang, and I don't know if she has the concept of, you know, what's really going on on the floor, and she's kind of a, you know, good old boy mentality with the 250. If we get an RN supervisor again, you know, things will change, but right now it's sort of scary.

Int: I'm going to ask about this good old boy thing – what do you mean?

Ann: Well, I think she, since she is more of a peer with these people that she just kind of grits her teeth and goes oh, gee that's still going on – and I feel like she really can't discipline these people. She needs to go to somebody of a higher position to do that. I think she's letting a lot of things slide. I've seen some of her, her judgments. And one was a silly thing. One of the MAs split out his pants and he said he wanted to go home. And to me, it's like, well get a pair of scrubs or put on a lab coat, but she chose to let him go home. You know, that type of thing. So, it's like, you know, oh whatever. That type of thing.

And there are some Medical Assistants whose performance is just incredibly terrible. And one day this person was written up three times in the same day and she's been very close to being fired, I think. And, I think she really should be for a lot of different reasons, and most recently I've heard, well, they may just let her transfer. Go through to another department. So, now she's going to be somebody else's headache. It's like she should be disciplined and fired. So, you know, and I don't know if this is really going to happen, but that's my – she just isn't able to take, take the situation and deal with it the way it should be.

You know this is a temporary, we're , we're in flux now. We're getting the new director has just started this week. And when she kind of comes in maybe things will get better. You know, the other director wanted the managers to be very hands off. You know, they're across the street and they're doing all this other stuff, well, meanwhile the, you know, the inmates are running the asylum. [laughter]

This quote characterizes unlicensed workers as unsupervised and "out of control," which compromises the quality of the work environment and creates a "scary" situation. What is scary? Having an unqualified person supervise unqualified people. Ann also saw the MA supervisor as not having the "whole picture" – a characterization of unlicensed workers doing direct patient care. By having MAs "replace" RNs in management positions just as in direct patient care, Kaiser was seen to care less about patient care and more about marginalizing and disempowering RNs.

Restructuring the "pecking" order disrupted the established occupational hierarchy organized around education, licensing and credentialling. By integrating unlicensed workers into direct patient care and into management, management sent a message to all workers that the relations of power among workers have changed – and RNs are no longer the authority figures they were previously. This message, however, collided with RNs legal responsibilities for – and subjective commitment to – patient safety – and set workers up to be opponents in getting the work done. RNs' accounts describe their feeling "outnumbered" by unlicensed workers who do not recognize RN authority and unique contribution to the health care labor process. The unlicensed workers I interviewed, however, did recognize this, and for the most part expressed a feeling of solidarity with the RNs, and against management and the physicians. RNs, though, feel "on their own" against management, physicians, and many of the unlicensed workers who personify Kaiser's campaign to downsize, demoralize, and exploit RNs.

Workers' experiences of the RN strikes

Protecting patient care and RN working conditions by fighting Kaiser management are the two major themes of RNs accounts. Most RNs expressed feelings of empowerment by striking, and by the CNA's success in the contract struggle with Kaiser. The RNs who did not express these feelings were more distant from local union politics – because of a more "individualistic" or "management" political orientation, and overall lack of "investment" in their Kaiser job. Despite the differences, when RNs talked about reasons for striking, they foregrounded "patient care" and treatment of RNs as the primary reasons for being out there, fighting Kaiser on quality issues.

RN accounts of being on strike reflected an "RN-centric" vision. They described feelings of solidarity among nurses and patients, interactions with doctors, but rarely mentioned Local 250 sympathy strikers. When I asked, they indicated that they went out at first, but in subsequent strikes did not – they either were discouraged or intimidated, or because of financial reasons felt it necessary to work. RNs' characterizations of unlicensed workers generally ranged from sympathetic to indifferent or slightly disparaging. The most favorable accounts are those that "understand" why Local 250 workers did not sympathy strike. As one RN said, "I can go work registry for a day, but the housekeepers, they can't just go and work somewhere for a day." Others described how Local 250 workers went in to work, got food catered to the scabs, and brought the food out for strikers. A few accounts characterized them as insensitive opportunists who were "having a grand old time" during the strike days when few patients came for care, or who went in for the free food and then left.

RNs were mostly tolerant (or indifferent) of Local 250 workers crossing, but were very angry at RNs who worked. To most of the RNs, the split in organized labor during strikes was based more on other RNs crossing the line, and less on Local 250 workers crossing; this is demonstrated by RNs use of "scab" exclusively for RNs who crossed, not Local 250 workers. Two interviewees reported that the car tires were slashed of an RN who worked, and attributed the deed to another RN. The RN informants who were activists expressed outrage and disgust over Kaiser's decisions to spend money to fly RNs up from Southern California, to put them up in hotels, and to order catered meals for the scabs and managers. They described yelling at the scabs as they crossed the line (and how the scabs were subsequently shuttled in by a Kaiser van through the Emergency

Department in order to avoid the strikers), and trying to look in the windows to see if they recognized any of the RNs.

Local 250 workers varied in their response to my question "What do you remember about the RN strikes?" A few unlicensed workers said they were not around, or did not notice the strikes, and indicated they did not want to talk about it. Most of the other Local 250 workers said they honored the RNs' strike, and either stayed home from work, or walked the line with the RNs. Most of the workers who talked about the labor conflict and strikes emphasized the common interests between RNs and other health care workers and the need for labor solidarity. As several workers said, "Whatever Kaiser's trying to do to the RNs, they'll try to do to us next."

Despite the political orientation to "solidarity," the Local 250 workers who went out sympathy striking did not describe interactions with RNs on the line, only that they went out on the line to support them. Two workers, each with a different political orientation towards unions, had somewhat disparaging characterizations of the RNs that countered the militant and righteous characterization that RNs and CNA were putting forth. One worker said the RNs on the line were saying "why are we doing this?" and she answered, "Because the takeaways SUCK!" A second worker, who was cynical and distant about unions, remarked that he arrived for work about an hour before the RNs began their strike in the morning, and that the RNs always "started late."

Political orientation towards labor solidarity appeared to be the main factor informing a Local 250 worker's decision to sympathy strike. Some workers, even those workers who were close friends with pro-union RNs and sympathetic to CNA's stance did not stay out if they felt that unions are weak and have no power against corporate

health care. One worker in particular who was very vocal about her support for CNA displayed no inter-union "consciousness," and worked – said that RNs have to stick together because of their small numbers but did not consider that inter union solidarity would be useful. Local 250 workers who struck in sympathy expressed strong feelings of the necessity of labor solidarity, even if they expressed negative feelings towards their union or some of the RNs at work. Lastly, while Local 250 sympathy strikers differed from RNs by emphasizing inter-union solidarity (rather than protecting patient care) in their discussion of why they joined the nurses' strikes, they emphasized the importance of protecting patient care in discussions of restructuring the health care labor process.

Undermining solidarity

Several Local 250 workers described a management strategy of "divide and conquer" through different tactics. One was Kaiser's hiring of (and Local 250 leaders' collusion with) immigrant workers who are more easily intimidated and will do as told, and who will not want to get involved in any labor action. A second tactic, reported by numerous workers, was management's attempts to intimidate workers from sympathy striking, and the subsequent docking of pay for workers who did not come to work. An equally important part of their stories was Local 250's cooperation with Kaiser against sympathy strikes. When workers complained to Local 250 about management intimidation or docked pay, they said that they "couldn't protect" them, and dragged out the process of aggrieving workers' docked pay. One person who was sick – and had a doctor's note to prove it – was docked because "someone saw [her] on the line."

To most RNs, Local 250 workers were seen as either unable or unwilling to strike, especially after their union and Kaiser worked together to discourage this. They appeared as intimidated or duped workers swayed by Kaiser intimidation and Local 250 leadership

propaganda, as low-wage workers who needed the day's pay and who could not risk jeopardizing their job, benefits, and seniority. For these reasons, they can't be counted on to stand up for patient care. Several RNs who expressed feelings that CNA was powerful enough to have its strikes successfully shut down patient care at Kaiser also expressed feelings that Local 250 needed CNA/RNs for any successful labor struggle of their own. Several RNs also suggested a feeling of "we don't need them" (although CNA leaders expressly say the opposite – about the Local 250 rank and file, not the leadership). This particular RN stance contrasted sharply with the sentiment of Local 250 workers who emphasized that each group needs the other to stand against Kaiser.

Maintaining working relationships

As the unions' and Kaiser's ideological positions became increasingly polarized, it is difficult to tell if co-worker relations became increasingly polarized as well. RNs expressed far more hostility to RN "scabs" from the local registry and who were flown up from Southern California, than to any of the Local 250 workers who crossed the line. Several RNs also talked about getting support and sympathy from the physicians and other workers in their units. Most informants (licensed and unlicensed workers) said that their relations with co-workers, managers, and physicians remained for the most part unchanged, and focused on getting the daily work done. Several, however, said they kept strike politics out of the work environment because they knew it was a contentious issue, and didn't want to add more stress to the already high-stress situation.

Several workers described antagonistic situations because of their decision to sympathy strike. One unlicensed worker said management became extremely angry when she struck in solidarity. One licensed worker aggressively confronted her manager and co-workers who, respectively, actively discouraged sympathy strikes, and worked during

the strike. While she said she "understood" how unlicensed workers could be intimidated by management, she felt that more educated workers had "no excuse" for working. She recounted telling co-workers they were "scum of the earth" and similar epithets for not respecting the nurses' strike.

As stress levels continued to remain high, it would not be surprising if workers' frustrations were directed towards one another. In several interviews, RNs frustrations with Kaiser seemed to be redirected at co-workers who represent what Kaiser's doing wrong. Likewise, several unlicensed workers reflected frustrations that RNs weren't doing their job "right" or "enough" and making their jobs more difficult. By and large, however, relations among co-workers were unchanged.

Conclusion

Workers' shared concerns about Kaiser's restructuring provided the opportunity for worker solidarity that potentially could challenge Kaiser's power and restore quality patient care. This potential solidarity, however, was continuously undermined by historical and local factors.

Most informants recognized the role of class and gender in structuring the reorganization of the health care labor process. Race was often not explicitly referenced by informants as they interpreted Kaiser's restructuring through the lens of their collective identity and sense of group position. However, race, like class and gender, informed the very structure of work and the workforce, and workers' constructions of their own collective identity and those of "others." These identity constructions were historically structured by the racial division of reproductive labor, and retrenched through the local situation in Northern California Kaiser, where the combination of Kaiser's

restructuring of the health care labor process, and different union orientations towards Kaiser coincided with the "racial binary" dividing the Kaiser workforce as an (un)organized entity.

Constructions of collective identity ultimately informed constructions of "others." RNs' construction of collective identity as "patient advocate" resulted in the construction of Kaiser and Local 250 as ultimately not acting in the patients' best interests. Local 250 workers expressed a "worker" identity that emphasized the need for worker solidarity – they empathized with RNs, or saw them as wishing to reinforce their power over subordinate workers. Thus despite what all interviewed workers shared – an increasing sense of exploitation, stress and anxiety over work and patient care, and a general agreement over the division of labor – the possibility for solidarity was undermined by the construction of "others" as obstructions or enemies to group interest and patient care.

In the name of "patient care," conflict between RNs and other workers was already likely given the history of nursing and racial division of reproductive labor. Kaiser's restructuring sought to replace many RNs with unlicensed workers, echoing earlier strategies of health care capital to divide the workforce and exploit the workers. Workers' experiences of restructuring and constructions of "others" in a new division of labor were informed by the legacy of racial segregation that devalued workers and pitted them against one another across the racial divide. However, the local situation simultaneously retrenched RNs' responsibility and undermined their authority over unlicensed workers, subverting and reinforcing the traditional "pecking order" of authority and responsibility. In this situation, racial "othering" was embedded as an often-

invisible process that informed inter-group relations and exacerbated pre-existing tensions stemming from the restructuring of the health care labor process.

The organization of race, gender, and class in Kaiser's restructuring and labor relations maintained a racially divided and conflictual workforce and entrenched workers' exploitation. Kaiser's restructuring and labor relations demoralized workers and demobilized the workforce as an unified entity, but it also propelled many workers to stand up and fight for patient care through daily acts of resistance or public displays of labor solidarity in the RN strikes. Workers' general agreement over "safe staffing" offered the opportunity for worker unity against Kaiser's corporate power, despite the fracture at the union level. However, the fracture in organized labor permitted Kaiser to continue its restructuring and exploitation of the workforce. In the daily relations of work, the chronic stress caused by Kaiser's restructuring eroded positive relationships and fomented conflict, and reinforced historically racialized tensions about "skill," "competency," and "respect." As workers struggled to provide quality patient care, historical divisions between workers were exacerbated by organizational actors struggling over control of the health care labor process.

Chapter 8
Conclusion: Maintaining intersecting inequalities

This dissertation focused on one site of Kaiser's Northern California restructuring, and its impact on health care workers, in terms of the structures, processes, and relationships of racialized and gendered exploitation. This study also focused on the impact of Kaiser's restructuring on inter-group relations among workers and whether restructuring enhanced or obstructed the possibility of labor solidarity. By providing a historical narrative to situate workers' accounts, this study aimed to understand workers' experiences of the changing nature of health care labor as a product of historical and local factors. Throughout the descriptions of workers' accounts, and my analysis of these accounts, I have applied a theoretical lens that continuously asks how race, gender, class, or other markers of social position "matter" for health care work, health care workers, and labor-management relations.

Based on workers' accounts, Kaiser's restructuring aimed to increase production at the lowest cost, through restructuring and intensifying the health care labor process. The workers I interviewed argued that the restructuring exploited the workforce and degraded the quality of patient care. Kaiser's restructuring, however, involved much more than capital exploiting workers. A confluence of historical and locally-specific factors reproduced structures and processes of exploitation, stratification and conflict among the Kaiser workforce, continuously undermining worker solidarity. The basic social process (Strauss and Corbin 1990) of Kaiser's restructuring involved entrenching exploitation of and divisions within a workforce organized by intersecting inequalities of race, gender, class, and other markers of social position.

This chapter is organized around major themes that address the racialized and gendered nature of exploitation under capitalist health care production processes. I first provide an overview of how intersecting oppressions of gender, race, and class inform the situation at Kaiser in Northern California. This is followed by a discussion of Kaiser's and the unions' struggle to gain control over the labor process, in which I extend Braverman's framework of monopoly capital and degradation of the labor process. The next section revisits workers' accounts of changes in the health care labor process, and explores how the transformation of health care labor goes beyond Braverman's deskilling thesis, as the changes of work are fundamentally informed by race and gender. This is followed by section that explores how changes in the health care labor process have reproduced divisions and conflict among workers. I then explore the implications of the different union positions, especially how Kaiser's restructuring has benefited (or not) the organizational actors and the rank and file health care workers.

The intersectionality of gender, race, and class: Rationalizing labor and controlling the workforce

Kaiser's restructuring of the labor process can be understood as a strategic response to increasing presence and dominance of monopoly capital in health care. In order to compete with the predominantly investor-owned HMOs in its California market, Kaiser sought greater access to capital, and one way to accomplish this was to restructure health care delivery into a more cost-effective process (elaborated in the 1995 Strategic Plan), based on the industry model of increasing production at the lowest cost. This provoked intense protest from labor unions. In response to Kaiser's strategy, the AFL-CIO countered Kaiser's move by proposing an alternative labor-management relationship based on genuine cooperation and power-sharing, where all parties' objectives could be

met. The CNA denounced the partnership as little more than organized labor capitulating to Kaiser's financial objectives, and that workers and patients would suffer from their decision. The AFL-CIO argued that Kaiser was committed to working cooperatively, and by doing so the partnership protected workers' jobs from outsourcing and deskilling, and patient care from an unbridled restructuring. The result in terms of the labor force was a transformation of work and workforce that closely mirrored the one described in the 1995 Strategic Plan. Whereas that document outlined Kaiser's "need" for a cheaper and more "flexible" new workforce of unlicensed, multi-skilled and non-union workers, the labor-management partnership created a new workforce of unlicensed, multi-skilled, and unionized workers.

Gender and race are central organizing principles in restructuring health care labor, and the situation at Kaiser Northern California reproduces the racial division of reproductive labor. At Kaiser, the CNA and Local 250 represent different race/class segments of the predominantly female workforce, each with conflicting interests in terms of the organization of the division of labor, especially in terms of jobs. The workers are oppositionally placed historically in a racially stratified hierarchy, as well as through local factors – Kaiser's restructuring, the radically different union positions towards Kaiser, the lines of union representation (RNs by CNA, other licensed and unlicensed workers by Local 250), and inter-union conflict over jobs, the division of labor, and approach to Kaiser. Kaiser as health care capital ultimately benefits by the fracture of organized labor, as inter-union conflict replaces a unified labor front that could be an imposing challenge to Kaiser's power to control the labor process.

As detailed in Chapters 6 and 7, while workers' shared sense of exploitation and stress nurtured solidarity, numerous factors undermined it. These factors are based in the interaction between managerial strategies of controlling the labor process, union accommodation or resistance, and the legacy of the racial division of reproductive labor. In particular, the racial division of reproductive labor – racial and gender stratification, segregation and ideologies that justify social and economic hierarchies in health care – has structured RNs subjectively and objectively as "different" from other health care workers, and structured relations of distrust and conflict as a "default" between different ranks of nursing workers. Workers' constructions of collective identity, group position, and "others" are informed historically by the legacy of the racial division of reproductive labor and structures and processes of oppression, and informed locally by union ideology and processes of capitalist exploitation at Kaiser. Workers actively resisted or accommodated changes in production based on different constructions of collective identity and group position, which led them to build alliances with other workers, or to close ranks and protect their own interests in an us/them dichotomy.

Extending Braverman: Monopoly capital, the degradation of the health care labor process, and the division of organized labor

Braverman's theory of monopoly capital and degradation of the labor process provides a useful context to interpret workers' experiences of restructuring, Kaiser's strategies for surviving in a changing health care environment, and organized labor's orientation to Kaiser. Kaiser's restructuring, exemplified by the 1995 Strategic Plan, was to adopt the industry-based model of a more "efficient" production process conducted by a "flexible" and "multi-skilled" workforce. This strategy was in response to a changing health care environment dominated by monopoly capital (largely for-profit HMOs with

easy access to capital, and hospital chains – both for-profit and tax-exempt), in which Kaiser was threatened with increasing marginalization.

The division of organized labor

Union conflict and cooperation with Kaiser, and inter-union conflict between the CNA and Local 250, centered on control over the labor process. The struggle over production was informed by social structures and ideologies of race and gender, and reflected how Kaiser sought to control the workforce and accumulate capital, and how organized labor strategized resistance or accommodation (Smith 1994). In Northern California, where there has been a strong union presence, it was to Kaiser's advantage to weaken unions' power in order to reduce labor costs, and in the mid-1990s Kaiser's plans included downsizing, contract concessions, outsourcing, and deskilling that appeared to reflect Taylorist principles of "scientific management" and newer, "soft" strategies of managerial control (Kraft 1999).

In the literature about Patient-Focused Care and similar industry models that restructure the health care labor process, "managerial control strategies" or similar concepts are not explicitly referred to or discussed. These new approaches to "cost-effective" patient care do not question the dominance of market forces in health care, and that "controlling" labor costs is essential for health care organizations to remain "competitive." Strategies for control over the labor process and its costs, however, are embedded in this ideology. Furthermore, like the historical exploitation of health care labor, this new brand of exploitation has definite racial and gender dimensions. While health care elites continually think of ways to "cheapen" and further exploit the labor of the predominantly female nursing workforce, they fail to question the "cost-

effectiveness" of the high-priced and largely white male consultants hired to help cut labor costs, demonstrating the continual devaluation of physical and caring work (Glenn 1991, 1992), and the inflated importance of the management strata (Braverman 1974).

Kaiser, like many employers seeking to cut labor costs and increase profits, planned on marginalizing or otherwise neutralizing unions in order to create a more vulnerable and low-waged workforce. Instead of neutralizing the power of organized labor by employing a largely non-union workforce, Kaiser's labor management relations structured both conflict and cooperation with unions, and resulted in a fracture within organized labor. The national AFL-CIO/Kaiser labor management partnership structured non-adversarial relations with the vast majority of its unions. By refusing to join the partnership and condemning it publicly, the CNA became one of the only organizations positioned oppositionally to Kaiser, and thus to the labor unions in the partnership, and was increasingly isolated in the labor community as it resisted Kaiser's restructuring (personal communication, Jim Ryder, Oct. 1999). The partnership effectively fractured organized labor and exacerbated inter-union conflict at Kaiser and beyond. While Kaiser's unions were not explicitly neutralized, organized labor as a united front certainly was. With labor divided, Kaiser could implement its restructuring with greater ease than if its workforce was united in opposition.

Deploying race and gender strategically

Kaiser's attempts to neutralize union power utilized different strategies for different segments of the workforce. In 1996, its contract negotiations with SEIU (including Local 250) overlapped with the AFL-CIO initiatives about a labor management partnership, and after a threatened strike, Kaiser retracted its concessions

and settled with Local 250 (and other SEIU Locals afterwards). Later that year, near the end of the RNs' current contract, Kaiser took a more aggressive stance towards the CNA. Largely due to the dynamics described earlier around Primary Nursing, RNs had made substantial gains in both compensation and influence on staffing, and at Kaiser, RNs had become the dominant caregivers in a nearly all-RN staff into the mid-1990s; Kaiser had begun reducing the RN workforce since 1994. As Kaiser sought to cut RN costs and weaken the union, RN labor was fragmented, devalued, and deskilled – constructing much of the labor as "unskilled" labor that could be done by lower-paid and unlicensed workers. RNs were constructed as "overpaid" for their work relative to RNs in other regions and hospitals, providing a rationale for downsizing the RN workforce.

The labor-management relations concerning RNs in the health care labor process was profoundly gendered in traditional and untraditional ways.[1] Kaiser's treatment of RNs was gendered through devaluing and deskilling caregiving work, yet Kaiser also demanded that RNs be "upgraded" – repositioned to quasi-supervisory positions (as in Team Nursing) without the authority of a supervisor. However, as Kaiser deployed gender to meet the needs of capital, the CNA also deployed gender to respond to Kaiser's strategy to dislodge RNs as the dominant caregivers. The CNA reappropriated the gendered construction of RN labor, arguing that even allegedly unskilled work was essential for RNs' assessment of patients, and modified RNs' image as a skilled professional, caregiver, and patient advocate into a more militant image role – RN as caregiver to patients became RN as defender of patient and public safety. This role

[1] The role of gender in organizing labor management relations and labor process is also present in the characterization of CNA as "unreasonable" in that it is "trying to turn back the clock" about health care, instead of dealing with the changes. This "unreasonable" charge is historically ascribed to women and other subjugated groups who refuse domination and insist on full citizenship and freedom.

expanded RNs self-image as caregiver and patient advocate – a self-image that resonated with RNs and was gradually internalized by RNs who were traditionally apolitical and less willing to confront more powerful others. The theme of protecting patient care was central to the CNA campaign – through its alleging that Kaiser's restructuring violates patient safety and community safety ("medical redlining"), through its demand for patient care data as a necessary component in collective bargaining, and through the use of a campaign "alerting" the public to Kaiser's alleged erosion of quality care (including strikes).

Kaiser's labor relations with the AFL-CIO unions were markedly less-gendered, treating workers and their interests as "generic" or universal. Race, however, was embedded in these relations, even if it was not directly alluded to. As numerous examples throughout history demonstrate, the "degradation" of work goes hand-in-hand with the transformation to a racial-minority and lower-waged workforce (Brodkin 1998). In different parts of Kaiser, when the health care labor process transformed into a series of largely "unskilled" tasks, the workforce composition transformed in terms of race, class, and gender. First, non-RN health care workers were displaced and repositioned into new roles, and new unlicensed workers brought in to meet the need for increased numbers of unlicensed workers in patient care. Most of these workers came from communities historically marginalized and channeled into lower-status and lower-waged occupations; many of them were racial-ethnic minority, lower classed, immigrant, and female. A growing percentage of Kaiser's labor force was comprised of a more vulnerable population, despite the strong union visibility. As Kaiser (and other health care

corporations) displaced skilled workers, they relied on this new "industrial reserve army" as a cheap source of labor.

Controlling the health care labor process: Beyond deskilling

Workers' accounts of exploitation diverged from Braverman's deskilling thesis through the embeddedness of gender, race, and class in the organization of work, and through new managerial strategies that exploit workers and maintain a divided workforce. As detailed in Chapters 2 and 3, nursing as the dominant health care labor process and as racially stratified "women's work" was historically devalued, deskilled, intensified, and racially stratified in order to create a (divided) workforce that met the interests of (white) RN leaders or (white) health care elites, or both (Brannon 1994, 1996; Glenn 1991, 1992; Hine 1989; Reverby 1987; Melosh 1982). Worker solidarity was neutralized by management through racialized inter-occupational tension and conflict with other health care workers, and all workers were vulnerable to exploitation due to the fracture in the workforce. The historical fracture in nursing labor, moreover, was a product of occupational structure and ideology about group identity and "others," as race and gender occupational segregation and race and gender ideology about the "appropriate" division of labor mutually informed one another in a self-perpetuating logic (Brodkin 1998).

In the 1990s, health care elites again constructed and devalued much of RN work as "unskilled" labor – and models such as Patient-Focused Care organized the redistribution of "unskilled" tasks to a lower-waged, lower-skilled workforce. At Kaiser, workers described two interlocking processes involved in the transformation of labor, notwithstanding the overall speedup and intensification of labor. In those departments where Member Focused Care or similar restructuring was introduced, health care labor

was fragmented into "tasks" isolated from the "caring" or broader medical context, and workers and patients were objectified into components or outcomes of an intensified production process. This was accompanied by an influx of unlicensed workers into direct patient care (displaced from their old Kaiser job or drawn from a surplus labor pool).

Brodkin (1998) argued that the degradation of labor and the change of race/gender makeup of the workforce go hand-in-hand, and bolster social ideologies that justify inequalities and oppression. Historically, as women and persons of color entered jobs or industries formerly dominated by white men, the labor became "unskilled," and status and pay declined to "match" the restructuring of labor and the race and gender characteristics of the new workforce. The nature of work changed from a "skilled" process to a series of "unskilled" tasks in which "unskilled" and low-wage workers were intensely supervised and "driven." These changes informed the race- and gender-ideologies that became commonsense ideas about a "natural" division of labor based on which kinds of workers were appropriate for different kinds of work. This dynamic entrenched race and gender occupational segregation, and entrenched antagonism and conflict between different groups of workers (Brodkin 1998).

In workers' accounts of Kaiser's restructuring, however, labor was not "degraded" in the classic Braverman model, as much as "intensified." Licensed workers were deskilled to a degree, but were also upgraded to roles where they were assigned only "skilled" tasks. Unlicensed workers were not assigned to repetitive tasks and intensely supervised jobs, but rather had a variety of work duties that required increased training and skill. All workers were intensely "driven," by the combination of chronic under-staffing and desire to provide quality patient care. Licensed and unlicensed

workers' jobs were "extended" to combine both old and new responsibilities, and workers rushed to take care of assigned tasks in a "laissez faire" environment that fostered stress, confusion, and conflict.

Kaiser's restructuring devalued and exploited licensed and unlicensed workers, using a rationale of making the workforce more "efficient" by eliminating "waste." These changes in production were gendered and racialized. Health care was devalued because "caring" and dirty work (e.g., housekeeping) were constructed as largely "unskilled," and because the people who do these kinds of work were not valued as highly as white male professionals (e.g., physicians). The industrial model of care in Kaiser's restructuring extracted the "care" through reducing the quantity of social contact between worker and patient, and exploited workers when the labor process was transformed into a more "efficient" and "cost-effective" system. As described in Chapter 6, workers' accounts described how workers were exploited largely because of the speedup from understaffing, and because certain things did not seem to be accounted for – including unforeseen complications or problems, patient anxiety, and the conflict over the division of labor – in a production model based on quantifying units of service, displacing qualitative relations of health care between caregivers and patients.

Based on workers' accounts, RNs were exploited as they were placed, unwillingly, in roles where their authority was challenged and their responsibility increased. They were repositioned as quasi-supervisors, assigned fewer patients for direct patient care (because the unlicensed workers are picking up these allegedly "unskilled" tasks), and were assigned more patients for "skilled labor," such as administering medications. As nursing was fragmented into "skilled" and "unskilled" tasks, RNs were

reported to end up working harder and faster because ultimately there were more patients, all of whom came under the RNs' license and legal responsibility. Despite the increased legal responsibility, the RNs had no authority to hire, evaluate, or fire unlicensed workers whose patient care work they were ultimately responsible for. Moreover, workers' accounts of conflict between RNs and unlicensed worker described that RNs' former authority in the division of labor could be ignored by unlicensed workers without sanction by physicians or managers.

Workers' narratives of restructuring also described how unlicensed workers were exploited as they were "split" between RNs, between units, and sometimes between floors. The rational planning of "unskilled" labor quickly fell apart within a labor process that is neither standardized nor predictable, and within a context of short staffing where everyone was expected to complete the work by shift's end. Frequently, the rational planning failed to account for multiple and simultaneous demands on an unlicensed worker – for example, two RNs needing the worker at the same time. The physical impossibility of meeting the increased number and often competing demands set workers up for complaints by patients, workers "higher" up in the division of labor, and physicians and managers.

Workers' agency

Kaiser's restructuring also provides some information on workers' resistance or accommodation to restructuring health care labor process. Workers' accounts focused on their perceptions of and experiences with the changing occupational structure, labor process, and division of labor. Some workers welcomed the changes, some accommodated them, and some regarded them as a threat to their jobs and patient safety.

While workers largely felt they must accommodate the changes in order to keep their jobs, they exerted their agency through resisting the changes in direct and indirect ways.

Based on workers' accounts, RNs and unlicensed workers resisted the changes by acting out their unwillingness to be restructured. Some RNs would not delegate work to the unlicensed workers whose job was to do "semi" or "unskilled" patient care tasks. Some RNs filed official protests of perceived unsafe staffing assignments (Assignment Despite Objection forms) or other perceived dangers to patient care, and called the State Department of Health, State Department of Corporations, and Cal-OSHA. Unlicensed workers resisted by using union grievance procedures to protest perceived unsafe or unfair work assignments. Of the unlicensed workers who did not like the patient care work, some simply did not do it, or quit. Unlicensed workers overloaded with work and stress called in sick, and occasionally mass walkouts of particular units were threatened. Workers also voiced their concerns and complaints directly to managers and physicians. "Acting out" through not doing the work, or through conflict over the division of labor, ultimately resulted in more work, stress, and more tension or conflict between workers. Workers' resistance to restructuring could be used by Kaiser as a workforce control mechanism because frustrations were often "acted out" against co-workers, thereby undermining solidarity that could be a powerful force against management.

Through both the "mechanics" and the social relations of restructuring, workers' agency and management's attempt to control the workforce and labor process were in a dynamic relationship as each side attempted to achieve their objectives. As detailed in Chapter 6, workers perceived a transformation of Kaiser's health care delivery due to the overall focus on cost-cutting – an intensified health care labor process that treated

workers and patients as objectified components and outcomes in the production process, and by more authoritarian worker-manager relations. In their accounts, Kaiser the organization appeared as a large, impersonal, and intractable institution dominated by management (physicians and non-clinical managers) and their focus on "budget." Through their accounts, workers constructed a dichotomy of "caring" – constructing physicians as caring only about "doing their procedures," and managers caring only about "budget" – versus workers, who, unlike the Kaiser owners-managers, cared primarily about the patients' well-being.

Worker informants said they accommodated the changes because they wanted to keep their jobs, and they wanted to deliver the best care they could despite the conditions that appeared to work against high quality care – reduced hospitalizations and understaffing. They compensated by working harder, faster, and by "picking up the slack" of co-workers not doing their "fair share" of the work, and often doing one another's work in order to get the work done. As rationalizing the health care labor process unraveled, workers shared a sense of frustration, exploitation, and anxiety about patient care. This potential for solidarity, however, was undermined by several factors.

Reproducing divisions within health care labor force

Kaiser's restructuring informs and is informed by historical race, gender, and class inequalities and tensions between physicians and management, RNs, and unlicensed workers. These inequalities at Kaiser refer to control over the patient care labor process – hospitalizations, staffing patterns, and "budget." Physicians and managers share interests because physicians have a financial stake in Kaiser. This convergence of joint interests (despite a certain degree of internal conflict – a topic that is beyond the scope of this

dissertation) dominated over RNs and other health care workers. Managers and physicians retained sole decision-making power over the health care production process, and they exercised social domination through bullying, abusive behavior, coercion, and other rituals of daily inequalities – and through their absence from and indifference to the work environment. Physicians and managers were consistently described as insulated from the turmoil on the work floor, and as having the power to get their way through coercive or bullying tactics. RNs did not have the same power, and were further marginalized through their displacement from former positions of (relative) authority and status by Kaiser's restructuring.

Flattening the occupational hierarchy?

The deskilling process operated in tandem with an apparent upgrading of workers, organized by gendered and racialized structures of nursing labor. First, the deskilling was facilitated by the racially gendered image and gendered nature of nursing as "women's work" – capital used this when devaluing the work and demanding lower wages and other concessions. RNs' labor was largely "white women's work" – historically in tension with subordinate occupations filled by largely women of color and lower-classed women. From workers' accounts, although RNs were deskilled, they were also "upgraded" into quasi-supervisor. The two tiers of unlicensed workers took up the "unskilled" RN work, but this was ostensibly an upgrade due to the greater variety of work. However, as workers were assigned expanded work responsibilities through this "upgrading" they were not given more authority or compensation for the increase in responsibility. Worker participation in labor-management committees through the partnership also offered an

increase in status by working as "peers" or "partners" with managers (especially since staff RNs did not participate in these meetings because their union is not a labor partner).

Inequalities seemed to be reduced further as the occupational hierarchy was flattened by restructuring the division of labor using a stratified workforce led by the RN supervisor-without-authority – and racial/class tensions between unlicensed workers and RNs destabilized RNs authority in getting the work done. This was reminiscent of Team Nursing but with a new twist: instead of the occupational hierarchy based on licensure and education, this new model was based around constructs of "skill." The division of labor based on "skill," rather than licensure, meant that the control over the labor process and occupational structure shifted from one segment of health care labor – Registered Nursing (whose leaders historically sought to control the work and occupational structure) to health care management. (However, despite the shift in control, RN licensure still mandated that staff RNs be legally responsible for the patients under their supervision and care.)

The apparent upgrading, moreover, may obscure the reinforcement of the racial division of reproductive labor – RNs as largely white working class females remain in-between physicians and lower ranked nursing workers who are largely women of color. The RNs do the "skilled" work and "supervise" the unlicensed workers. The unlicensed workers do more patient care work but it is largely the dirty and "unskilled" work – bathing, helping toilet, drawing blood. This work is also potentially rewarding because of the patient care contact and the emotion work involved (Brannon 1994; Melosh 1982; Reverby 1987).

Kaiser sought to increase profits and decrease labor costs by using a degraded labor process and a workforce of predominantly unlicensed workers, drawing on a surplus labor supply. Formal change at Kaiser meant a changing health care labor process and occupational structure. However, the new rationalized, industry-model labor process and occupational structure co-existed (and collided) with the pre-existing institutional norms and legal constraints and obligations. The traditional occupational structure was organized around education, and legal obligations and constraints (e.g., licensure). The new model was organized around constructs of "skill." The collision of the two occupational orders produced confusion and conflict over division of labor, as class tensions were often intensified by racial tensions between RNs and unlicensed workers positioned into new roles and relationships with one another.

Reinforcing the racial division of reproductive labor?

Based on workers' accounts, the "mechanics" of Kaiser's restructuring created tension as workers tried to get the work done under new or intensified conditions and social relations. Their accounts described a transformation of health care labor into a series of "tasks" done largely by unlicensed workers that limited RNs' abilities to "put all the pieces together." This stress – expressed by all the RNs and many of the unlicensed workers – was exacerbated by conflict over working together. Conflict often arose when RNs felt unlicensed workers were "inconsistent" (i.e., could not be trusted) or were not appropriate for certain patient care tasks, and when unlicensed workers felt they were competent to do certain tasks and resented RN surveillance and distrust. Class, and often race, exacerbated inter-occupational conflict over the division of labor by the "othering" of unlicensed workers as "inappropriate," or of RNs as "disrespectful" or "racist."

The contradictory class position of RNs derives from their composition as a predominantly white, working-class, female workforce. They are treated disrespectfully and devalued by physicians, and can turn around and treat subordinate workers – largely lower-class and/or women of color – with the same kind of disrespect. The legacy of the racial division of reproductive labor means that even when *individual* RNs are respectful, the *group relations* are historically characterized by this dynamic of racialized distrust and disrespect.

Inter-group relations at Kaiser are the product of historical and local factors. Based on capital's continual quest for cheaper staffing, RNs and other workers have been structured to regard one another as "others" with conflicting interests. This has been accomplished through relations of racialized and gendered relations in capitalist production (in competitive and conflictual ways as they compete over jobs, status, and control over their work) and ideology of race and class hierarchies (Brodkin 1998). Informed by the racial division of reproductive labor, RNs historically have shared a collective identity as "RN" or "caregiver" – rather than "worker" – and their legal obligations and value system has prioritized patients over labor issues. At Kaiser, RNs' collective identity as "patient advocate" resulted in the construction of Kaiser and Local 250 as ultimately not acting in the patients' best interests. Local 250 workers emphasized a "worker" identity that emphasized the need for worker solidarity – they empathized with RNs, but also saw many of them as wishing to reinforce their power over subordinate workers. Thus despite what all interviewed Kaiser workers shared – an increasing sense of exploitation, and increasing stress and anxiety over work and patient

care – the possibility for solidarity was undermined by the construction of "others" as allies or enemies to group interest and patient care.

Along with the historical structures of conflictual relations between workers, the changing division of labor based on "skill" rather than licensure fomented tension and conflict between RNs and unlicensed workers. The emerging occupational structure based on constructions of "skill" was designed not by labor or "professional" organizations, but by health care elites, and the goal was capital accumulation, instead of professionalization or upgrading. This shift in control over the labor process conflicted with the legal obligations of RNs for patient care, regardless of who does the work "under" their license and supervision. This conflicted with the new occupational order in which unlicensed workers were told by management they were qualified to do certain tasks formerly done by RNs. Workers' different perceptions of "skill" and "qualifications," and their perceptions of "others" as they shared the division of labor reflected the historical conflicts structured by the racial division of reproductive labor (Glenn 1991, 1992).

Gender, race, class, and age intersected in the relations of work. Race became a destabilizing force in the balance of power on the work floor. While Kaiser RNs in Northern California may well be more racially diverse than in other regions of the country, they still occupied higher social positions than subordinate nursing and unlicensed staff. RNs were perceived by informants as largely white, Filipina, and other Asian groups; unlicensed workers were perceived by informants to be largely African American, Latino/a, Filipino/a, and other Asians. The dominant RN racial/ethnic groups generally have higher social standing than African Americans and Latinas – particularly

when "race" was "seen" in the intersections with RN status and class strata, and when RNs' "race" was compared to the "race" of lower-status and unlicensed workers – many of whom were Asians and Filipino/as of lower classes than the RNs. "Race," then, was the intersection of race/class in the production of "othering" of unlicensed workers and RNs. This race/class tension exacerbated the pre-existing stress on the work floor, and intensified the divisions between RNs and unlicensed workers.

As RNs' patient responsibility increased, their authority decreased; as work relations eroded, so did the possibility for the predominantly white, female, working class RN staff to bond as "workers" with other, predominantly lower-class, racial-ethnic minority workers. Staff RNs could be discredited by being characterized as the "bad guy" and as "racist" when questioning the competency of unlicensed workers. While many unlicensed workers could well have been truly incompetent based on Kaiser's inadequate training, the legacy of the racial division of reproductive labor structured a "default" antagonistic perception of "seeing difference" across the occupational divide. White and Asian RNs were constructed as often "disrespectful" or "racist" to racial-ethnic minority unlicensed workers, and racial-ethnic minority unlicensed workers were constructed by RNs as often "unqualified" or "inappropriate" to do direct patient care work.

Race- and class- infused interpersonal tensions and structural conditions coexisted with workers' shared concerns about working conditions and patient care, a common ground on which lasting solidarity could be built. This potential, however, was continuously subverted by Kaiser's restructuring, and the different positions and ideologies of the CNA and Local 250 towards Kaiser.

Kaiser's restructuring intensified workers' labor and exacerbated the pre-existing schisms of the workforce and leadership of organized labor. The restructuring relied on the use of a racialized surplus labor force through reconstructing the bulk of health care labor as unskilled "women's" work, and reproducing inter-group conflict among the workers (Brodkin 1998). This incarnation of the racial division of reproductive labor meant that labor-management conflict can become effectively diverted, as different unions and different groups of workers fight among themselves over a division of labor informed by the maintenance of inequalities (Glenn 1991, 1992).

The different union ideologies, together with historical constructs of group identity and relations, informed workers' perspectives towards the "other" health care workers that often took shape as an "us/them" competition over jobs, status, and power to control one's part in (or the entire) health care labor process. While race/class tensions have historically informed occupational conflict and different constructions of collective identity in nursing, the union representation in Northern California that coincides with these divisions exacerbated the tension between different groups of primarily female workers. All informants shared a sense of increased workload, exploitation, and anxiety over quality of patient care. However, inter-occupational tensions, informed by race and class differences between licensed and unlicensed workers, were substantially exacerbated by the chronic stress of the work environment. The potential for alliances based on shared interest coexisted with the potential for divisiveness because of historical and current race and class hierarchies and tensions over the division of labor.

Implications of union positions

Union positions reinforced or challenged intersecting hierarchies of inequalities and processes of exploitation. Even if race or gender were not explicitly discussed by informants, they clearly informed the structure of the occupational hierarchy and division of labor, and of the alliances and divisions among workers (see Sacks 1988, conclusion). The unions' different stances towards Kaiser's restructuring represent different responses to corporate restructuring and the racial division of reproductive labor. The CNA stance that maintains RNs should be the primary caregivers certainly appears to reinforce the dominant group's interests in the racial division of reproductive labor, while also maintaining that they are standing up for general "working class" interests towards capital. The AFL-CIO partner unions' stances appear to support the flattening of the occupational hierarchy and reducing inequalities among workers. However their new relationship with Kaiser places them in an ambiguous position in the eyes of the rank and file informants; it is unclear whether the partnership is a genuine power sharing mechanism or if it obscures capital's domination over labor (Shaiken et al. 1997).

The new health care labor process and occupational structure undermined RNs' traditional authority in the health care hierarchy by shifting the balance of power over the division of labor (and the unlicensed workers) away from RNs and towards managers. The apparent change in relative status between RNs and unlicensed workers suggests an erosion of the racial division of reproductive labor in patient care work. It also suggests a substantive, socially conscious, anti-poverty project on the part of Kaiser and Local 250 to hire and train persons traditionally marginalized from jobs with living wages and benefits.

However, this apparent change coexists with the realities of the work and the traditional occupational hierarchies coinciding with race and class. Kaiser's training of the unlicensed workers was regarded as inadequate and unsafe by the majority of licensed/certified informants, and by several of the unlicensed workers. In addition, despite the nominal upgrade of unlicensed workers' status, they did not become peers of the RNs because they still worked as RN (or physician) "assistants" and "go-fers," doing much of the dirty and routine work. These workers were characterized by licensed and unlicensed informants as both more vulnerable to the demands of more-powerful others (e.g., to do work beyond scope of practice) and more privileged (e.g., if incompetence or insubordination was tolerated by physicians and managers). These ambiguous characterizations were often linked to the labor-management partnership – specifically, that Kaiser and Local 250 prioritized their joint interests (union jobs, lower-waged workforce) over the daily realities of working conditions and patient care.

For RNs' part, while they were not supervisors of the unlicensed workers, they were by licensure legally responsible for patient care, and they retained an occupational identity that prioritized patient safety. They were simultaneously marginalized and upgraded by the changing occupational structure and intensification of labor, increasing their responsibility without the authority to carry it out. For all workers, these conflicting constructions of "appropriate" division of labor set up RNs and unlicensed workers for sustained conflict, especially since these themes were promulgated through union ideology. Labor solidarity on the "shop floor" was thus undermined by numerous factors that relied on, expanded, challenged or reinforced historic inequalities based on race, gender, and class.

The way the restructuring was going seemed to signal the failure of Kaiser's rationalizing health care labor. The increased workload, inadequate training, and higher acuity of patients set up the planned use of unlicensed workers for patient care for failure – "proving" that RNs should be at the center. An important point, mentioned by nearly every RN and by numerous unlicensed workers, was that simply because something was legal did not mean it was safe (e.g., "early" discharges, use of the recovery room as overnight facility, Medical Assistants giving medications virtually unsupervised, low RN staffing). Furthermore, as numerous workers pointed out, the legality of these changes did not guarantee their long-term cost-effectiveness. Lastly, the prominent public relations campaign against Kaiser by the CNA appeared to disrupt Kaiser's full-scale planned downsizing and marginalizing of the RN staff. However, the divisions between workers, exacerbated by the antagonistic relations between their unions and the increased stress of the work itself, served to reproduce inequalities and exploitation within Kaiser's labor force, and ultimately weakened the power of unions to protect workers and patients from the consequences of the cost-cutting imperative that infused Kaiser's operations.

Benefits of restructuring

Restructuring at Kaiser had many negative consequences, but embedded in these are several benefits to each of the major actors. The CNA benefited by a cause that unified its membership in self-interest – protecting their jobs, wages, and benefits through RNs' role as "patient advocate."[2] Moreover, the CNA's decision to fight back against Kaiser constructed RNs as "on the side of patients" against the largest and most well-

[2] RNs were also positioned for sympathy by their public image as caregivers. A CNA leader pointed out that RNs are the second-most trusted occupation; number one was firefighters (personal communication, Jim Ryder, October 1999).

known symbol of "managed care," which most likely helped RNs and the CNA to garner sympathetic press coverage and public support. These factors allow the CNA to claim the "moral high ground" and criticize other unions – including RN unions and professional associations – for not being militant enough against corporate restructuring, or for joining the Kaiser partnership.

Local 250 benefited because they too claimed to be patient advocates – and at Kaiser, they could assume this role more effectively because they have an official "seat at the table" where decisions are made. This has the potential for good press and public support because it is a less confrontational and more creative way for unions to position themselves to protect patient care. In addition, Local 250 and the partner unions benefit through the gain of new dues-paying members (because of expedited organizing), and because they can then channel more financial and human resources to organizing drives at health care corporations that are far less union friendly than Kaiser.[3]

Kaiser benefited in numerous ways. First, the partnership obligated the unions to promote Kaiser to their members as the insurer of choice, so many new enrollees were expected. Kaiser also gained because of the short-term cost savings due to staffing changes, and because any potentially bad press of restructuring could be buffered by the construction that labor unions and Kaiser work together to ensure quality. Kaiser could be regarded as even more distinct and superior from the other health care corporations because it had labor's endorsement and participation in its decision-making, which suggested that Kaiser was truly committed to providing quality health care.

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[3] In Northern California, Local 250 could unofficially benefit because a core part of restructuring is the deskilling of RNs and the distribution of their work among unlicensed workers, which meant more jobs for unlicensed workers represented by Local 250. (Licensed professionals, also represented by Local 250 and other labor partners, did not report the same degree of deskilling as RNs.)

But perhaps the greatest benefit of restructuring for Kaiser is in terms of labor relations and workforce control. As alluded to in Kaiser's 1995 Strategic Plan, the creation of a "flexible" workforce depended on neutralizing or eliminating unions. However, a flexible workforce was created through both conflict and cooperation with the unions, centering on the labor-management partnership. First, the partnership structured an increase in unlicensed workers in patient care, many of whom were from historically marginalized groups. However, instead of non-union workers that could be easily exploited by capital, the partnership guaranteed these jobs for union workers. This meant protecting workers, to a degree, from Kaiser's blatant exploitation. But it also meant that the unions would not protest Kaiser too aggressively or publicly over training and staffing issues. While Kaiser could not restructure the labor process as "cheaply" as it may have originally wanted, it partially met this goal, through labor relations that structured cooperation instead of adversarial relations.

Who "won"?

Were Kaiser's unions "neutralized" as a powerful force that protected workers and quality of patient care? The CNA, despite its isolation from organized labor because of its vocal opposition to Kaiser and the partnership, and despite Kaiser's attempts to force a concessionary contract, apparently "won" in its 1998 labor conflict. Kaiser retracted its proposed concessions and implemented the CNA's demand for staff RNs as Quality Liaisons. However, Kaiser's restructuring still went forward in selected parts of Northern California, and RNs were exploited by the changed health care labor process and intensification of labor. While RN informants expressed frustration and demoralization, they also expressed a sense that with strong union backup, they could

(and did) succeed in restraining Kaiser, at least to a degree. At the same time, they acknowledged Kaiser's corporate power to restructure health care through different tactics – and it was up to RNs and other workers "on the side of patients" to intervene and counter Kaiser's moves. RN informants regarded the Quality Liaison positions as a tremendous success in the fight for quality health care.

In terms of the partner unions, the AFL-CIO "won" by convincing Kaiser to continue using a union workforce, instead of outsourcing or otherwise neutralizing the power of organized labor. Local 250's cooperation with Kaiser, however, seemed to accrue more benefits to Kaiser and the union, than to the frontline workers. The restructuring utilized more unlicensed workers in patient care, but instead of the non-union workers described in Kaiser's 1995 plan, these were new union members. Through the partnership, the union retained some degree of control over Kaiser's restructuring decisions by maintaining a union-dominated workforce that could negotiate with Kaiser over staffing and patient care issues, as well as traditional union areas (jobs, wages, benefits) as described in union publications and by some informants. Union leaders and union publications emphasized Kaiser's willingness to "listen" and "respond" to workers' concerns, in ways that met both labor and Kaiser's interests.

Local 250 informants, however, described a predominantly authoritarian management that was indifferent or hostile to workers' protests over staffing and patient care issues. Despite the partnership – or perhaps <u>because</u> of it – the power to decide about staffing, training, and patient care issues remained in Kaiser's hands. Local 250 leaders continued to struggle with Kaiser over adequate training and staffing. The general consensus among informants (licensed and unlicensed, Local 250 and CNA) was that

Kaiser was going to do what it wanted to regarding patient care, and that the partnership could not change that. Of the Local 250 workers willing to talk about union militancy and the CNA's labor conflict at Kaiser, all implied or stated outright that the only way Kaiser would change would be if Local 250 took an adversarial role and threatened to strike. All these workers were extremely supportive of the CNA strikes because "whatever Kaiser's trying to do to the nurses they're going to try to do to us."

While union publications celebrated successful negotiations of the partnership and the overall position and direction, the workers I interviewed expressed mistrust and frustration with the situation. Most of the Local 250 workers were demoralized, angry, and many felt powerless to change their situation; they expressed a sense of having to cope with Kaiser without substantive union support, because they believed their union placed less priority on worker support than its relationship with Kaiser. Some workers distinguished between the partnership's benefits for traditional labor issues, and the partnership's negative impact on staffing and risk to patient care. However, given both Local 250's history of collaboration with Kaiser and its official role as union "partner," it would be unlikely for the union to take up an adversarial posture towards Kaiser, especially if not in tandem with other union partners.

Based on workers' accounts, then, in Northern California, the partnership clearly benefited Kaiser much more than the unions or the workers. By structuring amicable relations with Local 250, which represents the majority of its Northern California employees, the partnership provided an institutional means for Kaiser to potentially neutralize or buffer criticism from other union partners. Moreover, the leadership of Kaiser's union partners can act (intentionally or not) as Kaiser's agent in quelling rank

and file unrest or militancy, as was the case in workers' accounts of the treatment of sympathy strikers. The partnership also can act as a mechanism to marginalize unions who are not partners – for example, by attempting to discredit the militant stance of the CNA. Lastly, the partnership exacerbated the simmering conflict and antagonism between Local 250 and the CNA, and caused what union leaders regard as a nearly irreconcilable rift in Northern California organized labor. With organized labor fractured and the majority of its unions as "partners," Kaiser may well expect to do what it wants to with far less opposition by the majority of its workers and the unions that represent them.

I suggest, however, that Kaiser may not benefit in the long term, if it continues in the direction described by informants. Any short-term savings will likely disappear through long term costs of remediating negative effects of reduced hospitalizations, and reduced workforce stability, as numerous workers described increasing turnover and incidents of worker injury. Kaiser will also be impacted negatively through an increasingly pressing labor shortage (of unlicensed staff as well as RNs), and the increased likelihood for continued labor conflict – both with the CNA and Local 250, and with frustrated and angry frontline workers. Moreover, if Kaiser continues in this direction, its distinctiveness from its monopoly capital competitors will continue to erode, through Kaiser's mimicking of their strategy and tactics of labor relations and health care delivery. Kaiser will continue to lose worker support, and very possibly public support, especially if claims about declining quality of patient care are widely broadcast by workers and unions through labor conflict.

Building solidarity: An alternative labor system for health care

The workers I interviewed – despite the historical and local factors that structure them in conflictual relationships – shared a fundamental concern for worker and patient well-being that can be a foundation for long-term cooperation and solidarity. This study has highlighted the different factors that undermine solidarity. This section explores different possibilities of reorganizing the health care workforce and division of labor into an *alternative labor system* for health care. This alternative system would nurture solidarity of the workers, and raise morale by emphasizing an alternative approach to improving working conditions and workers' perceptions of quality of care.

Regardless of opinion on the "ideal" division of labor, informants all argued that increased staffing overall, increased staffing of licensed professionals, and increased in-patient stays were necessary to improve both patient care and working conditions. They also argued that better training and supervision was necessary, especially if the division of labor continued to emphasize a rationalized labor process with unlicensed staff. Even the few RNs who argued for returning to a nearly all-RN workforce acknowledged that proper training of unlicensed staff and adequate RN staffing would reduce the risk to patients and improve working conditions. Unlicensed workers emphasized these same points, but also consistently mentioned the need for all workers to work cooperatively and respectfully with one another – that everyone's labor was valuable, and that everyone had an impact on the quality of patient care.

These perspectives offer ideas for an alternative labor system for health care that fosters cooperation and commonality – and which "re-values" workers and patients through adequate staffing, increased training and upward mobility (learning new skills), and respect for all types of work and workers. Would these changes, however, build

solidarity among frontline workers? Building solidarity is based on identifying workers' common interests, and avoiding a situation in which one group's loss is the other's gain. If a core component of the racial division of reproductive labor is that different groups of women workers have conflicting interests in a win/lose dichotomy (Glenn 1991, 1992), where is the common ground for building solidarity among different groups of workers?

A first step in constructing common ground might be the difficult task of acknowledging that the legacy of the racial division of reproductive labor is alive and well, even in diverse Northern California. If an alternative labor system for health care is set up to value different kinds of workers and different kinds of work, a major issue is that of working with an occupational hierarchy without reproducing the us/them dichotomy over jobs and division of labor. Since the racial division of reproductive labor constructs "skill," "value," and "qualifications" directly or indirectly on race, building solidarity would mean recognizing how race, in tandem with class and gender, organizes the occupational hierarchy and the social relations at work, informing workers' constructions of their own and others' group identities and interests.

Building solidarity means reconceptualizing and re-valuing different kinds of work. It would mean recognizing RNs' struggle to be acknowledged as a skilled professional, and not simply as women who are "overpaid" to do largely "unskilled" labor; and it would also mean that RNs themselves would have to recognize that the "dirty work" of nursing/health care is valuable no matter who does it. An alternative labor system that builds solidarity through re-valuing all workers may likely be based on flattening the occupational hierarchy, but in ways that would offer genuine "upgrades" to all, rather than merely the appearance. A more cooperative labor system such as this

could allow for genuine upward mobility for all segments of the workforce. Moreover, a cooperative labor system could also focus on recruiting under-represented minority workers through partnerships between Kaiser and nursing schools, community colleges, and vocational schools, to prepare potential workers with the necessary education and training to enter the Kaiser workforce and move upward in a career progression.

However, flattening the occupational hierarchy could still invoke the default relations of distrust and antagonism between different groups of workers if they were set up to compete for a finite, and reduced number of jobs, as Kaiser's restructuring was described by informants. Kaiser's restructuring and the response of organized labor together exacerbated pre-existing fractures in the health care labor force, by fostering the competition over jobs and tension between workers. However, in workers' accounts of restructuring, ideologies of the different unions, while certainly informing workers' perspectives, appeared to be less prominent in defining the problem than the realities of speedup and the urgency of short staffing. This suggests that, at least in one region in Northern California, the fracture in the health care workforce can be overcome in the absence of a restructured labor process, increased competition over jobs, and union ideology that fosters an us/them dichotomy of care.

Limitations

As detailed in Chapter 5, there are several prominent limitations of this study. The first limitation is that the accounts of working conditions, the restructured labor process, and the effects of the transformation of work on patient care are based on the interviewed workers' experiences, and reflect workers' partial and situated knowledges of local work environments. Moreover, the restructuring occurred at selected Kaiser hospitals, clinics,

and units within these facilities, and does not represent system-wide change. While this study does not aim to represent the experiences of all Kaiser health care workers, it does aim to accurately reflect the experiences of the interviewed frontline health care workers, whose voices are often ignored in discussions about staffing, training, and the implications for patient care.

A second major limitation involves a different kind of sample bias that informs what we can conclude after taking the first bias into account. Despite the numerical balance between RNs and Local 250 workers, the amount of data is skewed in favor of licensed/certified workers (especially RNs), who gave me longer and more detailed accounts of the transformation of work and the social relations of work. In addition, my sampling decision was to interview longtime workers whose jobs have changed during the 1990s. This excluded a group of unlicensed workers who were hired en masse in the 1990s, and so their perspectives are absent from this dissertation. Furthermore, the workers interviewed are those that stayed at Kaiser after restructuring was introduced. Numerous informants discussed the high turnover of RNs and unlicensed workers (both long-time and new); these workers' perspectives are also absent from this study. This means that ultimately, this study is about the transformation of health care labor process primarily from the perspectives of more educated and skilled workers who remained at Kaiser, most of whom were in their 40s, and most of whom were women – despite the considerable diversity of labor militancy, union affinity, and race and class background.

A third major limitation concerns the time factor. Data collection took place from Fall 1999 to Summer 2000. During this time, the labor-management partnership was just beginning to be introduced to frontline workers and middle managers at the Kaiser

facilities I studied, and according to informants, was greeted with considerable cynicism and skepticism. Whether or not workers and managers eventually willingly participated in these new labor-management relations is unknown, based on the data I collected. In addition, the period of data collection occurred one to two years after restructuring was introduced to the facilities I studied. It is quite possible that workers' attitudes changed over time, but these data refer only to the first year or two of the changes.

How can these limitations potentially inform what one can learn about the Kaiser situation? First, since the interview data privilege the perspectives and experiences of more educated workers, especially RNs, readers could draw conclusions that basically agree with the CNA's approach to Kaiser, assessment of restructuring and patient care, and the stance about safe staffing patterns. Because workers' accounts are about health care and ultimately center patient well being, readers may be especially inclined to react strongly to what they read, and could draw conclusions about the situation at Kaiser that reproduce dichotomous thinking in terms of "either/or," "right/wrong," and "good/bad." This dichotomous approach could lead to conclusions about which union position is "right" in terms of Kaiser, organized labor, and restructuring, and the consequences to patient care.

In truth, however, no such conclusions can be substantiated on the basis of this study alone. We are left with unanswered questions such as:

- Can unions, as representatives of working people, really have shared interests with capital?
- Does the AFL-CIO/Kaiser partnership genuinely share decision-making power on substantive patient care issues?

- Is it possible to provide quality health care within the context of an environment dominated by large and powerful corporations?
- If labor unions were united, would workers forge alliances, despite the legacy of the racial division of reproductive labor?
- Can workers forge alliances with one another despite the fracture in organized labor?

A second potential consequence of the limitations is that dichotomous thinking could also reify conceptual or ideological divisions between licensed and unlicensed workers. Readers could conclude that RNs and licensed/certified workers are agentic, reflexive, morally committed to "doing the right thing," and "correct" in terms of their perspectives about restructuring and its impact on patient care. Conversely, readers could conclude that unlicensed workers are non-agentic, unreflexive, powerless "victims" or "dupes" of Kaiser and union policies. This dichotomous, "either/or" approach obscures the complexities within groups and the heterogeneity of perspectives within these groups, and produces a reductionist analysis of the situation.

This approach fails to link structure and agency, and constructs "difference" between groups as a function of either the groups themselves or the structures of intersecting oppressions that enable or constrain the groups. One useful tactic to address this limitation is to consciously employ a "both/and" approach that links structure and agency, and is attentive to the complexity of the situation without losing sight of the overall picture. By rejecting dichotomous thinking, we are able to acknowledge both social structures/processes of inequality/exploitation and different workers' sense of agency, which together inform workers' material circumstances and opportunities, and individual and collective sense of dis/empowerment. We can acknowledge that

differences exist both between groups and within groups; and that shared perspectives and experiences both coexist and collide with conflicting interests over "safe" staffing and division of labor. Lastly, we can acknowledge that Kaiser's restructuring both eroded and reinforced the racial division of reproductive labor.

Concluding thoughts

The response of organized labor to monopoly capital in health care has been to link patient care with working conditions, linking patients' and workers' wellbeing. At Kaiser, the labor management partnership blunts the militancy of union rhetoric by its labor partners, replacing it with a rhetoric of union power through cooperation between Kaiser and labor. Only the CNA continues to deploy the adversarial militant union rhetoric. The fracture in organized labor in Northern California weakens labor's power at Kaiser – and more importantly, at less union-friendly health care organizations. The CNA and AFL-CIO locals will tend less and less to support one another's negotiations or conflict with management, as inter-union conflict continues to characterize organized labor in health care. While traditional labor issues (jobs, wages, working conditions) remain critical to workers' well-being, what is ultimately at risk is quality of the health care provided in the current historical period of "managed care."

Many workers shared increasing frustration, stress, and anxiety about working conditions and patient care, which nurtured worker solidarity. However, historical and local factors continuously undermined workers' common interests. The combination of Kaiser's restructuring and inter-union conflict fostered tension between RNs and Local 250 workers, and reinforced historical divisions and antagonisms within the health care workforce that coincide with race and class stratification within "women's work."

Kaiser's hiring practices, culture change towards workers, and tactics to discourage or punish sympathy strikers appeared to exploit the racial-class stratification of the largely female workforce in a divide and conquer strategy. Kaiser's attempts to prevent a larger union membership from supporting the numerically smaller RN workforce utilized tactics that bullied, coerced, and deceived workers that RNs constructed as "others" who were easily intimidated and/or already "not on the side" of the predominantly RN workforce due to pre-existing and historical tensions and conflicts. Kaiser's tactics widened the divide already in place by building on the racial-class constructions of collective identity and constructions of "others."

Local 250 and the CNA, by representing conflicting interests that coincide with the racial-class divide, also widened the divide – despite their desire that the union political divide did not exist in the first place. Labor relations at Kaiser deeply compromised the potential for inter-union solidarity for union leaderships and the rank and file. The unions' different approaches to defending their members and quality of patient care pitted them against one another and led to what appears to be an irreconcilable rift in organized labor. Workers' accounts of the costs of restructuring, and of the CNA strikes, illuminated how union ideology, Kaiser's restructuring tactics, and constructions of group identity inform the potential for worker solidarity.

As workers "maintained" under the stress, collective action against Kaiser was compromised by the division of organized labor. Kaiser top management was effectively buffered by the daily stress, which workers were forced to "take on" and often "take in" in order to get the work done with the quality they felt should be there. The inter-union conflict effectively prevented workers uniting behind their commitment to patients – and

ultimately tipped the balance of power to Kaiser (as well as to other health care corporations where the CNA and Local 250 represent workers). Kaiser's restructuring, then, ultimately worked to entrench workers' exploitation and inter-group conflict, by maintaining divisions in organized labor and within the workforce.

The implications of the Kaiser situation and union positions extend far beyond Kaiser, and do not bode well for working people and the overall quality of health care. During this current historical period where monopoly capital dominates health care, and the need for a united workforce increases with each corporate merger and acquisition, the Kaiser situation sets an unfortunate example of labor divided. The division of organized labor and the divisions among health care workers severely compromise the power of health care workers to advocate for patients and the public, as capital – no matter how historically "union friendly" or "socially conscious" – ultimately benefits as intersecting inequalities maintain a divided workforce.

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Appendix

Interview questions-CNA rep/worker (rev 10/13/99)
Today is _____, and this is an interview with _____.
You've read the consent form -- do you have any questions before we begin?
Can you tell me your occupation and position?
How long have you been at [organization]?

background – to provide context for questions about the recent conflict
1. How has the CNA been impacted by the changes in health care? how has the union responded? what are union priorities in the 1990s?
2. Have the changes in the health care labor process necessitated different organizing strategies for the union? in terms of the organization of workers, relations with management, relations with other unionized or non-unionized workers?

**3. Do you see changes in health care practice (i.e., who does what) at KP as contributing to the conflict/solidarity dynamics? were there big changes at KP?

<u>the labor conflict – where I'd like to concentrate most of the interview</u>
1. First, a "check-in" re: the history – the KP conflict 1996-1998 seems to be in three overlapping phases – is this accurate to you?
SEIU contract negotiations and conflict 1995-96, partnership signed spring 1997
CNA contract negotiations and conflict with KP 1995-6 - contract in spring 1998
CNA conflict with SEIU Local 250/AFLCIO affiliates spring 1997 –

2. What do you think led to the conflicts (CNA-KP, CNA-SEIU, SEIU-KP)

3a. What was the meaning of the conflict for the CNA?

3b. How did the CNA galvanize member support?

4a. What do you see as the consequences and implications of the conflict
labor-management relations -- quality liaisons CNA-KP, partnership agreement between AFL-CIO and KP
inter-union relations
inter-group relations within the KP labor force – daily work relations

4b. Have there been attempts to mend relationships between the unions?
Despite all the negative stuff that's gone on, what do you think makes it possible for healthcare workers to work well together?
What do you think healthcare workers can 'teach' union leaders and Kaiser mgmt. about working together for quality patient care?

5. As you know, one of my areas of interest is race, gender, and class dynamics. Could you talk a little about race and class dynamics of the different parts of the conflict?

6. Where do you or the CNA think health care needs to go in the future – and what has to happen in terms of labor relations in order to get there?
7. Are there any other questions you think I should ask?

Interview schedule – revised
Today is _____ and this is an interview with _____.
Can you tell me your occupation?
Do you work in the hospital or clinics?
How long have you worked at Kaiser?

The job:
What does a service partner/care partner do?
What do you do at work on a typical day?

How long have you been a service partner?

What was your job before?

What kind of people do you work with? (occupation, r/e)
What are the doctors like that you work with?

You've worked at KP for a long time. What kind of changes have you seen?
What have changes been like for you, or your co-workers?

Has the partnership made a difference in your work? how?

The CNA strikes
You were working at Kaiser when the CNA had their 1-2 day strikes -- what do you remember?

Did you go to work? pass by the strikers? What was it like?

After the strikes, was there any tension between people who were striking and those that went to work?

The CNA said they were striking because Kaiser was getting rid of RNs and using more care- and service-partners to take care of patients. CNA said this endangers patient care. What do you think?

Working conditions
Some of the workers I've interviewed already have talked about having much more work, much more stress. They've said that patients are sicker and require more care, and that there is less staff to take care of them, so workers are more rushed and pressured. Has that been your experience?

Also, they feel that the emphasis is less on patients and more on keeping costs down. What do you think about this?

Some workers have said that more stress has meant more tension in the work relationships -- has this been your experience?

Inter-Cultural relations:
Some workers have said that San Francisco Kaiser is a much more multicultural workplace than other parts of the state or USA. I am curious about how people get along at work.

Some workers have said that different cultures don't mix, others say they do. What do you see?
Are there prejudiced feelings that are expressed? Are there racist or social class or sexist relations?

Suggestions to improve patient care:
What do you think is needed to improve patient care at Kaiser?

Are there things you'd like to add? Were there questions I should have asked, but didn't?

Demographic profile of interviewees

	Name	Union	Job type	Work at	Sex	Race or ethnicity	Age (estim.)
1	Sandy	250	Kaiser division	union	m	white	40s+
2	Jim	CNA	Kaiser division	union	m	white	40s+
3	Terri	CNA	labor rep	union	f	Black	40s
4	Susan	CNA	RN	hospital	f	white	40s
5	Kriis	CNA	RN	hospital	f	white/ N.European	40s
6	Reba	250	Licensed*	hospital	f	white	30s
7	Willy	CNA	RN	hospital	f	white	40s
8	Jamie	250	UAP/MA	clinic	m	white	40s+
9	Blanche	250	Certified*	clinic	f	white	40s+
10	Dominique	CNA	RN	clinic	f	Chinese	60s
11	Ann	CNA	RN	clinic	f	white	40s+
12	T.U.N.	CNA	RN	clinic	f	white-Black	late 20s
13	Elena	CNA	RN	hospital	f	Filipina	40s
14	Bea	CNA	RN	hospital	f	ChineseAm	40s
15	Eileen	CNA	RN	hospital	f	Black	40s+
16	Lynn	250	Certified*	clinic	f	White	40s
17	Skip	CNA	RN	hospital	m	Black	40s
18	Lorna	250	UAP/SP	hospital	f	Filipina	40s
19	Fran	250	UAP/SP	hospital	f	Latina	30s
20	Maria	250	UAP/MA	clinic	f	Latina	30s
21	Kevin	250	UAP/MA	clinic	f	Latina	30s
22	Hermalind	250	UAP/CP	hospital	trans	Pac Islander	40s
23	Gene	250	UAP/CP	hospital	m	Filipino	40s
24	Tanya	250	UAP/CP	hospital	m	Black	40s
25	John	250	LVN	hospital	m	White	40s
26	Cheyenne	250	LVN	clinic	f	Black	50s

* occupation not specified to maintain anonymity of respondents

RN = registered nurse
UAP = unlicensed assistive personnel
MA = medical assistant
CP = care partner
SP = service partner
LVN = licensed vocational nurse

Information letter for...
Labor Issues At Kaiser Permanente: A Retrospective Study

Dear Friend,

I am a doctoral student in sociology at UCSF, and I am writing my dissertation about the labor conflict that happened at Kaiser Permanente in 1996 and 1998.

I am doing the research because I believe that the changes taking place in U.S. health care have changed health care delivery in numerous ways. I want to hear from health care workers themselves how different groups have responded to these changes.

The information from this study will help sociologists of health care, health care analysts, and anyone concerned about health care and work issues to understand the important linkages among health policy, health care delivery, and labor issues.

I want to interview Kaiser employees who were working at San Francisco Kaiser 1996-1998, and who were in collective bargaining units represented by SEIU Local 250 or the California Nurses Association. I want to interview employees who have different perspectives on the labor issues and on union activity in health care.

These interviews will be private and confidential. I will ask about your perspectives on the labor dispute, your opinions about collective bargaining in health care, and the implications of the labor dispute. The interview will be audiotaped and transcribed, but your real name will not be used. If you agree to be interviewed, you sign a consent form [with your real name], but I will keep this form locked up separately from transcripts and audiotapes. The typed transcripts and audiotapes will have personal identifying information removed, and will be accessible only to myself and my dissertation chair. Some sections of transcripts may be quoted in publications or used for educational purposes, but persons' identities will always be thoroughly disguised.

Thank you for your interest. If you would like to hear more about the study, or would like to be interviewed, please call me at (415) 502-4501.

Also, if you know some other people who may be interested in speaking with me, I would definitely appreciate your "passing the word" to them!

Sincerely yours,

Teresa Scherzer, MSW
Doctoral Candidate
Dept. of Social and Behavioral Sciences, Box 0612
University of California, San Francisco
San Francisco, CA 94143-0612
phone (415) 502-4501; fax (415) 476-6552

Purpose of the research: labor issues at Kaiser

Health care has changed in many ways since the 1990s. There is a tremendous stress on keeping costs down. This affects how health care is delivered in different ways, such as: closing hospitals or units in the hospital, discharging hospital patients much more quickly, having fewer supplies, having fewer workers, giving health care workers more work to do, using fewer registered nurses to do bedside care.

Most research about health care and "managed care" is about how patients are not getting the same quality health care as in earlier times, or how doctors have to do much more paperwork and get the OK from insurance companies for clinical procedures, or how organizations have to cut services because they cost too much.

No research is about how the majority of health care workers are affected. Labor unions are very concerned about this. I am very concerned about this. Yes, I think doctors are unquestionably important and how they are affected by changes in health care is also extremely important. BUT, most health care workers are not doctors. They don't get paid like doctors, they do much more demanding physical and emotional work than doctors. When health care organizations say "we have to cut costs" they make cuts in the non-physician workforce, and place more demands on these workers.

The purpose of my research is to find out how changes in health care have affected these non-physician health care workers and the unions that represent them. I will interview union representatives and health care workers to find out how people have experienced and have dealt with the changes in health care. I want to interview health care workers to hear from each of you how your working situation at Kaiser has changed (or not) during the 1990s. I want to ask workers if you think patient care has been affected, and what suggestions you have about improving patient care.

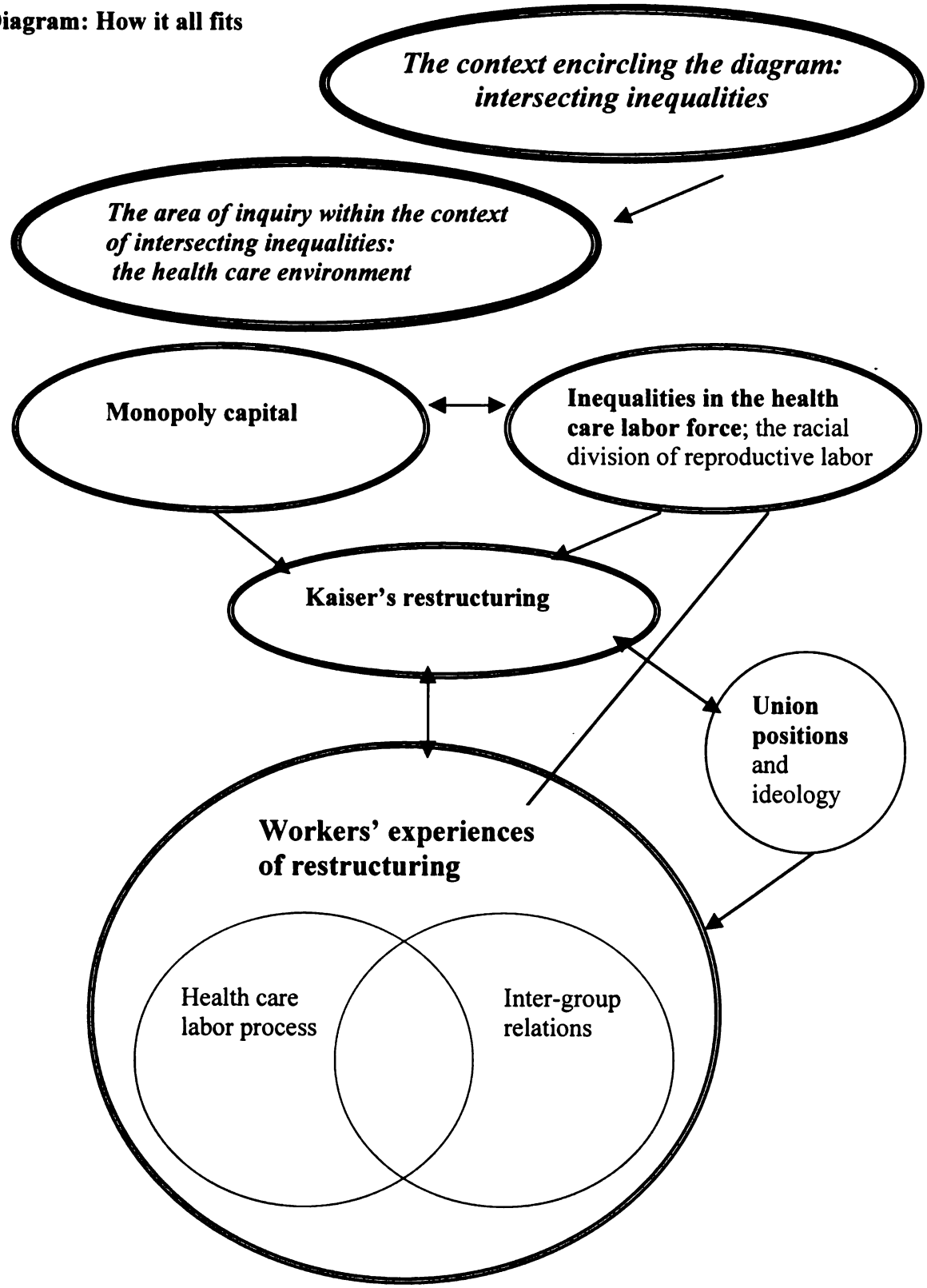
Why Kaiser? It's one of the oldest, and I think better health care organizations, and it has a long relationship with labor unions. Also, its two biggest unions, which represent two different classes of workers, have taken very different positions in how to deal with Kaiser. The nurses union is in a position of labor conflict. Local 250 is one of the partnership unions that is bargaining as a group with Kaiser.

I hope this research will help health care workers and labor unions in advocating for improved working conditions and improved patient care. When we can hear from workers directly about working conditions and patient care, we can take steps to advocate more effectively and meaningfully for workers and patients alike.

Thanks for your interest!

Teresa Scherzer
Dept. of Social & Behavioral Sciences, UCSF
(415) 502-4501

Diagram: How it all fits



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Service Partner - Med/Surg

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Duties: As a member of the Patient Team, under the direction of an RN and reporting to the Patient Care Services Manager, the Service Partner's duties are: Primarily responsible for all the environmental aspects of the unit, simple transports of patients and participating in meeting the basic core comfort care needs of the patient. Primary duties include, but are not limited to: environmental services daily room cleaning, equipment cleaning, general unit cleaning and trash management. Patient intake, collecting transport specimens and document transport; Nutritional Services - heating, serving and collecting meal trays, recording patient intake. Provide basic maintenance such a light-bulb changes, drain plunging, thermostat adjustments and use of one-stop-shop to submit request for repairs. Under the direction and assessment of the RN provide patient core comfort care, including providing blankets, giving a glass of water, answering, the phone, adjusting blinds responding to patient call lights and other activated that maintain a safe, pleasant and satisfying environment for the patient. Education: High School diploma or equivalent required. AHA BLS or ARC Professional Rescuer CPR Infant and Child CPR.

Qualifications: Six months experience in a sub-acute or extended care facility within the last two years in one of more of the following areas strongly preferred: 1) Housekeeping, 2) Food Handling, 3) Transporting patient and supplies, 4) Decontaminating instruments, containers, and equipment using detergent and disinfecting solutions. Good verbal and written communications skills in English, including legible handwriting. Demonstrated ability to work effectively in teams required. This position will be filled at the Hayward location.
Starting Salary Range: $14-$0

Additional Information
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Service Partner B385

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Duties: POSITION SUMMARY: As an integral member of a patient care team and under the direction of the Registered Nurse, the Service Partner is primarily responsible for all the environmental aspects of the unit as well as meeting the basic patient comfort core needs. The Service Partner performs multiple support functions directed toward positive patient care outcomes. As a team member, the Service Partner promotes cooperative working relationships, by facilitating and enhancing communication, displaying honesty and respect, displaying sensitivity to cultural differences, and expressing and accepting feedback in a positive manner. As a partner in the care team, the Service Partner fosters a harmonious work environment in which high-quality patient-centered care and customer service is consistently provided. Education: High School Diploma or equivalent required. CPR required. CNA Preferred.

Qualifications: TRAINING/WORK EXPERIENCE: 1.) Six months experience in environmental services, patient escort, nutritional services or as a nursing assistant/patient care assistant in an acute care setting in the last 2 years preferred. 2.) Students who have completed a medical assisting or nursing assistant program, had experience in the health care or hospitality industry, or experience in Environmental Services will be considered. 3.) Experience decontaminating instruments, containers, and equipment using detergents and disinfecting solutions preferred. 4.) Good verbal and written communication skills in English, including legible handwriting. 5.) Proficiency in using personal computers and mainframe systems preferred. 6.) Bilingual preferred. 7.) Demonstrated ability to work effectively in teams required. 8.) Willingness and ability to float to other patient care units. This position will be filled at the San Francisco location.

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Care Partner

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Duties: As a member of patient care team and under the direction of the Registered Nurse, the Care Partner is responsible for providing direct patient care in accordance with the patient's plan of care, physicians' orders, hospital policy, standards of care and performance. Primary duties include, but are not limited to: assistance with activities of daily living (ADL), patient feeding, patient core comfort care and other patient care duties as required of the position, simple documentation such as intake and output, assistance with basic respiratory and physical therapy treatments, phlebotomy/EKG testing. The Care Partner will also carry out basic duties of the Unit Assistant and the Service Partner as needed. As a team member promotes cooperative working relationships, by facilitating and enhancing communication, displaying honesty and respect, displaying sensitivity to cultural differences and expressing and accepting feedback in a professional manner. As a partner on the care team fosters a harmonious work environment in which high quality patient-centered care and customer service is consistently provided a harmonious work environment in which high-quality patient centered care and customer service are consistently provided. Education: High School Diploma or equivalent required. CPR (BCLS) required; CNA preferred; CA Phlebotomy Certificate preferred.

Qualifications: TRAINING/WORK EXPERIENCE: 1. 6 months experience as a nursing assistant or patient care assistant in an acute care setting within last 2 years preferred. 2. RN or LVN student currently enrolled in a nursing program who has completed the basic Medical-Surgical and/or Obstetric rotation. 3. Graduate from an accredited health school care program, e.g., Medical Assistant, EMT, with at least 6 months experience who have completed a program for Activities of Daily Living. 4. EKG and Phlebotomy experience preferred. 5. Proficiency in using personal computers and mainframe systems preferred. 6. Knowledge of medical terminology. 7. Good verbal and written communication skills in English, including legible handwriting. 8. Bilingual preferred. 9. Demonstrated ability to work effectively in teams required. 10. Demonstrated ability to meet position competencies. Willingness and ability to float to other patient care units.

Work Schedule: Sa

Additional Information
Date Posted: Apr-13-2001
Ref Code: SFO0100163

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Care Partner - Med/Surg

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Duties: As a member of the Bedside Patient Care Team under the direction of a Registered Nurse and reporting to the Patient Care Manager the Care Partner's duties are: To obtain, record and report vital signs, heights, weights and inputs/outputs of patients as directed. Observe, record and report patient response to care. Provide patient care, including but not limited to : AM/PM care, feeding, bathing, oral care, and assisting patients in and out of bed. Perform routine EKG, phlebotomy and perform basic physical therapy point-of-service testing activities not requiring a license (i.e., sputum collection, pulse oximetry, and incentive spirometry) treatments (i.e., continuous passive motion applications, endurance ambulation, range of motion and activities of daily living). Provide additional duties in support of other care team members as needed, such as heating and serving trays, transportation of patients, specimens, medical records, films and equipment. Provide patient core comfort care, including providing blankets, giving water, answering the phone, adjusting blinds, responding to patient call lights and other activities that maintain a safe, pleasant and satisfying environment for patient. Carry out basic duties of the Unit Assistant and the Service partner as needed. Required to work two (2) consecutive weekends, and off on the 3rd weekend. Certified Nursing Assistants from Convalescent/Long Term Care facilities represented by SEIU Local 250 are eligible to train into these positions through a six (6) week paid training program, May 29 - July 6, 2001. Interested applicants will need to complete an assessment at the Local 250 Offices in Oakland, and submit an application and resume to HR Recruitment Services at FAX#510-596-7481, Telephone# 510-596-6979, Contact Erin Langeston, Recruiter. Qualified candidates will be referred to hiring managers for interviews. Education: High School Diploma or Equivalent Required. Certification: AHA BLS or ARC Professional Rescuer CPR Infant and Child CPR, CNA Preferred.

Qualifications: Strongly preferred CNA or RN student with one semester in clinical setting or six months experience as a CNA in an acute care setting within the last 2 years. Must have experience in bedside nursing. Good oral and written communication skills in English, including legible handwriting. Demonstrated ability to work effectively in teams required.

Work Schedule: Mo
Starting Salary Range: $15-$0

Additional Information
Date Posted: Apr-25-2001
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Medical Assistant

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Duties: EXPERIENCE/TRAINING/SKILLS PREFERRED. Assist with patient care and provide support to physicians and nurse practitioners in the medical office. Duties include but are not limited to: answering telephones, making appointments using PARRS computer system, taking and returning messages per providers' instructions, taking vital signs and weights, preparing patients for exams, assisting providers with procedures, cleaning and restocking rooms, ordering supplies, filing material, taking care of equipment and instruments, running errands. Ability to work in a fast paced clinic. Perform other duties as assigned. Performance criteria available for review in Ambulatory Services. POSITION/UNIT SPECIFIC: Record accurate telephone messages according to standards. Follow appointment-booking quidelines to book appropriately and accurately or refer call to license personnel. Education: Graduate of AAMA recognized program and/or AAMA certification. BCLS Level C required. Senior RN Student preferred. Accredited Medical School Certification. HIRING IN STATUS: Must be willing to work in other areas as assigned in the Department of Medicine. This position may be required in the future to work evenings/weekends/holidays. VIETNAMESE REQUIRED, FLUENT IN ENGLISH.

Qualifications: One year recent work experiences as a certified Medical Assistant. Good medical terminology, strong interpersonal skills and the ability to function as a team member. Ability to respond appropriately and rapidly to high volume of member contacts. Good or excellent attendance preferred (subject to the terms of applicable collective bargaining agreement, if any). Demonstrated flexibility and the ability to work well under pressure. Willingness to accept and incorporate constructive criticism and direction. Strong oral, written, communication and typing skills. Demonstrated ability to work effectively in teams required. Prior phone experience required. Must be proficient in problem solving. Must have demonstrated history of excellent service skills exhibited by courtesy, cooperative spirit and tact when interacting with employees, members and visitors. Performance expectations must be competent. POSITION/UNIT SPECIFIC: Responsible for answering the phones according to Department of

Medicine productivity standards and customer service standards. Using appropriate safety precautions, must be able and willing to work with or around commonly used potentially hazardous substances, including high level disinfectants such gluteraldehyde (Cidex), as referenced in Material Safety Data Sheets. Skills: 20 WPM TYPING. CRT/ COMPUTER SKILLS.

Work Schedule: Sa
Starting Salary Range: $14-$0

Additional Information
Date Posted: Nov-02-2000
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Medical Assistant

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Duties: Nursing Process: Under the direction of the RN, ability to collect data/patient information in a systematic manner. Assists patients over the telephone (i.e. refer to RN as appropriate, give information, book appointments, messages to provider or use Healthwise Handbook to direct self care, etc.) Carries out a goal directed plan of care under the direction of the Registered Nurses. Scheduling of correct appointment types. Assists with the evaluation of patient care by giving input to the RN. Must treat external and internal customers ina respectful, friendly, helpful and professional manner at all times. Must adhere to service expectations of the department and facility. Education: Certificate of completion in a medical assisting program. BLS certification required.

Qualifications: High phone volume requiring telephone experience. One year experience in a clinic setting within the past (4) years preferred; new graduates accepted. Effective verbal communication and writing skills (in English). Bilingual capability preferred. Ability to work productively in a busy and complex environment. Accurate computation skills. Good interpersonal and organizational skills. Medical Terminology. Ability to record precise, complete telephone messages for physicians. Able to make decisions under stressful situations. Current knowledge of diagnostic tests, their functions and normal results. Able to function independently. Willing to rotate weekends and evening; occasional variation in starting hours. Prior good attendance record essential. Must have the ability to maintain relationships with patients and peers. Will be required to answer Medicine, Pediatrics and OB/GYN calls. This position is located at the Fremont facility.
Starting Salary Range: $15-$0

Additional Information
Date Posted: Dec-14-2000
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Licensed Vocational Nurse

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Education: Current CPR Certification. Graduate of an accredited LVN program. Current California LVN License.

Qualifications: One (1) year experience as an LVN required. PMG experience preferred. One year acute care preferred. Good attendance record required. Must have good communication skills, both oral and written. Must be able to understand and be clearly understood in English. Must be willing to work in any clinical area including TST. Must be willing to do all procedures. days and hours may vary. Must be willing to work eight hours, Saturday and Sunday, every other weekend. Must demonstrate courteous behavior in all interactions. Must be willing to work in a smoke-free environment. Will consider new graduate if unable to hire as above.

Work Schedule: Sa

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Staff Nurse I & II N125

Description: Great People. Great Medicine. Great Opportunities. Health care is changing. Kaiser Permanente leads the way. More than eight million people rely on us for their health care. Join our outstanding team and make a difference...every day. Our quality of care is unmatched and so are our healthcare careers. Positions are available throughout our California Region, made up of 28 acute care hospitals, including two specialty tertiary care centers and 120 ambulatory care centers. Our 85,000 employees and more than 7,000 physicians provide the highest quality of care to over 5.9 million members. Come join our award-winning team and enhance your skills in a full time, part time or per diem position. Kaiser Permanente is an EEO/AA/M/F/D/V Employer

Duties: As a member of a patient care team, the Registered Nurse (RN) provides leadership to the care team and ensures appropriate management of the care patients. The Staff Nurse I functions with guidance from the Staff Nurse II/III. The RN is accountable for the coordination and delivery of patient care in collaboration with other disciplines, through implementation of the nursing process, delegation and assignment of care to other members of the care team, and the supervision of these delegated and assigned tasks. Primary duties include, but are not limited to, assessment, planning, implementation and evaluation of patient care, leadership, patient education, care management, and patient core comfort care. As a team member, the RN promotes a cooperative working relationship by facilitating and enhancing communication, displaying honesty and respect, displaying sensitivity to cultural differences, and expressing and accepting feedback in a professional manner. As a partner in the care team, the RN fosters a harmonious work environment in which high-quality patient-centered care and customer service are consistently provided. Patient-centered care and customer service. Education: Graduate of an accredited school of nursing. BSN preferred. Current CA RN License. CPR(BCLS) required

Qualifications: STAFF NURSE: I: New graduate or continuing student in a RN program or re-entry RN STAFF NURSE: II: Minimum of six months experience as an RN in an acute care setting within the last two years required. Experience in area of specialty preferred. Demonstrated ability to meet position competencies Advanced verbal, reading and written communication skills in English, including legible handwriting required. Proficiency in using personal computer and mainframe systems preferred. Bilingual preferred Advanced arithmetic and analytical skills required. Ability to establish priorities and remain flexible when faced with multiple conflicting demands. Demonstrated ability to work effectively in teams required. Willingness and ability to float to other patient care units.

Work Schedule: Sa

Additional Information
Date Posted: Jan-31-2001
Ref Code: SFO0100073

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RN, Staff II - Extended Role

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Duties: * Coordinates with physicians and staff regarding patient care. * Plans, develops, assesses and evaluates care provided to members. In conjuction with physicians, evaluates and developes discharge plans, recommends alternative levels of care, and ensures compliance with federal, state and local requirements. * Coordinates, directs and performs concurrent and retrospective reviews, and monitors level and quality of care. * Encourages members to follow plans of care (e.g., drug therapy, physical therapy). make referrals tko appropriate services. Arranges and monitors follow - up appointments. * Identifies and recommends oppurtunities for cost saving and improving the quality of care across the continuum. Developes and collects data, and trends utilization of health care resources. * Interprets regulations, health plan benefits, policies, and procedures for member, physicians, medical office staff, contract providers, and outside agencies. Coordinates transmission of clinical and benefit treatment to patients and families. * Must have strong communication skills. * Experience in program development and evaluation. Education: R.N., California, Bachelor's degree of equivalent experience in nursing or health related field. Master's degree preferred.

Qualifications: * Knowledge of pathopsysiology of Diabetes, Vascular Disease and wound care. Diabetes, Vascular Disease, wounds including but not limited to medications, lab interpretation, risk factor management. * Excellent organizational and facilitation skills. * Excellent verbal and written communication skills in English required. Spanish speaking preferred. * Computer skills: word processing, developing/maintaining a database. Musty also be able to learn and be expert in our appointment system and other mainframe systems. * Excellent attendance record. * Must exhibit excellent customer service skills including courtesy, tact and poise when interacting with members, families and co-workers, and must project a professional image. * Knowledge of Nurse Practice Act, JCAHO and other federal/state/local regulations. Staff Nurse II - Salary $33.08 - $36.69 per experience. This position is located at the

Hayward facility.
Starting Salary Range: $33-$0

Additional Information
Date Posted: Apr-04-2001
Ref Code: HAY0100308

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