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Managing Professional and Labor Interests Through Organizational Change in the American Nurses Association: A Professional Society Case Study

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Managing Professional and Labor Interests Through Organizational Change in the American Nurses Association: A Professional Society Case Study

by

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DISSERTATION

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Sincerely,

Mark

ABSTRACT

MANAGING PROFESSIONAL AND LABOR INTERESTS THROUGH ORGANIZATIONAL CHANGE IN THE AMERICAN NURSES ASSOCIATON: A PROFESSIONAL SOCIETY CASE STUDY

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This study utilizes professional and labor theory to explore the organizational change process experienced by the American Nurses Association from 1999 to 2004. Case study methodology was used to conduct telephone interviews with nurse leaders of three national nursing organizations serving on their respective boards of directors during the time frame of interest: the American Nurses Association (ANA); the United American Nurses; the Center for American Nurses. Along with interview data, public documents from the ANA were examined to better understand the process of organizational change. The data illuminated the pressures driving the ANA in its organizational change, including the struggle in meeting member needs that are diversified throughout the country. Specific conflicts surrounding professional and labor interests among state nursing organizations competing for influence in the ANA spearheaded the change process. Differing interests among member state nursing organizations in meeting individual nurse economic and general welfare needs began to compete for organizational resources. The ANA's struggle to maintain its position as the representative of professional nursing in the United States was specifically challenged as organizational members within the society threatened to withdraw their membership, weakening ANA's representative status. Years of internal focus on organizational structure greatly influenced the ANA of today and of the future.

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CHAPTER ONE

Introduction

The past decade has witnessed major changes in the financing, organizing, and delivery of health care. These changes have had an impact on access to services, quality of care, and escalating health care costs (Harrington & Estes, 2004). Nurses in the U.S. have attempted to respond to these health care changes at the patient care level, within the delivery system, and at the national level in terms of policy development. As healthcare changes contributed to an uncertain environment in recent years (Harrington & Estes, 2004), nurses have created organizations to further the interests of the profession, including health care for individuals, families, and communities.

The American Nurses Association (ANA) was established in 1896 as a membership organization of registered nurses. From the beginning, the ANA was designed to be a full service professional society of nurses in the U.S., with organizational membership at both the state and national levels. It represents nurses with varying educational backgrounds and skills, across the full spectrum of practice settings. As part of the original charter, the ANA established the goal of addressing the economic and general welfare needs of its members and the profession (ANA, 2003). Historically, the ANA has struggled to elevate the occupational status of nursing to that of a profession, while at the same time engaging in union activities that have traditionally been utilized by occupations considered non-professional. Beginning in the 1940's the ANA began to serve in a combined role as both a professional society of nursing as well as a labor organization.

Over time, differing opinions within the organization have arisen as to the best means of addressing the economic and general welfare needs of nurses. Some members have wanted to focus on nursing education and the development of the profession through the establishment of professional standards such as a code of ethics and clinical practices. Some viewed achieving these efforts through a collaborative effort with hospitals and physicians to improve the practice conditions of nurses and demonstrate its influence on patient care. Other members sought to utilize more traditional trade union activities such as collective bargaining, involving strike actions and organizing activities established by the National Labor Relations Act (Wagner, 1980).

These two perspectives of professionalism and collective bargaining have created tension within the ANA. Wagner (1980) provided a background on this tension within the profession and the leaders of the ANA in his historical sociological perspective of the profession. The leadership of the ANA in the 1930s was concerned that traditional labor organizing of nurses supported the view that nursing work in hospitals was analogous to factory work. In contrast, hospital nurses viewed the labor movement in the 1930's as a means of expediting the improvement of hospital working conditions for nurses. The demand for improving working conditions was spearheaded successfully by collective organizing by nurses in individual hospitals throughout the country. This activity was at first independent of organized labor as well as the ANA, and was accomplished by nurses within individual hospitals (Wagner). Wagner illustrated the need for the ANA to respond to its members from the view of Gertrude Dubois, California Nursing Association president's editorial in 1937, "unless the professional

association [ANA] acted strongly on behalf of rank-and-file nurses, it was doomed as an organization" (Wagner 1980, p. 120).

Beginning in the mid 1990s, and throughout the early part of the 21st century, the conflicts within the ANA resulted in the disaffiliation of four state constituent member associations, the California Nurses Association (CNA), Main State Nurses Association (MSNA), Massachusetts Nurses Association (MNA), and the Pennsylvania Nurses Association (PNA), from the ANA. Three of the disaffiliations (California, Main, Massachusetts) were spearheaded by member leaders involved in the collective bargaining programs of the constituent member associations who were dissatisfied with the operations of both the state and national nursing organization.

The disaffiliations left nurses in these states without national representation, and the ANA quickly assisted these nurses to establish new constituent member associations within their respective states. However, these newly established state constituent member ANA associations no longer provided collective bargaining services to their nurse members. As a result of these events overall membership within the ANA was decreased, and the concern was that the membership declines would continue if additional constituent member associations followed suite in disaffiliating with the ANA. Disaffiliations would obviously result in decreased dues revenue.

In order to understand the organizational changes undertaken by the ANA from 1999 to 2004, it is necessary to have a general understanding of the structure of the organization. The ANA structural model was a federated model consisting of formal independent organizations united under one single organization. Within the ANA, the independent nursing organizations were the nursing associations of the individual states,

of nurses in the armed forces, and of U.S. territories such as Guam and Puerto Rico, and these organizations made up the membership of the ANA. Individual RNs were members of these independent nursing associations, and thus their interests were represented by the state and other local associations to the ANA; the individual RN was not a direct member of the ANA.

In addition to the federated model of organizational membership, the ANA required additional structures in order to conduct its work as a labor organization. Although ANA as an organization was never involved in labor contract negotiations, some of its members, the state nursing associations, were certified under federal and state law as labor unions. State nursing associations that were certified labor unions were found in those states that had adopted the use of formal labor union organizating as the generally accepted method of negotiating working conditions among employee and employer.

Labor laws and court case rulings have clarified the language regarding nurses as supervisors and their eligibility to be union members. The distinction is made between the nurse who supervises patient care and the nurse who supervises in the interest of the employer. The former is eligible for union membership while the latter is not ineligible (Zacur, 1982). Thus registered nurses served in both management and non-management positions within hospitals. However, once again, labor law mandates the structure of labor unions, and these laws require that a union's officers not hold supervisory employment positions (Zacur).

In order for the state professional nursing societies to be certified labor unions, organizational structures needed to be developed to insulate the work of the union from

the rest of the organization's work. This was necessary because the state nursing associations permitted all eligible RN members to serve as officers of the association, including RNs holding supervisory employment positions. Organizational structures within the state nursing associations maintained the full rights of members to serve on their respective board of directors, including the positions of board officers. To do so required a separate organizational structure governing the work of the union, and insulated from all other association work directed by the full association board of directors (Dolan, 1980; Lee & Parker, 1987). Within many state nursing organizations, this work was organized as the economic and general welfare program, governed solely by RN union members. However, this program remained part of the overall structure of the state nursing association, directed by the association's board of directors.

Since the ANA itself never engaged in union contract negotiation, the strict organizational structures of the union state nursing associations were not as critical at the national level. The ANA was thus not a certified bargaining unit by the National Labor Relations Board, but rather recognized by this Board as a labor organization. In order to represent its members, and to meet insulation requirements, the ANA maintained organizational programming for national representation of the state RN unions (Melosh, 1982). Since the vast majority of the state nursing union membership came from the ranks of hospital staff nurses, the state and national economic and general welfare programs became synonymous with representing the interest of the hospital staff nurse, regardless of their union membership.

The ANA adopted structural changes in the years 1999 to 2004 that resulted in the development of new membership categories within the organization. These changes

allowed for other organizations to become full participatory members within the ANA (known as Affiliated Organizational Members, or AOMs), along with the existing federation model of state specific nursing association members known as constituent member organizations (CMAs). Direct membership of individuals was also reintroduced, so that individual registered nurses could become members of the ANA without requiring membership in an AOM or CMA.

As a result of these structural changes, two distinct nursing organizations were formed and became the first AOMs of the ANA. The United American Nurses (UAN) was originally established in 1999 as the labor arm of the ANA. They affiliated with the American Federation of Labor-Congress of Industrial Unions (AFL-CIO) in 2001, and in 2003 became an autonomous, independent organization affiliated with the ANA (ANA, http://www.nursingworld.org/uan/about.htm, 2005).

Also in 2003, the second organization to become an AOM of the ANA was the Center for American Nurses. The Center for American Nurses was established as an autonomous, independent, professional organization in 2003, with ANA affiliation, and evolved from the ANA Commission on Workplace Advocacy, established in 2000 to address the workplace needs of nurses not represented through collective bargaining. The Center for American Nurses provides non-collective bargaining workplace advocacy to nurses (ANA, http://www.nursingworld.org/can/about/history.htm, 2005).

The distinguishing characteristic of these two organizations is the manner in which they address the workplace concerns of registered nurses. The UAN claims its membership base as the staff nurse, utilizing labor law to provide third party collective bargaining representation and organizing, and thus is a certified labor union. The Center

for American Nurses provides non-collective bargaining services to nurses in their workplace. They do not engage in labor negotiations or labor organizing, and thus are not certified as a labor union, but rather as a non-profit professional organization. Thus, the restructuring and reorganization of the ANA in the 21st century has created new options for the profession and the organization to address the economic and general welfare issues of nurses. This recent period of restructuring is important to both describe and understand. This study of the ANA focuses on the changes in the ANA organization in the 1999-2004 period.

Statement of the Problem

This study was designed to examine the changing structure and function of the ANA during the 1999-2004 period. The ANA has been the largest professional nursing organization which represents the nursing profession in national political and policy making arenas, as well as the U.S. nursing representative to the International Council of Nursing (ICN). Tension within the organization has challenged the ANA in its position as representative of the U.S. nursing profession, and has the potential for threatening its international representation.

Previous published analytic work focusing on nursing organizations in general, and of the ANA specifically, has been minimal. Of 567 published research articles, books, and dissertations found in the Cumulative Index to Nursing and Allied Health Literature (CINAHL), only 11 studies were identified as presenting research on a nursing organization(s) as the unit of analysis. These published research articles on nursing organizations examined the nursing organization in a specified time period, using historical research methodologies. Only five studies examined nursing organizations in

the U.S. The most recent study of the ANA was by Hegvary, et.al (1987) that examined options for future organizational structures.

Thus the literature on nursing organizations as the unit of analysis is limited, and even more limited in its focus on the ANA, with no studies appearing in the literature that examined the ANA since 1966. Such work is greatly needed to further understand the ANA and its activities in the U.S. and internationally.

As noted above, the ANA considers that it represents registered nurses in the U.S., claiming within its purpose:

> The … only full-service professional organization representing the nation's entire registered nurse population. From the halls of Congress and federal agencies to the board rooms, hospitals and other health care facilities, the ANA is the strongest voice for the nursing profession. …The ANA represents the interests of the nation's 2.7 million registered nurses through its 54 constituent state and territorial associations and over 150,000 [individual] members (ANA, http://www.nursingworld.org/FunctionalMenueCategories/AboutANA.aspx, 2005).

As with any organization over time, events and circumstances create challenges and opportunities for organizational leaders to reflect on where they have been, measure their successes to date, and plan for effective and purposeful activities for the future. Although the ANA claims representation of the U.S. registered nurse population, the actual number of RN's who are members of the organization is just 5.6% of the 2.7 million in the U.S. (ANA Board of Directors Meeting Agenda Item #2, December 2003).

With the complexity of constant change in the U.S. healthcare system over the past two and half decades, nursing has responded with its own changes. In representing the nursing profession, the ANA has been directly involved in these changes, and has, as an organization, also needed to adapt and change with the health care system and nursing and patient needs.

This study critically examined the ANA changes that have been made in a most recent period, including the intended and unintended results of its organizational decisions. Such a study provided insights into the organization's activities related to meeting its stated mission, goals, and purpose to date, as well as provided an opportunity to reflect on the activities required for the organization's future success in representing the U.S. profession of nursing.

Purpose of the Study

This study described and analyzed the ANA organizational changes that occurred during the period of 1999-2004, using an in-depth case study methodology. This period was selected because the ANA restructured from a single organization at the state and national level into three separate organizations with differing goals and activities. The study had two specific aims:

Aim 1:

To examine the changes in ANA's organizational goals, structure, and activities between 1999-2004, and the reasons for the changes.

Aim 2:

To examine agreements, conflicts, ideas, and values held by the ANA's leaders regarding the goals and objectives of the ANA in the period 1999-2004.

Two data sources were used: 1) ANA documents; and 2) interviews with three sets of nurse leaders: those who served as members of the ANA Board of Directors; those who served as Executive Council members of the newly formed United American Nurses Association (UAN), and those who served as members of the Board of Directors of the newly formed Center for American Nurses at any time during 1999-2004. Qualitative and quantitative data used were combined to address the two specific aims outlined above.

The study examined several questions. Were the structural changes in the ANA primarily designed to stem the tide in loss of membership through state disaffiliation which centered on concerns of addressing member economic and general welfare issues? Did the conflicts in ideas, values and goals among the ANA leaders focus primarily on the use of collective bargaining as the preferred method for addressing the profession's economic and general welfare concerns? Did the ANA's labor focus result in the redistribution of organizational resources away from specific nursing issues in order to address the internal conflict? Were the ANA's organizational internal struggles greatly influenced by leader ideas and values surrounding the organizations identity as both a professional society and a labor organization? What role did the external environmental and internal pressures play on the ANA's leadership and membership in making decisions about the structural functions of the organization in meeting the goals and objectives of the organization?

Significance of the Study

The organizational structural changes of the ANA from 1999-2004 were directly related to how the ANA addressed its member economic and general welfare needs. The ANA, as an organization, contains some unique characteristics that support its examination as a single case study. One of these characteristics is its function as both a national professional society and a labor organization of health care providers, specifically registered nurses. Although other national professional organizations, such as the American Federation of Teachers (AFT), serve in a similar dual capacity, the uniqueness of the ANA lies in its membership base. The AFT allows for membership of "teachers; paraprofessionals and school-related personnel (PSRP); local, state and federal

employees; higher education faculty and staff; and nurses and other healthcare professionals" (AFT, http://www.aft.org/about/index.htm, 2005). In contrast, the ANA has, throughout its history, maintained an organizational membership base exclusively of registered nurses.

This study focused on the ANA, which represented the largest number of health care providers in the U.S. health care system. As an organization, the ANA attempted to influence local, state, national and international health care policy and public health interests. Although a few studies of the ANA have been undertaken, no recent studies have examined this recent period of conflict and change.

This study provided a snapshot of the ANA's recent changes in organizational structure, and the factors influencing these changes. By identifying and reflecting on these changes, the study may lead to improved strategies for the future of the ANA.

Finally, this case study of the process of change within the ANA hopes to contribute to the study of organizations in general. Specifically, this study contributed to the critical examination of both organizational change and organizations as professional societies. The findings of this single case study capture a moment in time during a process of change within the ANA. As such, the findings capture specific themes that contribute to the change process, and are specific to the goals and objectives of the ANA and its special interests. The findings of this study may provide information valuable to other organizations undergoing a process of change, and specifically to other national professional societies whose priorities are both the members of the society and the profession they represent. From this study these organizations are provided insights into the struggles, accomplishments, and outcomes of a change process over a period of time

of a professional society's response in addressing the needs of its members and its profession.

CHAPTER TWO

Background

Throughout the 20th century nursing has made attempts at organizing itself to address the collective needs of those providing professional nursing care, specifically the registered nurse. Collaborative leaders within nursing in the U.S. began to organize themselves late in the 19th century. Initial efforts of these organizations focused on the service of nursing, including the setting of service, as well as education and standardization through licensure. In the early part of the 1900's two organizations emerged as prominent in representing the contemporary issues of nursing and evolved into what we know today as the American Nurses Association (ANA) and the National League of Nursing (NLN), with the NLN focusing on nursing education, and the ANA serving as the all encompassing nursing society.

In 1946 the ANA elected to become a certified bargaining unit, allowing it to begin the practice of organizing nurses in their workplace and represent them in contract negotiations with their employers. With this vote, the ANA had become a labor organization under the laws and regulations established by the National Labor Relation's Board (NLRB) and opened the door for individual state members to also engage in labor union activities. Levitan & Gallo (1989) provided a socio-political view of such an event, and identified the impact of historical developments in the U.S industrial society that have supported the occurrence of professionals using organized labor strategies to impact their work settings. Wagner (1980) specifically addressed such issues on nursing.

Although ANA's decision was made through a representative vote of its members, the decision to engage in union activity remained an issue. The concern

divided nurses. On one side there were those nurses who believed in the altruism of professional service and the control of the profession by its members through its institutions from those who felt the need to utilized federal labor law to meet the economic and general welfare of nurses, and the best means to address potential and real abuses of nurse labor. Such an ideological split within organized nursing has remained an issue that continues to this day. In fact, Yeager (1983) in examining factors affecting membership and the decision to join an association found that a "union-like role" (p. 50) by the organization factored into the decision to join or not join.

Formal legal challenges to nursing professional associations serving as collective bargaining agents have been addressed in the literature (Dolan, 1980, Lee & Parker, 1987), and even world wide comparison's between nursing associations and nursing unions of workplace issues have been offered (Clark & Clark, 2003). However Dolan's analyses was limited to the examination of nurses functioning as employed supervisors and the potential conflict such a role plays in their professional organization membership. Lee and Parker's analysis, although addressing the same supervisory issue, also examined the function and structure of the professional organization in its ability to legally serve as a union. Although Clark and Clark found similarities among worldwide nursing unions and nursing associations on their views of workplace issues, they did not discuss such findings in relation to what they may mean for the structure and operation of organized nursing in general.

The divergent ideological views regarding organized nursing's involvement in labor activity has become more critical over the past ten years within the professional nursing society. In 1994 the California state constituent member of the ANA voted

during their annual meeting to no longer affiliate with ANA as a state member, leaving the organization and its members without national representation. Such secession from the national organization focused on the issue of member services. With the majority of California members participating in collective bargaining services provided by the state organization, concern over the national use of membership dues monies and program prioritization believed to be favoring non-union activities became the driving force behind secession.

Two other state nursing associations followed California's example, and other state nursing associations have voted on whether to succeed and have not done so. Thus the division in organized nursing on the topic of providing union services remains an issue for the solidarity of nursing and the ability for any one organization to truly speak as the voice of all of nursing. Although such splintering of organized nursing into other specialty organizations has been occurring throughout the 20th century, the issue of the professional nursing society engaging in union activity has consistently provided conflict within the organization. And for the ANA, such a controversy may be affecting the ability of its state constituents to truly represent the profession in policy development effecting the profession, healthcare, and its services, when nursing unions, such as the California Nurses Association, begin to compete with the ANA as representing nursing to policy makers in both state and national arenas.

Review of the Literature

A review of the literature was conducted to examine the issues of organized nursing in its attempts to address the economic and general welfare issues of nurses through the activities of the ANA. Faced with a variety of challenges in this effort, the

ANA emerged as the organization representing professional nursing and its struggles throughout the 20th century and today. As a part of its original charter, the organization sought, as one of its primary functions, to address the economic and general welfare needs of its registered nurse members. Through the century the organization faced social, economic, political, and institutional challenges, both externally and internally, that influenced the organization and its structure in its attempts to continue to represent the issues faced by the profession.

To attempt to understand the impact of these influences on the ANA and its structural changes, a literature search was conducted through data base searches of the nursing data base CNAHL, PubMed, Sociological Abstracts, and the business data base, focusing on empirical studies done of nursing societies and organizations, nursing collective bargaining, unionization, labor, and professional occupations.

Professional Nursing Organizations

Previous published analytic work focusing on nursing organizations in general, and of the ANA specifically, have been minimal. Of 567 published research articles, books, and dissertations found in the Cumulative Index to Nursing and Allied Health Literature (CINAHL) using all combinations of the search term 'nursing organizations' and limited to research publications, only 11 studies were identified as presenting research on a nursing organization(s) as the unit of analysis. Research that focused on nursing individual membership within organizations was excluded where the focus concerned members and not the organization. Three studies were excluded because the research was focused on regulatory nursing bodies, specifically boards of nursing. Boards of nursing, as noted by Dalton, J.A., et.al. (1994) differ from professional

associations in structure, authority, and focus, with the boards' primary concern being the protection of the public and not the concerns of the profession.

All 11 published research articles on nursing organizations examined the nursing organization in a specified time period, using historical research methodologies. These studies examined nursing organizations both within and outside of the U.S.

Six studies examined international nursing organizations. Along with Grayson (1989), who explored a 32 year history of the nurses associations of Trinidad and Tobago, Richardson (1995) two works examined the historical relationship of the Canadian Association of University Schools of Nursing and the Canadian Nurses Association, and Strachan (1995) studied the professional and industrial roles of the nursing organization in Queensland, Australia from 1904-1950. Richardson (1998) examined Alberta's District Nursing Service from 1919-1925, while Arton (2003) examined the Asylum Workers Association in the United Kingdom during the late 19th century.

The remaining five published research works were on U.S. nursing organizations. Dykema (1989) and Fries (1991) provided histories of the Nevada Nurses' Association and Minnesota Nurses' Association respectively, and Mosely (1995) explored the National Association of Colored Graduate Nurses in the U.S. from 1908-1951. Only two studies were specific to the ANA; Woods (1996) studied the ANA's position on health insurance for the aged from 1933-1965, and Grando's (1997) analyzed the ANA Economic Security Program from 1946-1966.

Nursings' Economic and General Welfare Concerns

Six studies addressing the economic and general welfare and labor concerns of nursing and the professional society provided a variety of perspectives and means of studying the topic. These studies are presented chronologically.

Wagner (1980) provided a historical analysis of the literature to examine the effects of the great depression on the work of nursing, noting its influence in moving nurses from private duty to paid institutional employee position. He further noted the impact of hospital expansion and their evolution as the primary employer of nurses, noting the resistance by nurses in moving into hospital employment and its working conditions of the time. As such concerns remained with nurses increasingly employed in hospitals, Wagner noted the struggle of organizing the profession for union purposes, with nursing leaders expressing concerns of the inconsistencies of labor union activity with professional development and service. Despite the historical documentation of the specific labor issues faced by nursing in the years between 1932 and 1946, Wagner concluded that the nursing leadership of the time denied the struggles of nursing in an effort to avoid being subsumed by the generalization of the labor movement of the time.

Although providing a historical perspective of the internal struggle of organized nursing to address the work place concerns of practicing nurses, Wagner's (1980) study is limited to an examination of professional nursing journals of the time and to other secondary sources. What is lacking is a first hand account from practicing nursing during the time period studied.

Dolan (1980) provided a case study of the legal concerns of nursing associations serving as collective bargaining agents for practicing nurses. The issue of concern was

the potential role of nurse members of the association who work in supervisory positions in organizations represented by the association in collective bargaining negotiations. Dolan suggested that nursing organizations must have either no supervisors serving in leadership roles of the association, or the organization should stop providing collective bargaining services to members. Dolan attempted to support the latter claim by documenting historical trends in legal case studies. What is lacking in this study is an examination of the efforts made by nursing organizations in addressing such concerns. Lee and Parker (1987) provided such analysis.

Examining two circuit court findings and the structure and philosophy of three state nurses' associations (New York, New Jersey, and Pennsylvania), Lee and Parker (1987) provided a case study of the collective bargaining role of professional associations. They analyzed the legal background of challenges to supervisory participation in labor unions. They analyzed and compared two cases, describing the responses of nurses' professional associations to one case in the three noted states. They concluded the study by stating that there existed no need for different rules governing professional associations and trade unions when providing collective bargaining services. However, professional employees do engender unique characteristics, and such context should be considered in labor negotiations. They noted the need to consider the structure of the organization and its ability to insulate the collective bargaining activity from the governance of other association services so as not to jeopardize the labor process in contract negations by having the involvement of nursing supervisors in the provision of contract specific services. The study provided an analytic perspective in examining

supervisory participation in a professional association as a potential conflict with the legal dictates of the National Labor Relations Act (NLRA).

In examining the socio-political historical aspects that have influenced private sector professional organizations in decision making about how to address member's economic and general welfare concerns, Levitan and Gallo (1989) provided the historical development of the topic by examining physicians, attorneys, nurses, engineers and other scientists. The authors suggested that the increase in collective bargaining by professionals in the 1980's was almost entirely encompassed within the public sector, since only one in ten of all private sector professionals bargained collectively at the time (Levitan & Gallo). They suggested that one reason for the lack of need for collective bargaining among private sector professional associations is the fact that among their membership are top income earning professionals with higher than average job security, based on comparisons in unemployment rates, which see little need for collective bargaining (Levitan & Gallo).

A final suggestion of why professional associations in general had generally not utilized collective bargaining techniques to address member economic and general welfare needs was the extent that the organization had been able to control the profession. Levitan & Gallo (1989) noted the ability of organizations such as the American Medical Association and the American Bar Association to greatly influence their respective professional entry standards, such as education and credentialing requirements, and even the economics of healthcare and legal service provision.

To examine the opinions of nurses toward the ability of the professional nursing association as well as the nursing trade union to address professional and economic and

general welfare issues, Rispel & Buch (1991) surveyed 1200 nurses in South Africa. They found that nurses believed that the South African Nursing Association had performed reasonably in meeting nurses' professional needs, but poorly in meeting their socio-economic needs. There was dissatisfaction with some the Association's policies, specifically the racial nature of its constitution and unequal representation of the different categories of nurses on the regional boards and widespread ignorance about trade unions and health worker organizations, although they did indicate support for these organizations but felt resistance to striking actions. The highest ratings for the Association were for perceived improvements in the field of nursing education, raising the status of nursing, and development of an effective nursing service. But the association was viewed as less effective in addressing salaries, leave, hours of duty and pensions. Seventy-one percent of the respondents felt that socio-economic needs of nurses should be one of the main objectives of the Association, with professional advancement of members being of less concern (Rispel & Buch, 1991). This research offered a research method for use in the U.S. by the American Nurses' Association if they are to truly represent the overarching voice of nursing in this country.

Clark and Clark (2003) examined 56 nursing associations and 49 nursing unions in 76 different countries in gathering data on the organization's views and priorities of nursing issues faced within their countries. Every continent except Oceania was represented by at least nine survey responses. Six of 11 problems identified were viewed as moderately serious to very serious in most world regions with understaffing rated as the most serious concern globally, and very serious to extremely serious concern by nurses' organizations in North America. Safety and health problems were also seen as

serious in all regions, with mandatory overtime and privatization perceived by organizations to be moderately serious. Others identified as serious problems globally were floating and assignment of nursing assistants. Regional differences identified immigration as a problem.

Occupational health and safety problems were further broken down with stress ranking at the top. Ninety organizations representing 69 countries and every geographic region of the world reported a nurse shortage. Little difference was found in the identification of problems faced by nurses between the two types of organizations, association versus union, or in the strategies used to address them. However, the nursing associations reported that the first priority of their membership was patient care issues, while nursing unions reported salaries and benefits as top member concerns.

This study demonstrates that within nursing organizations worldwide perceived issues and their significance are very similar. What may differ among these organizations is their means of addressing the issues, thus it becomes important to examine such strategies of addressing these issues to compare the success of their outcomes.

One other published article, although an editorial supplement and another unpublished dissertation speak to the existing conflict in beliefs about collective labor bargaining and professional development activities within organizations. Kingma (1993) provided an international perspective of this conflict. Kingma supported the interdependence of professional and socioeconomic issues of nursing by providing examples in the areas of education standards, continuing education, practice standards, recruitment and retention, professional development, personnel management, ethics, and

occupational health. Kingma's writing provided the beginnings of what could potentially be developed as a conceptual framework for which to view the links between professional nursing and the socio-economic issues of nursing as addressed through organized efforts.

Scherzer (2001) examined the effects of restructuring within a large managed care run hospital in northern California on the interactions of RN's and other health care workers as their individual labor organizations negotiated the restructuring with hospital management. Specific to the topic of ideological conflict between an organization's ability to address both labor and professional practice issues, Scherzer examined the conflict between unions, one representing RN's, and the other representing all other nursing care providers, as they responded to and negotiated workplace issues during extensive restructuring of patient care services.

In Scherzer's (2001) study, the conflict focused around the professional legal accountability of RN's for the provision of nursing care to patients, regardless of delegation of specified tasks to lesser credentialed and educated personnel. In this study such delegation was subsumed under the restructuring, reorganizing the provision of nursing care among a variety of licensed and unlicensed nursing personnel. The reorganization redefined workplace roles and tasks into the provision of skilled and unskilled nursing care, allowing for any labeled unskilled care to be provided by the lesser credentialed nursing personnel. Only legally required skilled nursing care was performed and part of the role of the RN. Such reorganization seemed to elevate the work of non-RN nursing personnel, while leaving RN staff with increased responsibility

and less authority as their patient care numbers increased without change in their legal accountability for nursing care (Scherzer).

What Scherzer's (2001) case study demonstrated was how such reorganization of the division of labor among nursing personnel, differentiated not only by credential but also by their membership in and representation by different labor unions, actually added to increased tensions and working conditions among the nursing personnel. Although the union organizations clashed over their beliefs and ideals in addressing the restructuring issues, with the RN union increasingly utilizing militancy activities against the hospital in claiming patient care as their primary concern, and the non-RN union seeking a legitimized labor-management partnership with the hospital, there was consistency among the nursing personnel, regardless of licensure and role, of what was necessary for both improved patient care and working conditions. Scherzer noted that,

> informants all argued that increased staffing overall, increased staffing of licensed professionals, and increased inpatient stays were necessary to improve both patient care and working conditions. They also argued that better training and supervision was necessary…proper training of unlicensed staff and adequate RN staffing would reduce the risk to patients and improve working conditions (p. 298).

This noted agreement among the nursing personnel suggested that conflicts in ideology may exist between organizations and may not always be reflective of the organization's membership. The elevation of an issue to conflict may also have more to do with issues within and among organizations, and at best may not reflect, and at worst, overpower the realization of shared ideologies among individual members.

But perhaps Scherzer's (2001) work may serve as an example of the difference between professional practice and other occupational work. The insistence of the RN labor union that their major concern in the reorganization of nursing care services was its

impact on the quality of patient care is legitimized by Sullivan's (2005) differentiation of civic versus technical professionalism.

Sullivan (2005) described the civic professional as retaining a concern for the role of their work on the greater good of society as opposed to the technical professional's concentration on the performance of work and its singular, immediate outcomes. If nursing work is indeed viewed as practice, and their collective social function is professional, then it would seem to follow that these concerns would manifest themselves through collective bargaining and labor negotiations. Perhaps the conflicts between healthcare managers and direct care nursing staff that often necessitate the use of a third party in labor negotiations is linked to the difference in ideological views of nursing work as technical professionalism, viewed by managers, and the civic professional view held by practicing nurses and shared among nurses. However, if this were definite, then it would not necessarily explain the internal ideological conflict within the American Nurses' Association and within other organized professional nursing societies. This contrast in ideologies of technical and civic professionalism may open up new possibilities for reframing ANA's internal debates on nursing work and institutional impediments offering a better realignment of nursing with civic professionalism.

Defining a Profession

The analysis of professions was a major focus throughout the 20th century. Such analysis first appeared when in 1908 the Carnegie Foundation for the Advancement of Teaching authorized a study and report on the status of medical and legal education in the U.S. (Flexner, 1910). As a result, Abraham Flexner provided a report examining medical education from a developmental perspective and made recommendations regarding the

occupation (Flexner, 1910). In 1915 Flexner attempted to provide professional criteria as a means of determining social work's professional status (Flexner, 2001), while Bixler and Bixler (1945) provided criteria for such a status of nursing, with reexamination using the same criteria in 1959 (Bixler & Bixler, 1959). Cogan (1953) wrote of the evolution of the concept of profession using the disciplines of law, history, philosophy, government, and sociology, and Wilensky (1964) suggested a developmental process moving from occupational status to the attainment of professional status.

Goode (1969) attempted to move the analysis from a check list definition. He suggested that professional status stemmed from the existence of two central qualities: "1. A basic body of abstract knowledge, and 2. the ideal of service" (p. 277), while Eliot Freidson (1970, 1986, 2001) provided his social analysis of professional status through the examination of medicine.

Freidson (1970) derived a focus on five characteristics. First, the profession determined its own standards of education and training, and second its practice was legally recognized by state licensure. Third, its licensing and admissions boards were made up of professional members, fourth, it was involved in shaping legislation concerned with the profession, and fifth, its practitioners are relatively free of lay evaluation and control.

Continuing the study of professional status from a sociological perspective, Douglas Klegon (1978) also suggested the need to move beyond a check-list criteria in determining an occupation's professional status. He suggested the need to critically view occupational strategies within a social context that established the occupation's position as a profession.

Most recently, Sullivan (2005) noted that the traditional markings of professions, that being "corporate membership, controlled markets for their services, and monopolistic practices in training and recruitment" (p. 1) can no longer be measures of an occupation's professional status in society because such qualifications are no longer appropriate measures of professions in the current work settings. Such settings relate to the increase in corporate focus and employment of professionals as part of the corporate model, thus creating more of a shared authority for such markings.

Sullivan (2005) suggested that the contemporary professional is differentiated from other knowledge workers because of the profession's responsibility in ensuring public goods such as, "health care, civil regulation and social justice, technological safety and environmental regulation, publicly available information that is reliable and comprehensible, and high-quality education" (p. 4). It is this responsibility that Sullivan examined, terming the role as civic professionalism, requiring the professional to maintain a civic identity, concerned with public identity and values, and whose work contributes to public value. With such responsibility, in turn, comes public status and authority granted through the social contract between society and the profession (Sullivan). Along with Freidson's (1970) perspective of professions as being relatively free of lay evaluation and control, Sullivan's perspective here suggests a trusted balance between the profession and society. As long as society can trust that the profession is maintaining a civic contribution to the greater good of society, through efficient and legitimate self-regulation, then the notion of minimal social scrutiny is necessary. However, when a profession is perceived by society to no longer maintain a civic focus, for the greater good society may need to intervene and establish more scrutiny and

regulation of the society. Such events should not be considered undesirable, but rather provide an opportunity for critique and dialogue between society and a profession, perhaps a renegotiation of the social contract, maintaining the ideals of civic professionalism.

These authors' ideas on professions are well cited in the literature, and demonstrate an attempt to provide a critical analysis of occupations and the selective designation as professions. Their theoretical work on professional status has many common themes. Other researchers have incorporated the issue of professional status as an influence on nursing.

In providing a social view of a professional, Melosh (1982) noted the significance of the term expert as, "someone fully qualified to perform the task at hand, one who can be trusted to assess and act on important problems" (p. 15). These professionals are self supervised, well paid, and their status and work is a part of their community life. The professional is often called by titles both at work and within their private lives, and possess altruistic social values and behaviors. It is such status that Melosh (1982) stated has been the desire of organized nursing.

Melosh (1982) addressed the intellectual challenges in the academic attempt to define a profession, challenging the vague meaning of such required qualifiers as extended training and esoteric knowledge acquisition, apprenticeship training and theoretical education, and the quantification of a service orientation. She concluded this criticism by noting that "the conventional account is itself an example of professional ideology, not a definition of professions" (p. 17).

In an effort to study this ideology, Melosh (1982) offered that the study of professionalization as a process necessitated an examination of power and professional identities, battling both external and internal challenges. As occupations struggle to achieve professional status in society, dissent within the occupation is evident, and not unique to nursing. Part of the historical struggles experienced by the professions in their attempt to achieve professional status has included the establishment of educational and behavioral standards required by individuals to enter the profession. Such standards have traditionally and historically been set by elite members of the occupations, often alienating themselves from those who have previously been considered part of the field, practicing their craft without the newly established rigid requirements for entry to the field. She offered that the creation of such dissent within the profession helps to create a division of labor that provides "the elitist and exclusionary character of professionalism" (p. 22). Such a view is easily identified throughout nursing's history, and thus becomes a critical piece in the examination of the professional association and its development and provision of collective bargaining services. From a technical professional perspective such elitism is necessary to focus power, control and autonomy.

Critical examination of the occupation of nursing and its status in society as a profession may seem to some to remain a struggle for nursing. The debate of nursing's professional status is not significant here. However, in order to fully understand the work and focus of nurisng's professional society, one must understand that such a debate has been the focus in other works. It is clear that the professional status of nursing fits civic professionalism, and only becomes highly contested in a technical professionalism view.

Practice Issues of Nursing

In addition to the historical professional status struggles of nursing, the work settings of nursing practice has provided another context that has greatly influenced the ANA's role in representing the profession. Understanding the historical context of the work environments of nursing provides further background for exploring of ANA's development in addressing the economic and general welfare needs of nurses.

The literature on nurisng's practice issues has focused on the unique aspects of a female dominated profession that is dominantly employed within hospital bureaucratic structures. This literature provides a greater understanding of what this focus means for the work of nursing and nurses.

For nursing, Melosh (1982) suggested that part of the internal struggles of nursing and its efforts to achieve professional status directly related to the historical social status of women. As some nursing leaders pursued efforts to establish the standards necessary for nursing to achieve professional status, based on standards created by male leaders in male dominated professions, other female nurses believed in the uniqueness of nursing as women's work and its need to reflect the social values of such gender specific qualities (Melosh). What seemingly remains today of such notions, within organized nursing, are the unique needs of women workers who require income to support any number of familial needs, but to also continue in the female tradition of maintaining the upkeep of a family household and its members. Such responsibility that, when combined, required many nurses to incorporate the distinct roles of employee and homemaker, leaving little energy and time to uphold the traditional values and ideology of a technical professional as established early in the twentieth century by an exclusively male population of male

professions with the distinct male social roles of economic provider to the family with resources for political activism maintaining political power and control over the profession.

Using editorial comments written in nursing journals of the day, Melosh (1982) further illustrated the significance of gender in the development of nursing as a profession by noting that the nineteenth century ideology of womanly service, that included domestic concentration, was in direct conflict to the notions of specialized professional skill and monetary compensation for such skill. Such notions represented "narrow and self-seeking ambitions" (p. 23), characteristic of a technical professionalism. This perspective was used by nurses to distinguish their work from that of male occupations. The nurse valued service and altruism rather than power and control. Melosh identified these views as those of the traditionalist nurse who, "looked to the selfless woman, the nurturing mother – not to the expert" (p. 24).

In response to these notions, nurses pushing for the professionalization of nursing emphasized a woman's right to work, receiving compensation for the skill and labor provided, and a service that should be revered rather than a sacrifice of one's womanly duties. Such views Melosh (1982) identified as coming from the nursing leadership of the time. She concluded this observation of the impact of professional ideology on the development of nursing by stating the following:

> But their [nurse leaders] professional aspirations proved both unproductive and divisive. Adopting the exclusionary tactics of professionaliztion, leaders sought to secure the privileges of a few at the expense of many. As women they could not hope to win the privileges of a profession, and as aspiring professionals they cut themselves off from the broader support that a more inclusive program could have provided; they eschewed other occupational strategies, such as trade unionism, that might have proved more effective (p.29).

Another example of this struggle is noted by Malone (1994) in her case study of nursing's organizational leadership struggles in determining the use and training of unlicensed nursing personnel to serve as nursing assistance in the U.S. military as a means of addressing the critical shortage of trained RN's during World War I. While nursing care was greatly needed, among the nursing leadership there was conflict. On one side there was the belief that such shortened training of nursing assistance would not only offer needed services, but, as was being proven by enrollment in initial training programs of such personnel, offered a means of diversification for recruitment into formal nursing education programs. However the traditionalist nurse leader believed that such a practice would dilute the standards of the profession and undo all efforts to elevate the social status of the profession by de-valuing its established education and training standards. Although the influence of the social perspective of gender on nursing, predominately a female profession with men making up just under six percent of the professional ranks (U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing, 2005), remains a sociological study (Glazer 1991, England & Folbre 1999, Scherzer 2003), the impact of the practice setting on the development of nursing's professional status is the dominant focus of this work.

The working conditions faced by nurses understandably factors into how, as an occupation, they may choose to address their economic and general welfare needs. The literature was most abundant in providing studies that illustrate such conditions, and provided a perspective of the external influences affecting the ANA.

One external influence on nursing and the ANA found in the literature addressed the working conditions of nurses as hospital employees. Zacur (1982) interviewed nursing leaders, hospital administrators, and neutral parties to nursing strikes in order to understand nurse militancy or the reasons for unionized nurse strikes. In addition to the interviews, Zacur utilized case study methodology to explore the influence of environmental factors in hospitals and unions in two specific case histories of nursing strike situations. The most significant result of this study was that, regardless of varying attitudes toward union activities and strike initiatives, the participants were likely to engage in militant behavior through collective bargaining when administrative hierarchies of hospitals failed to provide a level of professional recognition to nurse employees. However, within the historical case studies of strikes within two hospitals, the greatest outcome of the strikes, noted by 82 and 74 percent of respondents respectively, was in wage increase and fringe benefit offerings. These areas were of least concern for the participant strikers, but there remained little or no improvement in "professional concern and administrative attitude toward nurses" (p. 79). In the minds of the nurses, the major reason for the strike, "was the attitude of hospital administrators toward nurses" (p. 79).

In attempting to minimize the militancy attitudes of nurses, Zacur (1982) noted that hospital administrators would do well to understand the professional issues facing nurse employees. She noted that the nurses voiced a lack of authority over their practice because of their lack of involvement in the organization's decision making around patient care matters.

Twenty-five years after this study such desires of hospital staff nurses remained as primary issues of concern in their working conditions. Popular nursing journals were abundant in their reporting of increased nurse militancy activity resulting from their desire to have a greater say in patient care decisions in their work settings, an issue addressed as both a work place condition and a professional issue.

Other significant events in the development of U.S. hospitals found in the literature and their influence on nursing included the effects of hospital restructuring. Aiken, L.H., Sochalski, J., & Anderson, G.F. (1996) explored the impact of hospital restructuring and design on nursing work hours. They found that between 1981 and 1993 hospital jobs increased overall, as did overall RN full time equivalents. However, when examining all nursing personnel, the overall nursing employment numbers in hospitals decreased, suggesting a larger RN staff with less supportive personnel. They suggested that the overall cost impact of increased hospital hiring on non-clinical personnel, while decreasing direct care clinical staff, had yet to be determined.

Although an overall increase in RN hiring was evident, so too was the increase in acuity of patient care needs, measured by the hospital-specific case-mix index from the Health Care Financing Administrations (HCFA). By controlling for this clinical factor, a factor that is used to demonstrate the increased clinical needs of acute care patients, the actual RN staffing remained unchanged, and thus the workload of the RN also remained unchanged (Aiken, L.H., Sochalski, J., & Anderson, G.F., 1996).

A historical examination of hospital restructuring and redesign, and its influence on nursing work environments for nurses, was provided by Brannon (1996). Viewing changes in hospital structures as an implementation of traditional industrial application,

Brannon provided an overview of two nursing service redesign methods beginning in the 1970's. Redesign was driven by concern for rising health care costs and was used to support the move in nursing service from team nursing to primary nursing, and supported the trend in the 1990's of reintroducing lesser and unlicensed nursing personnel with cross trained skills into the nursing hospital workforce.

Brannon (1996) noted that nursing service began to move from a skill mix of RN's, Licensed Practical/Vocational Nurses (LPN/LVN), and Nursing Assistants (NA) in the 1960's to a service staffed primarily with RN's, eliminating many of the LPN/LVN and NA positions through the early eighties. Such an effort was believed more cost effective for the hospital's overall production because RN's could perform the duties assigned to LPN/LVN's and NA's. This resulted in the introduction of the primary nursing care model where RN's provided the full range of patient care services in the hospital. For the nursing profession, this was initially viewed as positive in their struggle to gain professional status, as an all RN staff provided an all professional staff that would seem to increase the individual accountability of each staff nurse in the provision of nursing care. In reality, as noted by Brannon,

> RNs were sometimes forces to take back tasks previously relegated to non-nursing workers. Furthermore, at the same time that RNs' work was intensified they remained subordinate to physicians and administrators, and wit the leveling of the nursing hierarchy they were even more clearly accountable (p. 647).

By the 1990's, as hospitals continued their corporatisation, they aimed to increase their profits, contain costs, and to remain competitive in the healthcare industry;

> …in the current economic and political environment, work redesign strategies are being implemented by health care corporate executives principally to cut operating costs. Despite an ideological focus on quality, managerial interest in reducing costs appears to outweigh interest in quality improvement (Brannon 1996, p. 649).

Consequently, nursing work redesign began to reintroduce LPN/LVN and NA workers, placing RNs' in more supervisory roles and coordinators of care rather than as direct care providers. The lesser and unlicensed staff could then be cross-trained to work in a variety of nursing units, creating flexibility in redistributing staff based on workload needs.

Brannon (1996) specifically noted a challenge that such work redesign placed on the ability of RNs' to organize into unions. By placing the RN in a specified supervisory role the RN then became ineligible for coverage under the NLRA, as noted by a 1994 Supreme Court decision stating, "…when licensed nursing personnel supervise lesser-skilled workers they are not entitled to protection by the National Labor Relations Act" (p. 650). Additionally, Brannon noted that,

> within much of the management literature, professional and licensed work jurisdictions are viewed simply as barriers to the rationalization of production process. Consequently, battles are now taking place in many state legislatures as administrators lobby for the alteration or elimination of licensing and nursing practice regulations (p. 650).

These battles are a direct threat to the traditional values and understanding of all professions. Control of professions by corporate administrators directly challenges the ideal of professional autonomy and self-regulation through professional institutions established and led by members of the profession. And organized nursing, through both the lobbying efforts of the ANA and other labor unions, has responded:

> In their campaign to resist restructuring, the CNA [California Nurses Association] and other state branches of the ANA are more closely aligning their professional organizations with labor unions, including the Service Employees International Union and the United Mine Workers, creating controversy within the ANA. The CNA is also organizing across national borders and has cosponsored conferences with nursing unions in Canada…(p. 651).

Brannon's (1996) work provided an excellent example of the seeming lack of control that nurses have traditionally had over their work setting, and the important role

that organized nursing, both through labor organizations and professional societies, has played in attempts to gain control. As individual nurses within their singular work settings struggle for a role in decision making related to nursing service, they may find greater collective energy and resources through organized nursing.

In an attempt to understand the impact of managed care on nursing work environments, Buerhaus and Staiger (1997) examined states with high concentrations of Health Maintenance Organizations (HMO) and their impact on the employment and earnings of nurses. They interviewed 62 health executives about their views of changes in ten areas affecting nurse employment: wages; shifts in employment from one sector of the nurses labor market to another; collective bargaining activity and bargaining priorities; employer provided fringe benefits; patient acuity; nurse roles and responsibilities; substitution of RNs with lesser and unlicensed personnel; quality of patient care related to the changes; expected issues and trends affecting nursing employment during the rest of the 1990's. Buerhaus and Staiger provided a glimpse into the views of health care industry leaders on nursing in a managed care system.

Buerhaus and Staiger's (1997) findings need to be compared to the current state of the health care industry to see if the projections indeed have come to fruition. At the time of the study, health care executives in 11 states with significant saturation of HMO programs believed there would be an RN employment decrease in acute care hospitals with a subsequent increase in home health employment for both RNs and nursing assistants, and an increase in the employment of RNs in developing outpatient care. Collective bargaining by RNs was reported on the increase only in California, with a general lack of unionized activity, or unchanged activity, in the other states. Minnesota

executives reported a "philosophical shift away from confrontation to areas where there can be mutual gain" (p. 317). Legislative mandates of RN to patient staffing ratios were mentioned as possibilities for the future. In viewing other future trends, participants noted "…the health care system will increasingly emphasize illness prevention and health promotion and see RNs as being particularly well positioned to take advantage of this change" (p. 317).

Ponte, et.al. (1998) provided an overview of the impact of cost and quality health care issues influencing decision-making at a large urban hospital in Boston in 1996. The specific focus was on decision-making in leading unionized nursing staff to a strike vote.

Factors contributing to the strike vote came from examination of issues brought by the union to the bargaining table and by interviews with nursing staff. Although unions traditionally negotiate wage and benefit issues, it is interesting to note the greater impact of what might be considered more professional issues contributing to the work place environment. Among these were a perceived lack of responsiveness by nurse administrators due to the elimination of nurse manager and director positions, leaving those who remained with an increased scope of responsibility, a slow and cumbersome organizational decision-making process that created increased steps for the justification of patient care resources, the impact of the health care industry on the professional practice of nurses creating what appeared to be a greater focus on cost than on care, skill mix changes on patient care units resulting in an overall decrease in the number of RN staff and an increase in the number of unlicensed assistive personnel. Also of issue was environmental/workplace health and safety concerns with increased technology use in direct patient care.

Given these issues, along with traditional contract bargaining issues of wage and benefit negotiations, the nurses voted to strike in Boston in 1996. Eventually, a contract agreement was reached. In an attempt to mend relationships strained by the difficult and lengthy negotiating process, focus group interviews were conducted with approximately 25% of the nursing staff. Two thousand comments were categorized, and seemingly addressed the professional practice issues of staff nurses. The categories were as follows:

- Difficulties in delivering quality patient care, including continuity of care
- Diminished quality of work life with less focus on holistic care including patient education and family care
- Lack of teamwork and collaboration resulting from a sense of a lack of value and respect for nurses and nursing based on perceived negative feelings of administrators toward the nursing union
- Deteriorating professional practice with increased focus on cost over care
- Lack of consistent access to systems and supports for attaining and maintaining competency related to staff development and education (Ponte, et. al 1998, 40-43).

The authors noted that time would tell if such interventions addressing these categories were effective in improving nursing staff labor and management relationships. It is significant to note that these categories of concern among nursing staff went well beyond traditional industrial labor management issues.

Schraeder and Friedman (2002) examined the effects of recent reforms in the healthcare industry on developments in collective bargaining by nurses. Noting that of the 2.5 million nurses in the U.S. in 1996, 17 percent of them belonged to unions with numbers varying among states, and included 30,000 nurses as members of the California Nurses Association (Schraeder & Friedman).

Initiated as efforts to decrease healthcare costs, healthcare reforms had led to nurses working long hours and facing greater workplace demands while earning modest wages at best (Schraeder & Friedman 2002). As a result, Schraeder and Friedman (2002)

identified two major issues that became top negotiating topics for contract negotiation: nursing staffing levels and nursing role in decision making.

Staffing levels had even risen as issues beyond the bargaining table with the California legislature enacting nurse to patient ratios in 1999 (Schraeder& Friedman 2002). Gaining a role in decision-making, nurses believed as direct patient care providers in hospitals they have the best interest of patients as their main concern, and thus need to be involved in decision-making effecting quality patient care.

Unions in the Healthcare Industry

There exists in the literature work on the influence of unionization on the healthcare industry. Positive effects of unions in healthcare have been noted. Bruder (1999) provided some descriptive statistics about the positive effects of unions on health care working environments. Bruder expressed his beliefs that managers in general wished to maintain a perceived sense of control over employees. Such a perception perpetuated a paternalistic relationship with the manager as parent and employee as child. A unions presence, regardless of its negotiating techniques, attempted to create an equal playing field of control in influencing the direction of the organization (p. 38). Given such a belief, Bruder (1999) presented that "a unionized work force, operating in a competitive environment, will lead to improved quality, increased productivity, increased employee loyalty, increased employee benefits, and greater job stability" (p. 36).

With his perspective of paternalism, Bruder (1999) demonstrated the effectiveness of union bargaining in creating more professional work environments. He examined quality and productivity and noted that "the average unionized establishment recorded productivity levels 16 percent higher than the baseline firm, whereas average nonunion

ones scored 11 percent lower" (p. 37). Such an outcome is linked to the establishment of employee directed quality programs and a sharing in profits with many working in self-managed teams. Among the self-managed teams, productivity was 20 percent above baseline. Such a gain was greater in unionized environments than in non-unionized organizations that implemented the same practices.

This work provided more of a philosophical belief rather than presenting any empirical data to support Bruder's (1999) original claim. However, it did support the notion of collaborative efforts between unions and management in setting and meeting the overall goals of the organization.

Further noting the need for nursing unions to address professional practice issues of hospital employed nurses, Steltzer (2001) noted that research demonstrates that, "Wages, frequently cited as a significant issue among nurses, are much less important than other workplace issues" (p. 37) such as job security, empowerment, staffing and policies. In the study, Steltzer noted the use, by the Minnesota Nurses Association, of what they term interest-based bargaining (IBB) (p. 37). The IBB consisted of greater collaboration between the union and hospital administration to better understand the shared and unique perspectives of each parties staff issues. Steltzer stated that such a process may take longer in order to fully grasp party perspectives, but provided a different starting point from the traditional negotiation process where each side provides their goals and then make compromises to reach a mutual agreement. At one specified union hospital, such collaboration included increased involvement in staffing decisions through development of staffing tools based on patient population needs (Steltzer 2001).

Nursing unions seem to be playing a greater role in the healthcare industry as they represent the workplace issues of staff nurses. Such a role is likely to increase as more nurses turn to collective bargaining as a means of gaining greater control in their hospital work environments, providing nurse unions greater resources to participate in the political and economic arenas of the healthcare industry.

The presence of a union alone can create a variety of working conditions and benefits that certainly can improve the working environment of nurses. It may also contribute to specific attitudes among managers and between mangers and nurses. Other patient outcomes may also be affected in a variety of ways by the RN union. Although these questions are raised, Seago and Ash's (2002) study certainly provides a basis of interest for further exploration of the relationship of nursing unions and influence on patient care outcomes.

Seago and Ash (2002) studied 343 acute care hospitals in California, where 35 % of hospitals had RN unions at the time of the study demonstrated a positive impact of nursing unions. The study found that among these RN unionized hospitals there existed a 5.7 percent lower mortality rate for acute myocardial infarction when controlling for patient age, gender, type of infarction, chronic diseases, and many organizational factors such as number of beds, cardiac infarction discharges, cardiac services, staff hours and wages (Seago & Ash). Although causation can not be predicted here, the statistically significant potential influence of RN unions on patient outcomes was noted.

For the interest of this research, it would also be useful to examine relationships among nursing unions that provide collective bargaining specifically and exclusively to RN's versus those unions with a more diverse membership base.

As mentioned, the varied influence of union activity among nurses and patient outcomes requires further examination of such relationships. For example, union contract negotiations provide opportunities to address such nursing workplace issues as working hours, including the length of time on the job in a singular workday.

By conducting an exploratory longitudinal study of 744 hospital staff nurses working in hospitals going through restructuring and downsizing in Ontario, Canada from 1995 through 1999, Burke (2003) measured characteristics of shift work (length in a single shift, times worked beyond eight hours in a shift, and time worked two shifts in a row), work outcomes (job satisfaction, intent to quit, and absenteeism), psychological well-being (psychosomatic symptoms, emotional exhaustion), and perceived hospital effectiveness (errors and injuries, coordination across nursing units, patient care, and adequacy of time to care for patients).

In this study 48 percent of respondents worked 9-12 hour shifts, and 10 percent worked shifts of greater than 12 hours. Fifty eight percent worked more than eight hours in a shift "a lot during the past month" (Burke 2003, p. 1642), and 20 percent had worked back-to-back shifts "a few times or more during the past month" (p. 1642).

Examining the relationship of shift length to work outcomes, psychological well being and perceived hospital effectiveness, Burke (2003) found that longer shift work correlated with less job satisfaction, greater emotional exhaustion, and more psychosomatic symptoms, as well as an increase in the reporting of errors and injuries. Working back-to-back shifts correlated with perceived lower levels of coordination between nursing units (Burke).

In this study, Burke (2003) did not specifically address the impact of hospital down-sizing and restructuring, but rather assumed that, based on the literature, such activity contributed to the shift in work hours of nurses. Regardless of the cause of lengthened shift hours and double shift work, Burke provided data for consideration by nursing and hospital leaders when decision making about hospital operations influenced nursing staff working hours, as well as nursing unions when engaged in contract negotiations. A lack of recognition of the impact of shift hours worked on perceptions of well-being and on patient care and hospital outcomes may contribute to ill-feelings of nursing staff toward hospital leadership, leading to strained relationships in both unionized and non-unionized hospitals.

Moving beyond the traditional labor bargaining topics of wage and hours, Budd, Warino, & Patton (2004) identified the Interest-Based Bargaining (IBB) technique as a non-traditional means of collective bargaining. Differentiating IBB from traditional collective bargaining practices Budd, Warino, & Patton noted that its use is most effective when, "the goal is to establish shared governance structures that contribute to achieving organizational autonomy or control over practice" (p.6), and begins with an agreed shared goal decided by mutual collaboration among employer and union. This is in contrast to traditional collective bargaining processes that utilize techniques of argumentation, logic, and persuasion to maintain a position of power and winning of demands (Budd, Warino, & Patton).

In utilizing IBB, Budd, Warino, & Patton (2004) noted that communication, information sharing, and consensus building techniques were essential, and thus required training of both parties in the techniques prior to the start of negotiations. It also required

that the goal be shared. If, for example, the goal is for improved patient care outcomes through the implementation of a shared governance structure, then the result is likely to be mutually shared. However, if the goal is strictly for improved hours of work, wages and benefits, the outcome may not be mutual, and thus traditional collective bargaining techniques may be more useful (Budd, Warino, & Patton).

Budd, Warino, & Patton (2004) noted that IBB is difficult when management viewed itself as the authority, did not include employees in policy development, and was not trusted by employees, evidenced by an increased use of the grievance process. This distinction becomes significant in light of the fact that, although still important to nurses, wages and benefits are not priorities in more recent labor negotiations.

Budd, Warino, & Patton (2004) noted that common subjects addressed at the bargaining table for nurses include:

> mandatory and voluntary overtime, acuity-based staffing systems, use of temporary nurses, protections from reassignments, work encroachment by non-nurses, and mandated non-nursing duties, provisions for work orientation and continuing education, whistleblower protection, health and safety provisions, such as free hepatitis B vaccine, "just cause" language for discipline and termination, and provisions for nursing and multidisciplinary practice committees (p. 4).

It is easy to identify aspects of professional autonomy in practice in many of these issues, issues faced by any professional employed by another. This list goes well beyond the traditional contract bargaining issues of wages and hours, but may be considered part of the terms and conditions of employment that are eligible for negotiation at the bargaining table.

Budd, Warino, & Patton (2004) presented the background, use, and purpose of both methods of collective bargaining, paying special attention to their respective use in given situations. The study does not imply that one method is superior to another rather

that, depending on the desired outcomes in specified organizational labor management environments, there existed options in conduction of the contract bargaining process, and in the healthcare setting, such options may be heightened for nursing and other knowledge workers.

Contributing to the issue of hospital nursing work and its impact on errors and safety, Page (2004) provided a synopsis of the 2004 report of the Institute of Medicine (IOM) entitled *Keeping Patients Safe – Transforming the Work Environment of Nurses*, commissioned by the Agency for Healthcare research and Quality in an effort to examine the causes of, and propose interventions for, the reduction of medical errors. The study was done to identify, "key aspects of the work environment of nurses that likely impact patient safety, and potential improvements in health care working conditions that would likely increase patient safety" (p. 251).

As a result of the study, the IOM made specific recommendations for health care organizations, including hospitals and long term care facilities, in the categories of management practices, nurse staffing levels, knowledge/skill/collaboration, safe work and workspace, safety cultures, and research. Although all of the recommendations addressed some aspect of the working conditions of nurses, some specific recommendations identified have direct links to nursing and their work environments, and provided support for nurses to address such issues through methods such as collective bargaining or other collective means of addressing advocacy in the workplace.

These recommendations provided specific interventions for the improvement of patient care outcomes by addressing the workplace issues specific to nursing practice in both acute care hospitals and long term nursing care facilities. Regardless of how these

issues are addressed, whether through organized labor processes or organizational and professional influences, the issues are consistent in their impact on patient care.

Legislative and Policy Influence and the Unionization of Nurses

ANA's development as a labor organization governed by the legislative establishment of the National Labor Relations Board (NLRB) provides a perspective when examining the research focusing on the working conditions of registered nurses. The specific legislative issues that allowed the ANA and its state nursing association members to become certified by the NLRB are important in understanding yet another aspect of external influence on the ANA in its attempts at addressing its member economic and general welfare needs.

Zacur (1982) provided an informative, yet condensed history of significant legislation that contributed to the increased union activity conducted within nursing organizations. First was the passage of the Wagner Act, or the National Labor Relations Act in 1937, outlining unfair labor practices and supporting organizing efforts of employees and creating the National Labor Relations Board (Zacur). Since the Act did not specifically address the status of hospitals in applying the rules of collective labor negations, the early 1940's brought several court cases to better understand the fit of voluntary hospitals in the Act. Most court case findings of the time noted the following:

1. the Wagner Act (and associated state labor laws modeled after it) was not intended to extend coverage to the workers of nonporfit hospitsals.
2. the delivery of health care was essentially a governmental function. Thus, hospitals, like governments and their political subdivisions, were excluded form labor law coverage.
3. making voluntary hospitals subject to the provisions of comprehensive labor statues was not in the public interest (p. 8).

In 1947 an amendment to the Wagner Act, known as the Taft-Hartley Act, was passed providing for nurses both a positive and a negative effect on their unionization activities. First, the amendment provided that professional employees could not be included in the same bargaining units with non-professional employees unless such affiliation was approved by a majority vote of the professional employees. This change assured nurses that they would not be automatically included in labor unions representing workers whose interests were vastly different from their own. However, the amendment also specified the exclusion from the Wagner Act nonprofit hospitals and federal, state, and municipal government hospitals. Proprietary hospitals and nursing homes were not specifically included in the amendment due to their operations being related to interstate commerce (Zucar 1982). Only state statute language could provide for inclusion of nonprofit hospitals in the Act, and without such language, hospitals were free to not acknowledge any union for the purposes of collective bargaining, leaving nurse employees without collective power.

Contributing to such lack of collective power was ANA's opposition to nurse walk-outs and strikes, viewing such behavior as unprofessional, a position that stood until 1966 (Zucar 1982). Specific federal legislation addressing union activity in nonprofit hospitals was made in the 1959 Landrum-Griffin Act, the Labor Management Reporting and Disclosure Act (Zucar).

Finally, in 1974 amendments entitled Taft-Hartley Nonprofit Hospital Amendments were enacted as a result of lobby efforts by the ANA and others wishing to organize more nurses into collective bargaining contracts. These amendments included special features in the labor bargaining by nonprofit hospitals. These included a 90-day

(versus 60-day) notification period to address contract language, and 60-day (versus 30-day) notification of intent to terminate or modify expiring contract language. And in events of impending strike, notification of such a strike, including the exact date and time of its initiation be filed ten days before such action. In all events of health care labor relations situations, a mediator is immediately assigned to assess and provide written recommendations in 15 days for settling disputes (Zacur 1982).

It is important to note an additional court clarification of the language in the Taft-Hartley Act addressing the supervisory status of some nurses. Such language clarification was necessary as employers attempted to designate all professional nurses as supervisors, and to challenge the appropriateness of the state professional nursing association, affiliates of ANA, as labor unions. The specific language of the rulings addressing these cases is quoted by Zacur (1982) as follows:

> Although the professional nurses, whether a "supervisor" or not, has the clear right to join his or her professional association, and although the professional association has the clear right to work for economic security through collective bargaining, there is one limitation on the supervisor's membership activity in the association. The supervisor must not take part in the association's collective bargaining activities. This is the only limitation: the supervisor member may take part in all other association activities (p. 12).

Additional court decisions recognized the difference between professional supervision and supervision in the interest of the employer. Professional supervision involves hiring, firing, disciplining, evaluating, and scheduling the work of others. Where charge or head nurses supervise in the interest of the employer, the NLRB has ruled that they be excluded form the bargaining unit. Where head nurses supervise patient care and do not supervise in the interest of the employer, the NLRB permits their

inclusion in the bargaining unit. Thus titles are not indexes of eligibility, but job duties are (Zacur, 1982).

Specific case studies further demonstrate the challenge of the role of nursing supervisors in determining the legal appropriateness of the professional organization in collective bargaining (Dolan 1980, Lee & Parker 1987). The cases brought forth the concern of the labor organization leadership, specifically members of the board of directors, who were employed as nursing supervisors, responsible for the management of nursing staff. Since the organization allowed for membership, and consequential leadership positions, of all registered nurses, the question raised related to the appropriateness of the organization in addressing the workplace issues of the staff nurses, noting a conflict of interest with the supervisory nurses. Such questions ultimately led to the examination of the decision making structure of the organization, and influenced the organizations management of its economic and general welfare programs.

The literature addressing the legislative impact on the development of ANA as a labor organization is significant. Other literature outlines additional external organizational influences on this development.

The Professional Society as a Labor Organization

In addition to the previously presented literature there exists additional published works of other national professional societies and their management of member economic and general welfare needs. These studies provide a framework that demonstrate specific issues surrounding ANA's evolution in addressing the economic and general welfare needs of its members while continuing to serve as nursing's professional society.

The American Medical Association (AMA) has long been recognized as the professional society of U.S. physicians. Although concerned with the welfare of physicians the AMA has historically supported the physician within their independent practice of medicine. However, with increased physician employment by organizations, including group practices, hospitals, and managed care organizations, physician labor organizations have developed, and the AMA began to engage in collective bargaining for physicians.

The rise in these activities is well documented. Luepke (1999) provided a historical description of the rise of physician unions in the U.S. and described the influence of managed care on increasing physician use of collective bargaining. Luepke noted that the AMA had modified its position since 1984 of being in complete objection to the use of a labor union model by physicians, to actively supporting the unionization of physicians in Rockford, IL in 1997. Additionally, Luepke briefly documented some union organizing activities taking place among state and local medical societies. With such increasing activity, the AMA, governed by its house of delegates representing state medical societies, is likely to further consider the use of the labor union model in the future.

Such development has already been evident. Hoff (2000, 2005) documented a variety of reasons for the increase in physician unionization. He noted that from 1983 to 2000 the percentage of physician employees had risen from 24% to over 45% (Hoff, 2000). Additionally, physician unions in the U.S. began as early as 1957, and by 1996 there were a total of six physician-specific unions in the U.S., although none with any affiliation with the AMA (Hoff, 2000).

The AMA was not been immune to such a movement, and in 1999, through a decision made by the AMA House of Delegates, a collective bargaining unit was formed within the organization, named Physicians for Responsible Negotiotions (Hoff, 2000). However this unit did not endorse the concept of physician strikes as a labor negotiating tactic, and it had developed as a service for physicians within the structure of AMA rather than as an affiliated organization. Although some of the independent physician unions have approached the topic of affiliation with the AMA (Burdys, 1997), to date, no organizational affiliation has occurred between physician unions and the AMA.

Budrys (1997) provided an example in her examination of the Union of American Physicians and Dentists (UAPD). Beginning in 1977, Budrys followed the development of this organization in the medical and general press suggesting three frameworks for the study of a professional society and its labor union activity. First is the case perspective from the health services approach, encompassing the hands-on delivery of health care, examining its clinicians, systems, and policy leaders. A second framework, that of the industrial relations perspective, entails the examination of the labor union movement as a whole, while the third perspective provides an occupational and organizational perspective, viewing the process of occupational groups in utilizing organizational structures for the development and promotion of their own collective and group identities (Budrys).

Budrys (1997) provided detailed accounts of the UAPD's correspondence with the AMA in its attempts to convince the professional society of its significance in representing the issues of the profession. Although there existed specific labor laws that created specific situations in which physicians may or may not unionize to engage in

collective bargaining under the NLRB, Budrys noted the AMA's philosophical stance that unions';

> Traditional emphasis on collective action through strict majority rule is ill-suited to professional values of individualism and autonomy. Organizationally and philosophically, moreover, the labor union model comprehends neither of the pursuits that are of paramount importance to physicians organized in professional associations – the advancement of medical science and the promotion of public an patient welfare (Report F, quoted in AMA Board of Trustees Report L, 1984 in Budrys 1997, p. 118).

Such a statement helps to illustrate the ideological and philosophical conflicts faced by a profession in addressing the economic and general welfare and working condition issues of it members.

Budrys (1997) overall conclusions to the study of the UAPD were the need to reconceptualize collective work in a post-industrialized society. She suggested that today's worker, possessing increased specialized knowledge and skill, has viewed and organized themselves as occupations rather than as firms, suggesting a new class of intellectual workers (Budrys). Traditionally physicians have viewed and organized themselves in firms, however Budrys believed they would do better to change such a view to that of intellectual craft worker to better illustrate their role to "train new members, develop new skills and techniques within their own ranks, and maintain close ties outside of working hours that reinforce the sense of community" (p. 154). Budrys stated that what is of key importance is that members of any working group find a means to address the collective issues of their working conditions, and that perhaps the UAPD offered an example of a new organization that had successfully found a way to collectively address both the professional and workplace issues of its members.

Two U.S. national organizations represented the interests of the teaching profession. The National Education Association (NEA), and the American Federation of Teachers (AFT). Like the ANA and the United American Nurses (UAN), the NEA was concerned with teacher economic and general welfare, and the AFT specifically addressed such concerns as a certified labor union affiliated with the AFL-CIO. Although the AFT addressed professional teacher concerns in its labor activities, as did the ANA for nurses through its affiliation with the UAN, their membership base distinguished them as professional organizations. Whereas the AFT allowed for membership of "teachers; paraprofessionals and school-related personnel (PSRP); local, state and federal employees; higher education faculty and staff; and nurses and other healthcare professionals" (AFT http://www.aft.org/about/index.htm, 2005), the ANA and UAN membership remained exclusively of registered nurses.

> Also representing concerns of the teaching profession, the NEA stated that it is, …the nation's largest professional employee organization and is committed to advancing the cause of public education. NEA's 2.7 million members work at every level of education, from pre-school to university graduate programs. NEA has affiliate organizations in every state, as well as more than 14,000 local communities across the United States (NEA http://www.nea.org/aboutnea/index.html, 2006)

The NEA and the AFT developed a partnership, known as NEAFT, to collaborate on shared goals and interests. Its governance was through a 30 member representative joint council, including each organization's executive committees (NEA http://www.nea.org/aboutnea/NEAFTPartnership.html, 2006). Although this partnership was able to provide support and recommendations on joint organizational concerns to both the NEA and the AFT, their role in each organization was purely consultative in that

no formal governance participation opportunities were afforded to either organization in setting policies of the other. Thus their partnership was completely voluntary.

In contrast, the organizational structure that established an affiliation of the ANA with the UAN entailed a contractual arrangement with monetary requirements and voting privileges of the UAN on policies of the ANA, even though, as with the NEA and the AFT, the organizations were independently governed with separate governing structures.

Another significant difference between these organizational structures is the membership composition. Although it would appear that individual teachers might hold membership in both the NEA as well as the AFT, such dual membership is not required and has no impact on the partnership. In contrast, the individual membership of the UAN consisted only of members of the state constituent organizations of the ANA, and thus these individuals maintained all membership privileges afforded to all ANA members.

Historical Perspective of Organized Nursing

Literature addressing organized nursing's historical development as both a profession and a labor movement provides a rich context to the development of the ANA. ANA's historical development in addressing the economic and general welfare issues of nursing is dominated by internal conflict over the overall aim of the organization between achieving professional status and addressing the workplace issues of its members.

Melosh (1982) provided an examination of the development and role of the professional nursing organizations of the time. She noted that these organizations were initiated, in part, in the late nineteenth century in response to the largely unregulated proliferation of hospital training schools for nursing. These organizations, first initiated as alumnae associations from selected schools, excluding the smaller more specialized

programs formed, in an effort to create educational standards for entry to the profession. Within the first decade of the twentieth century, these alumnae organizations of Canadian and U.S. graduates first expanded their membership to include graduates of all accredited schools. By the end of the decade, they formed their own separate nationally based organizations, with the U.S. organization being named the American Nurses Association (ANA) in 1911, followed in 1912 by the establishment of the National League of Nursing Education to focus its mission on the standardization of nursing education programs, eventually becoming what is known today as the National League for Nursing (NLN) (Melosh).

Melosh (1982), "recasts nursing history from the viewpoint of nurses on the job, and places it in the context of women's history, labor history, and medical history and sociology" (p. 6). It is within this context that Melosh provided the divergent prospective of what she terms as "nurse leaders" and "nurses on the job" (p. 7). Providing a historical view of the profession from the 1920's to the 1970's, Melosh outlined the work setting of the "trained nurse" (p. 12) from that of private duty to public health and hospital based practice.

Melosh (1982) concluded her observations of the professionalization of nursing as an occupation by once again stating that the leaders of organized nursing continued the pursuit at the expense of the majority of practicing nurses. By emphasizing the need for higher academic credentialing for all nurses, and at the time, at least for those serving as heads of nursing education and practice, without consideration of a means to assist the advancement of already practicing nurses, the organized leaders maintained an elite status which alienated the majority of nurses, calling such strategy "restrictive" (p. 34-35).

In response to the working conditions faced by nurses in hospital employment, Melosh (1982) addressed the increasing use of labor unions to address these issues. She noted the contributing influences of women moving in and out of the labor market as they balance the demands of domestic needs with economic needs, and its subsequent contribution to nursing shortages in hospitals in post World War II America.

Organized labor, specifically the American Federation of Labor and the Congress of Industrial Organizations, began to recruit nurses in the 1930's (Melosh 1982). Such activity resulted in a statement by the ANA in 1937 opposing such organizing, touting the best means of addressing workplace issues for nurses was through the professional organization.

By 1939 it was reported that an estimated 5000 nurses had joined unions, with strong unionization occurring in Seattle, San Francisco, and New York (Melosh 1982). However, post-war anti-union sentiment and stricter constraints on labor unions as a result of the 1947 Taft-Hartley Act, exempting voluntary hospitals from the National Labor Relations Act (NLRA) seemed to support the professional organization's perspective opposing the unionization of nurses (Melosh).

But the cry of many hospital staff nurses began to strengthen with sentiments reflecting their lack in belief that the professional organization, with its professional ideals, was unable to address their working condition issues, including pay. Such increasing views forced the ANA to take a stronger advocacy stance for general duty nurses, spearheaded by the ANA's state constituent, the California State Nurses Association (CSNA) (Melosh 1982). Although such a state drive to keep nurses in the professional organization through the provision of collective bargaining services, the

CSNA found that hospitals were refusing to recognize the professional association as a union, and consequently the need to engage in labor negotiations with them. However, with persistence, the CSNA prevailed, and by 1946 the ANA established a national "economic security program for nursing," although maintaining a no strike policy until 1968 (p. 200-201). According to Melosh, struggle within the organization remained as the ANA membership consisted of both general duty and supervisory nurses, and without the threat of strike, general duty nurses often found themselves influenced by their supervisory colleagues, minimizing the overall participation of nurses in the ANA's Economic Security Program.

To meet the challenge, ANA reorganized its structure in the 1950's, placing policy setting for the Economic Security Program with its state constituents, removing authority from local districts and individual work settings (Melosh 1982). However an increase in dues payments to fund the program resulted in a membership decline. But with the inclusion of voluntary hospitals in the NLRA in 1974, nursing unions were able to improve the earning wage and working conditions of the general duty nurse (Melosh).

Although there seemed an improvement of the working conditions of nurses through the utilization of traditional trade union activities, in the 1970's their remained a conflict in the educational preparation of student nurses and the realities of nursing work in hospitals:

> The new collegiate nursing schools touted the nurse's authority and encouraged her to be an active advocate for her patients. But once on the ward, she slammed up against the limits of hospital bureaucracy, medical authority, and inadequate supplies and staffing (Melosh 1982, p. 205).

Such a statement epitomizes the issue facing nursing, between professional ideology and the bureaucratic working structures that influences how they practice nursing.

Perhaps one rationalization for the professional association's engagement in union activity is provided by Northrop (1987) in noting less traditional workplace issues that may be negotiated by professional nurses. Northrop provided a brief historical background of organized nursings' evolution in providing collective bargaining services. In addition, Northrop detailed specific laws governing the overall development of organized labor in the United States, differentiating between federally and privately employed nurses. She continued to describe those negotiating topics covered by the National Labor Relations Act and their impact on the collective bargaining rights of nurses. Northrop's writing is significant in elaborating the legal context of nursings' involvement in organized labor, and specifically the content of organized labor in such activity.

In addition to providing information on specific labor laws, Northrop (1987) addressed the enforcement of such laws, including the content of labor contracts significant to nursing. Such provisions included environmental and workplace safety issues beyond those covered by the Occupational and Safety Health Act, and procedures for addressing staffing concerns such as inadequacy of staff or skill requirements in performance of work functions (Northrop).

Other potential areas for contract negotiation included particular needs of nursing personnel. These needs included orientation and education, rules for the establishment of policies for hiring, firing, performance evaluation, and promotion. Additionally, professional practice committees were addressed including their recognition by the employer, their purpose and goals, membership, meeting requirements, and procedures for recommendations to administration and the time frame for their response (Northrop

1987). Northrop cautioned that such committees were not meant to take the place of the contract negotiating process among employer and employee, but rather were developed to address patient care issues from the perspective of the nurse employer. Northrop went on to describe how the labor contract was used to specify work related conflicts among employers and employees, including the grievance process.

The working conditions of nurses have certainly played a role in shaping the function of the ANA in addressing nurisngs' economic and general welfare needs. Others have written historical accounts of how the association has done so (Seidman 1970, Ponak 1981, & Grando 1997), even from an international perspective (Clark & Clark 2003). However, the conflict among its membership of how best to meet these needs, whether through more militant activity such as work stoppages and strikes, as provided by organized labor, or through more collaborative efforts through the establishment of workplace policies addressing the professional status of nurses, remains. Contributing to this debate in nursing are some sociological studies that have examined the conflicted issues of achieving professional status while placed in the labor market as an employee, suggesting control of professional practice by the employer (Wagner, 1980; Raelin, 1989). Although these studies offer a perspective for the study of professionals as employers, and particularly nurses as employers, what is needed is an examination to better understand the broader contextual issues that nursing has faced in attempting professional recognition.

Nursing's Perspective on Economic and General Welfare

Because the ANA membership consisted of all registered nurses without regard to their practice setting or working issues, the economic and general welfare concerns of its

members varied. Using case study methodology to examine nurses' views of professionalism at two New York City hospitals, Goodman-Draper (1995) studied nurses in various employed positions within the hospitals. To categorize the differences she discovered among the nurses, Goodman-Draper utilized E.O. Wright's (1976, 1980) concept of class delineation. This theoretical delineation supports the existence of a class structure within the labor process based on the worker perception of control over the economic, political, and ideological processes of labor. The economic control encompassed production and profits, political control represented position and consequential authority within the supervisory hierarchy, and the ideological process reflected control of conception and execution of production (Goodman-Draper, 1995, p. 8).

By utilizing Wright's theory, Goodman-Draper (1995) classified nurses into class positions within the employment setting, and examined their subsequent views of professionalism. She determined that nurses in, what she designated as low class position, or the traditional staff nurse role, generally viewed professionalism to mean collective work control that encompassed autonomy, job security, salary, and promotions, or control over the specific aspects of each in the conduction of their work. Goodman-Draper classified such a view as collectivism, a view most reflective of trade unions. This view broadly entailed the desire of workers, as a collective, to have greater control over the conditions of work. Conflict within organizations was frequently viewed by these workers as existing between management and workers (Goodman-Draper).

Continuing this class identification among nurses Goodman-Draper (1995) categorized high class position nurses as nurses in the upper management positions of

nursing director or nurse administrator. These nurses generally viewed professionalism from the more traditional social view, or free market individualism, or capitalist individualism (Goodman-Draper). Such a view entailed individual success through the control of markets, the taking of risks, and the possession of talent and the display of proper behavior, all of which was put to use for social good, and thus deserved high economic rewards (Goodman-Draper). These nurses, according to Goodman-Draper (1995), perceived their market control through professional control of schools of nursing, thus controlling how and who one enters the profession. Within the work setting, control of labor, staffing, workload, and pay was achieved through the attainment of higher positions of authority within the organization, and conflict was often perceived between occupations rather than among management and employees (Goodman-Draper, 1995).

Finally, Goodman-Draper (1995) categorized a third class position, that of the middle position class nurse. This class is described as the traditional head nurse and nurse manager. They viewed professionalism more as a combination of the two previous views. Such a view, named professional individualism, retained the collective strategy view of the low position class, and the adherence to credentials and proper behavior of the higher position class. However, this middle position class stoped short of viewing professionalism as the maximization of individual wealth and power (Goodman-Draper). Workplace conflict among these nurses was viewed as a competition among nursing and other occupations (Goodman-Draper).

Goodman-Draper's (1995) study helps provide what may be a contributing element to the divergent views among nurses as to the role of the professional nursing organization. If professional views are correlated with the daily work experiences and

perceived control of work, which varies among nurses depending on the employment setting and work position, then it seems logical that these differences would play out in how these nurses view the role of organized nursing in the profession. If there does exist a seemingly dichotomous view of professionalism among staff nurses and nurse administrators, as presented by Goodman-Draper, then such a view may contribute to conflict among membership in the professional nursing organization and the most appropriate and effective use of membership dues monies.

As registered nurse members of the ANA continued to face workplace challenges, often varying depending on their workplace roles, the organization was, and continued to be challenged in deciding how best to meet the economic and general welfare issues of its membership. The varied influences contributing to this issue made it difficult to reach and maintain a singular focus that reflected the desires of all members.

Conclusion

Synthesis of the literature helps to illustrate the diversity of influences affecting the ANA throughout the twentieth century. From its late 19th century beginnings, to its mid 20th century labor organization designation by the National Labor Relations Board, and its structural changes at the beginning of the 21st century, the ANA has been influenced by external economic, political, and social issues, and by its internal struggles to fully represent the diverse needs of it members. Throughout its history, it has remained the most comprehensive representative of the profession in policy development. However, as the most comprehensive representative of nursing the ANA has been challenged by members within its own ranks in its representation of all of nursing's special interests.

To state that the ANA is the representative of the profession of nursing suggests that the organization represents, and speaks for, the diversity of special interests among the profession's ranks, the registered nurse. As the literature demonstrates, this may be viewed as a daunting task given that registered nurses in the country not only have interest based on their clinical nursing focus, but can be found in a variety of positions in various forms within different organizations both within and outside of the healthcare industry.

Nurse generalists are varied not only in their clinical practice specialty but also their educational preparation and their employment responsibilities. In hospitals, these nurses are found caring for patients at their bedside, managing clinical practice areas, directing entire hospital structures, and serving as chief nursing officers and chief executive officers. Nurse specialists too are varied in their educational preparation, and they too have taken on a variety of roles in advanced clinical nursing practice, as nurse educators, nurse practitioners, clinical nurse specialists, nurse entrepreneurs, nurse attorneys, consultants, and policy specialists, just to name a few.

Within hospital organizations registered nurses can be found in a multitude of positions. Whether nurses themselves have chosen to see their work as labor, or whether their work has been deemed so by administrators, the literature demonstrates the profession's and the ANA's struggle with how best to address the economic and general needs of its members. Addressing these issues with the use of collective bargaining or by other pressures, other professions such as medicine and education have and continue to struggle with similar questions among their organized ranks.

As these professions evolve, so too does the industries within which they practice. Additionally, social and political changes influencing their evolutions challenges leaders to continuously find ways to best address the diversity of needs of the vastly different special interests of those they represent. And as the literature demonstrates, such a challenge is one continuously faced by nursing and its organized leaders in the ANA.

CHAPTER THREE - THEORETICAL FRAMEWORKS

Analysis of the ANA as a professional society and as a labor organization requires a theoretical perspective that provides a perspective of professions and labor. As the ANA is the representative professional society of nursing in the U.S., it is important to have a perspective of the evolution of nursing as both a profession and a labor force.

Also a comprehensive analysis of change within any organization requires a framework for organizing the variety of contributing factors in creating change. And if change is viewed as a process over a period of time and includes the diversity of human perspectives and actions about the change, then organizing this data becomes critical. Analysis of the ANA and its changes requires such a framework.

For the profession of nursing, the belief that the occupation indeed deserves professional recognition may be most evident in the examination of its occupational organizations. The establishment and development of organizations for the purpose of addressing the unique issues faced by the nursing occupation offer a context for examining the collective efforts of nursing leaders in the social and academic recognition of nursing as a profession. Specifically, in its attempts to establish itself as the one organization with the most overreaching interest in all of nursing's issues in the U.S., the ANA provides a rich source of data to examine nursing's struggles in achieving professional status for the occupation.

The theoretical framework for professional recognition presented here is the result of a review of the literature specific to the social definition of occupations as professions. The authors' ideas on professions demonstrate an attempt to provide a critical analysis of occupations and the selective designation as professions.

Additionally, Labor Process Theory (LPT) is presented as a means of viewing nursing's evolution as a labor force. Although LPT was introduced as a perspective for the study of factory laborers, its effort to identify labor as a process separate from the broader scope of the production process provides an opportunity to view nursing and its work as a unique process in the health care system. Additionally, LPT provides an opportunity to recognize the unique contributions of knowledge workers in the labor and production processes, moving LPT beyond its application in the industrial revolution.

Finally, a theoretical work on examining change as a holistic process occurring over time is provided. As a framework, this perspective was significant in supporting this study of change within the ANA.

Six key concepts of professionalism that most consistently have been addressed in the literature surrounding professional status include specialized knowledge, control of entry to the profession through education and training standards, a service orientation, control of the division of labor, autonomy, and practice. Although researchers may have included other traits in their analysis of the professions, these six concepts are most consistent among the work on professions. The collection of these concepts provides the theoretical framework for empirical examination of the ANA's experience in achieving professional recognition for the practice of nursing and its actions in serving as a labor organization.

Theoretical Perspectives of Professions

The analysis of professions was a major focus throughout the 20th century. Such analysis first appeared when in 1908 the Carnegie Foundation for the Advancement of Teaching authorized a study and report on the status of medical and legal education in the U.S. (Flexner, 1910). As a result, Abraham Flexner provided a report examining medical education from a developmental perspective and made recommendations regarding the occupation. In 1915 Flexner attempted to provide professional criteria as a means of determining social work's professional status (Flexner, 2001), while Bixler and Bixler (1945) provided criteria for such a status of nursing, with reexamination using the same criteria in 1959 (Bixler & Bixler, 1959). Cogan (1953) wrote of the evolution of the concept of profession using the disciplines of law, history, philosophy, government, and sociology, and Wilensky (1964) suggested a process for occupational attainment of professional status. Goode (1969) attempted to move the analysis from a check list definition by suggesting that professional status stems from the existence of two central qualities: "1. A basic body of abstract knowledge, and 2. the ideal of service" (p. 277), while Eliot Freidson (1970, 1986, 2001) provided a social analysis of professional status through the examination of medicine. Freidson (1970) derived a focus on five characteristics: First, the profession determines its own standards of education and training, second, its practice is legally recognized by state licensure, third, its licensing and admissions boards are made up of professional members, fourth, it is involved in shaping legislation concerned with the profession, and fifth, its practitioners are relatively free of lay evaluation and control. And Parsons (1954, 1975) was central in theorizing about professions and bureaucracies and will be discussed later (see pp 88-89)

Continuing the study of professional status from a sociological perspective, Douglas Klegon (1978) also suggested the need to move beyond check-list criteria in determining an occupation's professional status to a critical view of occupational strategies within a social context that establishes the occupation's position as a profession. In 1981 Lucie Young Kelly (as noted in Chitty, 2001) took Flexner's 1915 criteria expanding upon it in an effort to incorporate feminist perspectives.

Attempts at providing a means for classifying occupations as deserving of professional status have focused on the development of medicine, law, and the clergy. The interest of social science researchers in studying these occupations stemmed from their seeming distinction in social, economic, and organizational status from other occupations. As these designated archetypical professions were analyzed, their unique elements became the desires of achievement by members of other occupations' desiring professional status. Although comparative studies of other occupations achievement of professional status, such as nursing, social work, and teaching, has been attempted (Amitai, 1969), their status as full fledged professionals in society remains in question.

Beyond the idea of classifying professions through trait identification lays a broader social perspective. For professions, the integration of the traits of specialized knowledge and education and their service application becomes an important component in identifying an occupation as a profession. It is here that the notion of professional practice and civic professionalism must be included in the dialogue in distinguishing occupational work as a profession (Sullivan, 2005).

Six Concepts of Professional Status

Knowledge

Flexner's (1910) Carnegie commissioned report on medical education concentrated on the educational institutions of medicine, recommending reform that would standardize eligibility for entry to schools affiliated with universities. There seemed, at the time, no debate that the knowledge base of physicians dealt with the physical ailments of people, however Flexner proposed that such knowledge be based on science and that treatment methods be based on results of scientific inquiry alone. Consequently he proposed that, "a medical school is properly a university department; it is most favorably located in a large city, where the problem of procuring clinical material, at once abundant and various, practically solves itself" (p. 599).

In 1915 Flexner (2001) differentiated the work of professions from that of other occupations based on its intellectual character. He noted that although both groups may utilize physical tools in their work, it is the professional who employs a higher thinking process to achieve success, a process that requires the attainment and utilization of a specialized body of knowledge beyond that used for general purposes in routine endeavors. Such use of knowledge, according to Flexner, is theoretical, allowing the professional to make judgment decisions in the approach to their work. These decisions are at the discretion of the practitioner who thus is independently responsible for the outcome.

Also recognizing the significance of specialized knowledge in designating professional status Bixler and Bixler (1945) stated, "It is generally agreed that a profession utilizes in its practice a well defined and well organized body of specialized

knowledge which is on the intellectual level of higher learning" (p. 730). They noted that such knowledge entails the why of practice and not just the how. This knowledge is achieved through the use of scientific inquiry in the process of research to uncover meaning that supports the practice of the professional.

Cogan (1953) reiterated both previous points, differentiating special knowledge from simple skill. He pointed out that a previous judicial test of the professional status of an occupation lies in its intellectual activity and outweighs the manual skill employed. Additionally, he agreed that the intellectual knowledge achieved must have a scientific basis. What Cogan added to this examination was the need for the theoretical knowledge to be applied in the work of the professional.

Congruent with Cogan's work, Wilensky (1964) suggested the need for a balance between the theoretical and technical knowledge base of a profession, and offered that professional knowledge was both learned and tacit:

> In short, the optimal base of knowledge or doctrine for a profession is a combination of intellectual and practical knowing, some of which is explicit (classifications and generalizations learned from books, lectures, and demonstrations), some implicit ('understanding' acquired from supervised practice and observation)…If an occupation is based on knowledge or doctrine which is too general and vague, on the one hand, or too narrow and specific, on the other, it is not likely to achieve the exclusive jurisdiction necessary to professional authority (p. 150).

William J. Goode (1969) outlined seven major characteristics of knowledge in clarifying its concept in relation to professions. They were:

1. Ideally, the knowledge and skills should be abstract and organized into a codified body of principles.
2. The knowledge should be applicable, or thought to be applicable, to the concrete problems of living.
3. The society or its relevant members should believe that the knowledge can actually solve these problems.
4. Members of the society should also accept as proper that these problems

be given over to some occupational group for solution because the occupational group possesses that knowledge and others do not.

5. The profession itself should help to create, organize and transmit the knowledge.
6. The profession should accept as the final arbiter in any disputes over the validity of any technical solution lying within its area of supposed competency.
7. The amount of knowledge and skills and the difficulty of acquiring them should be great enough that the members of the society view the profession as possessing a kind of mystery that it is not given to the ordinary man to acquire, by his own efforts or even with help (p. 277-278).

This list demonstrated a view of what entailed professional knowledge. Others have also made attempts at clarifying what was unique about knowledge as it pertains to professional status.

Although Freidson (1970) agreed that the achievement of a specialized body of knowledge that supports a theoretical application is important in distinguishing an occupation as a profession, he differentiated the development of such knowledge, through scientific research, from its application in practice. He stated in his book *Professional Dominance* (1970) that expertise entailed both the development and use of knowledge, but suggested that the decision of how the knowledge was implemented as a service to society should be shared with other professionals and even layman. Freidson (1970) noted an important distinction in relation to knowledge. Although the professional does indeed possess a unique body of knowledge, the decision of how such knowledge was to be used by the professional is based on trial and error, and not scientific inquiry, and was referred to by Friedson as wisdom. Thus what Freidson (1970) did was support the limitation of the concept of knowledge, as it relates to the identification of a profession, to its development and not its implementation.

Collecting a brief description of professional taxonomy found in the literature, Klegon (1978) noted several scholars' views on professional knowledge. These views included Greenwood's 1957 list which included "a basis in systematic theory" (p. 260), Barber's 1963 inclusion of "generalized and systematic knowledge" (p. 261), Kornhauser's 1962 "professional status [is] to be based on specialized competence having a considerable intellectual content" (p. 261), Wilensky's 1964 belief that the professional job is "technical, based on systematic knowledge acquired through long training" (p. 261), and Moore's 1970 view that it entails "possession of esoteric but useful knowledge and skills" (p. 261). Chitty (2001) noted Kelly's 1981 inclusion of "…a special body of knowledge that is continually enlarged through research" (p. 154).

What is significant to note here is the consistency in the literature in attempting to distinguish professional occupations from others is the inclusion of some analysis of the concept of knowledge. Although many of these provisions for knowledge may have arguable points in their practical application to any given occupation, as a concept its consistency in the literature is notable.

Control of Entry

If it is generally agreed that for an occupation to be considered a profession it must produce, through scientific research, a unique body of knowledge that provides the theoretical basis for higher level thinking required for the provision of its work, then it seems logical to conclude that the educational and training requirements for entry to the profession be under the control of the profession. Thus the profession, through its institutions, determines the education and training standards necessary for individuals to

become members of the profession. And with a practice discipline, the practice setting for students of the profession must also be governed by professional knowledge.

Flexner (1910) suggested that by moving medical education within the university structure, and standardizing entry requirements to medical school, inferior programs would be forced to close, resulting in a fewer number of more highly trained physicians (p. 597). He also noted the need for a higher standard of medical education since the existing schools of the time only supported that "the crude boy or the jaded clerk who goes into medicine at this level has not been moved by a significant prompting from within; nor has he as a rule shown any forethought in the matter of making himself ready" (p. 598). Falling short of stating that the educational preparation of a professional must take place in institutions of higher learning, in 1915 Flexner did recognize the need for a profession to determine the educational requirements of the field, and the need for training to bring the application of education to life in the provision of service (Flexner, 2001). What Flexner stated was,

> …despite differences of opinion about details, the members of a given profession are pretty well agreed as to the specific objects the profession seeks to fulfill, and the specific objects that the practitioner of the profession must master in order to attain the object in question. On this basis, men arrive at an understanding as to the amount and quality of training, general and special, which should precede admission into the professional school; as to the content and length of the professional course (p. 155)

Such a creation of standard not only ensures that practitioners have fully achieved what they need to perform as professional members, but also to identify only those capable of such an achievement (Flexner, 2001).

Addressing the control of entry through educational programming Bixler and Bixler (1945) discussed the need of a profession to improve its techniques of education

through research, and thus entrust the education of its practitioners to institutions of higher education. Such a concept again flows from the discussion of the professional development of a body of knowledge. What they noted is the need for members of a profession to be taught the skill and knowledge of research in order to conduct the scientific inquiry that contributes to the body of knowledge. And in relation to the practice of the profession, they noted the need for any specialization within the profession be addressed through curriculum content rather than creating different educational levels or quality levels (p. 732).

Although lacking a specific reference to the educational preparation for professional status of members, Cogan (1953) did refer to professional practice as "founded upon an understanding of the theoretical structure of some department of learning or science, and upon the abilities accompanying such understanding" (p. 48-49). If such understanding was known to be accomplished in institutions of higher education, then here again such a level of education was necessary for members of a profession. Cogan (1953) noted at one point the need for "technical training, preceded by liberal education as proof of intellectual ability" (p. 37). He specifically noted this importants with the increasing number of occupations whose education occurred within universities who seek the title of profession, with such an expansion resulting in the identification of semi-professions. He also noted, in reference to business leaders, that when such training becomes a prerequisite to employment then business itself may be referred to as a profession. These points seemed to support the control of the educational preparation for entry to a profession by the profession as a means of control over who may enter it, and over the content necessary for its practice.

Wilensky (1964) also addressed the process of defining and refining competence as essential to professions and as a means for restricting entry to those willing to participate in the training necessary for achieving the specified competency. He suggested that control of such a process was lead by the profession through the formation of a professional organization developed by those establishing the criteria and by those who have gone through it.

The collection of professional taxonomy provided by Klegon (1978) in reference to education includes Kornhauser's 1962 reference to professional status being based on specialized competency with considerable intellectual content, and autonomy in the demonstration of competence. Further, Klegan included Wilensky's 1964 note of knowledge acquired through long training, and Moore's 1970 referral to the need for knowledge and skill achieved through specialized training and education. Kelly's 1981 statement is simply that professional "practitioners are educated in institutions of higher learning" (Chitty, 2001 p. 154).

Eliot Freidson (2001) referred to the ideal type profession and its educational elements as consisting of "a formal training program lying outside the labor market that produces the qualifying credentials, which was controlled by the occupation and associated with higher education" (p.127). Of significance here is the separateness of education from the labor market, signifying the control of the profession over the establishment of the educational needs and processes for entry into the profession. It also implied a high level of trust by labor that the profession is indeed supplying practitioners to meet what is needed in the market place.

The association with higher education differentiated professional and vocational or craft education, the latter not requiring a connection with higher education (Freidson, 2001). Teaching members of professional education were also required to be active in the refinement and expansion of the profession's body of knowledge through the conduction of research (Freidson, 2001). It was in this organized manner that a profession controlled the supply of professionals, restricting supply to impact market variables such as value placement and economic factors affecting the profession (Freidson, 2001).

Further noted by Freidson (2001) is the emphasis in professional education on the theoretical, often leaving the practical application to post-graduate training. He suggested that this focus supported the belief that a theoretical emphasis during the educational process allowed the practitioner the flexibility in practice to make judgment decisions supported by the theoretical training received during formal education. Such an arrangement of educational preparation allowed the profession to sustain itself, its reputation, jurisdiction, and practice discipline.

Thus one can begin to understand the importance of not only the location of learning in institutions of higher education, but also the control of such education as important criteria for identifying occupations as professions. Such control allows the profession to determine the educational standards for achievement of educational competency, and thus creates a set of selection criteria for entry into the profession.

Control of the Division of Labor

Previously the concept of knowledge and its need to be uniquely tied to an occupation for it to claim professional status was discussed. When such knowledge was

developed by the members of an occupation through scientific research, and was unique to the work done by the occupation, it seemingly made sense that the authority in application of the knowledge also be held by the occupation and its members. Such a view seemed to legitimize the status of medicine, law, and divinity as the ideal archetypes of professions, thus the division of labor among occupations occupying a less than professional status within each of the corresponding service arenas of health, legal systems, and religion was controlled by those with the broadest professional knowledge base.

Wilensky (1964) offered that, as occupations defined member competencies and delineated professional tasks, a "pecking order of delegation occurs" (p. 144). He continued:

> The doctor allocates much if his job to less-trained nurses and laboratory and X-ray technicians; the nurses, as they seek to professionalize, allocate much of their less attractive work to practical nurses, aids, and nurse assistants; and these, in turn, allocate some of their chores to ward helpers (p. 144).

As skilled knowledge is delegated and relegated by physicians to nurses, requirements for clinical reasoning in nursing practice have dramatically increased.

Freidson was the most prominent of all the authors on professions in examining the concept of division of labor and its role in professional status. One method of gaining control over the work of occupations noted by Freidson (1970) was through state established standards. In other words, a profession may have gained authority over other occupations through state regulation of education and consequent credentialing through licensure. Practice acts that defined the work of one occupation may have limited the working scope of others and even required supervision and delegation, supporting a division of labor. Such provisions often lead to a hierarchical structure within a given

field (Freidson, 1970). In delineating the paraprofessional within medicine, Freidson (1970) noted the following distinctions:

- Technical knowledge is at a minimum approved by the dominant profession.
- Tasks are assistive in nature and not a replacement for those performed by the professional.
- Work is done by request or by order of the professional.
- Public prestige is less than that provided to the professional (p. 48).

In viewing the occupational division of labor, Freidson (2001) provided a conceptual differentiation between a generalist and a specialist. He believed that when one specialized it was a part of a whole or work that was previously done as a part of the spectrum of work done by a generalist. Thus he suggested that the "most plausible method of control by an entire working class involves delegation of authority to managerial and technical specialists who then constitute and direct the concrete forms of the division of labor" (p. 55). He continued that,

> …each specialization controls the work for which it is competent, negotiates its boundaries with other specializations, and by that method determines how the entire division of labor is organized and coordinated. The actual performance of that work is, of course, carried out and controlled by individual members of the occupation (p. 55).

Of significance to professional status, Freidson (2001) stated that the division of labor was controlled by the occupation and can have a horizontal structure among cooperating occupations, a vertical structure where occupations have authority over others, or a combination of both. Such authority was based on the content and character of the occupational expertise and the functional relationships of that expertise to that of the others.

Autonomy

Flexner (2001) referred to the "large individual responsibility" (p. 156) that comes with the intellectual activity of a profession. He specifically noted that the professional agent "exercises a very large discretion as to what he shall do. He is not under orders" (p. 154). Since the professional's work was intellectual, as in all intellectual endeavors, according to Flexner, the thinker took the ultimate risk, and any order of work that flowed from this, be it physical or mental, and owed its origin to the thinker. The thinker, and "he alone deserves to be considered professional" (p. 154), and thus maintained a level of autonomy free from scrutiny by any lay individuals or institutions. Flexner's understanding of 'thinking' and the 'mental' followed a Cartesian individualistic notion; it ignored the social contribution of thinking and knowledge building.

As part of their criteria Bixler and Bixler (1945, 1959) noted that a portion of a profession's compensation was found in its freedom of action. They viewed such freedom not only in the provision of service but also in the provision of professional education through financial support of educational programs and of students. In specifying professional criteria they stated, "a profession functions autonomously in the formulation of professional policy and in the control of professional activity thereby" (p. 733, p. 1145). They recognized in 1945 the important role of a single professional organization in achieving this criterion. Although allowing for specialized organizations for the collection of shared interests, they stated the need that "all such organization(s) should be united as one profession by an over-all organization with inclusive objectives" (p.733). They reaffirmed this perspective in 1959 (Bixler & Bixler). However, what they did not address was autonomy by the individual in the performance of work.

Cogan (1953) also only took the view of professional self-control by examining the role and function that professional associations have taken within the political and governmental structures. He provided the opposing views of the role of professional associations as serving as agents of society versus addressing the issues of the profession and its members. Such differing foci seems to leave the best interest of society to play second fiddle to what is necessary to maintain the self-interest and control of the profession by its own hand.

Inherent in the establishment of codes of ethics is what Goode (1969) recognized as a precursor to societies granting of full autonomy to a profession, including self-regulation. This was the need for the profession to prove to society its ability to control the work of its members in the interest of the client. If such ability is not demonstrated, or ceased to be so, society has the right, or even obligation, through the state or other institutions, to remove such autonomy and authority from the profession.

Freidson (1970) agreed with this notion. In evaluating the question of professional autonomy he argued against a professions' complete autonomy over the work and its regulation. He argued that such autonomy ignored the role of the service recipient in any decision making process related to the implementation of the knowledge and the choices available. He suggested that the role of the profession should be to provide the options available, determined through their appropriate autonomy over knowledge development, in order to fully inform the development of social policy. And if such knowledge development and its sharing with the public, including its institutions, became less reflective of the needs of the layperson and based more on what the profession believed or claimed is what the layperson needs, then autonomy of knowledge

would be viewed negatively and theoretically the occupation lost its justification as a profession.

Providing a work related perspective of autonomy, Freidson's (1970) viewed autonomy as given by society, through its political and economic elite, to a profession. It included "the exclusive right to determine who can legitimately do its work and how the work should be done" (p. 72). Society had established the licensing process as a means to protect the layperson. Such a process required professional members to achieve a licensing credential in order to provide service, thus legitimizing society's deliberate provision of autonomy to the profession. Freidson (1970) stated that professional autonomy,

> represents freedom from direction from others, [and] freedom to perform one's work the way one desires. Only those who advance the claim to be professionals assert that their efforts to control the terms and content of work are justified because of the benefit occurring to those clients they work with or on. The freedom they ask for is the same as others and they ask to determine their own working hours, work load, compensation, the kind of work they do, and the way they do it (p. 368).

Other theoretical statements related to an occupation's need to achieve autonomy for recognition as a profession were provided by Klegon (1978). They include Greenwood's 1957 mention that authority be recognized by the professions clientele, and Barber's 1963 inclusion of the need for self control through a code of ethics. It continued with Kornhauser's 1962 belief that autonomy in the demonstration of competency was significant, and Moore's 1970 reference to the profession's need to proceed by its own judgment and authority, thus enjoying autonomy. All of these definitions fall short of including civic, altruistic, fiduciary, and advocacy responsibilities necessary for the practice of civic professionalism.

Utilizing Flexner's 1915 criteria for professional status, Kelly viewed autonomy as the relative independence of practitioners and control of their own policies and activities (Chitty, 2001). This view seemed to allow autonomy at both the individual professional level as well as at a more social and institutional level. With these views one could apply the concept to each of the previously discussed professional concepts. A profession controls its body of knowledge, who enters the profession, what education was necessary, what and how service was provided, and who performed the work within the discipline. Thus autonomy became an overarching concept to all other concepts in deciding the professional status of an occupation.

Service Orientation

The work of many occupations entailed the provision of service to the public; otherwise their work would be unnecessary. It was when their service was of such a specialized nature, requiring the use of a unique body of knowledge focused on theoretical abstracts and achieved only through higher levels of education, that the service became worthy as a concept for professional status. Such professional service was the use of knowledge, and served a higher, often altruistic social purpose beyond the selfish economic needs of the worker. This was not to imply, as Flexner stated, that the service was volunteer or underpaid, for individuals were not drawn to a vocation that did not provide a living wage in return for competent service (Flexner, 2001, p. 163). However, he did list as a professional criterion, the increasing altruistic nature of service as a motivating factor in the work of the professional. Simply put by Goode (1969), professional services were needed because professions had the knowledge needed for problem-solving, and thus had a monopoly over a valuable product. It was this monopoly,

as Goode suggested, that justifies the higher wage of professionals over other occupational workers.

Bixler & Bixler (1945, 1953) noted that a profession's practice was "vital to human and social welfare" (p. 732, p. 1145). As an example, they demonstrated how nursing may have achieved this by adopting a "social attitude…toward the emerging conception that every citizen is entitled to adequate health care, just as he is entitled to education, and that the welfare of the nation is contingent on the implementation of that idea" (1945, p. 733).

> In noting a 1933 court opinion Cogan (1953) quoted:
> A profession is not a money getting business. It has no element of commercialism in it. True, the professional man seeks to live by what he earns, but his main purpose and desire is to be of service to those who seek his aid and to the community of which he is a necessary part (p. 36).

Cogan attempted to scrutinize this perspective by providing the reader with an excerpt from an essay by Parsons. Parsons noted the resemblance of the institutions of profession and business in their focus on achievement and recognition. As individuals, neither the professional nor the businessman was characteristically altruistic or egoistic, but as institutions it was the profession that was more likely altruistic and the business egoistic. Thus Cogan concluded,

> If services are indeed so vital, then perhaps the performance of such services ought to be made to depend upon the fundamental relations of one man to another, not upon secondary relationships existing between money and services, or between any superficial considerations and services (p. 42).

Even here altruistic service was seen as significant to the status of occupations as professions, and Cogan completed his discussion by stating, "The profession, serving the vital needs of man, considers its first ethical imperative to be altruistic service to the client" (p. 49).

By examining the service orientation of medicine in contrast to other occupational public service, Parsons (1954) attempted to identify the uniqueness of professions from a social perspective. He compared specified social aspects to that of corporate business and government, analyzing the occupations and their members as altruistic versus egoistic, or oriented to the collective benefit of society as a whole, as opposed to being self-oriented. In doing this, he noted the resemblance of the institutions of profession and business in their focus on achievement and recognition, and as individuals neither the professional nor the businessman was characteristically altruistic or egoistic. However, as institutions it was the profession that was more likely altruistic and the business egoistic.

He further noted that the professions, exemplified by medicine, were an applied science, providing a service to society based rationally on scientific inquiry and not merely on occupational tradition. Parsons (1954) refered to such a rational based service as contributing to the authority held by a profession, for it is the professional who had achieved competence in a particular field of knowledge and skill which was sought after by the public for its greater good.

In 1975, Parsons continued his examination of the unique social service provided by medicine by analyzing the accepted social roles taken on by the provider and the recipient of service. Specific to this, he analyzed service to the ill in an effort to return the ill person to a functional state in society held prior to the illness. As an institutionalized social role, he suggested three social views of illness that provided for the establishment of a sick role. These views consisted of a belief that illness is not the fault of the person suffering from it, that in fact he was the victim of forces beyond his

control. Secondly, that when inflicted with illness one became relieved of obligations and expectations existing prior to becoming ill, and finally, the expectation that help may be sought to return to a status of health. It is the seeking of help in an effort to return to health that the physician was sought, since it was the physician who "has been institutionally certified to be worthy of entrusting responsibility to in the field of the care of health, the prevention of illness, the mitigation of its severity and disabling consequences, and its cure insofar as this is feasible" (p. 266-267). Such certified authority to provide service was noted by Parsons to be the result of the belief in the competence held by the physician because of specific technical knowledge and skill achieved through formal training and experience.

Thus Parsons (1975) suggested, "with respect to the inherent functions of effective care and amelioration of conditions of illness, there must be a built-in institutionalized superiority of the professional roles, grounded responsibility, competence, and occupational concern" (p. 271). With this, Parsons provided a framework that helped describe the characteristics necessary in viewing the service orientation of professions differently from other occupations.

Freidson's (2001) professional criteria pertaining to service orientation stated that the profession upheld "an ideology that asserts greater commitment to doing good work than to economic gain and to the quality rather than the economic efficiency of work" (p. 127). Although stated here, he suggested in his earlier work the need to differentiate between the service practice of individual professionals and the service orientation of the profession's institutions. He noted, "what professionals do represents their effective

knowledge or expertise; how they regulate what they do in the public interest represents their effective service orientation" (Freidson, 1970, p. 361).

From an institutional perspective, he suggested how a profession sustained its philanthropic orientation to service by allowing lay persons to serve as equals to members of a profession in those institutions where professional policy was developed, assuring both public interest and professional integrity (Freidson, 1970). On the level of the individual client and the provision of professional services he suggested the need to formalize the concept of client rights. In so doing, the client retained some control over the services he received, or chose not to receive (Freidson, 1970). Freidson also noted the need to empirically show how service orientation differed for professions from other occupations, including its manifestation among individual professional members.

Klegon (1978) rounds out the professional taxonomic lists in viewing professional service. He noted Greenwood's (1957) reference to an ethical code regulating relations with clients and colleagues, and Barber's (1963) mention of a primary orientation to community interest. Most simply stated by Moore (1970), a profession had a service orientation. Finally, Kelly (Chitty, 2001) addressed this topic by stating that professional "practitioners are motivated by service (altruism) and consider their work an important component of their lives" (p. 154).

Although the esoteric nature of service orientation was apparent as a component for occupational designation as a profession, its consistency as a concept supported its inclusion in any discussion on professional status. Such a discussion allowed for further examination of what is known as professional practice and its service orientation.

Practice and Civic Professionalism

Consistently utilized in the literature in discussions of professions is the notion of the professional's practice in the delivery of service. In presenting the notion of professional practice, Benner, Hooper-Kyriakikis, and Stannard (1999) noted that practice involved a mix of science, technology, and "the working out of knowledge, inquiry, and relationships in practice" (p. 19). This notion was similar to Friedson, pointing to 'wisdom' in implementing scientific knowledge in practice (Friedson, 1970). This mix required of the professional the use of ethical and clinical reasoning, of scientific norms and data, of combining expert knowledge with social interactions with families and other professionals and workers, and of their relationships. It was the integration and application of these elements into practice that demonstrated the work of professionals. Without this, the work was simply left to "menu-driven lists of possible actions and classificatory information" (Benner, Hooper-Kyriakikis, & Stannard 1999, p. 20).

Sullivan (2005) challenged the notion that professional practice was simply the application of learned abstract theory. He elaborated on Hubert and Stuart Dreyfus 1986 theoretical concepts of learning, demonstrating its significance in professional practice. The notion was that the beginning professional, fresh from formalized academic training rich in theoretical abstract thinking, began professional practice by applying such specialized knowledge. The beginning professional in practice initially viewed situations with singular fashion, and applied formalized knowledge in a checklist fashion. As the practicing professional increased their diversity of experience, they began to apply their expert knowledge in an evolving manner of thought, bringing into the practical

application of their specialized knowledge a greater holism of thinking. Such practice entailed processing experiences at an ever increasing pace in order to quickly apply the diversity of knowledge that provided expert service built on formalized theoretical knowledge, and it's ever increasing abstract application of knowledge built on years of professional practice (Dreyfus & Dreyfus 1986; Sullivan 2005).

It is this manner of understanding of the work of professionals that offered an additional consideration in what differentiates a profession from other occupations. Simply put, the goal in professional work was the integration of clinical skill with theoretical understanding and complex social context (Sullivan 2005). Such a notion supported the symbiotic relationship of theoretical knowledge and professional practice, each informing and developing the other. Of significant note was the integration of these two elements within a social context. Sullivan stated,

> the goal of professional education cannot be analytic knowledge alone (or perhaps even predominantly). Neither can it be analytic knowledge plus skillful performance. Rather, the goal has to be holistic: to advance students toward genuine expertise as practitioners who can enact the profession's highest level of skill in the service of its defining meanings (p. 254).

Within this quote one can glean the significant interplay of the previously noted traits of professions, that of formalized education, specialized knowledge, skilled know-how, skillful clinical judgment, ethical comportment and service orientation.

This final discussion brings to the meaning of professions their social obligation and their ability to meet such obligation. Such ability was often addressed through the notion of allowing the profession to control its education, the requirements for entry, and their standardization. It was this control that was often viewed as a component of the autonomous nature of professions. It is here, though, that a discussion of ethics becomes

important. To understand ethics as a part of professional practice, Sullivan (2005) offered that,

> [ethics] refers to the daily habits and behaviors through which the spirit of a particular community is expressed and lived out…It means far more than a code of rules or even a set of principles, though ethics can include that…it is the core commitments that define the profession (p. 215).

An example of how the profession accomplished this is presented by Fowler (1993). Fowler examined the influence of power structures on professional ethics, but cautioned the idea of an all-encompassing causation. In referring to the ethics of the professional association as an example, Fowler stated that what was important was a social equilibrium that created a balanced influence of power structures with meaning and value structures. She continued by providing an overview of ethics as presented by Ernst Troeltsch (1925). Simplified, this view described two halves of a circle of ethics, the ideal and the real. The ideal half-circle represented the pinnacle of all aspects of ethics desirable, while the real half-circle represented the lived social, cultural, and historical representation of ethics. It was the real circle of ethics that contains the social structures, including social power structures. Of importance was understanding that these two halves of the circle were mutually influential.

> The role of a professional association…in relation to ethics is to preserve, develop, and assert the meaning and value structures of the profession by balancing meaning and value with power structures in a reciprocal relationship. This is accomplished through the exercise of the profession's social ethics (Fowler, 1993 p. 16).

Using the term social ethics to encompass the act of doing good and right in efforts to shape human society, Fowler (1993) provided that professional social ethics contained three functions that addressed "reform of the profession, epidictic discourse, and social reform" (p. 16). These functions provided the overarching role of the

professional association. Reform of profession allowed the association to work toward the ideal, guiding the reality of the profession's practice and development toward achievement of such ideals through self-reflection and self-evaluation. Epidictic discourse encompassed the communication within the profession, demonstrating and reinforcing the profession's values, providing a constant challenge to established values, reinforcing and redefining them. Such discourse helped the professional association to then begin the work of social reform, bringing established values into the greater scope of society (Fowler).

Sullivan (2005) noted that the traditional markings of professions, that being "corporate membership, controlled markets for their services, and monopolistic practices in training and recruitment" (p. 1) could no longer be measures of an occupation's professional status in society because such qualifications were no longer appropriate measures of professions in the current work settings. Such settings related to the increase in corporate focus and employment of professionals as part of the corporate model, thus creating more of a shared authority for such markings. Sullivan (2005) suggested that today's professional was differentiated from other knowledge workers because of the profession's responsibility in ensuring public goods such as, "health care, civil regulation and social justice, technological safety and environmental regulation, publicly available information that is reliable and comprehensible, and high-quality education" (p. 4). It was this responsibility that Sullivan examined, terming the role as civic professionalism. This concept required the professional to maintain a civic identity, concerned with public identity and values, and whose work contributed to public value. With such

responsibility, in turn, came public status and authority granted through the social contract between society and the profession (Sullivan 2005).

Modern economic pressures challenged civic professionalism. To gain control of the economic pressures of efficiency and cost effectiveness, bureaucratic organizational structures were instituted to monitor production and supervise worker efforts, providing accountability pressures for performance in a myriad of organizational levels of production. As the professional became increasingly a member of these bureaucratic structures, their worth was measured more by the expert service provided rather than by any contract with society at large. Such a change was noted by Sullivan (2005) as technical professionalism.

In attempting to differentiate between the civic and technical professional, Sullivan (2005) stated that civic professionalism typically describes

> an occupation characterized by three features: specialized training in a field of codified knowledge usually acquired by formal education and apprenticeship, public recognition of a certain autonomy on the part of the community of practitioners to regulate their own standards of practice, and commitment to provide service to the public that goes beyond the economic welfare of the practitioner (p. 36).

Sullivan (2005) continued to discuss the tension created within professions between the notion of work as a calling and that of a career. In summary, Sullivan discussed the professionals desire to serve the greater good while also achieving a level of economic security. He suggested that the individual professional in today's market driven economy, was often challenged to concede to profit demands over professional standards, and this specific challenge was managed by the collective efforts of the professional organization. Such a notion supported the involvement of the professional organization or society as a third party, intervening on behalf of the professional, to

mediate such professional and economic conflicts in an economic society organized by bureaucratic systems. Within these systems, the professional was employed because of their expert knowledge. In this service, Sullivan stated that the professional organization needed to serve as

> healthy institutions make maintenance of high standards of competence and an orientation toward serving the public standard operating procedures. They also set the protective social context within which the goods of professionalism can be nurtured, understood, and passed on as a collective asset that defines a sense of common purpose within an occupation (p. 50).

Such a quote provided an over-arching role for the professional society in maintaining the civic professionalism of its occupation in every aspect of its operation.

Sullivan (2005) provided an illustration of the personal struggle of professionals and professionalism in the U.S. He offered that the professional of today was the product of the 1980's social term for youth as yuppies, representing Young, Urban Professionals. These individuals sought to satisfy both their personal and their professional obligations through specified demarcations in the activities of each. Work was meant to provide the resources for the individual to enjoy their personal life, a life bounded from their professional work. It was this perspective that Sullivan noted as contributing to the professional's eventual dissatisfaction with his work, for it lacked integrity and sincerity for serving the greater good.

In discussing the means to reinvigorate the civic duties of professions, Sullivan (2005) presented the perspective of professional capital. Professional capital was human capital that was gained through professional credentialing, providing a level of public expectation as well as contributing to social development. This interdependence of the profession with society required the perspective that what was understood to be the

property of a profession, agreed upon by both society and the profession, required the professional "be licensed by a professional community. This demands of the individual a demonstration of the character as well as the expertise that defines being [a member of a given profession]" (p. 182). It was the perpetuation of this agreement that ensured "competence, trustworthiness, and honesty generated by a community of practitioners through sustained cooperation" (p. 182).

Sullivan's (2005) perspective contributed greatly to the philosophical view that supported the service orientation needed for an occupation to be considered a profession. Such an overarching understanding of the concept of civic professionalism, embraced by both professions and society, seemingly supported the work of professionals as serving the greater good of society. However, how these agreements between society and the profession were ensured is seemingly lacking in Sullivan's work. How to legitimate and measure the activities of a profession, beyond the checklist view, in acknowledging and supporting its civic concentration remained a question. And beyond the profession, how was it ensured that the individual professional, as well as the role of their institutions, was able to live up to such responsibility while engaged in any number of roles, be they employee, employer, leader, or practitioner?

It would seem that the study of a professions' driving values and activities, as noted through their professional societies, might provide a means of answering such questions. Particularly for nursing, the question of the function of the professional nursing society as both pursuing the professional elevation of nursing as well as addressing the workplace issues of its members. The use of labor laws and workplace

advocacy techniques could provide a source of data in measuring the concepts of civic professionalism as presented by Sullivan (2005).

Implications for Nursing

Applying the five concepts of professions to nursing provides a framework for examining nursings' occupation as a profession. Each concept has, within nursing, its unique development. Such an application becomes important in understanding the professional practice and social role of nursing. Challenges faced by the occupation in its social recognition as a profession, as opposed to its designation as a semi-profession (Etzoni, 1969), can be more critically analyzed using the framework previously discussed.

Knowledge and Control of Entry

As an occupation, nursing had made attempts to establish that its work was based on a body of knowledge that was unique to nursing. This has historically been a struggle for nursing as its work was first performed by lay individuals without any specified training or knowledge. And even when the occupation began to establish standardized training for its members in the late 19th century through the early part of the 1900's, the knowledge imparted to students of nursing was provided by physicians, thus instilling in nursing students a sub-set of medical knowledge (Donahue, 1985).

As nursing educators developed the skill and training as teachers and researchers through the establishment of collegiate based academic programs for graduate nurses, beginning with Teachers College, Columbia University in 1899, and the first School of Nursing at Yale University in 1923 (Donohue, 1985), they began to establish a theory base for nursing practice, providing for the unique body of knowledge required of professional status. As noted by Donohue (1985), and first stated by Margaretta Styles in

1977, such graduate education was first established for nursing, later evolving into the education of nursing.

However, the continued criticism faced by nursing of its body of knowledge was that it was not unique to the profession, but rather drew on the knowledge base of other professions such as medicine, and other disciplines. Educators of nursing have not disputed such borrowing of concepts, but rather noted their unique reorganization and perspective in the practice of nursing. As a result, nursing theories were developed. Virginia Henderson and Hildegard Peplau are noted by Donohue (1985) as two early pioneers in the development of nursing theory, with others contributing to the theoretical framework in order to begin to critically analyze the practice of nursing as a profession.

Historically, nursing education has evolved from little if any training, to hospital – based training programs, and finally to traditional academic institutions, much as other professions have evolved. With such an evolution alone, and a subsequent establishment of nursing education in colleges and universities, one may argue the professional status of nursing. However, there remained in the profession a lack of consensus on a standardized level of education necessary for entry to the practice of professional nursing. Rather, the profession had established only standardized minimal requirements for licensure, with variance here among individual U.S. states. Such minimal licensure requirements, not standardized by educational preparation, and varying among states within the U.S., had allowed the development of five entry levels of educational preparation, from hospital diploma to professional doctorate, for preparation for licensure. Without standardization of the educational requirements for entry into the occupation, the professional status of nursing remained in question by researchers of professions.

Such arguments are supported when society views a profession as based on a body of abstract knowledge and thinking that is learned in institutions of higher education. For nursing, and increasingly an option in times of shortage, it is the requirements for licensure that are often lessened, and currently exist without an analytic examination of the academic preparation necessary for entry to the profession.

Service Orientation

Although esoteric, service orientation was apparent as a component for occupational designation as a profession, its consistency as a concept supports its inclusion in any discussion on professional status. However for nursing, this concept has remained its strongest argument for the status of profession.

Nursing has long been considered a service occupation. It has remained as part of service the care of the sick, and has evolved to include the provision of wellness care. Although service provision was the least debated concern for the recognition of nursing as a profession, it has created an area for debate when addressing the economic and general welfare issues of nurses. For, as noted above, a profession must have as its greatest concern the betterment of others, even to the sacrifice of individual gain. And yet, how can one provide for many without also having their own needs met?

Perhaps the empirical work of Freidson (1970, 1993, 2001), Benner & Hooper-Kyriakikis, and Stannard (1999), and Sullivan (2005) allow for a more contemporary exploration for nursing as a profession. Such inclusion assures the examination of practice from an ethical perspective, demonstrating the social contributions of an occupation as a method for measuring its professional status in society. For nursing, such a framework is significant in examining not only the practice of individual nurses, but the

function and role of its institutions. As mentioned, a profession's institutions, such as its professional society, need to be held to the same civic and ethical standards as the individual professional.

Control of Division of Labor

Nursing had managed to maintain some control over the division of labor within its own ranks. With the establishment and utilization of lesser skilled nursing providers such as Licensed Practical and Vocational Nurses (LPN/LVN), and certified nursing assistants (CNA), the Registered Nurse (RN) was identified as the nursing provider accountable for nursing care in an employment setting. However, it was not legally required that an RN supervise all nursing care, or even be employed where LPN/LVN and CNAs are utilized in the provision of nursing care. Although these nursing care providers were not legally accountable for the provision of nursing care, such accountability can fall to other health care providers such as dentists, physicians, and surgeons.

The need and contribution of nursing to the health of society was not of question here. However, it was the acknowledgement of such a need and how it was provided optimally that created concern for the nursing profession. The literature provided clarifies that professional control of division of labor included the professions ability to control its knowledge base and entry standards. Such a perspective provided a clear definition of this concept beyond that of supervision.

Flexner (1910) noted the impact of increased requirements for medical education on limiting the number of practitioners entering the field. For nursing, the societal need for its services limited the desire of the profession to restrict entry into its ranks. Nursing

shortages may have resulted in the creation of a division of labor within the field, and examination of quality outcomes and control to assure a standard level of quality has been lacking. Thus the question of what has the professional nursing society done to gain greater control of the occupation's division of labor, and subsequently improving the quality of nursing care provided to society, is an important question to ask in providing an analytical view of the profession's ability to control its division of labor.

Autonomy

Although it is easy to identify areas of nursing where autonomy is evident, such as in the establishment of state licensing boards, the accreditation of nursing education programs, and even the provision of judicial expert testimony, full autonomy of the practice of nursing by individual members of the profession remains debatable. Nursing history can be viewed as actually moving away from such autonomy when nursing service in the early part of the 20th century shifted from for hire in individual family residences to the nearly exclusive employment of nurses in organizational bureaucracies (Donahue, 1985). Although private nursing practitioners exist today, they are shadowed by the institutional employment of the majority of RNs (U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing, 2005). More contemporary views of professional autonomy, as provided by Freidson, Sullivan and others, provided a more realistic view of professional autonomy.

The ability of the profession to collectively demonstrate autonomy in decision making is also important. For nursing, this collective view provided an opportunity to examine the professional nursing society as it speaks as the voice for nursing. How has

the nursing institution addressed the issue of professional autonomy, and what challenges has it faced in establishing such autonomy? What are the functions of the professional nursing society in assuring the professional autonomy of nursing?

Practice and Civic Professionalism

Nursing as a practice profession has been well documented, particularly by Patricia Benner and colleagues (Benner, Tanner & Chesla, 1996; Benner, Hooper-Kyriakides, Stannard, 1999). Its use of an abstract body of knowledge in the provision of nursing care while integrating an ever growing complexity of organizational systems, family needs, and diversification of health care providers demonstrates the unique practice that is provided by nurses. Their civic professionalism is growing as the profession, particularly through its organizations, increasingly demonstrates the significant role that nurses and their care provide to the larger health aspects of a community and society. Nursing's increasing involvement in research, public policy, and healthcare leadership roles are examples of the increasing involvement of the profession in understanding its civic responsibilities.

What remains for study here is again the role of nursing's professional society in assuring the civic professional practice of nursing. By utilizing the concepts provided by Fowler (1993), Benner, et.al. (1999), and Sullivan (2005), nursing's professional society can be more closely examined for its collective efforts, on behalf of the profession, in assuring its contribution to the betterment of society through its involvement in the practice of nursing, its ethical components, and its social consciousness.

Nursing as an occupation continued to struggle with traditional western societal definitions of professions as it attempted to garner such recognition for its work.

Providing evidence for such a definition has been the focus of many authors and researchers. Six concepts of professions that have been presented most consistently in the literature are knowledge, control of entry, service orientation, control of division of labor, autonomy, and most recently civic contribution. Given their consistency in the literature, their utilization as a conceptual framework to support the study of organized nursing in its attempts to assure the professional status of its work, including its challenges, was supported.

Organized nursing has a long history of justifying its professional status through the use of the empirical work of professions done by sociologists. Often, this work has provided only an enumeration of specified qualities to be considered as evidence supporting an occupations claim as a profession. The desire of occupation's for recognition as a profession lies in the social contract that such a designation implies. The implication is that society allows the occupation to control itself in return for the profession's contribution to the betterment of society.

It is this overarching conceptual agreement between society and a profession that must be incorporated into any examination of the professions. By weaving this notion into the concepts presented here, a more contemporary framework for exploring today's professions, and their institutions, was provided. Such a framework provided today's researchers of the profession, including nursing, an opportunity to explore the broader and more socially linked contribution of an occupation as a profession. Each of the six concepts presented here were significant in framing an examination of nursing's professional society in achieving and maintaining the professional status of nursing.

As the ANA worked as a professional society to put into place structures for sustaining the nursing profession in society the diversity among its ranks challenged the distribution of resources in maintaining such structures. There is within each of the concepts presented a plethora of differences within nursing. Of greatest significance to this study was the various working titles and positions held by registered nurses. Nurses are viewed by society, and within the profession, as clinicians (both generalists and specialists), as supervisors, managers and administrators, and as educators and researchers just to name a few. All of these titles can be found in a single healthcare organization and hospital. Although all positions are held by registered nurses, they are often viewed differently, again by both society and within the profession, because of differences in education, training, and organizational status. And yet all are registered nurses represented by the ANA, the professional society of nursing. The conceptual frameworks society has provided in designating professional status is applied by the ANA to all whom the society represents. However, depending on the unique position held by registered nurses, there are unique professional needs. It is this diversity of needs that the ANA has attempted to represent throughout its history in various organizational structures. And in meeting its original charter to address the economic and general needs of the profession, various methods with subsequent organizational structures have been attempted.

One such method was the support of registered nurses in their right to organize under state and national labor law. However, specific labor law has limited this right to nurses in very specific employment positions, and the most evident of these has been the hospital staff nurse. As the professional society ANA has always represented the

professional issues of the staff nurse, and as hospital employees the registered nurse has looked to the ANA to support their economic and general welfare concerns. In doing so, the ANA had become both a professional society and a labor organization. However, by organizing themselves under labor law, the registered nurse staff nurse has found themselves viewed by many as simply organizational employees and thus labor within an organization's production process. Such a perspective provides an opportunity to view nurses, and the work of the ANA, from a labor perspective.

Labor Process Theory

Labor Process Theory (LPT) supported the analysis of the ANA as it serves as both a professional society and a labor organization for registered nurses (RNs) in the U.S. Professional concepts support the work of the ANA as a professional society working to continuously upgrade and maintain professional standards of registered nursing practice. Simultaneously, the ANA maintains certification as a labor organization in an effort to organize and represent registered nurse employees in meeting their economic and general welfare concerns through the ANA labor arm, the United American Nurses (UAN), an affiliate of both the ANA and The American Federation of Labor and Congress of Industrial Organizations (AFL-CIO).

The UAN consists of affiliate memberships by state professional nursing societies or their collective bargaining program. Although the UAN's constitution limits registered nurse membership only to those represented by their state nursing bargaining units, the vast majority of their individual members are employed by hospitals as staff nurses, as hospitals continue as the largest employers of RNs in the U.S. (U.S. Department of Health and Human Services, 2005). Such employment dominance allows

consideration of nursing and RNs as a labor group, an analysis supported within the broader historical development of LPT.

Although LPT has traditionally focused on labor process in relation to production within an industrialized context that seeks surplus and profit maximization, the hospital industry has increasingly been pressured to control its costs in an effort to control overall increasing costs of delivering health care in the U.S. As a result, hospitals have increasingly adopted traditional business and economic practices. These practices have had a direct impact on the work of registered nurses and nursing, which makes up the largest portion of a hospitals operating budget. Thus LPT provides an opportunity to analyze hospital nursing as a labor process.

In addition, hospital staff nurses, since World War II, have continued to make up the largest sector of the U.S. registered nurse population (U.S. Department of Health and Human Services, 2005). Thus, as the professional society of RNs in the U.S., the ANA has worked to structure itself to best address the majority of its constituency through programmatic methods that supported both the professional aspects of the occupation and addressed the economic and general welfare issues of its largest individual constituent, the hospital staff nurse.

Overview of Labor Process Theory

Harry Braverman published his research examining the labor process of factory workers and office workers, entitled *Labor and Monopoly Capital: The Degradation of Work in the Twentieth Century*, in 1974. Building on Marxist perspectives of labor this work sparked an interest in the academic analysis of work and its processes, analyzing Braverman's work in an effort to uncover a theoretical framework to support the process

of labor in a capitalist society. Prior to Braverman such analysis was considered as a component of a broader theoretical perspective, that of the production process. But with Braverman's concentration on laborers and their work, LPT began to be scrutinized as a theoretical framework worthy of analysis: A primary conceptual framework for the study of workers within the production process.

The overarching notion of LPT was the deskilling of workers, controlled by capitalists, in an effort to maximize surplus: Surplus maximization of product through increasing the efficiency of worker, or labor, output. In doing so, the product is produced more cheaply and, assuming its consumer value remains unchanged, its surplus creates greater profits. Braverman (1974) proposed that such worker deskilling was a result of increasing technology, particularly the implementation of Fredrick Taylor's work on scientific management introduced in the early part of the twentieth century.

Scientific management explored the mechanistic operation of workers in a production process, detailing manual operations that could be altered to improve efficiency. Such scrutiny lead to the discovery that the process of labor within the production process had some very routinized components that, if exclusively concentrated on by workers, could increase the rate of production. Duplicating this notion throughout the production process would maximize the rate of production. It is this notion that Braverman (1974) viewed as the deskilling of workers.

By limiting a workers focus in production, Braverman saw the deskilling of the craft worker from continuously focusing on the end product as he moved along in the production of a single product to concentration on a singular element within that production (Braverman, 1974). This process created a division of labor and allowed for

the introduction of management and the hierarchical system of organization within capitalist organizations.

According to Braverman (1974) the deskilling of the worker within the production process provided a need for others to focus on the totality of the production process. Such a need was filled by individuals who would monitor the collective work of the laborer in an effort to assure compliance to their specified tasks throughout the production process. These managers, and their work, were introduced into the capitalist organization in an effort to coordinate the now delineated tasks of shop workers. Although their function was coordination, managers were to maintain perspectives and loyalty to the organization and desires for surplus production to maximize profits (Braverman).

Thus Braverman's (1974) LPT provided the beginning elements for further analysis of workers and work. Although simplistically provided here, the ideas of LPT are easily understood in the context of an industrialized process within a capitalistic perspective. Although a component of the production processes, LPT provides concepts for further analysis of labor as a process itself. With this notion, researchers of LPT have offered many insights and provided newer concepts in the development of LPT.

Evolution of Labor Process Theory

Analysis of Braverman's LPT has provided an opportunity to continue to explore the attributes of LPT as a viable theoretical framework for research. Perspectives of LPT and criticisms are provided from the literature and help to expand the use of LPT in contemporary research works.

Control of the Labor Process

In discussing LPT Littler (1990) built on the work of Braverman by focusing on the theoretical framework in a capitalist society, noting specifically the concept of control of laborer (employee) by capitalists (managers), and the need for labor skill to be specialized in order to capitalize on profits. Littler noted that such control was believed by Braverman to be a central contributor to the deskilling of the workforce in a capitalist effort to control the production of labor, including the laborer, in an effort to maximize profit. The control of labor process by management is in opposition to a more traditional control of the varied aspects of the labor process by individual craftsmen who controlled the labor process in the production of their craft.

Littler (1990) identified a weakness in Braverman's work in noting his inability to provide an explanation for the change in labor process control from the craftsman to the manager. This omission provided an opportunity that allows for further exploration of organized labor as a means to maintain control of the labor process.

Littler (1990) provided two viewpoints regarding the result of management control. One is Braverman's own perspective that management control resulted from structural aspects that placed accountability for profit on the manager, who in turn places pressures on workers and their labor process in an effort to control profits. Such structural pressures, according to Braverman, naturally created resistance from workers towards the efforts of managers as the control increasingly influenced the worker's economic and social interests.

Alternatively, Littler (1990) noted the addition of a social process existing between workers and managers. This process was speculated to be just as important as

economic pressures in production as they could influence workers motivation and creativity, improving the labor process, thus improving economic outcomes of production. However, workers also maintained an interest in maintaining economic pressures of production as a means of work legitimacy and perpetuation of their employment. Thus in actuality the notion of control in the labor process may be more symbiotic between employee (worker) and employer (manager).

Littler (1990) also noted that economic pressures and organizational hierarchical structures were only one part of the picture of the labor process and control. Both sociological and political aspects were integral to the labor process (Littler). These aspects had been viewed in terms of organizational norms that were established both formally and informally between workers and managers in meeting production pressures and control, as well as established methods of legitimization that necessitated a dialogue of negotiation between the two groups (Littler).

Perhaps where one might analyze the sociological and political aspects of the labor process is in the measurement of production efficiency. Littler (1990) wrote that efficiency can be explored both quantitatively and qualitatively, noting Gordon's 1976 conceptual definitions that focused on control over production processes from a class perspective. The quantitative being control of the measurable economic elements of efficiency and profit, and the qualitative being the control of other aspects of the labor process that produces compliance from workers and the costs of working class control through labor strikes and the like (Littler).

Littler (1990) attempted to continue the examination of the labor process as a theory and focused specifically the concept of control. In defining labor process, Littler

noted Marx's interpretation as a general category interested in, "the relationship between task performance, the objects of work and the tools or technology" (p. 77). Notably absent in this philosophical perspective is both a socioeconomic process and a subjective process

Littler (1990) provided a more recent conceptualization of the labor process. He provided three components to the process for analytical scrutiny: 1. Technical division of labor and job design; 2. Control of structure; and 3. The employment relationship. Within these three components existed the opportunities for the exploration of tasks and technology, control of task performance and human resources such as performance monitoring and evaluation, and accountability structures, and the internal and external influences contributing to established relationships among employers and employees. He also included socio-political norms and legislative procedures addressing hiring, training, promotions, dismissals, and the like (Littler).

Additional Concepts in LPT

Smith (1994) continued Littler's (1990) critique of LPT, offering additional concepts for further analysis. Smith focused on three areas pertaining to changes in the theory. The first change was a greater focus on the subjective experiences of workers, the second was the analytical work on the specific influences of gender on LPT, and the third was research that focused on the comparison of different managerial strategies in attempting to control workers at the point of production.

Smith (1994) noted that theorists' criticism of LPT often ignored the influence of workers' subjective experiences on the transformation of labor processes. As opposed to Braverman's (1974) simplified view of increasing class struggle with capitalist motives

to achieve maximum surplus in production resulting in the ever increasing deskilling of workers at the point of production, other theorists have focused on the motives and actions of workers to balance control in the labor process, including labor's participation in the process of meeting capitalist and organizational goals.

Smith (1994) stated that Braverman did not necessarily ignore gender in his work, but he neglected to analyze or even offer insights for analysis of the potential gender specific influences in LPT. More recent theorists of LPT have made attempts to recognize gender as a social implication that provided variability in behaviors and decision making within the control components and thus provided a gender specific perspective to the deskilling notion of Braverman's LPT (Smith).

In exploring the focus of managerial behavior in influencing LPT and the deskilling process, Smith(1994) noted the need for the theory to analyze such behaviors and their potential differing influences on the process. Such differing tactics of managerial control have examined the concepts of flexibility, employee participation, and self management as part of the concept of responsible autonomy (p. 413) and as methods of managerial control.

Other work noted by Smith (1994) focused on the increasing bureaucratization of organizations with differing positional levels controlling subordinates. Such organizational structures have been explored as a means of controlling employees with increasing higher levels of skill and consequential market power. Ideas of worker consent to participate in such bureaucracies has been noted as a method of shared control of the labor process among workers and managers with the compliance behavior

occurring in response to the hopes of organizational promotion and thus increased market power (Smith, 1994).

A final element of managerial control of workers noted by Smith (1994) entailed managerial methods to control worker personalities. Such methods included study of how workers think about their tasks, thus providing managers an opportunity to influence such thoughts as a means of controlling the tasks of production. Such notions came from studies that recognized the increasing difficulty of managers in controlling workers highly educated with specialized, unique skill, giving them a greater degree of labor market control over traditional line factory workers. What these studies have proven is that the trajectory of worker deskilling in capitalism is not universally shared as suggested by Braverman and have shed light on the variety of ways managers supervise and monitor workers (Smith, 1994).

Continuing a focus on the study of subjectivity as an area for further analysis in LPT, O'Doherty & Willmott (2001) defined subjectivity as, "space where work organization gets produced and reproduced in the everyday accomplishments of agency and social interaction" (p. 459). These researchers challenged the either/or analysis of LPT's need to focus on subjectivity or the economics of efficiency, suggesting the need to analyze work from both collectivism and individualism when addressing subjectivity (p. 462). In viewing power struggles, O'Doherty & Willmott "understand power relations to be co-implicated with existential concerns and identity, together with the economics of managing the employment relation" (p. 470).

O'Doherty & Willmott (2001) provided an encompassing perspective of the criticisms of LPT, noting the struggle within organizations between a focus on

historica/political and capitalist ideologies as driving the labor process, and the focus on the worker as agency and their subjective experiences and reactions as factors within the labor process. Thus within the labor process there is an interaction "of political, economic, psychological and existential processes" (p. 465).

Economic Perspectives

Other criticisms of LPT have suggested the need to incorporate a more economic perspective into the theory. Rowlinson & Hassard (1994) challenged the need for LPT to expound on the concept of the labor theory of value. Such a perspective focused analysis on an economic perspective that labor has value and is itself a service provided by workers who sell their service in the production process. Economic perspectives of cost and price are then brought into the analysis of labor as process. Without such a perspective, Rowlinson & Hassard believed analysis of LPT was reduced to a managerial perspective, thus confusing LPT with organizational theory. Rowlinson & Hassard wrote that if LPT were to focus more on the aspects of labor subordination as a result of capitalist property and ownership rights, the necessary economic influences would be apparent.

Rowlinson & Hassard's (2001) also suggested that since LPT was conceptualized within the capitalist economic perspective of achieving surplus production processes, then the theory must further explore the concepts of surplus value, labor value, and labor power and control. Incorporation of such concepts may allow for expansion in the use of LPT in research beyond capitalist perspective (Rowlins & Hassard, 2001).

Other Influences on Labor

Rowlinson & Hassard's (1994) perspective hinted at the concept of collectivism within the labor process. Such a concept is further explored as a necessary component of LPT by Lucio & Stewart (1997). Their work explored the concepts of individualism and collectivism and criticized writing of LPT in lacking these concepts. Collectivism within LPT is simply viewed as the collective influences and processes upon workers in efforts to create surplus value during production (Lucio & Stewart). They viewed this need as researchers of LPT increasingly focused on more subjective influences on workers that viewed responses from an individual perspective. Lucio & Stewart's perspective is critical if one is to research the influence of organized labor and professional societies in supporting labor process through collective efforts.

An example of research focused on the subjectivity of individual workers is provided by Ezzy (1997). By providing a research methodology for data collection of worker experiences, Ezzy provided insight into how individuals give meaning to work as a component of self, providing perspectives on work control and perceptions in defining work itself. Ezzy suggested the use of participant self-narrative as a means of analyzing and understanding worker experiences as a means to better understand labor process. By incorporating Ezzy's work in further exploration of LPT, one can begin to uncover the variety of influences contributing to the process of labor, from both an individualistic as well as a collective perspective if worker narratives were collected within a single industry. Thus Ezzy provided a qualitative research perspective to further analyze and develop LPT.

Looking broadly at the scholarly work on LPT, Wardell, Steiger, and Meiksins (1999) provided a collection of perspectives in the evolution of LPT. Wardell, et.al. (1999) categorized scholarly criticisms of Braverman's work into seven areas. First and secondly was the need to broaden the analysis of skill decline beyond that of craftsman and to question if skill levels have actually declined or have they simply changed over time. Thirdly was the perspective of work degradation in capitalism as occurring throughout history in a linear manner, thus limiting the possibility of changes in work, workers, managers, and their relationships over time that would, for example, allow for the building of skills among workers and thus a reconceptualization of the labor process presented by Braverman. Fourth was the stated focus of the labor process by Braverman solely on its structure and objectives, ignoring the more subjective aspects and their potential influence.

Braverman had also been criticized for overemphasizing the contribution of scientific management and Taylorism (Taylor, 1911) in forming contemporary labor processes, and simplified this contribution by focusing analysis at the immediate point of production, the factory floor, and missing the contributions of managerial strategies, markets, and political influences. The globalization of the labor process presented by Braverman as consistent in the workplace regardless of the industry, workers, or managers involved finalizes the seven categorical criticisms of Braverman's Labor Process Theory as noted by Wardell, et. al. (1999).

In reviewing the scholarly debates of LPT Jaros (2001) supported the ongoing analysis of the theory. Jaros specifically took a positive perspective to Braverman's view of LPT as having a historical and inevitable trajectory in deskilling workers, more often

negatively viewed by contemporary scholars of LPT. Here, Jaros suggested that such a trajectory allowed for the need for continual analysis of LPT rather than its abandonment. Jaros also encouraged the combination of LPT with other contemporary theories to further explore the subjectivity of workers to include an increasingly broader classification of workers including knowledge workers as well as the politics of labor and processes, and organizational theory.

These published works addressing LPT provided an overview of areas for further exploration and analysis in the development of labor process as theory. Most noted areas for exploration were the inclusion of worker subjectivity influenced both historically and politically. Additionally, the incorporation of economic perspectives provided greater context in the exploration of both worker and managerial outcomes within the labor process. And finally, a need to expand the focus of LPT beyond the factory shop floor to incorporate an ever-increasing classification of workers, including knowledge workers, as both individuals and as a collective, provided support for LPT as a grand theory in analyzing work and workers.

Nursing and Labor Process Theory

Using the critiques and analysis of LPT above suggests that whether nursing and nurses are viewed as labor, employed by hospitals, or as professionals to be considered as knowledge workers matters little if the desire is to understand their work experience. And if the exploration focuses on the work of nurses in hospitals, employed by the hospital in both the provision of nursing care as well as its management, then LPT provides a framework for uncovering their work processes both individually and collectively, for it is the shared individual experiences of registered nurses that has

provided the opportunity of collective organization and the establishment and evolution of the ANA as both a professional society and a labor organization.

Using LPT as a framework for analyzing hospital nursing care delivery models Brannon (1994) contrasted the elements of team and primary nursing models. She noted that team nursing was viewed as allowing RNs to perform professional duties while creating a division of labor for RNs to delegate tasks to lesser-licensed workers. Although some nurses felt this was a move away from professional nursing practice, because it further removed RNs from direct patient care, others viewed it as a way of allowing RNs time to focus on the planning and oversight of nursing care.

In contrast, primary nursing moved nurse staffing toward an all RN staff with the belief that there would be a need for less direct supervision of nursing staff and also improved productivity in patient's achieving a healthier status and minimizing stays in the hospital. However, in contrast to team nursing, primary nursing practice models left little delegation opportunities for RNs, requiring them to perform tasks perceived unnecessary, even beneath the work of a professional nurse.

Brannon (1994) concluded, through a socio-political, economic and historical perspective of hospital development and nursing work that professionalization and proletarianization in hospital nursing was complex. It demonstrated the struggle of nurses as both professional knowledge workers and laborers in a hierarchical, bureaucratic organization.

If one is to assume nursings' work as knowledge work, even when performed as employees of hospital systems, then measuring their productivity as a component of LPT becomes more sophisticated. Beyond Taylorism and scientific management, where time

studies and task efficiency were dominant, measuring the productivity of knowledge workers may seem incompatible. However, Moody (2004) provided a rationale and understanding for viewing productivity within the healthcare system, providing a perspective for measuring human and intellectual capital. For nursing, such measurement was being tested through the development of nurses' knowledge classification systems (Moody). These models may provide analytic evidence that allow a measure of worker subjectivity and rationalize its inclusion as part of LPT. However, such tools may also challenge the notion of deskilling as an inevitable component of LPT. This may perhaps simply suggest a need to evolve LPT from its deskilling origins, instead placing examination of concepts of control, management, and collectivism more heavily on the shoulder of an economic and political foundation.

Supporting the need to better incorporate economic theories with LPT, Robinson (2001) provided an analysis of hospital market and employment practices, particularly pertaining to nursing. Discovering that nurses decisions about their work setting depended more on their training, childrearing responsibilities and spousal work needs more than any other factor, Robinson contributed to the economic literature that viewed nursing in hospitals as a monopsony. With a specific number of hospitals in a designated geographic region the utilization of nursing is rather fixed. Thus traditional economic theories of supply and demand did not hold up when exploring nursing in hospitals (Robinson). This demonstrated an example of the importance of analyzing economic circumstances with LPT in order to fully understand the labor process, in this case, the labor process of nursing in hospitals.

Nursing as a labor force provides a rich opportunity to further explore the usefulness and effectiveness of LPT. As knowledge workers employed within hospital systems, the study of nursing and nurses allows for the expansion of LPT to incorporate an analysis of worker subjectivity with managerial influences and control within a historical, political, and economic perspective. Such an opportunity exists through an analysis of the ANA and its organizational structures in addressing both the professional needs of RNs as knowledge workers and their collective economic and general welfare needs as hospital labor workers.

The theory of labor process's focus on the deskilling of workers can be utilized as a perspective in viewing the profession of nursing and its practice. Just as the production process moved from control by individual craftsman to factories during the industrial revolution, the provision of healthcare moved from private residences to hospital structures. With this movement, so too moved the provision of nursing care.

In factories, craftsman highly skilled in the totality of product development were no longer efficient. Product development became much more efficient and cost effective with the development of the assembly line, and the assembly line required workers specialized in a small piece of the production process. Within the healthcare industry, as specialization increased, and physicians and hospitals collaborated in the process of healthcare production, nurses were highly sought to work for the hospitals. As hospital systems became more complex, a greater number of highly specialized healthcare workers were needed to focus their skills. Nursing practice in hospitals evolved to incorporate the concepts of labor efficiency in factories, and nursing practice began to be viewed as a series of tasks that could be controlled and managed to efficiency.

With the introduction of managed care and the need to control expenditures (and in some cases the desire to make profits), the desire to control the process of healthcare production increased. As nursing made up a large portion of hospital budgets, nurses and their departments were targeted as a means to control costs, their practice diminished to a series of tasks controlled by others.

Although nurses moved into hospital leadership positions, their ability to serve both the professional practice of nurses and the capital interests of hospitals became strained. As employees, their income depended on the hospital, and their loyalties seemed to drift away from the practicing nurse, leaving the nurse at the patient's bedside unrepresented in matters of their work.

As factory workers began to empower themselves through organized labor established through federal and state legislation, so too did hospital staff nurses find the need to organize collectively to have their needs addressed. However, as noted in the literature, for nurses to organize under the laws of collective bargaining unique issues of labor in hospital organizations needed to be addressed. Additionally, since nurses served in a variety of positions throughout the hospital organizations, some supervisory, there was a need to specify whom among nursing's ranks in hospitals were eligible for representation through collective bargaining. Since the mid 1940's, hospital staff nurses have been recognized as eligible for such organization.

Such a late entry into the labor movement represents the unique issues concerning the work of nurses in hospitals as opposed to the laborer in factories. Within hospital organizations, the production process engages the provision of health care to people, whereas in factories the production process usually pertains to the development of non-

living materials consumed by people. The complex difference between the two processes is obvious.

LPT attempts to move the focus from the production process to the labor process. Although some have argued that labor process is merely a component of the production process, the introduction of the knowledge worker in today's industrial society seems to support the concept of labor as a process worthy of specialized study independent of the production process. And with the introduction of the concept of knowledge workers, viewed as professionals with specialized control of their work, as employees their labor becomes a commodity and valued as process contributing to but independent of the production process. It is this perspective that LPT helps to view registered nurses practicing their craft as staff nurses employed by complex healthcare organizations, particularly hospitals.

Organizational Change as Process

The study of organizations as a field of inquiry is relatively new, beginning in the mid-twentieth century with studies examining organizational elements as single organizational units to organizations themselves as fields of analysis, with the unifying belief among scholars that organizations are "social structures created by individuals to support the collaborative pursuit of specified goals" (Scott, 1998, p. 10). Such studies have created the need to provide theoretical structures to support the empirical examination of organizations in an attempt to legitimize the field. These frameworks provided the basis for further empirical examinations of organizations in an attempt to study their structures, forms, functions, and activities to learn more about the significant

components of effective organizations (Scott). One component or area of interest in the examination of organizations is the involvement of change in organizational development.

The study of organizations undergoing change has utilized organizational theory to help understand what makes an organization successful in managing change so as to continue survival and growth, while other organizations appear unable to adapt. According to Pettigrew (1985) what was lacking in empirical studies of organizational change was a more holistic view of the complexity of organizational experiences with change. He suggested that traditional studies of organizational change had focused on change as an event, responded to by the organization and its leaders with singular and bounded action. Such examination had tended to focus on a specific change event and leadership response rather than on the "dynamics of changing" (p. 274). Thus he suggested the need to move from viewing organizational change, or strategic change, from linear and strictly rationale with distinct beginning and end points, focused on the top organizational manager or leader, toward a view of change as strategy involving a variety of individuals and groups, involving more than simply reactionary behavior that is specified, rational, and strictly choice-driven from a pre-conceived plan (Pettigrew, 1985).

The literature on strategic change as a methodological framework used in the study of organizational responses to change is complex. Focusing on Andrew Pettigrew's theoretical perspectives in viewing organizational change holistically provided an understanding of such a view and its use in empirical examinations of organizations. It also offered a methodological means for analysis of change within the ANA, providing the means for guiding an in-depth study of the influence of organizational change on its operational structures.

Van de Ven and Poole (1995) supported the analytical need to view organizational change as a process through their provision of a single typology to represent what they determined as four types of process theories. The authors used a conceptual framework (or motors) for understanding the theories and their application to the study of organizational change. They defined process as "the progression (i.e. the order and sequence) of events in an organizational entity's existence over time" (p. 512), and change as,

> one type of event, …an empirical observation of difference in form, quality, or state over time in an organizational entity…where entity may be an individual's job, a work group, an organizational strategy, a program, a product, or the overall organization. Development is a change process (i.e., a progression of change events that unfold during the duration of an entity's existence – from the initiation or onset of the entity to its end or termination). We refer to process theory as an explanation of how and why an organizational entity changes and develops (p. 512).

Van de Ven and Poole's (1995) four theoretical types of organizational change represented the ideal-type, to provoke further empirical work in the change process. The four types identified were life-cycle, teleological, dialectical, and evolutionary.

Life-cycle theories explained organizational development as an "entity from its initiation to its termination" (Van de Ven and Poole, p. 513), noting the focus can be on the organization, products, ventures, as well as developmental stages of individual careers, groups, and organizations as they begin (birth), grow (adolescents), mature and decline to eventual death. Change was considered imminent, prefigured as an organization or entity progresses through its life cycle, following a pre-determined sequence of order (Van de Ven & Poole).

Teleological theories focused on the establishment of purpose or goal as the end state to be reached by an entity, thus providing the framework for development, and the rationale for adaptive change and its evaluation. Sequences of events were not pre-described, but rather creativity in adaptability enabled progress to a selected goal, constrained only by environmental determinants and recourses. Achievement of goals did not necessitate death, but rather the establishment of new goals influenced by previously learned activities and existing constraints (Van de Ven & Poole, 1995).

Dialectical theories were categorized based on the belief that there existed an internal and/or external conflict created among two or more distinct entities. Such conflict created a power struggle among the entities with change occurring as the entities jockied for power dominance and control, suppressing the mobilization of opposing group(s) (Van de Ven & Poole, 1995).

Finally, evolutionary theories addressed the "cumulative changes in structural forms of populations of organizational entities across communities, industries, or society at large" (Van de Ven & Poole, 1995,p. 517-518). Change resulted from variation, selection, and retention through selective determinations influenced by competition for scarce resources, thus providing for the survival of certain entities and the extinction of others (Van de Ven & Poole).

A review of the literature by Dumphy (1996) suggested that the study of organizational theory was in its early developmental stage since the field lacked any broadly accepted or all encompassing theory of change. The existing theories, as viewed by Dumphy were influenced by ideology, and thus were value-driven. Such a view, he continued, was not meant to be a negative criticism, but rather a recognition that "all

theories, and particularly social theories, the truth is always partial and even theories of the natural world are strongly influenced by social ideology" (p. 542). Therefore, Dumphy emphasized the need for researchers to be explicit in their views in order to contribute to the field of organizational change by challenging its value base.

It is here that Dumphy (1996) identified five elements necessary for identifying theories of organizational change. These elements were: (1) an organizational metaphor that helps define the nature of the organization; (2) an analytical framework with specific process linked variables for understanding the change process; (3) an ideal-type organizational model including values used for evaluation of success; (4) an intervention theory to support actions to move the organization toward the ideal; and (5) a defined change agent. Through these elements, Dumphy believed that a theory of organizational change could be evaluated to be either a full-fledged theory or simply a component of a greater theory. Of significant note here was that Dumphy provided two examples for utilization of the five elements. A weakness in Dumphy's theory of change is the lack of focus on environmental and external and internal forces for change.

In comparing the two examples he noted the use of a systems analogy, with one at the organizational level and the other at the industry/societal level (Dumphy, 1996, p. 544). His examples appeared to allow the researcher some flexibility in determining the unit of analysis for examining organizational change and its contributing factors, thus allowing the researcher to incorporate ideologies in directing their examination. A potential variance in understanding this would be to view such ideologies as assumptions, identified at the onset of an analytical study, providing what is then understood as direction and guidance in analysis.

Thus what Dumphy (1996) suggested was that with clear identification and articulation of the value placement in a theory, i.e. successful organizational change is lead by a designated, single leader, its use in examining organizational change can then be measured empirically, noting the interplay of variables in an analytical framework and their implementation to evaluate the effectiveness of a given organizational change. However theoretical use in the empirical study of organization change must allow for variability in order to include the diversity of influences on organizational change.

These works supported the need to view organizational change as a complex process of interaction among environmental, operational, and social aspects both within and external to organizations. Such a view included the interactions among actors at various levels and the elements that influence their actions. Methodological examination needed to include an organizational description with linked variables including value laden beliefs and change agents and their role in action implementation

The significance and role of studying organizational strategic change from a process and contextualist perspective appears evident in the literature. Such a perspective provided for a study of organizations experiencing change, allowing for the inclusion of a multitude of influential variables to be examined at a variety of levels of analysis. The impact, function, and interplay of organizational actors, their actions and beliefs, their ways of operating, and the internal organizational and external social, economic, cultural, and political influences on organizational change were all supported by the theoretical concept of viewing organizational strategic change as a process. The significant analytical perspective was the process of changing as opposed to the bounded elements of a change event.

Utilizing this perspective for the examination of organizational change provided an opportunity to study the organizational structural change of the American Nurses Association (ANA) in the first decade of the 21st century. Specifically, the changes that created affiliated organizational status and independent structures of the United American Nurses (UAN) and the Center for American Nurses. What was of interest was the processes involved in creating the new structure and organizations, including the elements involved in decision making by organizational leaders, the influences of current and historical events (both internal and external to the organizations), and the philosophical underpinnings initiating and sustaining the change process. Since the UAN and the Center for American Nurses were specific organizations directly involved with the ANA in its organizational structural change, and since these organizations addressed the economic and general welfare issues of the membership in all three organizations (through professional control, organized labor, and workplace advocacy methods), the boundary of a case study centered on the professional and labor issues of nursing, and how, as a professional society for nursing, the ANA changed to meet the needs of its members.

Conclusion

Any study of the ANA as an organization requires a perspective that allows it to be viewed as both a professional society and as a labor organization of RNs. As a professional society the organization has established and maintained nursings' professional standards. Part of those standards has been the economic and general welfare needs of those who make up the profession. In meeting such needs, the ANA has evolved as a labor organization, providing organizational structures that have allowed

state nursing associations, members of the ANA, to become certified as labor bargaining units organizing and representing individual RNs for the purposes of collective bargaining and labor contract negotiations.

The literature on professions is rich with a variety of theoretical frameworks provided by a variety of schools of thought. An attempt was made to analyze this literature for reoccurring themes in order to provide a comprehensive perspective of the critical analysis of professions. In doing so, six reoccurring themes were identified, most frequently addressed throughout this literature. The themes of specialization in professional knowledge, control of entry into practice, control of the division of labor, autonomy of professional practice, provision of a service orientation, and the practice of civic professionalism were identified. These themes provided a perspective in viewing both the profession of nursing and consequently the work of the ANA as its representative professional society.

Since the ANA had served as both a professional society and a labor organization, a perspective of nursing as labor was necessary. Because nurses, as members of a profession can be recognized as knowledge workers employed by healthcare organizations and hospitals, a theoretical perspective that allowed for RNs and their work to be uniquely analyzed within that context was necessary. Since Labor Process Theory (LPT) was presented as an attempt to view labor process separate from the process of production, it allowed the researcher to view the laborer as independent from the end product of their work. Thus LPT provided an opportunity to view nursing as an employed worker with unique aspects. Such uniqueness encompassed the nurse as a knowledge worker with specialized education in the provision of healthcare to

individuals within hospital organizations. Although nurses are a part of the production of healthcare services of the hospital (production process), their unique characteristics as professionals warrants their labor to be viewed as a process separate from that of the organization.

And finally, to focus an analysis of an organization on its changes required an understanding of how one might view organizational change. Here the goal was to explore change not as bounded by specified markers, but rather to understand it as a process over a period of time greatly influenced by a variety of internal and external pressures including the interplay of human participants.

Together the theoretical perspective of professions and of labor process provided an analysis of the ANA as both a professional society and a labor organization. And viewing organizational change as a process over time provided an opportunity to analyze the ANA and its changes holistically. All three views allowed a more comprehensive analysis of the ANA's organizational structural changes as it attempted to address the needs of the nursing profession and its members. And to fully analyze these changes they must be viewed holistically over a period of time to capture the full spectrum of the change, the matters influencing the change, and the results of the change.

CHAPTER FOUR – METHODS

This study described and analyzed the ANA organizational changes that occurred during the period of 1999-2004, using an in-depth case study methodology. Prior to this period, the ANA struggled to elevate the occupational status of nursing to that of a profession, at the same time it engaged in union activities that had traditionally been utilized by occupations considered non-professional. During the years 1999-2004, the ANA restructured from a single organization at the state and national levels into three separate but ANA affiliated organizations with differing goals and activities.

According to Stake (1995) case studies take on one of three characteristics, depending on the questions asked. With intrinsic case studies the interest is in a particular case, an interest to learn more about that specific case without the curiosity of a larger role. In contrast, with instrumental case studies the interest moves beyond the case studied, and the desire is to study a case to illuminate a particular element of a greater question. If the researcher studies numerous instrumental cases to better understand a broader interest, the research then becomes a collective case study. Stake (1995) noted the difference here as significant only in guiding the research methods employed (Stake 1995). Thus in order to determine the kind of case study to be utilized, this research needed to start with the question to be answered.

According to Stake (1995), the qualitative case study is meant to assist in finding greater understanding of the chosen case by studying its uniqueness and complexity within its contexts. The role of the question or questions is to "sharpen the focus, minimizing the interest in the situation and circumstance" (p. 16), thus helping to organize the study. This study utilized the process for developing the research question

presented by Stake, that of first asking what are the issues imbedded in the case to be studied, and forming a list of two or three issues used to guide observations, interviews, and documentation of data. In establishing the initial issues of interest, it was important to remember that in qualitative research these issues are only a starting point, for they may change and even become obsolete as the research progresses (Stake).

Stake (1995) suggested beginning the statement of the research question by first establishing a conceptual structure question. Offering that issues are connected to social, political, historical, and personal contexts, Stake stated,

> Issues draw us toward observing, even teasing out, the problems of the case, the conflictual outpourings, the complex backgrounds of human concern. Issues help us expand upon the moment, help us see the instance in a more historical light, help us recognize the pervasive problems in human interaction (p. 17).

For this study, a conceptual structure was gleaned from the following question: *What elements within the profession of nursing have contributed to the conflict among nurses over the use of traditional labor methods of collective bargaining in addressing the working conditions and economic and general welfare concerns of nurses?* The existence of the conflict mentioned and some of its contributing factors are noted in the nursing literature.

Stake (1995) suggested the development of issues questions to further hone the research question. For this research such issues included:

1. What are the potential and actual conflicts a professional society experiences in serving as both a bargaining unit and as a professional society?
2. In what ways, if any, does an organization's designation as a trade union impede or interfere with its work as a professional society?

3. What, if any, issues at the bargaining table become unique to professional practice when the professional society serves as the certified bargaining unit?
4. Is it appropriate for a professional society to also serve as a labor organization?

By asking these questions it became apparent that their answers may be found in a professional society that also is a labor organization. Given that it is already known that conflict existed within nursing and the ANA over the correct answers to the questions asked above, the following information questions (Stake 1995) served as beginning points in organizing data collection:

1. What is at the core of the conflict?
2. How has the conflict played out within the ANA?
3. How has the ANA responded to the conflict?
4. What elements does the ANA use to evaluate their success in addressing the conflict?

This set of questions helped to guide the case study research and are termed by Stake (1995) as topical information questions. These questions helped to guide the information needed for case description. With these questions it became apparent that the ANA served as a case study in exploring the issues and questions, and thus would utilize the research methodology of instrumental case studies.

The overarching aim of this research was to better understand the issues that have contributed to nursing's struggle with elevating the occupational status of nursing to that of a profession while engaging in union activities that have traditionally been utilized by occupations considered non-professional. The ANA, as a professional society of nursing that is also a labor organization, served as an outstanding example of an organization that has had to respond to this struggle, and thus became a source for data collection in the

conduction of research to answer the questions presented. Since this study will explore a broader issue of professional status and labor issues, it fits with Stake's (1995) definition of instrumental case study research.

This study explored the organizational change process and the structure of the ANA, using a qualitative perspective to examine the complex social and humanistic situational contexts as suggested by Lincoln, Y.S. & Guba, E.O. (2000). As noted in Chapter One, this study had two research aims.

Research Aim 1: **To examine the changes in ANA's organizational goals, structure, and activities between 1999-2004, and the reasons for the changes.**

This aim was focused on documenting the specific changes in the ANA organization, the activities involved, and the issues that such changes addressed, as well as to understand the external influences contributing to the changes within the ANA. This aim also examined the impetus for change to specific organizational changes in goals, structure, and activities, as well as external influences, thus providing data for evaluation of organizational performance.

Research Aim 2: **To examine the agreements, conflicts, ideas, and values held by ANA leaders regarding the goals and objectives of the ANA in the period 1999-2004.**

This aim was designed to uncover internal organizational agreements and conflicts that influenced the organization's change process. These agreements and conflicts focused on how to represent the professional interests of nursing while supporting collective bargaining and workplace advocacy.

For this study, a case study methodology was utilized, allowing for the use of different sources of evidence (Yin, 2003). This method was utilized to collect and

analyze a variety of data to describe and explore both the changes and the context for the organizational actions over a specified time period (Kitchener, 1994). This study collected data from two sources.

First, semi-structured interviews were conducted of organizational leaders within the ANA, UAN, and the Center for American Nurses who served as members of the board of directors of one of these organizations at any time from 1999-2004. Second, the study collected data from the ANA public records and documents from 1999 to 2004.

Interviews

Because this study, as with most case studies, was about human affairs (Yin, 2003), the utilization of interview methods was important. The thirty-four individuals who met the criteria of serving as an organizational executive director or member of the board of directors of ANA, UAN, and the Center for American Nurses from 1999-2004 were selected for interviews, and interviews were requested. This specific population was chosen as it was assumed that they participated directly in the decision making process regarding changes in the ANA during the specified period of time. Requests for interviews were sent by email when available, through personal contact during an annual meeting of the ANA House of Delegates, and through telephone over a six-month period. Fourteen individuals responded and agreed to be interviewed. All contact with potential participants included written information explaining the study, and included a statement that consent to be interviewed would be obtained from the interview participant verbally prior to beginning interviews.

Semi-structured interviews were conducted on the organizational leaders that agreed to participate. These interviews included participation from the ANA leadership

(6), UAN leadership (4), and the Center for American Nurses leadership (4). An interview guide of semi-structured questions was used to collect the data (See Appendix A). Semi-structured interviews were utilized as some information pertaining to organizational changes was understood as fact, and semi-structured interviews offered corroboration of these facts (Yin, 2003). The interviews also provided content data regarding perspectives on organizational relationships not captured in organizational documents.

Table 1. ANA Organizational Case Study Participant Interview Groups

Study Participant Groups	ANA Leadership 1999-2004	UAN Leadership 1999-2004	Center for American Nurses Leadership 1999-2004	Total of Study Participants
Number of Participants Solicited	18	8	8	Total Solicited: 34
Telephone Interviews	6	4	4	Total: 14

Public Records and Documents

Public records and public documents from the ANA archives were collected from within the ANA headquarters in Silver Spring, Maryland. They included organizational records (i.e. budgets), memos, meeting minutes, and other documents found as part of the public record of meetings of the Board of Directors of the ANA from 1999-2004.

Documentary evidence resulted from the examination of the following:

- Letters, memoranda, and other communiqués
- Agendas, announcements and minutes of meetings, and other written reports of events of board of directors and annual association meetings
- Administrative documents – proposals, progress reports, and other internal records

- Formal studies or evaluations of the ANA organizational structures
- Newspaper clippings and other articles appearing in the mass media or in community newsletters

This data further provided context in the organizational change process. As recommended by Yin (2003), document data collection was collected to "corroborate and augment evidence from other sources" (p. 87).

Access Negotiation

For entry into the ANA for the purposes of document research, permission was requested of the ANA Executive Director, the ANA President, and the ANA organizational Librarian. Permission was granted after endorsement of the researcher was provided to the ANA attorney by a former ANA president. Solicitation of interviews of organizational leaders encompassed a request by email to participate to ANA, UAN, and the Center for American Nurses board of director's officers and members, and executive directors. One follow-up email to those who did not respond and attempts at telephone contact was utilized to assure equal participation from all three organizations. Verbal consent for participation was obtained before any interviews were conducted.

Data Analysis

ANA public document data was examined at the ANA headquarters in Silver Spring, MD. Access was granted to the researcher to only public documents, and covered the time frame from 1999-2004. Documents were reviewed chronologically. Document data relating specifically to the research aims was photocopied at ANA and later converted to an electronic PDF format. Documents were then further analyzed by the researcher extracting information specific to the research aims and ANA's

organizational restructuring process. The data were organized noting the chronological categorical themes as follows:

- 1999: Conflict Between State Nursing Associations
- 2000: ANA Structural Groups Compete for Power
- 2001: Significant Changes in Organized Nursing
- 2002: Organization and Bylaw Changes
- 2003: Implementing Organizational Changes
- 2004: Looking to the Future

Data from interview transcripts were then analyzed and themes were identified within each set of interviews; the ANA, the UAN, and the Center for American Nurses (See the Appendix B). The identified thematic topics were then matched with the corresponding categorical themes from the documents noted above. To fully illustrate the process of change over time, and focused by the research aims, all interview themes and their corresponding transcripts were incorporated into the chronological arrangement of the document data. Thus with each categorical theme from the archived records interview themes from all three organizational interviews were incorporated, providing a distinction between the perspectives leaders of the ANA, the UAN, and the Center for American Nurses. Agreements and conflicts among these three groups of participants could then be analyzed and made explicit. This provided both documentation of the actual changes occurring within the ANA as well as the corresponding conflicts, ideas and values of the organizational leadership surrounding these changes. Thus a holistic analysis of the change process within the ANA was achieved.

Research Aim 1: **To examine the changes in ANA's organizational goals, structure, and activities between 1999-2004, and the reasons for the changes.** For Aim 1, both interview data and documents were conducted and collected.

The ANA public records were analyzed for documentation pertaining specifically to organizational changes and any communiqués that would indicate contributing variables in the change process. Only those items noting organizational goals, structure, and contributing activities were lifted from the documents for further analysis.

From these documents the historical evolution of the change process was established and documented chronologically by month and year (See the Appendix C). Further analysis of this research aim was provided from the interview data. A semi-structured interview guide was utilized in conducting the interviews.

The goal of this research aim was to examine the specific changes in the organization, the activities involved, and the issues that such changes addressed. This provided data for linking the impetus for change to specific organizational changes in goals, structure, and activities.

Again, strategic planning documents and records of the ANA Board of Directors provided organizational goals. Proposals for organizational restructuring, as well as proposals put forth to the ANA House of Delegates, including by-law changes, provided support for the change process in organizational structures. These documents directed the researcher to specific internal organizational documents of specific activities implemented to effect organizational changes in goals and structures.

Interview questions were asked to further explore the reasons driving changes in ANA organizational goals, structures, and activities. These questions provided data for

exploring the context of change and leader beliefs, meanings, and thoughts reflected in the process of these changes. Specific questions included:

- Describe the changes in ANA's organizational activities and structure between 1999 and 2004.
- What are ANA's organizational values? What is important to the organization?
- What was the reason for creating a membership category for organizational affiliates?
- How would you evaluate the ANA's performance and effectiveness over the past five years?

An additional goal of this research aim was to understand reasons for the changes within the ANA. This provided a broader perspective of understanding of events outside of the ANA that influenced its leadership to implement organizational changes.

Documents and records of organizational proposals for structural changes were analyzed to find rationale for the organizational changes. These records were examined for influences outside of the ANA that contributed to organizational change. Subsequent examination of newspaper clippings and other articles in the mass media and community newsletter found within the ANA documents supported a greater understanding of these external influences. Other pressures influencing organizational change were explored through documentation of membership trends and financial reports, both administrative as well as formal reports as part of the ANA House of Delegates.

Interview questions provided further data regarding leader perceptions of external and other pressures driving the organizational change. Interview questions guiding this exploration included:

- What have been the major influences outside of the organization that have contributed to this change?
- What was the reason for creating a membership category for organizational affiliates?
- What was the reason for establishing an ANA affiliate organizational membership with the United American Nurses (UAN)?
- What was the reason for establishing an ANA affiliate organizational membership for the Center with American Nurses?

Research Aim 2: **To examine the agreements, conflicts, ideas, and values held by ANA leaders regarding the goals and objectives of the ANA in the period 1999-2004**. For Aim 2, both interview data and documents were conducted and collected.

The goal of this research aim was to uncover internal organizational agreements and conflicts that influenced the ANA's change process. This data provided an understanding of these influences to support evaluation of organizational changes.

Public documents and records that explored this research aim included organizational mission, vision, and values statements and organizational activities to support these. Documents of the ANA strategic plans, including goals and activities and subsequent evaluation were explored for potential internal agreements and conflicts, and directed the data collection to records and documents of specific organizational structural

units. Subsequent minutes of meetings that included discussion of conflict topics and consequential activities to reach agreements were noted.

To analyze the agreements, conflicts, ideas, and values held among the ANA leadership documents and records were examined including ANA internal memoranda, letters and communiqués, along with internal meeting agendas and meeting minutes. These documents provided insight into the ANA's dominating thoughts, central objectives, and sources of motives for initiating the change process between the years 1999 and 2004. To explore the methods of implementing change, ANA administrative documents, such as proposals and progress reports, were reviewed. This review focused on the ideas, values, and goals of organizational leaders in the decision making process of organizational restructuring. Agendas, minutes, and correspondence from annual meetings of the ANA House of Delegates provided insight into the ideas and values of ANA's leadership, and organizational goals.

Further analysis of this research aim was provided from the interview data. A semi-structured interview guide was utilized in conducting the interviews.

The interview questions further supported the data on organizational goals and objectives, and assisted in illuminating organizational agreements and conflicts. The questions utilized in collecting this data included:

- What are the overarching goals and objectives of the ANA?
- To what extent have the ANA goals and objectives changed over the past five years?
- What are the agreements and conflicts that have helped solidify these goals and objectives?

- What are ANA's organizational values? What is important to the organization?

Other interview questions supported this research aim and provided insight into leader ideas and values and helped to connect them to the organizational goals and structural changes. The questions utilized in collecting this data included:

- What was the reason for creating a membership category for organizational affiliates?
- What was the reason for establishing an ANA affiliate organizational membership with the United American Nurses (UAN)?
- What was the reason for establishing an ANA affiliate organizational membership for the Center with American Nurses?
- If ANA is to continue as the professional society for nursing in the United States, what priorities does the organization need to have?
- How would you evaluate the ANA's performance and effectiveness over the past five years?
- How do you expect the ANA to perform in the next five years?

Data collection from documents and records further clarified and assisted in refinement of questions during participant interviews in order to help validate data. Interviews were examined for overarching themes and categories using an open coding methodology described by Strauss and Corbin (1998). The researcher documented interviews from notes taken during the interview. The researcher immediately following each interview typed the notes from the interviews, and this document was then shared electronically with the interviewee for validation of its content. Interviewees were

permitted to make any changes to the document utilizing Microsoft Word track changes. Suggested interviewee changes were incorporated into the interview document by the researcher.

To analyze the change process, the interviews were analyzed noting themes and categories and compared with specific events from records and documents, noting movement, sequence and change and its evolution in response to changes in the organization (Strauss and Corbin, 1998). For example, document data noting the initial discussions pertaining to organizational restructuring were analyzed through content comparison with interview data in an attempt to illuminate the process of change implementation through leader ideas and organizational activities and goals. Such analysis entailed the exploration of themes and actions through the designated time period of 1999 to 2004. Since the organizational structural changes of the ANA during the time of study had likely been influenced by the disaffiliation of state constituent members, an exploration of the response of the ANA to such occurrences provided data for the exploration of the organizational change process.

Utilizing case study methodology for the examination of organizational change provided an opportunity to study the organizational structural change of the ANA in the first decade of the 21st century. Specifically, the changes that created affiliated organizational status and independent structures of the United American Nurses (UAN) and the Center for American Nurses. What was of interest was the processes involved in creating the new structure and organizations, including the elements involved in decision making by organizational leaders, influences of current and historical events (both internal and external to the organizations), and the philosophical underpinnings initiating

and sustaining the change process. Since the UAN and the Center for American Nurses were specific organizations directly involved with the ANA in its organizational structural change, and since these organizations addressed the economic and general welfare issues of the membership in all three organizations (through professional control, organized labor, and workplace advocacy methods), the boundary of a case study centered on the professional and labor issues of nursing, and how, as a professional society for nursing, the ANA changed to meet the needs of its members.

Summary of Methods

Data were collected from both semi-structured interviews of organizational leaders of the ANA, UAN, and the Center for American nurses to help clarify documented organizational change processes found in ANA document data. Access to document data was limited to public documents, and included minutes of meetings of the ANA board of directors and documents archived as part of those meetings. Interview and document data provided a holistic view of the process of organizational change within the ANA from 1999-2004.

CHAPTER FIVE – FINDINGS

The overall aim of this work was to study the process of organizational change in the ANA from 1999-2004. The findings are presented in a chronology from 1999 to 2004 in order to demonstrate the evolution of the change process of the ANA. The events of the specified year are noted in the narrative and contain data from ANA's public record archives of the years under study. Excerpts from the semi-structured interviews are placed in context with events noted from the archived records. Interview responses appear as quotations and are excerpted from interview transcripts written by the researcher and reviewed by the interviewee for validation.

Two research aims guided the collection and presentation of data.

Aim 1:

Examine the changes in ANA's organizational goals, structure, and activities between 1999-2004, and the reasons for the changes.

Aim 2:

Examine agreements, conflicts, ideas, and values held by the ANA's leaders regarding the goals and objectives of the ANA in the period 1999-2004.

Introduction

What follows is a chronology of events extrapolated from ANA documents with integration of data obtained from semi-structured interviews of members of the Board of Directors of the ANA and the Center for American Nurses, as well as members of the Executive Council of the United American Nurses (UAN) holding position during the years 1999-2004. The organizational change process experienced by the ANA and its leadership is described as they worked to meet the needs of the diversity of their organizational membership. Spearheaded by ANA's members, the state nursing

associations, ANA's restructuring was focused on nursing labor issues, with ANA member organizations looking to ANA to provide resources to support the individual state member associations. This created tension among the membership as non-union member state associations perceived an imbalance of resources while the more established union state nursing associations viewed themselves as revenue generating through increased organization of new labor contracts that automatically increased individual nurse membership, positively contributing through increased dues income.

As the threat of losing membership, and revenue, became increasingly a reality, the ANA leadership was pushed by its organizational membership to make a change in the way the organization conducted its business. Strengthening the labor structure of the organization, the ANA leadership granted greater autonomy from the ANA to its labor arm, supporting their affiliation with a national labor organization and simultaneously maintaining an organizational relationship with the ANA that ensured sharing of financial resources.

Desiring an increased voice in organizational decision making, the non-union member nursing associations formalized their own organizational structure. Wanting to demonstrate neutrality in perspective regarding methods for addressing nursing's labor issues, the ANA leadership created an organizational structure that established an equal organizational process in resource allocation between ANA, its union and its non-union structure, referred to as workplace advocacy. Although the organizational change was specific to creating organizational structures to address member labor issues, this structural change established opportunities for organizational growth of the ANA by providing a means for additional organizational relationships with the ANA.

ANA's organizational structural changes were part of a broad process. Creating change within the organization required understanding of the operational processes necessary for such change. As a tax-exempt membership society, the ANA was governed by its members through a representative organizational structure and an elected representative board of directors. Such a model was often referred to as a federated model. Membership in the ANA was held by the nursing associations, and any change process was strictly guided by the organization's membership approved bylaws. The process for changing bylaws is deliberately and specifically established within the bylaws. Thus, creating an organizational structural change in the ANA required an approval by the membership, a change in the organizational bylaws, and policies for implementation of the change. All of this required consensus building around a topic laden with emotion and personal beliefs. As evidenced by the ANA documents and nursing leader interviews, change in ANA's organizational structure occurred over several years. The implementation of changes during the change process occurred between the years 1999 to early 2004.

1999: Conflict between State Nursing Associations

Beginning in the early months of 1999, conflicts were reported to occur between some state nurses associations who provided collective bargaining services and some state nurses associations who dealt with workplace issues by means other than collective bargaining. At stake for both the state nurses associations and the ANA was membership growth and revenue generation.

Whether solicited by individual nurses or initiated by the state nurses association's economic and general welfare program (E&GW) which engaged in union

organization, there was organizing activity occurring across state lines (ANA minutes, February 1999). For example, according to an ANA Board interviewee, the states involved at this time were Wisconsin, Minnesota, New York, and New Jersey. The apparent conflict was that the state nurses associations of the non-union states, Wisconsin and New Jersey, were not consulted or communicated with prior to such organizing activity within these states by Minnesota (organizing in Wisconsin) and New York (organizing in New Jersey). The national nursing labor group of the ANA, the State Nurses Association Labor Coalition, consisting of state nursing associations who were certified bargaining units, were asked by ANA to commit to refraining from organizing nursing labor contracts outside of their respective state geographies (ANA minutes, February 1999). One obvious concern of this activity was the probable loss of state membership dues that the non-union state nursing organization would experience as those members organized by union state nursing associations would become members of the labor nursing organization of a state nursing association different from their own geographic state nurses association. Dual state nursing association membership by these nurses would be unlikely as that would require dual payment of dues.

This event demonstrates what would be a growing conflict among the ANA membership. State nursing associations who provided collective bargaining services were willing to organize nurses under union contract in neighboring states where the state nursing association did not provide collective bargaining services. However it appeared the conflict surrounding this activity was initiated as the union association began this process without collaboration with the nursing association of the non-union nursing

association. This conflict would escalate and permeate the ANA organizational change process.

Initial Bylaw Amendment Proposals

Also during this time, the ANA Board of Directors prepared for the proposal of bylaw amendments to the June 1999 meeting of the ANA House of Delegates. These bylaw changes were designed to begin the ANA structural change, establishing within the ANA the UAN labor arm, and create the Congress on Nursing Practice and Economics (ANA minutes, February 1999).

The Congress on Nursing Practice and Economics would focus on socioeconomic, political and practice trends in nursing and in health care, identify issues and recommend policy alternatives to the ANA Board of Directors (ANA Report to the Board of Directors, Agenda Item #15, March 2000). As stated by an ANA Board interviewee, such a structure was viewed as necessary to more efficiently assist the ANA Board in deliberation of issues. The new congress would result in the merger of two existing ANA Congresses, The Congress on Nursing Practice and the Congress on Nursing Economics. These Congresses were often analyzing similar nursing issues with similar proposed outcomes. By consolidating these groups and establishing an election process and member representation into one Congress, resources were presumed to be better utilized.

Task Force on Affiliation

Regarding the desire to provide greater autonomy to the UAN from the ANA, in February 1999, ANA and its labor program established the Task Force on Affiliation to propose a method for ANA to explore affiliation with a national labor organization. The ANA Board of Directors approved the method for exploration of affiliating with a

national labor organization, the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO) or another national labor group (ANA minutes, February 1999). Union leadership interviews revealed that such an affiliation was viewed to be necessary to strengthen the work of the ANA union as the union would be affiliated with both the national nursing society, ANA, as well as a strong national organization focused on labor concerns. The perspective of all UAN interviewees' was that affiliation was desirable to help end the union raids that occurred during the decade of the 1990's; fellow American Federation of Labor-Congress of Industrial Unions member affiliates agree not to conduct raids on one another. One UAN interviewee stated, "The affiliation primarily provided raid protection. You simply do not raid other unions within the same group."

However, affiliation of ANA with a larger, established national labor union raised concern among some of the ANA leadership. Some ANA leader interviewees shared that there existed among some of the ANA membership a desire for ANA to no longer be considered a labor organization. Thus the national labor organization affiliation was proposed to explicitly be an affiliation of the UAN with a national labor organization, with ANA's involvement an organizational technicality given the UAN's organizational connection as a structural unit within the ANA.

From the perspective of the UAN, there was a desire to establish affiliation with a well-established national labor organization while still maintaining organizational independence as a labor union of registered nurses. Such independence was expressed by the UAN leadership in understanding the significant difference of the nursing union from other national labor unions who also represent RNs. One UAN interviewee stated:

> What is most significant for nurses as members of the UAN are that when they get together it is a solely registered nurse group addressing the issues of registered

> nursing. In other national unions nurses make up only a portion of the union's total membership. Thus during their meetings, the nurses struggle or compete with other non-nursing members to have their issues addressed. Struggles and conflict are good, but if they continue without abatement and resolve, there is little hope of moving forward.

Task Force on Workplace Advocacy

As activity progressed in strengthening the UAN as ANA's labor arm and affiliation with a national labor union, the Task Force on Workplace Advocacy was formed by the ANA Board to examine the needs of member state nursing associations who were not certified labor unions. As mentioned earlier, workplace advocacy was the term used to describe the programs and products used by non-union state nursing associations in addressing their individual nurse member workplace issues. This task force requested clarity from the ANA Board of Directors on The Board's definition of workplace advocacy and collective bargaining, and a request to further establish the Task Force on Workplace Advocacy as an ANA Commission, which would require a bylaw amendment. This would more permanently establish the program within the ANA structure. For purposes of clarity it is important to note that the workplace advocacy group evolved to become the Center for American Nurses.

According to several interviewees who served as leaders of the current Center for American Nurses, the outgrowth of the workplace advocacy program, the request to form the Commission on Workplace Advocacy was necessary in assuring that ANA resources were more evenly distributed among all of the Association's programs, including its labor program. Two participant interviewees from the Center for American Nurses noted the following:

> The impetus for change centered around the work of the workplace advocacy group, a rather informal group within ANA that consisted of state nursing

> organizations of ANA who where not involved in collective bargaining but had concerns about workplace issues of nurses. This group grew to include 23-32 states. The Center for American Nurses was formed to provide equal resource allocation to workplace issues faced by non-union nurses.

Concerns of ANA's resource allocations in 1999 were expressed by other Center for American Nurses interviewees. The Workplace Advocacy Commission and the state nursing associations who supported the Commission's work grew concerned over the seemingly unbalanced focus of the ANA leadership on issues of collective bargaining and its labor arm, the UAN. Two Center for American Nurses interviewee perspectives reflect this:

> There was a battle in the House of Delegates among collective bargaining and non-collective bargaining states over the utilization and parity of resources within the ANA. Each side perceived the other as dominant, and the restructuring provided a means to address this concern. It was also seen as an opportunity to provide a variety of membership models through individual, state, and organizational memberships, and an opportunity for state nursing associations to do the same. It [the organizational change] was necessary in order for ANA to find its own identity and to determine how the ANA could be more productive. There was a decrease in membership, and a sense that ANA was giving more time and attention to the union activity and to collective bargaining at the sacrifice of issues of concern to local (state) associations, the Constituent Assembly, right-to-work states, and blended states.

In responding to the specific question of the need to create a separate organization for workplace advocacy, one Center for American Nurses interviewee expressed that, "Perhaps it [ANA leadership] did not feel the need, but it was a way to address the concerns of non-union members, or states without collective bargaining or right-to-work states who may have felt the focus of the ANA was too heavily union." Thus the restructuring was necessary to demonstrate a balanced focus by the ANA leadership between collective bargaining and non-collective bargaining means to address nursings' economic and general welfare needs.

Other Center for American Nurses participants shared this concern regarding unequal distribution of resources as influencing the restructuring of the ANA:

> The development of the workplace advocacy group into a more formalized organizational entity was influenced by the concern that ANA's attention was directed more by the more vocal and organized UAN, leaving the non-union states to feel they had less of a role in the organization. The Center for American Nurses [workplace advocacy states] felt disenfranchised by the ANA. The UAN had greater numbers in membership and thus had a greater influence. From non-collective bargaining members, there was expressed concern with the quality and parity of services provided by ANA.
>
> State nursing association members of ANA who did not provide collective bargaining services were also concerned with the quality and parity of ANA services. Non-collective bargaining state nursing associations desired specified programming in order to provide more service parity [with services provided through collective bargaining and the UAN]. They supported the creation of a generally informal group of state nursing associations that focused on workplace advocacy issues [as opposed to unionization], which led to the Commission on Workplace Advocacy [and eventually the Center for American Nurses].

The push for representation of non-union nurses in their work settings by means other than through collective bargaining ranged from a simplistic perspective that there are different methods of representation to a more specific anti-union belief. As mentioned by two Center for American Nurses interviewees:

> It seemed that collective bargaining had a closed mind set, which is that it is my way or no way. There was a sense of rudeness and belief that there is only one effective strategy to make the workplace for nursing better and that way is through organized collective bargaining. They [UAN] view workplace advocacy as less effective. This view has remained, and there is polarization. Much of the restructuring was driven by dissatisfaction by ANA members involved in collective bargaining and the belief and concern that ANA's focus on collective bargaining was too limited.

In 1999 the workplace advocacy program was given resources by the ANA Board to further their work, including a dedicated ANA staff specialist. In explaining the establishment of the workplace advocacy group as an ANA Commission one Center for American Nurses interviewee shared the following:

> When the Workplace Advocacy Commission first met, we did not assist individual nurses in workplace advocacy by representation, we worked to empower the individual nurse through the constituent member organization. If an individual member asked for representation that was not what the Center for American Nurses is about. The initial objective was to be nurse friendly, inclusive, educational. We wanted to focus on policy development and in decision-making.

The perspective among the UAN leadership on the reason for establishing the workplace advocacy program was more conflicted. One union leader shared the perspective that the need for ANA to restructure was undertaken to provide workplace support to nurse members as an alternative to unionization:

> With restructuring the ANA proposed that the workplace advocacy program was promoted as a counter program to the UAN. States that did not want to, or politically could not be affiliated with unions, wanted to provide help to their nurse members who were suffering the issues of healthcare reform of the 1990's [losing jobs to hospital restructurings and closings].

Thus the establishment of the workplace advocacy task force by the ANA Board in 1999 began the process of establishing a greater presence within the ANA structure an additional method of addressing nursing's economic and general welfare needs. This task force was supported by ANA state nursing association members who did not engage in collective bargaining or other union activities in addressing the economic and general needs of their individual nurse members.

Institute of Constituent Member Collective Bargaining Programs

UAN leader interviews provided a perspective on the organizational changes occurring within the ANA during the late 1990s. Because the rights of the collective bargaining units and programs remained the purview of individual state nursing associations within ANA, these states required a presence within the national

organization. As mentioned by one UAN interviewee, the ANA formed the Institute of Constituent Member Collective Bargaining Programs (the Institute):

> Programmatic control was the impetus to the collective bargaining state nursing associations establishing within the ANA in the mid 1980s the Institute of Constituent Member Collective Bargaining Programs, referred to as The Institute, to provide a national constituency of state nursing associations involved in collective bargaining. However, it was felt The Institute was given little organizational power and involvement in the ANA organizational structure.

Further summarizing the remarks of this UAN interviewee, the Institute of Constituent Member Collective Bargaining Programs worked with the staff nurse caucus, an informal group of staff nurse member delegates to ANA, to assure that their constituency of staff nurse members represented by collective bargaining programs played a greater role in the policy and decision making process of the ANA. The interviewee continued that not all state nursing associations provided collective bargaining services to their membership, and that all staff nurses in the U.S. were experiencing the same issues of job security from the decade of healthcare reform of the 1990's that required an increased focus by the ANA. The ANA leadership proposed a structural division within the ANA that would encompass all programs and services related to workplace issues. Such a workplace advocacy umbrella would include the Institute of Constituent Member Collective Bargaining Programs.

Although the proposal for an umbrella workplace advocacy structure within ANA never came to fruition, it did spark dialogue pertaining to the need for greater autonomy for the Institute of Constituent Member Collective Bargaining Programs. As discussed by one UAN interviewee:

> There began, within ANA at this time, a movement to create a workplace advocacy program that would serve as an umbrella to all workplace issues faced by nurses. This ANA division or program would handle all nursing workplace

> issues, thus the Institute would be an arm of this division or program. However, anti-union/anti-labor fractions appeared to be in competition with the work of the Institute of Constituent Member Collective Bargaining Programs.

In October 1999, the Board of Directors accepted the Workplace Advocacy Task Force's report to establish the Workplace Advocacy Commission. (ANA minutes, October 1999). The Commission on Workplace Advocacy had the approval of the ANA leadership. However, conflict between the state nursing association members remained.

Working Group on Crossing State Boundaries

With the issue of organizing across state boundaries still of concern, the ANA Board of Directors established the Working Group on Crossing State Boundaries. This group consisted of three representatives each from workplace advocacy state nursing association members and union state nursing association members, and two representatives from state nursing association members who engaged in both activities (ANA minutes, October 1999). The Working Group on Crossing State Boundaries quickly convened as the Board of Directors accepted their request to have the issue of organizing across state boundaries brought to the ANA Constituent Assembly (ANA minutes, October 1999). Funding was provided for two conference calls and one face-to-face meeting with an expected report to the Constituent Assembly in spring 2000 (ANA minutes, December 1999).

It is important to understand here that the ANA Constituent Assembly consisted of presidents and executive officers of all ANA member nursing associations. They were generally an informal structure within the ANA organization; however they served as a highly consulted group by the ANA Board of Directors. They were also often utilized to

help the ANA Board have a better understanding of the concerns of their member nursing associations.

Interviewees from the ANA provided perspectives as to why this working group was necessary. Equal participation in the ANA was considered the critical issue. Within the ANA, the union state nursing associations tended to have large constituencies of organized labor nurses, and thus greater representation in ANA matters. With larger individual numbers of members in these unionized states, the states had larger economic resources. As noted by several ANA interviewees, the concern about the imbalance in organizational influence between union and non-union state nursing associations appeared to have influenced the ANA's restructuring. This is demonstrated by the following ANA interviewee perspectives:

> The changes were a result of perceived differences in the goals and priorities among state constituents who loosely organized themselves around those states who provided strong collective bargaining services to their members and those who did not provide this service. The issue concerned the direction and focus of the ANA as the national organization, and its use of resources on issues of concern to those states with strong and dominating membership through labor organizing, and those who did not provide this service. There also existed a state constituent perspective that remained uninvolved in the emerging struggle, but rather served as observers. These states may or may not have provided collective bargaining services to their membership, and simply did not seem to share the concern regarding ANA's focus and direction. However the concerns of the vocal states, both union and non-union, greatly concerned the Board of Directors at the time, and influenced the need to restructure.

This ANA participant interviewee continued:

> The state nursing association members were organizing themselves into two separate caucuses within ANA, one consisting of labor states and the other non-labor states. The labor state caucus had a longer history within the organization and was more formalized than the non-labor state group when it was created. The labor state caucus, prior to 2000, always recognized the desire to have a relationship with ANA and conducted their business transparently, holding open meetings and inviting the ANA leadership to their meetings. The non-labor union caucus, which evolved into the Workplace Advocacy group, expressed discomfort

> with the ANA, believing that the national organization was increasingly moving toward a single focus on labor issues and being perceived from the outside as simply a labor union. These states, which did not provide collective bargaining services, provided economic and general welfare services to their members by means other than traditional labor organizing covered by state and national labor laws. Both groups, union and non-union states, sought to have recognition of their work, and equal value within the ANA.
>
> When states have a great philosophical variance in perspective, as with how best to meet member economic and general welfare issues, they begin to look to the national organization to represent their specific philosophies. The changes [in ANA] are a result of the union wanting more autonomy from ANA, but wanting to remain a part of ANA.

Thus conflict between state nursing associations that provided collective bargaining and state nursing associations that did not provide union services was heightened by the prospect of union state associations organizing nurses in non-union Border States for the purposes of collective bargaining. The issue at stake was that of association competition for members and thus revenue.

Historical Perspectives on the Division within the ANA

Such positioning within the ANA by these groups is given a historical perspective as provided by some UAN leader interviewees. From their perspective, nurse educators serving in nursing education management positions formed the ANA. As one UAN participant commented, this has continued and contributes to the conflict within the association:

> The political agenda of the staff nurse is different from the nurse manager/administrator, nurse educator, and increasingly the advanced practice nurse. The ANA was originally founded by nurse educators focused on establishing the social norms necessary for nursing to attain the status of a profession. In the 1940's, the organization needed to address nursing labor issues, mainly in response to the use of nursing students as indentured servants in hospitals.
>
> The goal of ANA's early leaders was to establish and enforce the standards for nursing education and nursing practice necessary to elevate the status of nursing to a profession. As this work continued throughout the first half of the 20th century, the leadership of the ANA continued to come from the ranks of

> nursing educators and nursing managers, administrators, and executives, as mentioned above.

Another participant shared a potential reason for this continuation today:

> The ANA was formed by mangers. Non managers do not tend to be risk takers, they [staff nurses] are not trained to be leaders, and on a whole, we [ANA members] do not perceive that non-managers and non-leaders can be in leadership roles, and thus the non-manager member feels that the organization just wants their money [dues] and then they should not participate, and remain silent. We don't invest enough in people who are not managers and are not educators. The better view to take is that all nurses are managers and educators in their nursing practice, and thus every nurse has an influence on the profession. ANA has never had a collective bargaining or staff nurse as president. No one runs because they know they would not be elected, and the organization just continues to go forward as it always has. It is just the way it is.

In summarizing one UAN leader participant's views, as the profession grew, hospital staff nurses became increasingly concerned that staff nurses did not share the views of nursing educators and nursing administrators. The belief was that nurse leaders aligned themselves increasingly with the views of hospital leadership, and therefore they did not understand, or forgot, the issues of the bedside practicing staff nurse. One nurse union leader included the ranks of advanced practice nurses (nurse practitioners, clinical nurse specialists) among nurses whose healthcare and nursing agendas simply did not match those of the hospital staff nurse. They shared this perspective: "It remains that the ANA's leadership comes from the ranks of education, administration, and nurses with advanced degrees, and again, these nurses have a different political focus than does the hospital staff nurse." Thus, as nursing has developed its practice into advanced nursing roles so too was the need for ANA to develop its representation of these nurses. This need was demonstrated by the 1999 ANA House of Delegates.

Actions of the 1999 ANA House of Delegates

The 1999 ANA House of Delegates directed the Board of Directors to explore potential ANA membership structures for the variety of national specialty nursing organizations. Such a membership structure was thought to better assist the ANA in meeting its mission as the voice of all nursing in the U.S. As a result, the ANA Board appointed the Task Force on Membership Options (ANA minutes, November 1999).

Also, the 1999 House of Delegates moved to create a more permanent ANA structure for the workplace advocacy program. The board directed the Workplace Advocacy Task Force to further their work in implementing the action of the House of Delegates. In doing so, the Workplace Advocacy Task Force solicited input from the Constituent Assembly, the State Nurses Association Labor Coalition, the Workplace Advocacy Coalition, state nursing association national regional groups, the Congress on Nursing Practice and Economics, and the UAN Executive Committee. These solicitations raised concern that creating a permanent workplace advocacy structure within ANA was an attempt at creating a parallel structure to the UAN and thus compete for resources with the UAN (ANA minutes, December 1999). Although discarded as a rationale for establishing the Workplace Advocacy Commission (ANA minutes, December 1999), the concern demonstrated the idea among ANA's stakeholders of resource competition between these two entities. And, as mentioned previously, the ANA Board of Directors approved the report of the Workplace Advocacy Task Force to be established as the Workplace Advocacy Commission.

With the concern noted, the Board of Directors approved the submission of bylaw proposals to identify within ANA the Commission on Workplace Advocacy, including its

purpose and function (ANA minutes, December 1999). The concern of creating a UAN parallel structure within ANA was further expressed by two UAN participant interviewees as follows:

> As part of the negotiation then to establish greater independence of the UAN [union states] from the ANA, state constituent members of the ANA who considered themselves non-union and sometimes anti-union, felt that if the UAN was granted greater independence and autonomy from the ANA, then these states wanted an organization too, thus the establishment of the Center for American Nurses [evolved from the Commission on Workplace Advocacy].
>
> Clearly the union states would want to be separate, so the workplace advocacy state nursing association members wanted the same status so as not to lose their voice. Yet the workplace advocacy program was more comfortable being an integral part of the ANA. So, there was a move to create two parallel groups, and this needed to be translated into bylaws language.

These interviewees' comments illustrate the variance in perspective among the state nursing associations on how ANA resources should be utilized in meeting member economic and general welfare concerns. It is important to note here that there does exist among the ANA leadership, according to one ANA interviewee, a belief that the membership structure contributed to this conflict among state nursing associations:

> If the ANA was not organized under the federated model [membership is by state and other nursing organizations, not individual RNs] it would not have this internal conflict. States are fighting against states, union vs. non-union. When there was individual direct membership, anyone who came to convention could vote, and the delegate count was based on total membership within the state. As expressed by another ANA interviewee, the effort was to be more accommodating to all of ANA's membership, and to address the issues in a manner that allowed ANA to maintain a leadership stance and neutrality on the issues.

Other events in the fall of 1999 included the first meeting of the Congress on Nursing Practice and Economics, and a request by the Massachusetts Nurses Association (MNA) Labor Relations Program to be provided a seat on the Task Force on Affiliation [examining national union affiliation for the UAN]. Although the Board of Directors

supported the request for involvement, no action was taken in making them a formal part of the Task Force (ANA minutes, October 1999).

Ending the year, the ANA Board of Directors moved forward with affiliation discussions with the AFL-CIO (ANA minutes, December 1999). This was agreed upon by both moving to approve a specified step process for guiding discussions, as well as approving when steps were to be initiated (ANA minutes, December 1999). According to a former ANA Board member, the need to create a variety of task forces and to deliberately consider and approve a discussion process for union affiliation were necessary as to assure consistent and formal methods to address what was considered a volatile issue, that of union activity by the professional society.

Table 2. ANA Structures: 1999

Institute of Collective Bargaining Programs established in the 1980's to support state nursing associations that are unions, evolved to the United American Nurses (UAN), the labor arm of the ANA
Staff Nurse Caucus (Labor State Caucus) informal group of ANA labor state nursing associations within the ANA House of Delegates
ANA Constituent Assembly Formal ANA structure of Presidents and Executive Officers of member state nursing associations
Congress on Nursing Practice and Economics Formal ANA structure established in 1999 by combining Congress on Nursing Practice with the Congress on Nursing Economics
Task Force on Membership Options Established in 1999 to explore ANA membership structures for national specialty nursing organizations
Task Force on Affiliation Established in 1999 to explore affiliation of the UAN with a national labor union
Task Force on Workplace Advocacy Established in 1999 to support state nursing associations that are not unions
Working Group on Crossing State Boundaries Established in 1999 to explore the issue of union nursing associations organizing nurses in states where the nursing association is not a union

As illustrated in Table 2, in 1999 the ANA leadership relied on eight different task forces and working groups within its structure to address the variety of events happening within the organization. Such multitude of ad hoc groups may be an

illustration of the internal organizational political climate that desired complex representation of interests in the decision making process. These groups were utilized by the ANA leadership to provide the board of directors with recommendations for action.

2000: ANA Structural Groups Compete for Power

The ANA Board of Directors began the year by officially proclaiming a process to be utilized in all decision making by the Board. Such a process, the Knowledge-Based Strategic Governance Model, a model copyrighted by Tecker Consultants L.L.C. was the Board's attempt to conduct business in a forward thinking fashion rather than have decision making done based on past events. Such a process was hoped to be effective in building trust, clarifying roles and facilitating successful achievement of ANA goals (ANA Report to the Board of Directors, Agenda Item #22, March 2000).

Union Affiliation and Request for Seats in the ANA Structure

As the process for exploring an ANA/UAN affiliation with a national union progressed, the Task Force on Affiliation surveyed UAN members, and 21 Executive Directors of state nursing association UAN members responded. The majority of their concerns focused on the timing of affiliation, the desire to know the costs and benefits of affiliation, and concern over maintaining current levels of autonomy with an affiliation. (ANA Board of Directors, March 2000).

Perspectives on the national union affiliation were provided by participant interviewees. All four of the Center for American Nurses interviewees shared a perspective on the UAN affiliation with a national labor union:

> The affiliation with the American Federation of Labor-Congress of Industrial Unions was important to provide credibility to the UAN as a national labor union in order to assist them with their outreach and growth in organizing nurses. Affiliation of the ANA, in its previous structure, with the American Federation of

> Labor-Congress of Industrial Unions would further strengthen the perception that ANA was a union, and thus it was believed beneficial to have a more separate organization, the UAN, seek the affiliation.
>
> The American Federation of Labor-Congress of Industrial Unions wanted the use of the ANA name; to say they are a part of the ANA gave them authority to go after other healthcare workers. The concern was that when the affiliation of the UAN with the American Federation of Labor-Congress of Industrial Unions occurred, the UAN would take as much money from the ANA as they could and go completely with the union organization, but the American Federation of Labor-Congress of Industrial Unions wanted the ANA name, so this was considered unlikely.
>
> The national labor affiliation was important to the UAN as it would minimize challenges from other unions in labor raiding of local units, as unions within the American Federation of Labor-Congress of Industrial Unions agree not to challenge other member unions, thus the collective unions with the American Federation of Labor-Congress of Industrial Unions charters would not challenge each other through raids.

With its establishment as an ANA structural unit, through ANA bylaw amendments by the 1999 House of Delegates, the UAN Executive Council began work to assure their active involvement in ANA. They requested a designated seat on the ANA reference committee. This seat would be significant as the responsibility of the reference committee was to manage the process for and deliberation of hearings addressing reference proposals (ANA Bylaws, 2003). When approved, these proposals served to guide the association in positions and actions pertaining to specified topics of concern. The ANA Board of Directors provided the UAN Executive Council a non-voting appointed liaison to the committee, as well as a non-voting liaison seat on the ANA Board of Directors, and membership on the ANA Board of Directors Committee on Legislation (ANA Board of Directors, March 2000). The UAN began to gain powerful positions of influence within the ANA organizational structure. This was noticed by the non-union nursing associations working in the workplace advocacy program.

The struggle between labor and non-labor state nursing associations continued to be apparent. In March 2000, the Work Group on Crossing State Boundaries reported to the ANA Board of Directors that arranging meetings had been difficult, and suggested that group member's views were too divergent on the group's purpose for achieving successful outcomes. The ANA Board of Directors reaffirmed their commitment to the work of this workgroup (ANA Board of Directors, March 2000). However, one interviewee of the ANA leadership noted that this workgroup would ultimately be unable to bring any other recommendations forward to the Board, and eventually a report did come at the end of 2001 from a different ANA task force, the Business Arrangements Task Force.

Internal Conflicts Heightened: Disaffiliations Considered

The struggle between the state nursing associations was apparently not the only internal conflicts facing the ANA. The Massachusetts Nurses Association, a constituent member of ANA, held an unsuccessful vote for ANA disaffiliation among its own members. The ANA president reported, without specifics, that the Massachusetts Nurses Association would again vote for disaffiliation (ANA Board of Directors Agenda Item #3, March 2000). Remember that the Massachusetts Nurses Association had previously requested direct involvement in the Task Force on Affiliation, which the ANA Board of Directors verbalized support without action.

According to an ANA interviewee, issues congruent with those surrounding the disaffiliation by the California Nurses Association in 1995 influenced Massachusetts's disaffiliation desires. The Massachusetts Association was very active in collective

bargaining, and desired a greater use of their resources to be directed at collective bargaining. One UAN interview participant succinctly provided the following view:

> In relation to membership, it was not believed that changes in membership numbers as a result of disaffiliating states was a driving force in the [ANA] structural changes. Rather, these state leaders felt in the minority when it came to the ANA addressing issues of the staff nurse and specifically issues of the unionized staff nurse. The membership even felt that many of ANA viewpoints and positions on health care issues and nursing issues were in opposition to the viewpoints of members in these states, thus it was this difference that initiated the desire for the union segment of the ANA to have a greater voice in representing the concerns of their members, the staff nurse.

Two other UAN interview participants felt the ANA structural change served a more practical purpose other than a reaction to the disaffiliation of state nursing associations:

> The impetus to the change was to increase membership. There are other organizations out there with larger memberships and they are speaking for the voice of nursing, but not doing the work of nursing. Who speaks for nursing and who are the members' matters. With the structural changes in ANA, we can increase the whole of nursing in the House of Delegates. The restructuring was necessary to calm the concerns of the union member wanting more autonomy and control over their dues dollars.

And still other UAN interviewees' views of the structural change suggested that as the union was becoming more organized as a structural unit within the ANA, the non-union member state nursing associations simply demanded equal time and resources from the Association:

> The Workplace Advocacy group felt threatened when the UAN began to form. The Center for American Nurses is an alternative to the UAN, sometimes better because you don't have to dirty your hands with 'blue collar' stuff. If states are unable to provide collective bargaining, for whatever reason, then we have the Center for American Nurses products.

As summarized by one UAN interviewee, it was, and continues to be believed by many union nurses that the issues faced by the staff nurse, often referred to as the

'bedside nurse,' who are employed by hospital organizations, were not being addressed by the ANA:

> The UAN is viewed as challenging the authority [of ANA], interloping. ANA believes they are doing everything for everybody, but they have not met the needs of the staff nurse. The UAN looks out for staff nurses because it is what is best for all of nursing and for patient care.

And this need was expressed by other UAN interviewee comments:

> Part of this concern is rooted in the historical make-up of the ANA Board of Directors. Overwhelmingly, the elected members of the Board are registered nurses serving in management/administrative positions or as educators in academic and healthcare organizations. Staff nurses have rarely been elected or even been candidates for such leadership positions.

This has created perspectives among the union leadership that ANA may simply be unaware of the issues of the staff nurse, as expressed by two UAN interviewees:

> Everyone wants autonomy. They want to feel independent and autonomous. ANA speaks for nursing overall, and all of us are in practice. We are not always all on the same page, there are disagreements, but there is understanding that we are the same when it comes to nursing. Sometimes the perception is that ANA is out of touch with the membership on some fronts.
>
> Historically, the ANA will say that they support collective bargaining, that it brings more members into the organization. ANA promotes nursing, but they do not promote collective bargaining. The question is what are the labor issues in the right-to-work states, and how do they deal with that?

In summarizing interviewee comments from the leadership of the Center for American Nurse, some of the leadership within the Workplace Advocacy group were reportedly concerned that the ANA leadership focus on the UAN was unbalanced with other association interests. With the focus on the UAN and its relationship with the ANA, the Workplace Advocacy Commission began to become concerned that their work, and the interest of the nurses they represented in the right-to-work states, was being ignored by the ANA leadership. One Center for American Nurses interviewee discussed the need for the Workplace Advocacy group to capitalize on statements made by the former ANA

President, Dr. Beverly Malone that the ANA serve as the voice of all of nursing in the U.S.:

> This time frame, prior to 2000, encompassed the time when Beverly Malone was serving as ANA President of the ANA. It was stated that her goal at the time was to develop a House for all, meaning an organization that represented the global issues of professional nursing in the U.S. The challenge to this vision was how to efficiently use resources and manpower to accomplish this.

Thus, the Workplace Advocacy Commission leadership sought equal attention with the UAN by the ANA leadership. One Center for American Nurses interviewee discussed that the Workplace Advocacy Commission leadership was further concerned that the UAN represented a larger constituency of the ANA, and at times its members were much more vocal and demanding of the ANA than the members of the Workplace Advocacy group, and thus would continue to garner the greater attention and a greater use of ANA resources:

> The UAN was more established, well organized, and much more vocal within ANA in addressing the workplace issues of RN's through collective bargaining, and, in the beginning of this re-organizational influence, consisted of nine very vocal and active state nurses associations who were very vocal and organized in organizing RN's under collective bargaining.

The issue of member desires was complicated by the ANA's organizational structure. One UAN interviewee shared the following:

> When individual members approach the ANA, they are told they are not members of ANA, but rather members of their state nursing organization or the ANA affiliated organizational member. Although it is true with a federation model that it is the organization that is the member of the ANA, the ANA remains a membership organization.

Each union leader interviewee participant expressed these struggles:

> It is felt that the organizations leadership uses these terms [surrounding membership categories] at their discretion and pleasure when addressing the organizational members. It is felt that as a membership organization, the member and the Board were not in control of this organization, but rather the

> organizational staff, the President, and the first Vice President, not even the Board of Directors. If the membership were in control, the majority of member issues and concerns would be addressed by the organization, and they currently are not. Isolation and management is part of the problem, but ANA is recognized by the National Labor Relations Board as a labor organization but they do not have direct membership as a union. The states are the ones who hold the bargaining rights for the Units they organize. Therefore, ANA is really a union without members. This has been the problem with the federated model where the states are the members of ANA-NOT the individual nurse.

The impact of this issue was further expressed by another UAN interviewee:

> With the UAN, individuals are direct members to the organization, and thus have individual rights. With a federated model, the membership rights are with the member organization. …this structural model has been the major dissatisfaction with our members. If you think about it, there is no connection between the individual and the parent organization that happens to be receiving a large portion of their dues. In marketing jargon, this would be seen as a business that does not meet the needs of its clients. The crux of the problem is what do I, as an individual member of my state association, get as a service for my dues? This was the main reason that the UAN wanted to assure that the individual had membership in their national organization. We are already seeing the benefits of this connection. There remains speculation as to who runs the organizations…i.e. controlled more by association staff vs. the elected volunteer leadership, and thus contributing to dysfunctional organizational behaviors.

It appeared that the ANA organizational structural changes further establishing the UAN as the ANA labor arm escalated the internal conflict between ANA member state nursing associations. With its structure solidified in the ANA the UAN sought greater input into the ANA operational structures. In granting UAN's requests for more direct involvement the ANA Board was questioned by its non-union member nursing associations and the Workplace Advocacy program regarding these decisions. To them the ANA Board was providing greater resources to the UAN and behaving more like a labor union rather than a professional society. Thus the leadership of the Workplace Advocacy program began work to further formalize itself as a structural unit within the ANA, and Commission status was sought. The ANA leadership responded.

ANA Increases Role in Workplace Advocacy and Reaches out to Specialty Nurses

The Work Place Advocacy Group continued to establish itself within the ANA structure. In November 1999, the program was moved to the ANA Constituent Affairs Department and a full time staff member was assigned to the program. Work was beginning on developing workplace advocacy programs in state nursing associations (ANA Report to the Board of Directors, Volume One Agenda Item #1g, March 2000).

Implementation of other action taken by the 1999 House of Delegates was moving forward as the Task Force on Membership Options presented to the ANA Board of Directors two tentative financial models for ANA membership by specialty nursing organizations with pilot projects planned, and an expected report in June 2000 (ANA Report to the Board of Directors, Volume Two, Agenda Item #9, March 2000). This proposal was presented at the same time the Nursing Organization Liaison Forum (NOLF), an established link for ANA with several nursing specialty organizations, reported that they had met with the National Federation of Specialty Nursing Organizations (NFSNO). Together, these nursing specialty groups requested an immediate appointment of a working group to examine the specialty nursing community's organizational needs and evaluate the current structures of the two organizations. The working group's vision was to seek a unified voice for nursing (ANA Report to the Board of Directors Volume Three, Agenda Item #23, March 2000).

The ANA Board provided greater resources to the Workplace Advocacy program and recognized the need to reach out to the specialty nursing organizations. This was critical if ANA was to continue as the voice of professional nursing in the U.S. But the ANA leadership needed to address the financial impact of organizational change.

Financials Revealed: Workplace Advocacy Seeks Commission Status

The establishment of new structural entities within ANA had a financial price. In a March 2000 memo from the ANA president addressing the 2000 annual budget it was indicated that the establishment of the Federal Nursing Association, the UAN, the Workplace Advocacy program, and the Congress on Nursing Practice and Economics cost the ANA $400,000. Additionally, staff reductions made in September 1999 occurred in all ANA areas except the UAN and the Workplace Advocacy program (ANA Board of Directors Meeting, Volume Two, March 2000).

By the June 2000 meeting of the ANA Board of Directors, the ANA Executive Director reported the hiring of a UAN Director, participation in discussions with the Massachusetts Nurses Association regarding disaffiliation from the ANA, and work with state nursing associations to develop statewide workplace advocacy programs in Virginia, Utah, and Nebraska (ANA Report to the Board of Directors Volume One, Agenda Item #3, June 2000). In addition to this work, the Workplace Advocacy program presented proposed operating guidelines for the Workplace Advocacy Commission (ANA Report to the Board of Directors Volume Two, Agenda Item #4, June 2000), and it was reported that nine commissioners would be appointed to the Workplace Advocacy Commission, and the concept of workplace advocacy was clarified (Stierle 2000).

Conflict surrounding membership influence on the ANA Board of Directors remained a concern as expressed by one UAN interviewee. With the majority of the individual membership ranks holding positions as union nurses, and the board of directors of union state nursing associations remaining dominated by non-union nurses, debates of power and control arose within the association. This struggle was illustrated

and noted by one UAN participant interviewee in remembering a specific event during an ANA House of Delegates meeting:

> When the members of the [ANA] House [of delegates] encircled the delegates in early 2000, they did that to demonstrate the significant number of members in the House who were staff nurses. It was a powerful statement. The staff nurse caucus organized the occurrence.

Conflict between union and non-union member state nursing associations was now explicitly expressed in an open meeting of the ANA House of Delegates meeting. How the ANA Board would respond through its organizational structures would definitely have a financial impact. The changes already made within the structure were costly. The ANA Board realized the need for external help in looking to its future.

The Futures Task Force, External Consultant, and Insulation: ANA Refocuses

By September 2000, the ANA began to look more closely at its purpose and structure. The Business Arrangements Task Force, convened by the ANA President in March 2000 upon recommendation by the ANA Constituent Assembly for ANA to "…create a task force charged to frame a futuristic new organizational structure for ANA recognizing the changing nature of the constituent members and the diversity of purposes within the association" (ANA Board of Directors Futures Task Force, August 2001, unmarked p. 2), submitted recommendations to the Board of Directors for membership on a new task force, The Futures Task Force. The Futures Task Force membership included representation from 16 internal and external nursing organizational groups and would be initially tasked with drafting statements for an envisioned ANA future. It was also recommended that external consultant Tecker Consultants, L.L.C. be utilized for facilitation of the Futures Task Force work (ANA Board of Directors minutes, September 2000).

From the ANA leadership perspective, it was understood that the process of organizational structural change began with the establishment of the Futures Task Force. One interviewee discussed this Task Force, and in summary noted that the Futures Task Force was convened in September 2000 and consisted of representatives from ANA, specialty nursing organizations and the student nurses association. An external consultant was hired to facilitate the process. In June 2001, the core ideology, vision, values, and strategic priorities from the Futures Task Force was presented to and approved by the House of Delegates. A second ANA interviewee, in summary, stated that the group was given the task of examining the ANA and look to reinventing it. [The external consultant] was the same consultant who worked with the National League for Nursing in reinventing that organization. There were visionary approaches presented regarding what ANA could be.

The Board of Directors began to further identify its existing purpose and structure by reviewing an ANA/UAN organizational chart, a status report from the Workplace Advocacy program, and the establishment of five outcome-oriented goals to focus their work. These goals were professional practice advocacy, public policy, knowledge and research, inclusive membership, and workforce and workplace advocacy (ANA Board of Directors minutes, September 2000).

In addition, there was an apparent desire to assure a clear understanding among the Board of Directors what was meant by organizational insulation in relation to labor law, as talking points for discussion outside of the Board were reviewed. Broadly, and in brief, the Board of Directors understood the issue to be the need to fully 'insulate' the business of the organizations labor arm from that of the broader organization, as

leadership in the broader organization could be held by individuals in supervisory employment positions. In contrast, the business of the labor arm of the organization must follow other national labor laws in its conduction of business, and only its members represented under collective bargaining contracts are permitted to do such business. Since the ANA business, of which the UAN was a structural component, was conducted by the elected Board of Directors between meetings of the House of Delegates, the organization needed to provide insulation from conflict of interest among leaders who served in supervisory roles and those covered under labor contracts held by the state nursing association when addressing all labor business covered under national labor law (ANA Board of Directors minutes, September 2000). Such focus on labor issues may have been further supported by the Maine State Nurses Association joining the Massachusetts Nurses Association in their consideration of disaffiliation from ANA, as reported to the ANA Board of Directors by the UAN chairperson (ANA Board of Directors minutes, September 2000).

The labor issues of the professional nursing society were evident in the recommendations brought forth by the Futures Task Force. One ANA interviewee noted that it was the ANA Board of Directors, at the recommendation of the Futures Task Force, who decided to bring forth bylaw changes in 2002, as well as from discussion and recommendation from the Constituent Assembly meeting of November 2001. One major issue was that ANA should consider no longer being a labor organization.

The recognition of the involvement of the Constituent Assembly, a structural body within the ANA consisting of the presidents and executive officers of each ANA member state nursing association, is significant. Many ANA interviewees remembered

the discussions in this body regarding the needs of state nursing association members who provided collective bargaining services, and those state nursing associations who did not, as being productive. It was mentioned that each state nursing association appeared to have an understanding of the issues, concerns, and member needs of each other. However, this expressed understanding seemed not to have transferred to the larger ANA governing body of the House of Delegates. One ANA interviewee stated, "The proposals were presented at two House of Delegates meetings, during which the sentiment was, we love it, but…. Everybody wanted their own issues and concerns addressed within the models presented."

Thus it would appear that the impetus to the ANA structural reorganization at the start of the 21st century was centered on the continuing conflict between the sociological issues of labor and professions. For the ANA, whose membership base at this given point in history is the state nursing association, varying throughout the country in providing collective bargaining services, the resolution was hopeful to come from the Futures Task Force. But perhaps the issue remained too complex for the Task Force to address, as mentioned by an ANA interviewee:

> The question was how does the ANA really speak for nursing? So much of the energy was devoted internally that the other pieces in answering this question were not nurtured, so the potential of the Futures Task Force never really took off.

But the ANA leadership had made an effort to transparently examine its future. Directed by the House of Delegates the ANA Board created an internal task force to take the lead in exploring the association's future. Help was sought through an external consultant, and recommendations were beginning to be brought forth. Clarification of the ANA's role as a labor organization and its complexities were clarified.

Unity Temporarily Maintained

The ANA president reported in December 2000 that the Maine State Nurses Association voted in October 2000 to remain united with the ANA (ANA Report to the Board of Directors, Volume One Agenda Item #4, December 2000). This was preceded by the same decision made by the Massachusetts Nurses Association (ANA Board of Directors Minutes, November 2000).

Also the UAN director reported that talks were continuing with the American Federation of Labor and Congress of Industrial Organizations regarding affiliation, and that other national unions would be approached for affiliation with the ANA/UAN if these talks failed to produce affiliation. It was also reported by the UAN director that a third option for the ANA was suggested by the Minnesota Nurses Association. The option, to have the UAN sever all ties with the ANA, was immediately rejected by the UAN Labor Coalition, the representative membership governing body of the UAN (ANA Board of Directors Minutes, November 2000).

Finally, in response to concerns expressed to the ANA President and Executive Director by 18 individuals representing workplace advocacy concerning the perceived Board's disinterest and lack of focus on the Workplace Advocacy program, the Board of Directors approved a non-voting seat on the ANA Board of Directors for the Workplace Advocacy Commission (ANA Board of Directors Minutes, November 2000). Unity within the ANA seemed apparent, but tenuous.

More Financial Impacts

Even with unity maintained, the ANA Board of Directors continued to struggle financially. In December 2000 the Board of Directors approved a $1.675 million deficit

budget for 2001, providing for a 30% growth in the UAN. With UAN growth anticipated, the Board provided a $600,000 increase to the UAN budget (ANA Board of Directors Minutes, December 2000). The ANA Committee on Finance presented to the Board of Directors programmatic expenses for the Workplace Advocacy program, ANA/UAN, and other ANA programs, 1999 actual, 2000 projected, and 2001 proposed budget. For the Workplace Advocacy and the other programs there was a projected decrease, however the ANA/UAN was indicated to increase (ANA Committee on Finance, December 2000).

Structural units of the ANA discussed above are depicted in Table 3. These structures represent those entities influencing the ANA throughout the year 2000.

Table 3. ANA Structures: 2000

Task Force on Crossing State Boundaries Fails to produce a recommendation regarding union nursing associations organizing nurses in states where the nursing association is not a union
Nursing Organization Liason Forum (NOLF) National organization of specialty nursing organizations originated by the ANA
National Federation of Specialty Nursing Organizations (NFSNO) Formal national organization of specialty organizations (begins talks with NOLF regarding shared goals)
Federated Nursing Association (FedNA) Established in 2000, formal nursing organization of nursing serving in the armed forces and a constituent member of the ANA
Workplace Advocacy Commission Established in 2000, formal entity of ANA from the Workplace Advocacy program, supports state nursing associations that are not unions
Business Arrangements Task Force Established in 2000 by the ANA Board to recommend a means to explore ANA's future
Futures Task Force Established in 2000 by the ANA Board as recommended by the Business Arrangements Task Force to address ANA's future, consists of representatives from 16 nursing organizations
UAN Labor Coalition Governing membership body of the UAN, separate from the ANA house of delegates as required for Insulation, and made up solely of nurse members represented by UAN union contracts.
ANA House of Delegates Governing membership body of the ANA, made up of representative delegates from constituent member organizations

Work on the changes within ANA moved steadily forward throughout 2000. However, significant changes throughout nursing's organized community were about to occur that would greatly affect ANA's structural future.

2001: Significant Changes in Organized Nursing

External to the ANA itself, changes in some state nursing associations began to happen in 2001. These changes greatly impacted the membership of the ANA, and challenged ANA in serving as the voice of nursing in the U.S.

Disaffiliations Considered Likely: Membership Surveyed

Although previously voting twice to remain united with the ANA, the Maine State Nurses Association scheduled a third vote for March 2001 to consider disaffiliation with the ANA. In response, the ANA Board of Directors allocated $127,000 ($50,000 from the 2001 UAN budget, the remaining from all other ANA programs) to support efforts to maintain the MNA as a constituent member association within ANA (ANA Board of Directors Minutes, January 2001). In addition, the UAN director reported that the Maine State Nurses Association had scheduled a special meeting in April 2001, and it was anticipated that disaffiliation from ANA would be discussed (ANA Board of Directors Minutes, February 2001).

Perspectives on the issues influencing disaffiliations were provided by interviewees from the UAN leadership. During the turmoil of healthcare reform in the 1990's, described by one UAN interviewee as the time when hospitals were reorganizing and RN positions were being changed or eliminated, it was felt by staff nurses and their union leadership in the state nursing associations that the ANA was at best not doing enough to protect the jobs of its nurse members, and at worse aligning themselves with

hospitals in dealing with the reforms of the decade. As expressed by two UAN participants:

> It was only after such conflicting viewpoints emerged did the union nurses begin to question how ANA was spending their dues dollars. With a large sum of member dues going to the ANA, whose viewpoints were increasingly in opposition to those of the union nurse and ANA member, the membership began to question what they were getting for their money. Those states who chose to leave ANA simply felt they could manage their member needs better than the ANA was currently managing them. The union nurses in other union states worked very hard to maintain California and Maine in the ANA, and now believed that things remain unchanged and the ANA learned nothing when California and Maine left the organization. The restructuring was necessary to calm the concerns of the union member wanting more autonomy and control over their dues dollars.

From a second UAN interviewee:

> Frustrations by staff nurses did not go unnoticed by other unions with units representing nurses, where many state nursing association units across the country were experiencing successful raids by these well financed unions. Such concerns were played out most strongly in the state nursing associations of California, Maine, and Massachusetts.
>
> Beginning in California in 1995, the state nursing association economic and general welfare program leaders and members successfully were elected to Board of Director positions governing the association. These new leaders garnered membership support to sever their relationship with the ANA, and focus member dues monies to continue more aggressive labor work in organizing and providing staff nurses with collective bargaining services.

The influence of disaffiliations on ANA's organizational changes was mentioned by one UAN interviewee:

> The creation of these two organizations [UAN and the Center for American Nurses] occurred to satisfy the needs/desires/demands of members of non-union or anti-union states, and was partially influence by the disaffiliation of California and Maine from the ANA.

With potential loss of membership, the ANA Board reviewed written responses to their membership satisfaction survey. The survey represented 33 centrally billed, meaning ANA managed individual member dues, non-collective bargaining states with

an n of 5298. Respondents ranked ANA services that they most valued. The results indicated the services rank value from highest to lowest to be Nursing Practice and Policy, Continuing Education, Government Relations/Lobbying, Advocating for all Nurses, Workplace Advocacy, Promotion of the Nursing Profession, Providing a Powerful Political Voice for All Nurses, Collective Bargaining, Providing Nurses a Seat at the Health Policy Table, and Strategic Planning (ANA Board of Directors Volume One Agenda Item #1&2, March 2001).

With the loss of two additional member state nursing associations from the ANA becoming apparent the ANA leadership had to acknowledge that something had to change within the organization. To better assess what changes would be most responsive the ANA leadership surveyed its individual nurse members. With survey results compiled, the ANA leadership began to focus on what would be required to change the ANA. Bylaw language had to be considered.

Focus on Proposed Bylaw Changes

The March 2001 meeting of the Board of Directors appeared to be a very active and informative meeting. Many events were reported to the Board as they also considered new proposed bylaw changes to present to the 2001 House of Delegates. The ANA president presented the NOLF/NFSNO draft proposal for a merged organization to be named the Alliance of Nursing Organizations. The Futures Task Force reported a draft of strategic plans and preliminary organizational structures to be presented to the 2001 House of Delegates, and the Committee on Bylaws presented what was referred to as controversial proposed amendments submitted by the UAN and by the Maine State Nurses Association, which the Board indicated they would address in an upcoming Board

of Directors conference call meeting (ANA Board of Directors Minutes, March 2001). It is unclear from the ANA records the specific amendment proposals that were brought forth from the UAN and the Maine State Nurses Association. However, the Board moved forward and reviewed all draft proposed bylaw amendments for 2001 (ANA Report to the Board of Directors Agenda Item #8e, March 2001).

The proposed bylaw amendments appeared to require much discussion among ANA structural units. The proposed bylaws that would go forth to the 2001 House of Delegates addressed issues of membership compliance with the ANA's function and purpose, disciplinary action for member violation of bylaws, provision of a UAN seat on the ANA Board of Directors, UAN representation on the ANA committee on bylaws and references, changing the UAN officer titles from chairperson and vice chairperson to president and vice president, shared responsibility between the ANA executive director and the UAN Executive Council for the hiring, evaluation, and termination of the UAN program director, and moving responsibilities for the UAN from the ANA executive director to the UAN program director (ANA Board of Directors Futures Task Force, August 2001).

On May 20, 2001 the ANA Board of Directors met with representatives from the UAN Labor Coalition and the Workplace Advocacy Commission to discuss concerns over the proposed amendments. According to several interviewees from the ANA, UAN, and the Center for American Nurses, these concerns were mainly centered on the apparent power increase the bylaws provided to the union, and the influence of these actions as a reaction to actual and potential future disaffiliations from ANA. Agreement was reached to work to remove all proposed amendments except Article VIII, Section 5

that addressed collective bargaining constituent member association membership in the UAN, making such membership a requirement if the state nursing association engaged in union organizing. (ANA Board of Directors Minutes, May 2001).

Although the ANA leadership was working diligently in making changes in the organization, it seemed to not be enough. The ANA was about to again experience the loss of membership over disputes concerning ANA's support of its union member state nursing associations.

State Nursing Associations Disaffiliate: AFL-CIO Affiliation Occurs

Disaffiliation attempts in Massachusetts were finally successful when the Massachusetts Nurses Association voted to disaffiliate from the ANA on April 30, 2001. Forty-eight delegate seats at the 2001 House of Delegates were consequently vacated. However, quickly the ANA Board of Directors accepted the Massachusetts Association of Registered Nurses (MARN) as an ANA constituent member association. The ANA Board of Directors was also aware of an April 28, 2001 disaffiliation vote scheduled for the Maine State Nurses Association (ANA Board of Directors Minutes, May 2001).

Also, the Board approved the proposed affiliation charter of ANA/UAN with the American Federation of Labor and Congress of Industrial Organizations and forwarded the charter onto the UAN's National Labor Assembly for action. The ANA Board decided that membership funding for the first two months of the American Federation of Labor and Congress of Industrial Organizations affiliation would come from the UAN dues grant awards budget, 0.53 cents per UAN bargaining unit member per month, or approximately $50,000 per month (ANA Board of Directors Minutes, June 2001). Also,

the Board of Directors approved for presentation to the 2001 House of Delegates the ANA Draft Strategic Plan (ANA Board of Directors Minutes, May 2001).

In preparation for presentation of bylaw proposals to the 2001 House of Delegates, constituent member association feedback was solicited by the ANA Board of Directors. Conflict among union and non-union state nursing associations was again apparent. In a briefing paper to the ANA Board, a source of tension within ANA was coming from "conflicting demands for limited resources among internal constituencies, such as those using collective bargaining or workplace advocacy strategies" (ANA House of Delegates, June 2001, p. 2). Still, the Futures Task Force moved ahead with strategic proposals, and presented a timeline for ANA structural changes to be covered in proposed bylaw amendments to be presented to a special meeting of the 2002 House of Delegates (ANA 2001, *Forging the future overview: What is the Futures Initiative?*).

Perhaps as a result of internal tensions among union and non-union views the ANA Board of Directors sought consultation from Tecker Consultants, L.L.C. In June 2001 the Board received from Tecker a document addressing the identification of a professional association and a trade association. The document claimed that traditional models of these two associations is becoming less distinctive of each other, thus creating a potential new hybrid association model named by Tecker as the Open Association Model (Tecker Consultants, L.L.C. 1998). By August 2001, Tecker presented to the ANA Board of Directors a revised document of six possible future ANA structures (Tecker Consultants, L.L.C. 2001).

An additional loss of membership in the ANA was apparent as evidenced by December 2001 ANA documents indicating the disaffiliation of the Massachusetts

Nurses Association from the ANA. Individual membership numbers were now approximately 156,000, and although significant losses in membership were noted as a result of the disaffiliation of California in 1995, and subsequent disaffiliation of Massachusetts and Maine, membership had remained fairly constant. More than 70% of ANA revenue was dependant on membership dues dollars (ANA Board of Directors Meeting, July 2001). As mentioned earlier, the Massachusetts disaffiliation left vacant 48 seats in the House of Delegates, and Main's disaffiliation left another 43 seats vacant. But again, the ANA Board of Directors quickly approved constituent member association membership for the newly organized ANA-Maine, as it had previously done in Massachusetts. Because these were newly formed organizations it was difficult for ANA to follow already established ANA policy for apportionment of House of Delegates seats calculated on the percentage of membership dues, thus both the ANA-Maine and Massachusetts Association of Registered Nurses were allotted the minimum guarantee of three delegate seats each for the June 2001 House of Delegates meeting (ANA Board of Directors Meeting, July 2001).

With membership losses, the Board of Directors provided grant money to state nursing associations through the UAN in order to increase membership through collective bargaining organizing. The Workplace Advocacy Commission was also focusing on membership recruitment, and the ANA goal was set to increase membership by 2,000 in the following year (ANA Board of Directors Meeting, July 2001).

The disaffiliation of four state nurses associations (although not apparent in the ANA documents, the Pennsylvania Nurses Association had also disaffiliated) from the ANA left the ANA not only initially unrepresented in these states, but also decreased the

ANA's membership numbers. Five ANA interviewees discussed this concern, one noting that the Futures Task Force wanted to focus on the profession, but members were looking for direct services. The ANA interviewee further noted that there was also the reality of the loss of the state nursing association of California, Massachusetts, Maine and Pennsylvania. One ANA interviewee stated the following:

> ANA knew that the next generation was not likely to join something that sounded ethereal, so the question was how to create the work of the ANA. If we look at the age of the member and measure if our work was more successful based on an analysis of the change in the age demographic of the membership, we might be able to make assumptions about whether our restructuring was successful or not.

Another ANA interviewee stated:

> With the successful disaffiliation of California from ANA in 1995, these threats were taken very seriously by the Board of Directors who felt a need at the time to take every opportunity to effectively manage the pressure mounting within the organization between labor and non-labor states to allow time for the organization to determine how best to structure itself for survival.

In summarizing another ANA interviewee, disaffiliation was an option considered by both labor and non-labor state nursing organizations, and noted that the labor states wanted a clearer focus, and the non-labor states sought affiliation outside of ANA. There continued to be dialogue of disaffiliation if there were no changes made within the structure. The desire of ANA was to create a balance; however the disaffiliation of California provided a template and opportunity for other states to emulate.

Membership and resource losses dominated the ANA's leadership. Two other ANA interviewees emphasized this concern in stating that:

> The changes were influenced by the challenges facing membership numbers, such as how to grow the membership after the constituent member association left, and these associations were major collective bargaining states, thus a need to re-tool. There was also concern of other state disaffiliations such as New York, and thus the desire of the leadership of ANA was to listen more to the membership and create options.

In summary, it was mentioned by one interviewee from the ANA that the California Nurses Association activities and propaganda, following their disaffiliation from the ANA, specified their desire to compete with ANA's union services nationally, including their raids of ANA unions in other states, and this greatly influenced the restructuring efforts. Specifics of this were not discussed other than the ANA recognized the California Nurses Association as a threat to ANA's membership numbers.

In summarizing ANA and UAN interviewee comments on the disaffiliations from ANA by the state nursing associations, there seemed to exist both a perspective of opportunity for growth along with a concern that other state nursing association may consider disaffiliation from the ANA, and thus the need by the ANA leadership to address these member issues. It is important to remember here that the disaffiliations mentioned were mostly initiated and led by the union leadership and members in the disaffiliating states. Although Pennsylvania was the exception here, where disaffiliation by the union portion of the state nursing association was agreed by all the majority of the leadership, not exclusively the union leadership, the issue spearheading disaffiliation remained the function of the state nursing association as a labor union affiliated with the ANA. Emotions would be high at the 2001 meeting of the ANA House of Delegates.

House of Delegates Send Bylaw Proposals Back to Committee

After apparent efforts to assist the 2001 House of Delegates to address the proposed bylaw amendments, action of the 2001 House of Delegates was to refer all proposed bylaw amendments to the ANA Committee on Bylaws. The ANA public documents did not specify the language of these bylaws, however the proposed amendment Article VIII, Section 5 requiring constituent member association's providing

collective bargaining to be members of the UAN, was sent to the Futures Task Force for consideration for future bylaws. The House of Delegates also moved to have the work of the Futures Task Force be completed and bylaw proposals for organizational re-structuring be brought to the 2002 House of Delegates (ANA Board of Directors Meeting, July 2001).

Structural units of the ANA discussed above are depicted in Table 4. These structures represent those entities influencing the ANA throughout the year 2001.

Table 4. ANA Structures: 2001

Nursing Organizations Alliance Established in 2001 by the merger of the Nursing Organization Liaison Forum (NOLF) and the National Federation of Specialty Nursing Organizations (NFSNO), a national nursing organization representing specialty nursing groups
ANA Committee on Bylaws Committee of the Board charged with managing all matters pertaining to the ANA bylaws
UAN Executive Council Elected representative officers of the UAN
UAN Nation Labor Assembly Evolution in name of the UAN Labor Coalition, it is the governing membership body of the UAN

External to the ANA, nursing's specialty organizations consolidated resources and included ANA within their ranks. Within the ANA the UAN further evolved.

By the end of 2001 the ANA approved operating guidelines for the Congress on Nursing Practice and Economics (ANA Board of Directors Meeting Agenda Item #4, October 2001). They also confirmed the formation of the Nursing Organizations Alliance (NOA) with operating guidelines to assure a relationship and membership with the ANA, and thus dissolving the NOLF and NFSNO (ANA Board of Directors Meeting Volume One Agenda Item #3h, December 2001).

The Constituent Assembly, as mentioned earlier consisting of the Executive Directors and Presidents of ANA's constituent member organizations, held a meeting in November 2001 attended by 106 representatives from the constituent member

associations and the members of the ANA Board of Directors, the Congress on Nursing Practice and Economics, the Futures Task Force, the Workplace Advocacy Commission, the UAN Executive Council, the ANA Committee on Bylaws, and partially by the Economic and General Welfare program directors from state nursing associations. The meeting focused on providing input to the work of the Futures Task Force. It was moved but defeated to postpone submission of proposed bylaw changes from the 2002 House of Delegates to the 2003 House of Delegates. The Constituent Assembly wished to honor the 2001 House of Delegates action for submission of proposals the following year (ANA Board of Directors Meeting Volume One Agenda Item #3p, December 2001).

Finally in December 2001, the ANA Board of Directors was presented a final strategic plan draft from Tecker Consultants (Tecker Consultants, L.L.C., Agenda Item #7a, 2001) and viewed a draft document of advantages and disadvantages of six potential ANA organizational structures (Tecker Consultants, L.L.C., Agenda Item #7c, 2001). Also, the Business Arrangement Task Force reported on the issue of providing collective bargaining services across state lines.

As expressed by one ANA interviewee participant, the Task Force on Crossing State Boundaries was unable to bring forth a recommendation to the ANA Board on this issue, and thus providing a recommendation to the Board on this issue was a charge given to the Business Arrangement Task Force. Both internal and external legal counsel recommended that, to avoid challenges based on insulation issues, "In order to reduce the risk of an 'insulation' attack, non-collective bargaining constituent member associations should not take active steps to discourage organizing efforts" (ANA Board of Directors Meeting Volume Two Agenda Item #10, December 2001, pp. 1-2). This generated other

questions pertaining to communications among groups when UAN organizing was taking place in a state where the state nurses association did not engage in union organizing. Obviously tension remained among the groups.

2002: Organizational and Bylaw Changes

For 2002 the ANA Board of Directors began to narrow its work on deciding the future of the organization. This was the year for a special meeting of the ANA House of Delegates specifically called to address proposed bylaw changes pertaining to ANA structural changes.

House of Delegates Address Organizational Restructuring and Strategic Plan

In attempting to clarify the necessary changes in bylaws language, the Board of Directors continued to decide on ANA's future structure. The ANA Board narrowed their structural choices to two models, and they began to compare these models to the existing structure. To focus this comparison, the models were examined for key features; governance, finance, and workforce. Not requiring bylaw changes were the topics of programs, and knowledge and information (ANA Board of Directors Meeting Volume One, March 2002).

In addition to this comparison, the Board discussed the issues surrounding individual/direct membership, the ANA's involvement with collective bargaining and workplace advocacy, their identification as a labor organization and potential autonomous status for the UAN and Workplace Advocacy Commission, organizational membership of nursing specialty organizations, and the recognition of "competing interests and a desire to minimize strain and conflict within a new structure" (ANA Board of Directors Meeting Volume Two Agenda Item #1e, March 2002). To assist the Board,

the Committee on Bylaws solicited feedback from constituent member associations and other stakeholders in hopes of collecting enough information to help facilitate presentations and dialogue prior to and during the 2002 House of Delegates meeting (ANA Board of Directors Meeting Volume Two Agenda Item 4m, March 2002).

Pertaining to the autonomous status of the UAN and the Workplace Advocacy Commission the following view was shared by one Center for American Nurses interviewee:

> The UAN requested of the ANA their own structure and self-governance model with affiliation status with the ANA. At this time, the ANA leadership approached the Workplace Advocacy states, working through the Commission on Workplace Advocacy, asking if they wished to also develop their own structure and self-governance model with affiliation with the ANA. The Workplace Advocacy leadership was surprised by this question, as they did not consider this until the ANA Board suggested it. The reason for the offer was not clear.

Some of the ANA interviewee perspectives on the 2002 meeting of the House further highlight the tension in this process of creating separated structural units with affiliation in the ANA. As noted by one ANA interviewee, the first House of Delegates to address the proposed structural changes expressed discomfort with the manner in which the Board of Directors brought forth the bylaw changes in addressing the need for organizational change:

> At the House of Delegates meeting in Philadelphia in June 2002 there was a committee of the whole created to engage in informal discussions. At the committee meeting the delegation decided that they would not deal with four very different sets of bylaws that had emerged during the spring of 2002. The committee instructed the ANA Board to meet with the leadership of the UAN and workplace advocacy group and bring to the 2003 House of Delegates a single set of bylaws that all three organizations [ANA, UAN, and the workplace advocacy program] supported.

In summarizing further comments by an ANA interviewee, this decision by the House of Delegates was influenced by the floor debate regarding the initial bylaw change

recommendation. The debate on the House floor demonstrated a lack of agreement among the delegates present, and a desire to have the interest of the ANA, the union (UAN), and the non-union group (workplace advocacy) interests addressed in the proposed organizational restructuring. The UAN desired a level of autonomy from the ANA, the Workplace Advocacy program wanted equal recognition from the ANA, and the ANA wanted to maintain its status as the representative of professional nursing in the U.S. Another ANA interviewee expressed this process by the following comment:

> The House of Delegates gave a deadline for resolution that established a smaller group of the Board to negotiate and represent the Board in these negotiations, making the negotiations more difficult. Everyone felt pressured. The President of ANA wanted a resolution that would protect all parties, the ANA, UAN, and the Center for American Nurses [Workplace Advocacy], as well as meeting the demand of the House of Delegates.

The power of the House of Delegates to influence the direction and decision making process of the structural change may have also been a result of other factors. As expressed by one ANA interviewee:

> It was an election year for the Board of Directors, and candidates wanted to be able to say, we got this [accomplished]. They did not want to appear anti to the House, and felt the House was greatly influenced by the UAN member states and the politics. This was the year of the House of Delegates meeting when the delegates from union/UAN states stood and encircled the remaining members of the House in an effort to demonstrate/emphasize their numbers and their solidarity in the House of Delegates.

Contributing to the apparent frustration of the House of Delegates was the presentation to them by the Board of Directors of three options. One ANA interviewee noted these perspectives:

> There were several ways to look at changing the ANA. My favorite was to re-title the association as the American NursING association [as opposed to the American Nurses Association], then it would truly be the professional association, and nursing groups would then join the association. There was agreement that the ANA should bring together nursing from a variety of entities, thus when ANA

> spoke, it was without a doubt representing the profession of nursing. Another option was to return to the former model of individual direct membership in the ANA, and discontinue the federated model. The federated model never went away, and the organization became transactional, with membership asking, where do I fit into this organization? The membership took on a selfish perspective to the development of the ANA. The alternative was that the ANA could remain as it was, a federated model with the UAN and the Center for American Nurses programming completely under the ANA without the need for affiliation agreements.

In addition to the proposed bylaw changes, the House of Delegates would also address proposed organizational strategic plans as a result of a 1994 House of Delegates mandate for ANA to adopt organizational goals and priorities in odd-numbered years; however it was deferred by the 2001 House of Delegates to the 2002 meeting. The Board agreed to propose a three to five year strategic horizon/plan that identified clarity of purpose, focused and achievable agenda, financial solvency, and federal influence on health policy, and focus the organization on professional practice excellence, healthcare and public policy, knowledge and research, unification, and workforce and workplace advocacy (ANA Board of Directors Meeting Volume Two Agenda Item #10a, March 2002). Pertaining to these items, the June 2002 House of Delegates adopted the ANA Core Ideology, Envisioned Future, and 2002-2003 Goals (Tecker Consultants, L.L.C., 2002).

The 2002 ANA House of Delegates endorsed the structural changes of the ANA, creating new membership categories. They also endorsed the association's strategic initiatives, and it seemed that ANA was ready to move forward.

Bylaw Changes Approved: UAN and Workplace Advocacy Made Autonomous

With the approval of bylaw changes, the Board of Directors began negotiations with the newly autonomous UAN and Workplace Advocacy Program. By December

2002, a draft agreement entitled *Autonomy and Affiliation Agreement between American Nurses Association and United American Nurses, AFL-CIO,* identified the UAN as a "wholly autonomous, self-governing national labor organization, affiliated with ANA, and the only Associate Organizational member of ANA for collective bargaining" (ANA, December 2002). It also stated that ANA shall not accord membership status or formal affiliation to any other non-constituent member association union, identifying the UAN as ANA's only Associate Organizational Member for collective bargaining (ANA, December 2002).

The process of getting to this point was difficult, and is reflected by several interviewee comments. ANA interviewees expressed the issues surrounding the negotiations in preparing the final recommendation to the House of Delegates. Five different ANA interviewees discussed this perspective, beginning with one stating that, "Among those states that do not provide collective bargaining services some simply do not provide the service while others are adamantly opposed to the activities of unions." Other comments were as follows:

> The purpose of establishing the Center for American Nurses, [out of the Workplace Advocacy interest states] was due to the concern that if this was not done, then these non-union states would leave ANA. The threat of leaving was a huge impetus. Both groups needed to sacrifice because neither had the votes alone [in the ANA House of Delegates] to control what would happen. In the process of creating two independent organizations [UAN and the Center for American Nurses] we have diluted the resources of the ANA. It is hard to say that the ANA speaks to nursing. More accurately, ANA's voice is diluted.
>
> [In regards to the Center for American Nurses] it is NOT in competition with the UAN, but rather a means of providing workplace resources to nurses in states that have traditionally not engaged, or engage minimally, in the use of labor unions to address workplace issues. The concern is that the UAN and Center for American Nurses are in competition, and that one is viewed as better than the other. The organizational goal of the ANA, in its restructuring, was to provide balanced resources for nurses in the workplace in addressing their economic and general welfare needs.

> In relation to the Center for American Nurses, they do not see their organization as a representative body, but rather a facilitator in workplace issues, addressing these issues by means other than through collective bargaining. It was felt that both methods work, depending on the circumstances occurring in the workplace. To the contrary, the UAN believes that every nurse should be represented solely through collective bargaining. As the restructuring process began, perhaps these individuals felt their identity and work would get lost within the greater or larger structure of the ANA and thus they wanted to ensure a clearer identity for themselves as a group.
>
> The hope was that with the structural changes, the ANA would focus on nursing standards, political action, and policy development, and workplace issues would be handled by the other organizations. There were trust issues, though, and the ANA couldn't afford to support the focused interest of the group to the level that the groups wanted.

Among the union leadership interviewed there existed a variance in opinion as to whether the desire for autonomy from the ANA was best achieved through complete disaffiliation from ANA or through creation of an autonomous, ANA affiliated organization. However, consensus was definite that there was a desire for greater independence from ANA and thus increased control of the work of collective bargaining for staff nurses.

The opinioned differences among union leaders is somewhat evidenced by the verbiage used in referring to the affiliation agreement with ANA. Since the UAN defines its membership as both individual direct members as well as affiliation with state nursing associations, some of the union leaders are concerned with distinguishing between being an organizational affiliate and a member. Thus, there is a desire to refer to the affiliation agreements as autonomy agreements, as explained by one interviewee:

> I prefer to call them autonomy agreements. The UAN brings its affiliates, the states, and then the UAN has an autonomy agreement with the ANA. Not everyone is using this language, but it distinguishes between the UAN state affiliate and the UAN agreement with the ANA. The federal nurses, through the VA, are the only nurses who are direct members of the UAN; all others are members of the state nurses association who are affiliated with the UAN.

This difference provides insight into the different perspectives passionately held by the union leadership in referencing the relationship the UAN had with the ANA as a result of the restructuring. There also remained among some of the union leadership interviewed a perspective that such agreements with ANA by the UAN may not continue. Among other leaders interviewed, it was expressed that at no time did the UAN ever desire to leave the ANA entirely:

> Change is inevitable. The change resulted in the formation of the UAN in 2000, which was a positive move. There were now two structures that are different in the way they approach workplace issues of nurses…there is now another organization to back up nurses in the workplace, thus making the organization (ANA) more powerful. The work of the ANA continued to occur in the House of Delegates, which is the representative body of the state nursing organizations. ANA is still the voice of nursing in the U.S.
>
> The fear is that once the UAN had [autonomy from the ANA], they would leave ANA. The UAN had never wanted to leave the ANA. ANA continued to be recognized as a labor organization that does not do collective bargaining, perhaps due to tax status benefits. ANA wanted to bring all nurses together to represent nurses, but separation from the ANA by the UAN was a reality.

With the ANA membership category of Affiliated Organizational Member established in the ANA bylaws, and the newly ANA autonomous status of the UAN and the Workplace Advocacy group, it appeared that ANA was moving forward. However, fully implementing these changes would find that the conflict of union and non-union activity and organizational equity remained an issue. Although it would take formal development as an official organization, the Workplace Advocacy group would evolve to become the Center for American Nurses, and thus are referred to as such for the remainder of this chapter.

2003: Implementing Organizational Change

ANA Defines Membership Categories

The work of the ANA and its Board of Directors in 2003 was generally focused on the continued implementation of the strategic goals and bylaw changes made by the 2002 ANA House of Delegates. Such work included clarifying policies of operation for the newly created organizational structure, specifically the creation of internal structures for managing relationships with newly created Affiliated Organizational Members, the UAN and the Center for American Nurses. Two ANA interviewees clarified this process:

> The bylaws allowed for exclusionary language regarding the UAN as the collective bargaining arm of the ANA and Center for American Nurses as the workplace advocacy program of the ANA. Now, with the federated model, the delegate count [in the ANA House of Delegates] is based on the states membership in the UAN or the Center for American Nurses.

In addition to the establishment of these two affiliated organizational membership categories, the bylaws allowed for other nursing organizations that represent specialty nursing interests beyond collective bargaining and workplace advocacy to also obtain affiliated organizational membership status with the ANA. One ANA interviewee noted:

> Part of this change had been the role that these organizations can play in the business of ANA. All affiliate organizational members could participate through their president, in open ANA Board of Directors meetings, and in executive general sessions of the Board. However, they were not participants in the meetings of executive business sessions of the ANA Board where strategic business relationships are discussed.

Thus the ANA had succeeded in restructuring itself in relation to how it would address the labor concerns of its constituent members, and allow for the potential of additional nursing organizations to gain formal affiliation with the ANA. As clarified by some ANA interviewees, conditions of these organizational agreements were to be represented through legal documents referred to as affiliation agreements. Each

affiliation agreement is unique to the individual organization seeking affiliation. The initial bylaw changes provide for only one organizational affiliate to represent the union interests of RNs (the UAN), and one organizational affiliate to represent the labor interests, other than through unionization, of RNs (the Center for American Nurses).

Although the impetus to creating the membership category of Affiliate Organizational Member was initially the strategy to provide autonomy to and ANA affiliation for the UAN and the Center for American Nurses, there remained the opportunity for other nursing organizations to become ANA members as Affiliate Organizational Members. The idea was expressed by one ANA interviewee, stating, "The [ANA] Board really did believe that they could get additional Affiliate Organizational Members through the changes made in the language of the bylaws, but the impetus for the change was the independence of the UAN from the ANA."

Clarification of ANA membership categories was just the beginning in realizing the organizational changes. The Affiliated Organizational Members, the UAN and the Center for American Nurses, needed to formalize their relationship with the ANA. This was done through official documents known as Affiliation Agreements.

Affiliation Agreements Established

In January 2003, at the UAN Special National Labor Assembly, the delegates overwhelmingly supported the ANA/UAN autonomy and affiliation agreement. Also, the affiliation agreement with the Workplace Advocacy Program was drafted and reviewed by February 2003. Different from the UAN affiliation document, this draft document did not use the word 'autonomous' in its title, but rather was entitled *Affiliation Agreement*, and pertained to the relationship of ANA with the American Nurses Coalition for

Workplace Advocacy (ANC\WPA), identifying the ANC\WPA [Center for American Nurses] as an Affiliate Organizational Member of ANA (ANA, February 2003). The difference in the agreement titles coincides with several interviewee comments from ANA, UAN, and the Center for American Nurses that stated the workplace advocacy program was always considered a part of ANA, and that its autonomous organizational status was granted only to parallel the status of the UAN.

The work expectation by the ANA Board of Directors of the newly autonomous Center for American Nurses was identified in an ANA briefing paper focusing the ANA's strategic goals on the nursing shortage, staffing, workplace rights including health and safety, and patient safety/advocacy. The Center for American Nurses was identified as the key organizational component of the ANA responsible for many aspects of these topics (ANA Board of Directors Meeting Volume One Agenda Item #1&2, March 2003).

The details pertaining to the financial arrangements between the Affiliate Organizational Member and the ANA were negotiated in the affiliation agreement. As shared by one Center for American Nurses interviewee:

> The structure provided more independent organizational entities with ANA affiliation, and thus their governance would be independent, how were resources to be provided by ANA, and how were resources to be maintained by the self-governed organization? This was addressed through the development of the Affiliation Agreements.

Regardless of the perspective, the ANA bylaw language governs all affiliation agreements with the ANA. The ANA bylaws (2003) state the following:

a. Definition

> An associate organizational member (AOM) is a nursing organization that establishes a working relationship with the ANA through a formal affiliation agreement approved by the ANA Board of Directors. There shall be only one AOM for collective bargaining, that is, an organization that has as its primary

> focus offering collective bargaining representation in the workplace, and one AOM for workplace advocacy, that is, an organization that has as its primary focus offering non-collective bargaining representation in the workplace.
>
> b. Qualifications
>
> To be qualified as an AOM, the nursing organization must be one that – is composed of individual members or organizational members and may include organizational affiliates.
>
> 1) has articles of incorporation or constitution and bylaws that govern its individual members and regulate its affairs.
> 2) has stated and demonstrated purposes and functions congruent with those of the ANA.
> 3) has entered into an affiliation agreement with the ANA.
>
> c. Responsibilities
>
> Each AOM shall comply with the provisions of affiliation agreements and memoranda of understanding between the AOM and the ANA.
>
> d. Rights
>
> The president of an AOM, if elected in conformance with federal law, shall have an *ex officio* voting seat on the ANA Board of Directors. The AOM presidents shall participate in all portions of the Board of Directors meetings except those specified in the Board of Directors policy and as designated by the ANA president that address business matters or involve confidential discussion regarding ANA's strategic position in relation to other organizations (ANA bylaws, June 23, 2006, pp 9-10).

One ANA interviewee perhaps best described the process of establishing the affiliation agreements among these organizations stating, "The road got rocky with negotiation of the affiliation agreements." Other ANA interviewees also discussed the apparent difficulty in negotiating the affiliation agreements, noting that, "The restructuring negotiations were quite intense, with each organization (UAN, Center for American Nurses, and ANA) having attorneys involved in negotiating contracts, budgets, and other resources."

Another ANA interviewee shared that, "The biggest challenge of the change was the process of developing the affiliation agreements, mostly the negotiation of resources after the development of the affiliation with the UAN and the creation and affiliation with the Center [Center for American Nurses]." Another perspective from an ANA participant: The UAN approached the discussions related to creation of the entity [UAN] in the same way they approached negotiations with employers. This approach created much angst between the ANA and UAN, and as a result, areas of the affiliation agreement were left vague, thus creating difficulties in interpretation in the future. An example of this was the omission of language addressing individual member roles in the organizations and serving on more than one Board of Directors simultaneously.

And from another ANA interviewee, "The Center for American Nurses discussion was focused on getting their share of the financial pie. The Board felt the state members of the Center for American Nurses did not represent as large a group as the state members of the UAN."

More specifics on this were shared by one Center for American Nurses interviewee. In summary, the participant noted that membership in The Center for American Nurses was by the state nursing association, which is also a constituent member of the ANA. This arrangement does not allow for individuals to be direct members to either organization, although new language in ANA bylaws and proposed changes in The Center for American Nurses membership would allow such direct individual membership, as shared by two Center for American Nurses interviewees:

> Membership categories within the Center for American Nurses include 1. Constituent Member Associations, which are the state nursing association members of the ANA who pay an additional fee to belong to the Center for American Nurses, 2. Individual Nurses, or Association Members – this category

> is presently being activated and dues will soon be set by the Board of the Center for American Nurses, and 3. Specialty Nursing Organizations and/or hospitals – also in the process of being activated. The Constituent Member Association was the initial Center for American Nurses members, and these were 39 state nurses associations who are the state constituent members of the ANA, out of a total of 54 constituent ANA members, and a separate dues is paid to belong to The Center for American Nurses.
>
> The leadership involvement in The Center for American Nurses from these constituent member associations has been mostly of nurses who are administrators and educators. There were, however, improved relations between ANA and the Center for American Nurses, with those negotiations [formation of the affiliation agreement] going smoothly. The initial Center for American Nurses affiliation agreement was negotiated for five years, with subsequent agreements covering a two year time period.

Although it seemed clear that the UAN's work would focus on nursing labor issues and collective bargaining and serve as the union for RNs, and the Center for American Nurses would work on RN labor issues through programs of workplace advocacy, the focused work of the ANA was not delineated. One ANA interviewee expressed this concern:

> ANA had specified and delineated the work of the UAN and the Center for American Nurses, and neglected, in the process, to delineate their own focus. It was similar to a divorce where precious valuables and other house contents are being removed from the house and divided among the parties, leaving the house sit and watch.

Another ANA interviewee shared that, "The restructuring created two new entities, but we never negotiated the work of these new organizations in relation to the ANA. We negotiated structures, but not the work."

And a third ANA interviewee stated:

> There were complex and exhausting meetings of members of the ANA board, UAN board and Center for American Nurses board, who were informally referred to as the negotiating team. Part of the philosophical questions asked, regarding the restructuring and the creation of affiliated organizations, was what focus these organizations would have. If it would be understood that the UAN would be focused on collective organizing, and the Center for American Nurses would focus on non-union workplace products that support the nurse in the workplace,

> what would be the focus of ANA….in other words, what is left for ANA to do. When the restructuring proposals passed the affiliation agreement and by-law process, members seemed satisfied, and there are still some pieces to address.

In summarizing some ANA interviewee comments, it is important to understand the relationship between the terms of the affiliation agreements and the conditions of the organizational affiliations addressed by the ANA bylaws. Whereas the affiliation agreements may address non-membership issues of organizational affiliation, as membership organizations, these initial organizational affiliates specifically entail the sharing of membership, and thus membership dues distribution remained an issue of debate in maintaining negotiations of the agreements. Three interviewees from the ANA shared the issues of concern in explaining the affiliation agreements:

> Any new changes in existing affiliation agreements are governed by the language of the bylaws, and thus must abide by that language, but changes can be negotiated by the ANA Board of Directors without House of Delegate approval so long as the House policies are not violated.
>
> Because the ANA was limited in its financial resources, part of the dues members pay to states, and part to the ANA, which then is divided between ANA and the Workplace Advocacy Program and UAN (if the constituent member association is a member) or both. There was never a clear-cut distinction between what the groups do differently. The UAN is now even created their own political action committee.

The affiliation agreements are time limited and thus must be periodically renegotiated among the organizational leadership as specified in the agreements. Such an arrangement does allow for affiliations to be discontinued rather than be renewed. One ANA interviewee shared the following individual perspective on the potential for non-renewal of the affiliation agreement, particularly with the UAN:

> Personally, this will not happen because the individual nurse member views their affiliation with the state constituent member of the ANA rather than with the UAN. If the UAN would leave the ANA, the constituent member association would remain a member of ANA. The individual member would have to drop their membership with the constituent member association and ANA and join the

> UAN, and this would be unlikely given their affinity toward the state nurses association.

Still other ANA interviewees shared their perspective on the topic:

> In discussing the affiliation agreements and their need to be renegotiated at times, it was shared that the UAN has made the statement that if their needs are not addressed by the ANA, they will end the affiliation agreement. A present issue under negotiation regarding the affiliation agreement is the UAN' request to do a one time dues assessment of its membership, with 100% of that money going to the UAN for organizing purposes. The ANA has a problem with the UAN raising the dues of its members, who are also ANA members, without ANA getting any additional revenue.

Negotiating the Affiliation Agreements between the ANA and the UAN and the ANA and the Center for American Nurses was not an easy task. Concerns of control, power, and autonomy remained, greatly contributing to a level of distrust among these three organizations. Clarity of work focus missing, and concerns of organizational encroachment were real. There was seemingly a lack of a shared vision and lack of solidarity in justifying the new organizational structures. The desire to protect the organizational powers prevented a collaborative effort toward common interests and goals. Conflict within the ANA continued, and the ANA leadership confirmed their identity as a labor organization.

Organizational Terminology Clarified: ANA Remains a Labor Organization

As the ANA Board refined its work and structure, they also clarified their language. Preparing for yet additional bylaw amendments for the 2003 House of Delegates, the Board of Directors prepared a glossary of terms defining, among others, the *Associate Member Division*, an option for both organizations and individuals to be associate members, *Labor Organization*, defined under the Labor Management Reporting and Disclosure Act as an organization that exists, in part, for the purpose of dealing with

employers regarding terms and conditions of employment, *Member at Large*, individuals joining ANA directly as members and able to exercise full membership rights, and *Professional Practice*, the broad scope of ANA's purview encompassing nursing standards and ethics; education; advocacy for nurses and patients, including legislation and political action; policy development and analysis; building knowledge resources; and supporting credentialing and research (ANA Board of Directors Meeting Volume Two, March 2003).

It is during this time that the ANA Board of Directors reaffirmed its identification as a labor organization. As expressed by one Center for American Nurses interviewee, "ANA was perceived by many to be exclusively a labor union, as opposed to a professional society that provided collective bargaining services to its members. This perception was expressed by state nursing associations not involved in collective bargaining services." The Board identified the ANA as a "multi-purpose organization with a designation as a labor organization under law and will reflect this status and designation in bylaws proposals" (ANA Board of Directors Meeting Volume One, March 2003, p. 5).

From the ANA leadership perspective among the ANA interviewees, if the organization was to no longer be viewed or even designated a labor organization, the work of the Workplace Advocacy Commission would also need to be further delineated from the work of ANA. As mentioned by one Center for American Nurses interviewee, The Workplace Advocacy Commission was approached by ANA's leadership and asked to also consider establishing themselves as an independent organization with an affiliation with the ANA; "The Workplace Advocacy Commission never wanted to leave

ANA, but ANA forced it. It was the bylaws changes that created the UAN and Workplace Advocacy Commission."

According to one Center for American Nurses interviewee, although this came as a surprise to the [Workplace Advocacy] Commission leadership, it was viewed as an opportunity to ensure its share of the pie of resources from the ANA, and provide parity with the UAN. This was expressed by another Center for American Nurses interviewee:

> The creation of the Center for American Nurses, out of the ANA Workplace Advocacy Commission, was perhaps created to demonstrate outwardly to its membership that ANA was providing equal resources to both union and non-union members in addressing the economic and general welfare concerns of its membership. The restructuring was perceived as a way of focusing labor resources and responding to members who expressed concern that ANA was just a labor union, concerned only with labor issues, and not addressing the more global issues of the profession of nursing.

One ANA interviewee provided additional background to this discussion. To further examine this issue, it was made clear by an ANA interviewee that one must distinguish between the terms 'labor organization' and 'labor union.' The interviewee provided specific language and quotes to make this distinction:

> As background, the Labor Management Reporting and Disclosure Act defines a labor organization as one that exists for the purpose, in whole or in part, of dealing with employers concerning grievances, labor disputes, wages, rates of pay, hours, or other terms and conditions of employment. The interviewee noted that because of its collective bargaining and workplace advocacy programs, ANA has consistently abided by the terms of the Labor Management Reporting and Disclosure Act. Even though the ANA is a multi-purpose professional association, and not a union, it is deemed a 'labor organization' under the law. In addition, some of the workplace advocacy programs of the ANA could fall within this definition because the Department of Labor has historically interpreted the definition of 'labor organization' quite broadly; it does not require direct dealings with employers.

The interviewee continued:

> On this issue, there is some old Department of Labor guidance on labor organizations that includes a specific example of a state nurses association [that]

> states in its bylaws that one of its purposes is to promote and protect the economic and general welfare of nurses and has an economic security program authorizing the association to improve the employment conditions of nurses by using all appropriate instruments including collective bargaining. Such an association may be said to exist at least in part for the purpose of dealing with employers as a representative of employees regardless of whether or not the association actually negotiates directly with employers at the present time.

Thus, the ANA is viewed as a labor organization, but not a labor union. It is the state nurses association who holds the specific labor contracts with employers, not the ANA. ANA does not negotiate labor contracts with employers. However, since the ANA member, the state nursing association does such activity, the ANA does engage in labor issues, and is thus considered a labor organization.

Conceptually, if ANA were to no longer serve as a labor organization, it would no longer be engaged in the labor or work issues of nurses. As a professional society, it would only engage in the issues pertaining to the practice of professional nursing regardless of where those practices were implemented. The ANA interviewee continued, stating:

> The ANA itself is NOT a certified bargaining representative, but it is a labor organization. But in the labor community, labor union and labor organization are used interchangeably which creates confusion in the nursing community about ANA; specifically, some in the nursing community view ANA as a union, even though it is a multi-purpose professional association.

In distinguishing the professional focus of ANA's labor work, one ANA interviewee discussed the work of the UAN in comparison to other national labor unions:

> In regards to how the UAN differs from other national unions that represent nurses, the UAN has always promoted professional performance over promoting the economic value of nursing. The meaning of the term economic and general welfare as utilized by the ANA in its 1896 charter was that the ANA would utilize strategies to work with and address our direct contribution to society.

The interviewee made reference to a comment from Ada Jacox in the 1940's when the ANA created the Economic & General Welfare program:

> When Ms. Jacox noted the desire of nurses to be professional, to say they are a union is viewed as non-professional. It really is a demonstration of the power of the political climate within each state in relation to their view of unions and right-to-work vs. non right-to-work states.

Taking an organizational perspective, the same interviewee noted that for the ANA Board to state that they wanted to remove the language of being a labor organization from the bylaws would only feed the paranoia that the ANA is simply not interested in nursing being unionized and not interested in supporting the UAN, and not committed to union nurses. "This is really not true, and the California Nurses Association and the Massachusetts Nurses Association would actually use such a declaration against ANA because it would affirm their dissatisfaction with ANA and their ultimate disaffiliation with the ANA."

Regarding the ANA's consideration to no longer serve as a labor organization, one ANA interviewee noted that ANA remains a labor organization:

> The Board of Directors did not bring forth to the House of Delegates the recommendation for removing any references to ANA as a labor organization. This was a unanimous decision of the Board of Directors in 2002, to remain a labor organization, and thus no language changes to the bylaws.

These comments refer to the ongoing struggle within the ANA as the organization continues to battle with the more philosophical issue in defining the difference between labor and professions. Even with clarification of terminology and references, among the organizational membership there remains a conflict that has influenced ANA's most recent restructuring. One UAN interviewee offered another perspective:

> There is an elitist attitude in the organization. If you ask nurses, they think the union would be conflicting with the public's trust in nurses. The values of

> nursing and the work we do are what society knows. When you talk about 'blue-collar' that is a stereotype. Nursing is a profession and we are employees of organizations. The recent restructuring is a continued display of the philosophical struggle between blue-collar versus professional issues. The bottom line is that the staff nurse at the bedside is hired as an employee of an organization, and thus his/her concerns and needs related to his/her work are the focus of the UAN.

Other concerns surrounding this issue are expressed by other UAN leader interviewees and summarized. The state nursing association, as a certified bargaining unit by the state labor organization could not have the union activities of its economic and general welfare program administered in any way by members who held management and supervisory employed positions as defined in labor law. To manage this within the state nursing association of ANA, the organizations needed to provide an organizational structure and operating policies that insulated the union work from being administered by the non-union nurse administrators, including the management and distribution of member dues dollars. One ANA interview participant explained this need:

> There must be insulation from management influence in collective bargaining units. The Boards of Directors in all of our state associations contain managers, administrators, and educators who have traditionally made decisions that adversely affect staff nurses represented in collective bargaining. The states that do collective bargaining have insulated those programs by establishing a governance system for their collective bargaining units that do not contain non-union members.
>
> If you look at what occurred in California and Massachusetts you can see how they effectively used the insulation issue in their goal to disaffiliate from the ANA. Most recently, the restructuring in Hawaii and Michigan was also an example of using the insulation issue to insure that non-union management must be excluded from their state Board of Directors.
>
> The friction that continued with the UAN and the ANA was that the ANA Board continues to make decisions and feel they have influence over the UAN. Often times these decisions and policies are adversarial to staff nurses represented in collective bargaining. I do not see this conflict being resolved until the ANA is willing to abide by its own autonomy agreement and structural change.

Thus the last interviewee comment above illustrates the perspective that the affiliation agreement between the ANA and the UAN was indeed a document that fully

legitimized the work of the union as separate and autonomous from the ANA. The last statement is a reflection of the union leadership belief that the ANA leadership continued to make efforts to control the work of the UAN.

Addressing the issue of professionalism and unionization another UAN interviewee provided the following:

> As staff nurses across the country began to utilize traditional union activities in organizing themselves in order to have their needs addressed, the concern among nonunion nurses was that the profession would begin to lose its professional status and be viewed as blue-collar laborers.

According to another UAN interviewee, and summarized, among nursing's union leaders, this was not a concern as they organized themselves collectively and exclusively among the ranks of RNs, negotiating nursing practice and patient care issues among traditional wage and work hour issues. "The UAN is concerned with professional practice issues and includes those issues in contract language and at the bargaining table, along with concerns of working conditions such as picking vacation and seniority, as examples."

As the debate continued, the Board identified the Workplace Advocacy Commission as a future autonomous entity of the ANA family. Both groups signed the affiliation agreement on February 27, 2003 and the Center for American Nurses became an affiliated organizational member of the ANA (ANA Board of Directors Meeting Volume One Agenda Item #6b, March 2003).

The ANA clarified its identity as a labor organization, and explicitly clarified the difference between a labor organization and a union. However years of philosophical debate regarding professional involvement in union activity remained. Individual nurse leaders continued with passionate beliefs and perspectives regarding this issue. Although

there was clarity, more bylaw changes would be required to continue the development of the ANA.

More Proposed Bylaw Changes

The ANA Committee on Bylaws prepared for additional proposed bylaw changes to be addressed by the 2003 House of Delegates. The committee reported receipt of field review comments on the proposals from 23 constituent member associations, the ANA Board of Directors, the American Nurses Foundation (ANF), Workplace Advocacy Commission, UAN Executive Council, and four individuals from Missouri and Ohio (ANA Board of Directors Meeting Volume One Agenda Item #6k, March 2003). Bylaws proposals were reviewed which included the change from existing bylaws and the rationale for change (ANA Board of Directors Meeting Volume One, March 2003). Two areas of concern expressed by 29 constituent member association's was the length of time between meetings of the House of Delegates as one proposal is to move the House of Delegates meeting from annually to every other year, and concern of membership confusion with implementation of the individual/direct member option, and thus the constituent member association's are requesting this as a pilot program (ANA Board of Directors Conference Call Meeting, May 2003).

In addition, the ANA Board began the process of establishing a new dues structure to reflect the new organizational relationships with Affiliate Organizational Members. This was necessary as the newly formed Affiliate Organizational Members, the UAN and Workplace Advocacy, have shared constituent member associations as members (ANA Board of Directors Meeting Volume One Agenda Item #10, March 2003).

By June 2003, the ANA Board of Directors addressed the concerns of constituent member associations regarding the proposed bylaw changes. In addition to making the individual/direct member a membership option on a pilot project/state option basis requiring agreement between the specified constituent member association and ANA, the Board addressed concern from constituent member associations that the House of Delegates has final approval of any proposed mergers and acquisitions by ANA. The Board also began discussion regarding Affiliate Organizational Member presidents on the ANA Board of Directors, bringing up issues of "transparency, reciprocal representation, distinguishing between business and policy agenda items, and competition" (ANA Board of Directors Conference Call Meeting, June 2003).

While the ANA volunteer leadership addressed full implementation of the new ANA organizational structures and membership categories, management of these new organizational components needed to be addressed among the ANA staff. ANA internal policies and procedures were developed to direct the management of the new ANA. Issues such as human resource allocation within the ANA, and office space use now needed to be negotiated as the UAN and the Center for American Nurses maintained their home within ANA headquarters.

Internal Management of New Organizational Structures

The Implementation of internal policies and operations to reflect the newly established Affiliate Organizational Members and their affiliation with the ANA moved forward, but not without a struggle. The ANA Board decided to establish a committee consisting of representation from ANA, UAN, and Workplace Advocacy staff to address operations and infrastructure issues. A Leadership Committee of elected and appointed

members and ANA, UAN, and Workplace Advocacy staff leaders was also created to address relationship policies. The Workplace Advocacy Commission chair expressed concerns that [restructuring] negotiations had been painful and there existed a need for healing and coming together, while the UAN chair expressed that there may be times where the entities will simply need to agree to disagree. In addition a report from the Bylaws Strategy Work Group, meeting weekly at times prior to the 2003 House of Delegates in June, identified concerns raised among constituent member associations regarding establishment of Affiliate Organizational Members including the management of ANA and Affiliate Organizational Member conflicting positions, perceptions of the Workplace Advocacy Program being badly treated during [restructuring] negotiations, and the impact of dues restructuring on Constituent Member Association revenue (ANA Board of Directors Volume One, June 2003).

One UAN interviewee expressed that with the organizational restructuring and the establishment of the Affiliate Organizational Members through affiliation agreements there was created a requirement for a meeting of the executive officers of the boards of the ANA, the UAN and the Center for American Nurses. It is believed that these meetings were not productive and often not fully participated in by all three organization's executive board members. It was felt by the UAN that the Center for American Nurses was circulating propaganda to the states that the UAN is being antagonistic and not participating in the process.

Staff level meetings were held as planned. As mentioned, these meetings were attended by key staff and leadership of the ANA, UAN, and the Center for American Nurses, and were occurring to transition to the new ANA structure. The meetings

resulted in the identification of 77 action or information items to be addressed with the passing of proposed bylaw amendments by the 2003 House of Delegates (ANA Board of Directors Meeting Volume Two Agenda Item #9, June 2003).

ANA participant interviews further illustrate the significance of needing to address these internal organizational operational issues. The issue of distribution of work among the ANA, UAN, and the Center for American Nurses is critical because before the establishment of the UAN and the Center for American Nurses as autonomous from but affiliated with the ANA, the work of these two organizations was structured under the auspices of the ANA. Without distinction in the role or work focus of these organizations, confusion remained. One ANA interviewee expressed this concern:

> Although the UAN and the Center for American Nurses have formed, ANA continued to do the work of these organizations. There were multiple fears. ANA was fearful, as it is conceivable that the organization would continue to dwindle, and the UAN feared that its clout was related to the affiliation with ANA. The Center for American Nurses was supportive of the core work of ANA, but very busy with establishing their own organization, and their constituency was not as large and established as the UAN constituency.

Another ANA interviewee expressed the following:

> The Center for American Nurses was busy trying to legitimize itself, thus the issue really revolved around the discussions between the UAN and the ANA. The struggle has not changed, other than the existence now of the UAN as a separate organization. ANA continued to view the UAN as an integral part of ANA, not a very different view from the way the ANA viewed the UAN prior to the restructuring and the affiliation agreements, and yet the bylaws language clearly stated that the Affiliate Organizational Member is an autonomous entity from the ANA, affiliated through the agreements.

Even with clarity in bylaw language and legal affiliation agreements, the ANA, the UAN, and the Center for American Nurses were still clarifying their identities and their relationships with one another. Housed in one building, sharing resources, and

negotiating what it meant for the UAN and the Center for American Nurses to truly be separate but affiliated with the ANA proved to be difficult.

Workplace Advocacy becomes the Center for American Nurses

In addition to the meeting of the ANA House of Delegates in June 2003, the first Governing Council of the Center for American Nurses was held on June 27, 2003. The Center for American Nurses [formally the Workplace Advocacy Commission] meeting was attended by 35 Constituent Member Associations and addressed proposed Center for American Nurses bylaws, election of officers, and strategic organizational development. The 35 Constituent Member Associations declared their intent to belong to the Center for American Nurses (ANA Board of Directors Meeting Agenda Item #4b, June 2003). Almost simultaneously, the UAN National Labor Assembly met, and delegates overwhelmingly ratified the Agreement on Autonomy and Affiliation between the UAN/AFL-CIO and ANA (ANA Board of Directors Meeting Volume One Agenda Item #4c, June 2003).

An additional challenge of The Center for American Nurses had been its own identity and portrayal of that identity in relation to the UAN. The majority of The Center for American Nurses leadership perceived its work as providing services and products to individual nurses through the state nursing association to support them within their practice environment. The distinction of what they do had evolved from the language of providing workplace advocacy to nurses, to providing workforce advocacy. This distinction was mentioned by two Center for American Nurses interviewees:

> The biggest challenge for The Center for American Nurses was to inform nurses of the work it does and how it can help them. Nurses were simply not aware of what workplace advocacy is. In fact, The organization changed it's verbiage to utilize the terminology of 'work force' advocacy as opposed to work place,

> clarifying that the organization's focus was on the nurse and not on the practice setting. A significant change in the verbiage used by The Center for American Nurses in the work that they do is the change from stating they provide 'workplace' advocacy to 'workforce' advocacy, reflecting the focus on the person or nurse rather than their work setting. This is a distinction from collective bargaining that may focus more on the workplace. The Center for American Nurses provided resources to individual nurses so that the nurse could individually advocate for themselves in their specific work settings. The 'work-setting' is all encompassing, including the full spectrum of work settings in which nurses practice.

The belief is that this distinction further differentiates The Center for American Nurses from the work of the UAN in that The Center for American Nurses's focus is the individual nurse in practice, regardless of the practice setting, as delineated by two Center for American Nurses interviewee comments:

> It [The Center for American Nurses] provided products that land in the laps of individual nurses to assist them with their practice within the setting that they practice. As The Center for American Nurses developed, it focus was understood to be purely on the nurse. This is analogous to the solar system, where the nurse is the sun and the rotating planets are the working conditions. By supporting the individual nurse in their work setting there was believed to be a link to improving patient care outcomes.

In summary, this is in contrast to the UAN whose work is focused on organizing nurses collectively under union contracts in order to address the workplace issues of nurse as employer to an employee. The challenge to The Center for American Nurses has been its portrayal as an alternative to collective bargaining, and even being anti-union. In response to this challenge, one Center for American Nurses interviewee noted that The Center for American Nurses leadership stated their membership consists only of those who are not represented by collective bargaining contracts who seek products to support them in their work setting:

> The Center for American Nurses is not an alternative but rather provided products and tools for nurses who are not involved in collective bargaining, either by choice because their work organization had not chosen to organize, or because

> their state nurses association did not provide collective bargaining services. The Center for American Nurses provided workplace support to individual RNs through their state nursing association membership in The Center for American Nurses by providing products and tools for RNs to use in addressing their workplace issues. The Center for American Nurses is a 501c6 professional organization.

Two Center for American Nurses leaders interviewed expressed a positive reaction to the establishment of the UAN as an independent organization affiliated with the ANA, for now there existed a specific national nursing organization, run by registered nurses, whose work is the representation of nurses through collective bargaining. In summary their comments reflected that having the UAN as a separate, insulated organization was helpful. Although there appeared to be no large changes in membership as a result of the restructuring, it was expressed that by having a separate organization that can focus on collective bargaining could increase membership as resources could be better dedicated to organizing more labor units, however specific targets/goals/outcomes were not provided.

In summary, several interviewees from the ANA, UAN, and the Center for American Nurses expressed that the work of the UAN was clear, and permitted other nursing organizations to continue their work for nursing. However, this perspective was not well communicated throughout the nursing community, and most nurses continued to have no understanding of the work of ANA, the UAN, or The Center for American Nurses.

Constituent Member Associations Affirm Commitment to the ANA

As mentioned previously, ANA's Constituent Member Associations were consulted, and concerns regarding the proposed bylaw amendments were raised. With bylaw passage, the Constituent Member Associations further discussed their relationship

with ANA through meetings of the Constituent Assembly. There was an expressed need to reaffirm the Constituent Member Association relationship to the ANA, especially in light of previous Constituent Member Association disaffiliations. It was noted that "…any action that weakens a CMA [Constituent Member Association] and threatens or dissolves its relationship with ANA affects every other CMA and ultimately becomes a survival issue for ANA as the voice for registered nurses and the nursing profession" (ANA Board of Directors Meeting Agenda Item #2, December 2003, p. 1). The Constituent Assembly also noted that since 1995, beginning with the disaffiliation from the ANA by the California Nurses Association (CNA), ANA had lost nearly 50,000 members, and membership in 2003 was at 151,000 RNs. It was also recognized that any further decline in membership would threaten ANA's seat at the policy-making table in state, national and international settings (ANA Board of Directors Meeting Agenda Item #2, December 2003).

Finally, it is also recognized that the existing California Nurses Association and Massachusetts Nurses Association were campaigning in Arizona, Missouri, and Hawaii in an attempt to compete with ANA by encouraging further disaffiliations of the Constituent Member Associations in those states (ANA Board of Directors Meeting Agenda Item #2, December 2003). Meanwhile, the Center for American Nurses met on November 7, 2003 announcing the passage of bylaws for incorporation in October 2003, and the national search for an Executive Director (ANA Board of Directors Meeting Agenda Item #6g, December 2003).

A busy restructuring year ended for the ANA, and found the full establishment of two new independent nursing organizations with ANA affiliation agreements. Relationships among these organizations would continue to evolve in the coming months. But years of focusing on the internal needs of the ANA and its work as both a professional society and a labor organization did not go unnoticed by the membership. Years of struggle with conflict, control, and resource allocation created a level of distrust among the leadership of the ANA, the UAN and the Center for American Nurses.

Years of Internal Organizational Focus

With the accomplishment of the House of Delegates approving the bylaw changes that allowed the ANA to restructure, it remained the work of the leadership among the newly established organizations and the ANA to determine how the structure would now impact the work of the organizations in addressing the professional and labor issues of nursing. Although this work may have been expected to occur through negotiations of the affiliation agreements, there remained a need for clarification and an existence of conflict surrounding philosophical beliefs of control as the ANA continued its role as the voice of nursing in the U.S. Such conflict has resulted in the ANA spending years internally focused on its structure. As mentioned by one ANA interviewee:

> When you examine organizational structure, the purpose of the organization needs to drive the structure. Just because you change the structures it does not necessarily improve the relationships in the organization. Momentarily, structural change is helpful, but not long lasting if the relationship issues have not been resolved.

Such reference to relationships issues are related to the organizational leader's inability to create a shared vision and common goal for the profession of nursing and its practice.

Throughout the process of interviewing the ANA leadership there was an expressed concern regarding the time and effort the structural changes have had on the work of the ANA. Many ANA interviewees expressed concern that the lengthy focus inward on organizational restructuring was occurring at the expense of ANA's purpose to represent the nursing profession in addressing national issues of health care. This inward focus on structure at the cost of fully addressing organizational goals in representing the profession illustrates an organizational displacement addressed my Robert K. Merton (1940). The methods of reaching the organizational goals were divergent among union and non-union organizational leaders. The divergence rose to conflict as organizational activities no longer fit the established organizational bureaucracy. Lacking experience in addressing the conflict, the organizational leaders displaced their conflicted concerns inward to organizational structures. This displaced focus may also be related to inequities in status among nursing ranks with hospital bedside nurses mis-recognized as subordinates rather than as knowledge workers. However, the conflicts remained. One ANA interviewee addressed this concern as follows:

> Many resources were spent on governance. The internal environment and the external environment also needed to have a focus…the external environment being the participation of ANA in the larger health care arena in the U.S., as well as with other nursing organizations, and other health related organizations. The focus on [internal] governance meant that ANA had been unable to participate as much as it should in this larger arena. An excellent example of this was provided when the House of Delegates failed to approve the move to a bi-anneal meeting of the House until a later date, thus creating the need to finance an additional meeting that would not have been necessary if the initial time for implementation of the two-year meeting would have been approved. However, the members of the House [of Delegates] felt that the meeting was necessary in order to deal with reorganization issues.

Whether this internal focus was necessary for the continued evolution of the ANA, or more of a result of sociological beliefs of behaviors of oppressed groups, there

remained concern among the leadership of the toll it was having on the work of the ANA, as expressed by one ANA interviewee; "There remained a chronic internal focus. A focus on how we manage ourselves and perhaps this is a reflection of our history as women and nurses and of feeling oppressed, taking the minority perspective, and the victim role."

Four other ANA interviewees weighed in on this issue:

> Perhaps part of the inertia in ANA's ability to specify its work was related to the performance of the ANA staff leadership who seemingly remained internally focused on struggles among the staff and the relationship among the staff of the newly formed organizations. Perhaps also the make-up of the newly elected ANA Board of Directors in the early part of the century also reflected the battle among the states, with each attempting to levy power and control while in the federation model and preparing to restructure.
>
> With greater understanding of the financial implications of programming run by the UAN and the Center for American Nurses, it had created somewhat of a power struggle among the UAN, the Center for American Nurses, and the ANA. Part of this struggle was the need to understand that some ANA programming was revenue producing, while other programs were overhead. All of this had contributed to the increasing focus of ANA on fiscal matters, and thus the continued focus inward.
>
> The focus on dealing with relationships with the UAN was taking resources that could have been used in other arenas. There existed paranoia on the part of some that the UAN would ultimately completely disaffiliate with ANA. Although the UAN stated that they were not interested in this happening, their behavior in relation to dealing with ANA seemed to indicate the intent to ultimately leave.
>
> The restructuring probably weakened the ANA…we had less of a piece of the pie because we were spending more time discussing the relationship with the UAN and not getting to other issues, and the House of Delegates had complained that the Board of Directors was dealing too much with this and not enough on practice issues.

Thus there was a consensus among the ANA leadership interviewed that there was indeed a large focus inward in managing the process of change in the organizational restructuring. Of concern was the influence such an extended period had on the ANA's ability to serve as the professional society for nursing in the U.S. as expressed by one ANA interviewee:

> ANA's performance as a professional society since the reorganization could be assessed as poor, and understandably as it had continued to struggle financially it had also lost an increasing number of paid support staff resulting in less people to get the work done.

The UAN leadership also provided a perspective on the organization's years of internal focus. Each UAN interviewee addressed the internal focus, with one stating that, "During ANA meetings of the Constituent Assembly at conventions, the assembly often spoke of their desire to focus more on nursing issues and less on organizational by-law changes, and yet the ANA continued its focus inward."

Other comments from the UAN interviewees were as follows:

> ANA had focused internally at the expense of serving the profession. This had to do with both staff and volunteer leadership on both sides. ANA needed to take advantage of the Center for American Nurses and the UAN rather than struggling with them. There needed to be collaboration, but it seemed as though the ANA was being controlling.
>
> The Center for American Nurses was more a part of the ANA [than the UAN] because of the structure of each organization. The question remained, 'who is the member?' The structure was governed by the bylaws, and the affiliation agreements were individualized in the negotiating process.
>
> ANA continued to be internally focused, at least the leadership was. Staff worked on external products, but the leadership remained internally focused.
>
> The current structure did not help alleviate the anger and resentment that developed [among the UAN, ANA, and the Center for American Nurses] over organizational activities that became internally conflicted due to the differences in the political agendas among the variety of nurse members, i.e. administrators, educators, advanced practice nurses, researchers.

And, in summary from the Center for American Nurses interviewees, internal focus may have challenged the ANA in its focus on national policy issues that affect nursing as a profession. In addition, ANA needed to continue its good work providing nursing practice standards and maintaining the profession's code of ethics. If the ANA was to survive as the professional society for nurses in the U.S. it had to establish its niche, increase its external focus and greatly decrease the internal focus created in

attempting to manage the internal organizational conflict among the state nursing associations pertaining to workplace advocacy and collective bargaining. Such strong statements were supported by the comments of two Center for American Nurses interviewees:

> Also occurring within ANA at the pre-2000 time was the merger of two organizational structures, the Congress on Nursing Practice and the Congress on Economic and General Welfare. Such a consolidation weakened ANA's focus on nursing practice issues such as practice standards, ethics, and policy development with an outward focus of the organization, to a greater inner focus on the organizational/professional issues of how the organization was addressing workplace issues of nurses. This struggle supported the ANA's increasing internal focus on its organizational issues rather than focusing on the broader issues of national nursing practice issues.
>
> ANA had become internally focused with addressing the issues. Restructuring was not addressed to external challenges. The UAN had been rebellious, and ANA leadership had given into this behavior. The Center for American Nurses had been less rebellious but developing as an organization. We remained internally focused.

The need of the ANA leadership to focus internally for so long was perhaps felt by members and leaders as necessary for its survival. Certainly it was done in response to member concerns, as is appropriate for a membership organization. But perhaps also developed was a lack of confidence by individual nurse members of each organization's ability to fully address the concerns of the membership and the profession. It seemed the bigger issues facing the profession had been overtaken by concerns of organizational viability and power.

2004: Looking to the Future

In addition to further establishing the relationship of ANA with the UAN and the Center for American Nurses, the ANA Board of Directors began to look to how their new structure could be further implemented. Policy details continued to be established.

Policy Development to Manage Organizational Structural Changes

The ANA Board of Directors addressed implementation of bylaw Article II, Section 2d pertaining to Affiliate Organizational Member presidents' involvement in ANA business during meetings of the ANA Board of Directors. The Board moved the following:

> The AOM [Affiliate Organizational Member] presidents shall not participate in portions of ANA Board of Directors meeting s that address business matters or involve confidential discussion regarding ANA's strategic position in relation to other organizations. This policy does not extend to minimal or passing references to business matters or ANA's strategic position in relation to other organizations. This policy applies to formal meeting as well as informational meeting such as 'touch base' meetings connected to the House of Delegates or other structural meeting of the association that are called by the President of ANA (ANA Board of Directors Meeting Volume One, March 2004, p. 7)

Looking to the future, the ANA president announced the establishment of a task force to develop criteria for and possible expectations of future Affiliated Organizational Members (ANA Board of Directors Meeting Volume One, March 2004). The Task Force quickly drafts Criteria *for Consideration of Organizations as Future AOMs* [Affiliate Organizational Members]. The document addressed possible legal difficulties if the Affiliate Organizational Member operates a political action committee (PAC) that under federal election law be considered an affiliated PAC, and the issue of competing programs with the ANA (ANA Board of Directors Meeting Volume Two Agenda Item #12a, March 2004). The need for such discussion is further addressed by one UAN interviewee.

The UAN interviewee expressed that with the restructuring we now had the UAN and the Center for American Nurses, separate and independent organizations from the ANA. Other details needed to be worked out, for example, when lobbying, does ANA

really still need a labor lobbyist if the UAN and the Center for American Nurses are doing this work?

Other concerns, according to one Center for American Nurses interviewee, regarding the independent establishment of The Center for American Nurses pertained to a philosophical perspective of further splintering the work of the ANA and specifics pertaining to actual work distribution and control:

> Change was only in the structure and that what needed to occur is a change in strategic thinking and strategic operations. ANA needed to be careful not to perceive itself as a parent and its organizational affiliates as the children.

From the Center for American Nurses perspective, ANA had an opportunity to now allow The Center for American Nurses to focus on workplace advocacy and the UAN to focus on collective bargaining, as mentioned by one Center for American Nurses interviewee:

> With the restructuring ANA needed to define who they were…. they were not a union, they were not a workplace advocacy group – other organizations now provided these services (UAN, The Center for American Nurses). Although the core issues and objectives may have served the ANA well, they were very broad and far-reaching. The organization needed to better understand what was important to the next generation of nurses in order to be relevant.

Perhaps, as expressed by one Center for American Nurses interviewee, the ANA needed to re-examine its view of the meaning of economic and general welfare as it pertained to the nursing profession:

> The ANA would benefit from an examination of what does E & GW [economic and general welfare] now mean? The ANA needed definitions that did not overlap with other Affiliate Organizational Members, and then determine how the ANA collaborated with the Affiliate to do the work of nursing?

Work to develop other membership options continued. The individual/direct membership categories were being piloted in several states, and a Task Force on

Organizational Affiliates was established to explore the Affiliate's role within the Constituent Assembly (ANA Board of Directors Meeting Volume One, March 2004). Additionally, the Board directed the ANA staff to initiate an environmental scan to assess progress with the strategic plan utilizing an approved form to report ANA's progress against strategic objectives (ANA Board of Directors Meeting Volume Two Agenda Item #6, March 2004). In anticipation of potential conflicting views or differing positions on public policy issues, the ANA Board drafted a decision tree pertaining to ANA-Affiliate Organizational Member policy coordination (ANA Board of Directors Meeting Volume Two, March 2004).

It appeared that the ANA, the UAN, and the Center for American Nurses continued to uncover potential conflicts in managing their new organizational relationships with each other. More detailed policy was needed, and the work of the ANA leadership remained internally focused. The future of the ANA, the UAN, and the Center for American Nurses will not only need to include continued legitimization, but will also need to include continuous examination of their relationships with each other. Such examination needs to go beyond formal structures and formalized bureaucratic policies toward efforts at collaboration in achieving a shared vision for the profession. Perspectives on the practice of nursing based on individual experiences need to be articulated and shared among the organization's leaders. With mutual understanding of the diversity in perspective and the experiences that helped to shape them the leadership can then established a shared vision for the profession that will then support structural establishments.

Perspectives on ANA's Future after Restructuring

The effect of this restructuring on ANA's ability to continue to meet its goals of serving as the professional society of nursing in the U.S. were mixed among the ANA leadership interviewed. Generally, it was understood that labor issues of the profession could now be addressed by the UAN and the Center for American Nurses, as expressed by three ANA interviewees:

> The good point of the reorganization was that the groups were held accountable for their activities since there was greater clarity in the costs of running such programs and the financial implications to ANA in maintaining a relationship with these programs.
>
> The structural changes in the ANA addressed the overarching goals and objectives of the ANA. The organization's work was now more specified because there were now two other organizations, the UAN and the Center for American Nurses, who were focusing on the economic and general welfare issues of members, allowing the ANA to focus on other nursing concerns. The ultimate goals of each organization were the same…nursing and patient care, but the methods of achieving the goals may be different, and all are necessary in order to achieve the goal.
>
> As the professional society of nursing, ANA needed to concentrate on practice standards and practice issues and workplace issues through the Congress on Practice and Economics, and there should be no duplication of work between the ANA, UAN, and the Center for American Nurses. The Congress can make a recommendation to the ANA who can then decide which organization; the UAN or the Center for American Nurses should handle it. This is appropriate because both organizations have a seat on the Congress.

And from the UAN leadership perspective, ANA's restructuring required additional changes in organizational behaviors. From the UAN leadership perspective, issues in addressing the professions' concerns seem to have been arising in the absence of ANA's ability to redefine and delineate its work from the UAN. Each interviewee shared their perspective regarding the continued and great need for the ANA to find their niche as the professional society of nursing:

> The challenges were numerous as change is often, and naturally, difficult. The main challenge was to determine what the UAN and the Center for American

> Nurses would focus on in their work, and what the ANA would focus on after these two organizations clarified their work.
>
> ANA needs to find a way to work with the UAN. There is great concern of what may happen if they are unable to do this. ANA can not be all to everyone, they need to find their niche, figure out how to work with the UAN on a daily basis, and find a better way to do business. The organization is not in a really good place right now. ANA did a lot of great work, but they did not get it down to the people and nurses who can support and help the organization.

In relation to the ANA's ability to continue to serve as the voice for U.S. professional nursing, it was discussed by a UAN interviewee that ANA needed to have a primary focus and work on public policy and broader healthcare issues such as access to care, universal care, and quality care and safe work environments, as examples. The focus should be on the practice of nursing such as practice guideline development. The interviewee expressed the desire to let the UAN speak as the labor voice for nursing and the organization that works to organize nurses in the workplace.

And yet one UAN interviewee expressed a seemingly logical perspective in viewing the restructuring and the concern over organizational priorities and differences:

> The UAN continued to promote itself as the labor arm of the ANA. Many nurses see the organization as a professional society. Many feel a disconnect between the professional society and the union. Separating the UAN and allowing its affiliation with the American Federation of Labor-Congress of Industrial Unions freed the ANA to do the work of the profession nationally, and allowed the UAN to do the labor work of nursing nationally.

From the perspective of the Center for American Nurses, three Center for American Nurses interviewees expressed the following:

> Concern was expressed by ANA members that the restructuring would further splinter the ANA, splitting up the organization into affiliated organizations, and that the ANA was stronger if it remained a single organization without organizational affiliates. This was addressed through grassroots efforts at the state level, with the state nurses association leadership communicating to the membership the meaning of the restructuring and its opportunity to create entities that could target issues and thus target resource utilization. As an organization begins to grow and flourish, it remained to be seen how such a process would play

> out in the future. The potential was always there to discontinue the affiliation among the organizations, and as an organization reaches its adolescence, and desires to grow further, new challenges may arise that would impact an affiliation with the more established organization. At some point the more established organization will need to allow the newer organization to fully embrace the services it provides as part of its purpose, and not duplicate these services in the more established organization in order for the growing organization to reach its potential. If this is not achieved it will challenge affiliation continuation.
>
> When the ANA restructuring created The Center for American Nurses it was understood that as a new organization The Center for American Nurses would experience an identity crises. What was not apparent at the time was that by creating separate entities for addressing nursing's' economic and general welfare, ANA too would experience an identity crises.

Public relations and marketing remains a challenge to all three organizations, as mentioned by two Center for American Nurses interviewees:

> Challenges faced by The Center for American Nurses included identifying who they were, why they existed, and how the work they did was different from other groups, including how it is different from the ANA. The Center for American Nurses was not in competition with the ANA.
>
> Speculation was provided through the ANA membership survey of December 2005 showing that the UAN and The Center for American Nurses were not well known by many of the individual ANA members. They did not know or understand ANA, the UAN, or The Center for American Nurses programs, thus raising the question that if current members are unaware of this, then we would expect that the organizational structural changes would have little impact on membership enrollment…. this was provided as a potential public relations and organizational branding issue, and a reminder that The Center for American Nurses was only three years old.

Interview participants from the Center for American Nurses were asked to share their perspectives of ANA's future in continuing to serve as the professional society for U.S. registered nurses. Most participants agreed that the organization was doing a good job in addressing the policy issues faced by the profession, and representing the profession in Washington. Their existed concern regarding ANA's internal focus as expressed by one interviewee participant:

> The restructuring provided an opportunity for the ANA to increase its role in providing the voice of the profession in the U.S., and building consensus among

> the nursing organizations on policy statements. However, the challenge remained to ease the concern of each organization's feelings regarding protecting their own organizational turf. ANA needed to provide leadership for nursing in health care reform, establishing and maintaining standards for nursing practice, facilitating collaboration among nursing and other specialty healthcare related organizations, and serve as the voice for nursing in the U.S. ANA needed to stop making attempts at providing services that other organizations provided.
>
> In regards to membership, ANA was not addressing the membership's needs. It remained too focused on Affiliate Organizational Members and its internal issues. As a professional society, it had performed well with practice standards and in national policy issues. As a labor organization, it remained to be evaluated in reference to the affiliation status with the UAN.

Other Center for American Nurses participants shared their perspective that perhaps the organization needed to spend more time on internal issues:

> In relation to the future needs of the ANA, the organization will need to answer the question of who we [ANA] need to be to move forward, and this answer needs to be provided in a timely manner. What is the relationship that ANA has with other organizations? Ultimately, ANA will need to examine its federation model structure and answer tough questions about organizational control and power… If an organization focuses on its internal conflicts it will drain its resources, creating vulnerability to outside influences. An organization must understand well its core, and how to protect it.

And still others among the Center for American Nurses leadership felt the need for the ANA leadership to do both:

> ANA needs to have products that are user friendly to individual nurses. When individual nurses are asked what the organization can provide them, they either do not or cannot answer the question. So much of the flavor of the ANA is a reflection of the leadership. Leadership needs to look at the broader issues of nursing. When one becomes part of the Board of Directors of ANA, they need to let go of the constituent member association from where they came…they need to look broader, beyond the local. There needs to be a better understanding of what it means to be a national leader. We need to always take into account the external influences of the social, technological, environmental, economical, and political perspectives. Staff may have been, at times, too involved in influencing the direction of ANA. Sometimes the House of Delegates is also not effective as a representative body.

The greatest challenge that the ANA has in serving as nursing's professional society is being able to represent a profession with such a vast diversity in education,

practice, and work settings. Two Center for American Nurses participant's best captured this challenge:

> For ANA to be the professional society representing all RNs in the U.S., the restructuring allowed for continued representation on a larger scale…representing the totality of issues faced by members of the profession (RNs). The biggest challenge is in maintaining a membership base open to all RN's, meaning the organization's ability to address the diverse concerns of the professional nursing population, which are vast, thus being all to everyone and everything. Certainly some things remain constant for the organization in its provision of professional standards, ethics, and practice issues, but with limited resources, how can the organization meet the needs of a profession with such diversity?

Part of nursing's diversity included the manner in which it chose to address its economic and general welfare needs. As a professional society, ANA continued to serve in the capacity as a labor organization, even with two autonomous organizations now addressing this specific need of nurses. This perhaps remained a struggle for the organization as expressed by one participant:

> In response to the ability of a professional society serving as a labor union I am not sure an organization can do both well as the needs and approaches to achieving these organizational goals are different. When this was attempted, there appeared to be a subset of the organizational membership that always felt underrepresented. There is then conflict when there is a perceived power inequity. For nursing, this may be a result of the profession feeling oppressed as both women and as a component of the healthcare system, and the understood behaviors of oppressed groups may be playing out within the organization. To remedy this, there needs to be a perception of a level playing field.

It would appear that the ANA continued to struggle with its identity as both a professional society and a labor organization. The organizational restructuring may have addressed the immediate concerns of membership loss as a result of member state nursing association disaffiliations, however there remained concerns surrounding full operational implementation of the new structures. Exactly how the ANA legitimizes itself as the

representative of professional nursing in the U.S. remained unclear. Developing future membership options was needed.

Future ANA Membership Options

As mentioned, the Task Force on Organizational Affiliates was established, and their first recommendations were presented to the Board of Directors. The recommendations included an organizational dues fee of $500,000, representation at the ANA House of Delegates to include one voting seat held by an RN and ANA member who would be prohibited from having a vote pertaining to dues, bylaws and election of ANA board officers, one non-voting House of Delegates seat which could be held by a staff member for purposes of reporting and presenting on the Organizational Affiliate's area of expertise, representation in the Constituent Assembly by the Organizational Affiliate president and chief administrator or designees of which one much be an RN and member of ANA, as well as a Constituent Assembly non-voting seat with voice but no vote, and finally a non-voting liaison representative to the ANA Board of Directors. Among all Organizational Affiliates, there would be one non-voting seat on ANA Board of Directors representing all Organizational Affiliates (ANA Board of Directors Volume Two Agenda Item #12b, March 2004). In describing this membership category, one ANA interviewee shared the following:

> This group is an elected group with specified seats, such as staff nurse, nurse educator and such. They address more specific issues of nurses and nursing at the grass-roots level…they help the ANA get a pulse on the issues to support position statements and policy development. There are specified elected positions of the congress and that allows for direct involvement in the ANA by staff nurses who face direct patient care issues every day, and allows them to participate in developing national policy standards. The Congress [on Nursing Practice and Economics] is getting people from the affiliate organizations as well.

The organizational affiliate would offer the variety of nursing specialty organizations an opportunity to participate in the work of the ANA as mentioned. Such an occurrence would provide an opportunity for ANA to legitimize its role as the professional society of nursing in the U.S. as it would serve an umbrella status in bringing together nursing's' special interest organizations. Six ANA interviewees shared this positive perspective in describing the role of Organizational Affiliates with the ANA:

> [The Organizational Affiliate Member] provides a specific structural involvement of nursing specialty organizations. There does appear to be an increased participation from the specialty organizations. They have continued to look to ANA as an organizing group. Perhaps the best way to view ANA now is that it is providing an opportunity for all nursing groups to come to a table for nursing, and that ANA will serve as the facilitator of the meetings. This allows the organizations to maintain their independent and individual identity separate from the ANA while allowing for coalition building and discussion of the diversity of issues concerning the nursing profession.
>
> The membership category of organizational affiliates was strengthened giving them vote and voice at the House of Delegates and on the ANA Board of Directors. As a result, the number of ANA organizational affiliates has grown over time.
>
> This category of membership [organizational affiliate] is increasing as evidenced by their involvement in the ANA Congress on Nursing Practice and Economics and their desire to have a voting seat with the Congress.
>
> The Organizational Affiliates elect one representative to the ANA Board of Directors who has voice but no vote at the ANA Board of Directors open sessions. Each Affiliate Organizational Member and Organizational Affiliate has one voting seat each in the House of Delegates.
>
> There is a need for ANA to be a voice in the provision of healthcare services, for nurses at the bedside, and for nurses in general. The ANA is the national organization with clout and respect about national nursing issues on Capital Hill and in influencing legislation. This is the advantage of organizations becoming affiliates with ANA. It also maintains its clout throughout the profession. This will only continue until someone else is believed/perceived to do it better, and is the reason for increased organizational affiliates coming to ANA for assistance. The ANA has years of credibility that has the opportunity to grow with the organizational structure.

Providing organizational membership in the ANA as organizational affiliates provided ANA the opportunity to create a legitimized structure that broadens the

governance of the ANA throughout the nursing community. This would appear to be an opportunity for the ANA to begin to look beyond their own internal struggles by providing opportunities for nursing's diverse specialty organizations a means to collaborate through the ANA structure of organizational affiliates. However, creating such an environment of collaboration was not easy and greatly influenced by ANA's internal focus as shared by one ANA interviewee:

> Although the ANA Board tried to keep the organizational internal struggles from the public scrutiny, other nursing organizations stated that they could identify that there were issues within the ANA and they did not want to get involved…thus no other nursing organization was interested in becoming an Affiliate Organizational Member, but instead chose to be less intimately affiliated through the category of organizational affiliate. This allowed the specialty organization to participate in the work of ANA through the Congress on Practice and Economics, but not have representation on the ANA Board of Directors.

With these reports and perspectives the ANA Board of Directors began the process of looking forward to the future of ANA within its new structure. Work would continue throughout the months of 2004 and beyond in managing the new ANA structure. Conflict has resulted in the ANA spending years internally focused on its structure. As mentioned by one ANA interviewee:

> When you examine organizational structure, the purpose of the organization needs to drive the structure. Just because you change the structures it does not necessarily improve the relationships in the organization. Momentarily, structural change is helpful, but not long lasting if the relationship issues have not been resolved.

In part differences in perspective surrounding the influence of restructuring on ANA's overall membership growth may contribute to the future of ANA. It is believed by the UAN leadership that their effort in increasingly organizing nurses is the most likely and most efficient means of increasing ANA's membership numbers. One UAN interviewee expressed such a perspective, stating, "The union is where the growth of the

organization is and we all can benefit from this. The other membership categories, created by the by-law changes are not occurring, and not bringing in more members."

This perspective is also believed to be an organizational difference between the UAN and the Center for American Nurses in that the organization of nurses under collective bargaining is revenue generating for both the UAN and the ANA, given current affiliation agreement language. One UAN interview participant provided that:

> In regards to membership growth, it is in ANA's best interest to maintain the UAN relationship as an Affiliated Organizational Member. The UAN's goal is to organize nurses under collective bargaining contracts. When this occurs, the ANA instantly gains up to thousands of new membership, depending on the number of nurses organized in a hospital or health care organization. Thus membership in ANA should increase as the UAN organizes more nurses. It has been communicated among these organizational leaders that non-collective bargaining membership growth is stagnant. Thus growth in organizational membership is through the efforts of union organizing.

In contrast, the Center for American Nurses offered no direct revenue increasing opportunities to the ANA as their membership consists of the state nursing associations and thus revenue production through increased membership lies with the individual state association. Such a perspective, shared by one UAN interviewee, also supports the belief among the UAN leadership that the Center for American Nurses remained more significantly tied to the ANA, requiring more of ANA resources than does the UAN:

> One of the concerns surrounded the desire for the Center for American Nurses to have equal affiliation with ANA as the UAN. However, the UAN disagrees, viewing the Center for American Nurses as more aligned to ANA and requiring greater ANA resources for operation than does the UAN, mostly because the Center for American Nurses does not have a revenue producing membership base.

Membership in The Center for American Nurses by state nursing associations has reached a high of 40 at the time of this writing, as verified by one Center for American Nurses interviewee; "We have 40 constituent member organizations as members of the

Center for American Nurses, others are in the UAN, and California remains independent."

In perspective, the ANA is made up of 54 constituent member associations, including Guam, Puerto Rico, and the Federated Nurses Association representing nurses in the U.S. Armed Forces. Establishing The Center for American Nurses had little effect on the overall membership within the ANA, as mentioned by one Center for American Nurses interviewee:

> Membership remained unchanged, but there are now different ways to become a member. ANA believed that The Center for American Nurses would not survive and the right-to-work states would simply come back into the ANA fold. The Federal Nurses Association has not grown. All of this is about money and dues. ANA's provision of regional conferences were canceled due to low attendance. There appears to be a disconnect between dues paid and services provided.
>
> It was hoped that by providing specific services directly to individual RNs through the state nursing association that more RNs would join the state association and improve the overall membership representation of the ANA. As with the ANA, The Center for American Nurses has considered ways to expand its membership base by increasing membership eligibility through organizational and individual dues structures.

The ANA needed to continue to look for additional options of membership within the organization for two reasons. First, it must be able demonstrate that the association indeed represented the interests of the whole of the nursing profession, and second it continued to rely on membership dues dollars as a large portion of revenue for the association.

Serving as an umbrella organization for the nursing profession has its challenges. Addressing organizational differences in perspective on nursing issues is necessary in order for the profession to maintain a strong voice in the public policy arena.

Organizational Disagreement on Select Nursing Issues

Although it appeared logical when looking at the purpose of each organization and their organizational structural links that each had a distinct role and means to address specific issues of nursing practice and labor concerns, these nursing organizations may not always share the same position when it comes to such issues. An example of this was provided by one ANA interviewee:

> Regarding staffing ratios, here existed a difference between the UAN and the ANA, where the UAN was in general supportive of staffing ratios, ANA had yet to take a strong stand on them due to concerns of being unable to change such standards in the future, when needed, if they are legislated.

Perhaps, as mentioned by one ANA interviewee, collaboration was the solution in these events:

> In looking at staffing ratios, the UAN was able to speak to the issue from a strong staff nurse perspective, and maintain that perspective, allowing the ANA to take a broader perspective regarding how ratios developed and their influence on other areas of the healthcare system, nursing, and the patient. The restructured organization allowed a more independent voice from the UAN that has a specified interest, while allowing the ANA to assure its perspective was addressing all of nursing and the organizations membership. Collaboration occurred because the organizations were joined since the UAN was an Affiliated Organizational Member of the ANA.

It is here that the greatest challenge and opportunity existed for these organizations in representing professional nursings' issues. The challenge was to be able to maintain independence as organizations while understanding that the organizations shared a common interest, that of professional nursing. Three ANA interviewees provided a positive perspective of ANA's future:

> Some people wish to be more radical and rebellious in action, while others prefer more subtle and subdued means to influence. Nurses often use the excuse that ANA is a union as a reason for not joining, and yet in their own employment they may be represented by a union, for example faculty members. The influence of this on the ANA's restructuring was that union members felt they had more

> independence in making decisions and taking positions on issues separate from ANA, thus they had more control over what was important to them.

From another ANA leader perspective:

> There needs to be a balance. ANA has now walked this line, and actually has done so since the 1940's. They have created a new organizational version of how to deal with the issues of professionals in labor unions and recognized that each state has different perspectives on the issue. The success of this structure needed to be evaluated through the success of the ANA. What one saw depended on where one sat, and the significance of maintaining a national organization that represents the totality of the nursing profession needed to be understood.
>
> The old guard of ANA viewed the organization as a labor union as opposed to a professional society, and the restructuring allowed for a greater separation of the work pertaining to collective bargaining and work not pertaining to collective bargaining. However, the core values and ethics remained unchanged. There was a need to re-tool for the 21st century.

Potential conflicts between the ANA and the Center for American Nurses are also possible. Two Center for American Nurses interviewees addressed the potential overlap of work with the ANA:

> ANA had yet to harness their niche. ANA needed to allow affiliated organizations [currently the UAN and The Center for American Nurses] to control their own daily work without ANA influence. ANA's priority had to be in the government affairs arena. ANA needed to be the spokesperson for nursing nationally and internationally. The UAN spin-off was good. ANA should now be able to allow others to do the labor work, but they had seemingly been unable to let go of the work.

From the perspective of the Center for American Nurses participant interviewees, the ANA's niche was that of serving as the voice for nursing in the U.S. One Center for American Nurses interviewee expressed the following:

> I feel very confident in understanding ANA's niche to be the practice of nursing, including practice ethics and professional policy development at the national level, and supporting the same work of the state nursing organizations at the state level. It was also felt that ANA could serve as the nursing organization that provided a collaborative voice for the countries' various practice specialty nursing organizations. However, ANA had remained internally focused on continuing work that needed to be understood as the work of other nursing organizations, such as the UAN and the Center for American Nurses.

However, specific issues facing these organizations were expressed by the UAN participant interviewees. Among some of the most significant needs to be addressed between the UAN and the ANA in maintaining an affiliation was the manner in which the organizations agreed to manage nursing's labor issues and how they would proceed when differences of opinion existed on other nursing and health related issues. Specifically mentioned by the UAN leadership is the work of the American Nurses Credentialing Center for American Nurses and the Magnet Status Recognition Program.

The Magnet Status Recognition Program was established to acknowledge those healthcare organizations that employ RNs and their efforts in providing nursing practice environments that attract nurses. The integration of how an organization views and recognizes organized labor as a component of achieving Magnet Status is of concern to the UAN. An example of this opposing view was provided by one interviewee:

> In regards to the Magnet Recognition Program, this program, sponsored by the American Nurses Credentialing Center, is supported by the ANA, however, as it recognized nursing in health care organizations and hospitals, the UAN has issues with the program and its activities in regards to the staff nurse.

Other variances in perspective between the two organizations pertained to national legislation addressing nurse/patient staffing ratios and hospital lift teams. The variance was over mandating that hospitals implement such programs, the perspective of the UAN, versus language that would support the further research on the significance and influence of such programs on patient health outcomes before making such mandates. The UAN supported such research, but felt that staff nurses have an immediate need that mandated legislation would alleviate while conducting the needed research. One UAN interviewee stated:

> Other opposing issues surrounded state legislation mandating hospital staff lift teams, versus this being voluntary. The same is true with staffing ratio legislation, mandating versus doing more research. ANA supported voluntary lift teams and further investigation of staffing ratios, whereas the UAN supported the mandate of both. Further investigation of staffing ratios was important, but the staff nurse was getting no relief from staffing issues that could be greatly assisted with simply great staffing numbers.

An issue of standardizing nurse competency through the American Nurses Credentialing Center certification was another idea that provided different views between the two organizations. One interviewee addressed this issue as follows:

> ANA was supporting a drive to have staff nurse competency measured and validated only through American Nurses Credentialing certification. Currently such certification remains voluntary. If certification were to be required to measure staff nurse competency, does this imply that nurses who are not certified by the American Nurses Credentialing Center are incompetent?

And finally, a more recent occurrence further demonstrated the need for the two organizations to determine how to address differences in perspectives. The need concerns the issue of competing forces between the two organizations in the nation's capital and on national policy issues. The ANA had an established political action committee (PAC), utilized for fundraising in determining the organization's support for national legislative candidates. In early 2007, the UAN, through the request of its membership, voted to establish its own organizational PAC (United American Nurses 2007 Spring). If fully established there would exist in the national political arena two national nursing PACs that claim representation of the nation's RN's, and at times have very different perspectives on issues as noted above.

Conclusion

The review of ANA's public documents and interviews of leaders of organized nursing from 1999 to 2004 present a picture of the development of ANA's organizational

structure by the middle of the first decade of the 21st Century. As with any public documents one is privileged to note only those items captured in writing, and only during formal, generally open meetings of the organization. Much occurs within organizations in closed sessions, and even in open sessions where dynamics and events may not be captured in the written word. The processes of individual and group decision-making are also difficult to fully grasp in documentation alone, including the influences of external forces. One can only make possible suggestions about choosing such events and speculating their possible influence in the decision making process. However, document review can provide a beginning point for exploring such possibilities, and gaps left in the documents may be filled through interviews with leaders who served the organization as members of the board of directors during this time.

For the ANA and it's restructuring at the beginning of the 21st century the documentation and interviews clearly focused on how the organization would address its obligation to meeting the economic and general welfare issues of contemporary nursing practice, and specifically of the ANA member on a national scale. Diversity throughout the country pertaining to how state nursing organizations address the workplace and workforce issues of registered nurses was and continues to be a challenge for the ANA as it attempts to maintain its claim as the voice of professional nursing in the U.S.

CHAPTER SIX – DISCUSSION

This organizational case study was designed to examine and describe how the American Nurses Association (ANA) organizational goals, structural and process changes were influenced by internal and external contexts and the ideas and values of the organization's leadership during the period 1999 - 2004. The study focused specifically on the ANA as it served a dual role as the U.S. professional society of nursing and a labor organization. By examining the organizational structural changes and the perspectives of organizational leaders of the ANA , the UAN, and the Center for American Nurses, through records and interviews over a five-year period, it was possible to see competing interests among the ANA organizational membership, and how these competing interests affected change in the ANA.

Research Aim 1

The research aim was to examine the changes in ANA's organizational goals, structure, and activities between 1999-2004, and the reasons for the changes.

The goals of the ANA were not so much changed as they were made more explicit during the change process. The association leadership clarified and affirmed its recognition as a labor organization, and made explicit this designation as separate from a labor union (ANA Board of Directors Meeting Volume One, March 2003, p.5). Also, the leadership made explicit in 2002 that their goals were professional practice excellence, healthcare and public policy, knowledge and research, unification, and workforce and workplace advocacy. Focus on the specific strategic goals of the nursing shortage, staffing, workplace rights, health and safety, and patient safety and advocacy were also identified (ANA Board of Directors Meeting Volume Two Agenda Item #10a, March 2002).

Changes in the organizational structure of the ANA focused on its relationship with its labor arm, the UAN, and on the ANA membership structure. Seeking to continue to serve as the organizational representative of the nursing profession in the U.S., the ANA broadened its membership categories to included the specialty nursing associations (Organizational Affiliates) (ANA Board of Directors Volume Two Agenda Item #12b, March 2004), and provided opportunities for individual RN membership directly in the ANA rather than through member nursing associations (ANA Board of Directors Conference Call Meeting, May 2003). Although the membership category of Affiliated Organizational Member (AOM) was introduced, allowing an opportunity for any nursing organization to have a greater involvement in ANA governance than that provided by the Organizational Affiliate Member (ANA bylaws, June 23, 2006, pp 9-10), this membership category seemed to be developed specifically to address the unique ANA affiliations of the UAN and the Center for American Nurses.

The greatest change in the activity of the ANA was the extended years of internal focus (ANA, UAN, and Center for American Nurses Interviews, 2006; 2007). This focus, from 1999 to 2004 had been necessary to stop a potential trend of losing membership from ANA disaffiliations by state nursing associations. It also forced the association to begin to address the difficulties in serving a dual role as professional society and labor organization, and the conflict among members this created.

The internal conflict was evident among the ANA ranks throughout the 20th Century. Beginning in 1995, this conflict began to literally tear apart the structure of the ANA, and union state nursing associations, beginning with California, left the ANA (ANA Board of Directors Meeting Agenda Item #2, December 2003). By 2002, the

union state nursing associations of Massachusetts and Maine also left the ANA (ANA Board of Directors Minutes, May 2001).

Because the ANA relied heavily on dues revenue, and strength in membership numbers supported the organization's claim as the representative of the profession in the U.S., the ANA leadership reaffirmed its commitment to addressing nursings' economic and general welfare needs through collective bargaining. However, with increased organization by non-union state nursing associations within the ANA, the ANA leadership was forced to clarify its position regarding the goal of addressing nursings' economic and general welfare (ANA, UAN, Center for American Nurses Interviews, 2006; 2007).

The ANA leadership maintained its goal to be the representative of professional nursing in the U.S. In doing so, the leadership needed to maintain and grow its membership. To do so, they addressed the concerns of the current state nursing association members, and their conflicted perspectives regarding the ANA's work in addressing nursings' economic and general welfare needs. Perhaps because the conflict between the member state nursing associations centered on equitable distribution of resources, organizational structural changes were determined by the ANA leadership as the best means of addressing the member conflict (ANA interviews, 2006; 2007).

Changes in Organizational Structure

The ANA's organizational structural changes created a more autonomous structure for its labor arm, provided an equitable distribution of resources to organizational programs, and created varied organizational structures for membership

representation and growth. The impetus for providing the labor arm of the ANA with greater autonomy had both a practical and perhaps emotional motive.

The practical support in providing greater ANA autonomy to the labor arm, the UAN in 2003, was driven by the legal need of the ANA to provide insulation of the union's work from the work of the remainder of the association (Zacur, 1982). This was necessary as many members of the ANA Board of Directors served in supervisory positions and thus were required to be excluded from any decision making by the UAN regarding labor issues. However the established more definitive UAN within the ANA required formal structures to identify the role of the UAN in the governance of the ANA.

Although the UAN governed its labor work, it remained a structural unit of the ANA, thus ultimately governed by the ANA House of Delegates and the elected annual ANA Board of Directors (American Nurses Association, June 26, 2000). In organizational matters, the UAN needed the support of all the ANA membership in order to accomplish its own union goals. Although the UAN leadership desired to remain a part of the ANA, this need to consider the ANA membership not directly involved in the work of the UAN was difficult and viewed unnecessary (UAN Interviews, 2006; 2007).

The initial organizational structural change in 1999 that provided insulation to the UAN further supported conflict within the ANA. This conflict played out during annual ANA meetings of the House of Delegates between union and non-union member nursing associations, necessitating the ANA leadership, through its Board of Directors, to take action (ANA, UAN, Center for American Nurses Interviews, 2006; 2007).

With rising conflict among the membership, and threatened loss of membership through state nursing association disaffiliations, the ANA leadership attempted to

appease its members. The ANA leadership understood the need of the UAN to govern its matters and in 2001 supported its affiliation with the AFL-CIO (ANA Board of Directors Minutes, June 2001). Such charter member affiliation not only provided great labor resources to the UAN, but also provided the UAN with much needed raid protection from other charter member AFL-CIO union affiliates (UAN interviews, 2007). The ANA leadership also demonstrated its commitment to its non-union member nursing associations by providing a more formalized structural unit within ANA for these members beginning in late 1999. Since the conflict between these members centered around ANA resources provided in addressing nursing's' economic and general welfare needs, the non-union state nursing association members organized under the term workplace advocacy (ANA Report to the Board of Directors Volume Two, Agenda Item #4, June 2000).

Work to establish the workplace advocacy program within the ANA organizational structure required great effort (Center for American Nurses Interviews, 2006; 2007), as this group lacked the more than fifty-year history of the labor program (Melosh 1982). However, by 2002 the group developed from an ANA special interest to a formal program, to a recognized ANA Commission. However, conflict remained as the UAN leadership was concerned that the workplace advocacy program leadership viewed itself at best as an alternative to unionization, and at worst a movement that was anti-union (UAN interviews, 2007). Thus there existed at times a feeling that the UAN leadership was threatened by the development of the workplace advocacy program. Again the ANA organizational structural changes did not resolve the member conflict.

As conflict remained, the ANA leadership made their final effort at equalizing resources between the state nursing associations. The union state nursing associations were now members of the UAN (ANA Board of Directors Minutes, May 2001), and the non-union state nursing associations were aligning with the Workplace Advocacy Commission (ANA Board of Directors Meeting Agenda Item #4b, June 2003). Through a collaborative effort among the ANA, UAN, and Workplace Advocacy leadership, and 16 other nursing organizations, the Futures Task Force was formed in 2000 (ANA Board of Directors minutes, September 2000). The Task Force utilized an external consultant, and organizational structural changes were proposed by the summer of 2002. The UAN was formally established as an organization autonomous from the ANA, and the Workplace Advocacy Commission would be further developed into an ANA autonomous organization titled the Center for American Nurses in 2003. These two newly established national nursing organizations remained connected to the ANA through specific negotiated contracts know as affiliation agreements. Within the ANA bylaws, these two organizations held a new ANA membership status as Affiliated Organizational Members. Expectations of membership were outlined in the ANA bylaws and approved by the 2003 ANA House of Delegates in addition to other membership categories (American Nurses Association, June 26, 2003).

Although Affiliated Organizational Membership was open to any nursing organization, this membership category was developed specifically to address the ANA membership of the UAN and the Center for American Nurses, and designated the UAN as the only labor organization permitted to hold this ANA membership, and the Center for American Nurses the only workplace advocacy organization to hold this membership

(ANA, February 2003). This membership category was made distinct from the Constituent Member Association category held by the state nursing associations and other nursing associations.

Other membership categories established in 2003 were Individual Direct Members of the ANA, and the ANA Organizational Affiliate. The Individual Direct Membership consisted of individual RNs who held membership only in the ANA and not members of a Constituent Member Association and whose governance in the ANA would occur through the Individual Member Division (American Nurses Association, June 26, 2003). The division was necessary because of ANA's federated model structure. The Organizational Affiliate member consisted of any nursing organization who wished to be involved in the ANA governance but who wished not to hold more specified Affiliated Organizational Member status. Generally this membership category was established for the more than 100 specialty nursing organizations (American Nurses Association, June 26, 2003).

Thus the ANA organizational structural changes occurred to first maintain the ANA memberships of its union and non-union state nursing associations, conflicted with each other over the desire for equitable ANA resources between the two interests in addressing nursings' economic and general welfare needs. And second, the structural changes created an opportunity for increased membership by individual RNs and other nursing organizations, thus strengthening the ANA's position as the representative of nursing in the U.S.

Although changes were meant to address the loss in membership, the records indicate this was not an immediate occurrence. ANA individual membership numbers

were noted in December 2003 to be 151,000 (ANA Board of Directors Meeting Agenda Item #2, December 2003). July 2001 documents indicated a membership of 156,000 (ANA Board of Directors Meeting, July 2001). Over a two-year period, and after setting a membership goal for 2002 of 200,000, the ANA had lost approximately 5,000 members. The focus on organizational restructuring to address the conflict expressed by state nursing association membership regarding ANA's resource allocation and philosophical perspectives of serving as both a professional society and a labor organization may have stopped further losses in membership, but it did not encourage membership growth.

Changes in Organizational Activities

The greatest change in ANA's activities occurring within the ANA between 1999 and 2004 was its increasing internal focus (ANA, UAN, Center for American Nurses Interviews, 2006; 2007). As the professional society of nursing in the U.S. the ANA has worked at the national level representing the profession of nursing in establishing and maintaining the professions code of ethics, practice standards, and social contract. Additionally the association has represented the professions' interests in the national policy arena. However, with rising conflict between its membership over its role in addressing the professions economic and general welfare needs, and the consequential loss of membership, the ANA leadership shifted resources internally (ANA,UAN, Center for American Nurses Interviews, 2006; 2007).

The ANA House of Delegates was the governing body of the association. Made up of elected individual members of each Constituent Member Association of the ANA, the delegates were proportioned among the associations based on their individual member numbers (American Nurses Association, June 26, 2003). Larger association

memberships translated to larger delegate representation in the annual meeting of the ANA House of Delegates. The House of Delegates met annually to provide direction to the ANA and to elect its officers. It was during these meetings that the ANA leadership was directed by the membership on national matters significant not only to the association but also to the profession of nursing. However, during the time frame of study an overwhelming amount of time, energy, and resources were devoted to the organizational structural changes of the ANA.

Because the conflict within the association was spearheaded by the state nursing association membership, and contributed greatly to feelings of distrust between the two competing fractions, much of the time of the House of Delegates was spent negotiating detailed bylaw language and questions of resource allocation. Although different organizational entities, such as the Futures Task Force, the Constituent Assembly, and the Bylaws Committee were charged with addressing conflicts and bringing forth recommendations to the House of Delegates, once these recommendations were brought forth, the members of the House of Delegates spent the vast majority of their time in 2001, 2002, and 2003 rehashing the issues (ANA,UAN, Center for American Nurses Interviews, 2006; 2007). Bylaw changes regarding organizational restructuring were presented in 2001, debated and sent back to the ANA leadership for presentation in 2002 (ANA Board of Directors Meeting, July 2001). In 2002 the bylaws were again debated and the House of Delegates requested at that meeting a group represented by the ANA, the UAN, and the Workforce Advocacy Commission work throughout the meeting to bring to the House a single set of bylaws (ANA Interviews, 2006; 2007). Even then, the recommendations were debated at length, and although passed in some form, bylaws

were again addressed at the 2003 House of Delegates meeting (ANA Interviews, 2006; 2007). This ongoing bylaw focus indicated a lack of trust among the House of Delegates members toward the work of the ANA structural groups. Fear of hidden agendas and behind-the-scene deal making as well as concerns of lack of transparency on the part of the ANA staff and Board were apparent (ANA & UAN Interviews, 2006;2007). Any progress within this body with these issues took time to accomplish.

The focus of the ANA House of Delegates each year was on issues of organizational restructuring. Implementation of any changes took their toll on internal resources such as human and financial resources. The ANA operating budget was in deficit, and programmatic activities were cut in all areas except the UAN and Workplace Advocacy (ANA Board of Directors Minutes, December 2000). Although there was stabilization in individual membership numbers by 2002 after four state nursing association disaffiliations, there was no indication of membership growth (ANA Interviews, 2006; 2007).

Structural changes were costly to the association, and membership numbers remained unchanged. The changes increased the complexity of the organization, and required special negotiations to establish the UAN and Center for American Nurses affiliation agreements with the ANA. Additionally, changes in the structure required navigation through the complexities of the ANA and its existing structures in order to establish bylaw changes necessary to enact the structural changes. This process took nearly five years to accomplish the changes, shifting the activities of the ANA inward at the expense of fully representing the profession in various healthcare policy arenas. Navigating the organizations complex structures provided part of the picture of the

change process in the ANA. Understanding the agreements, conflicts, ideas and values of its leadership throughout the process provided the rest of the picture.

In addition to the aim of examining the changes in ANA's goals, structure, and activities this study was interested in the agreements, conflicts, ideas, and values held by the ANA leadership during the time under study. The ANA leadership was defined as members of the Board of Directors of the ANA, the Center for American Nurses, and the Executive Council of the UAN.

Research Aim 2

The research aim was to examine agreements, conflicts, ideas, and values held by the ANA's leaders regarding the goals and objectives of the ANA in the period 1999-2004.

Many of the agreements, conflicts, ideas, and values held by the ANA leadership are briefly touched on under research aim 1 above as they contributed to the reasons for ANA's organizational changes. However exploring these items helps provide a broader picture of the change process. Agreements and conflicts were explicitly presented throughout the interviews, and illustrated the ideas and values of the ANA leadership.

Agreements

The agreements among the leadership throughout the process of organizational change were difficult to find as the vast majority of the change process was driven by conflict. Yet some agreements shared among the leadership of the ANA, the UAN, and the Center for American Nurses were evident. Specifically there were agreements regarding the function of each organization, the need for clarity in relationships among these groups, and the need for the ANA to continue as the representative of professional nursing in the U.S. (ANA, UAN, Center for American Nurses Interviews, 2006,2007).

There was also agreement regarding concerns of the ANA spending years internally focused on its organizational matters.

Among those leaders interviewed, the organizational focus of each group was clear. Each interviewee was most clear about the function of their respective organization, however there was also agreement about the function of the other organizations represented. It was stated that the ANA's function was to serve as the professional society of nursing. What this meant was that ANA was responsible for maintaining the profession's code of ethics and representing the profession in national policy issues. The UAN was clearly identified as the labor union for RNs in the U.S. Different from any other national union that may represent nurses is that the UAN was exclusively an all RN bargaining unit. The Center for American Nurses was clearly to function as a national nursing organization assisting RNs and nursing organizations that were not represented, for whatever reason, by union organizations. The focus of the Center for American Nurses was on product development to support individual RNs, whereas the focus of the UAN was to provide collective bargaining services, including contract and labor negotiations under laws governed by the National Labor Relations Board.

Explicit in the ANA records were the ANA's strategic goals, presented and approved by all ANA member stakeholders. Thus it appeared that these three organizational entities had shared values and interests regarding professional practice excellence, healthcare and public policy, knowledge and research, unification, and workforce and workplace advocacy. Included and approved were specific strategic goals of the nursing shortage, staffing, workplace rights, health and safety, and patient safety

and advocacy (ANA Board of Directors Meeting Volume Two Agenda Item #10a, March 2002).

Thus there appeared to be agreements among the groups regarding the contemporary concerns faced by the profession. And although agreement on organizational functions was shared, how these three organizations related to one another was difficult to articulate, and how they would each share and contribute to meeting the organization's strategic goals remained unclear (ANA, UAN, Center for American Nurses Interviews, 2006; 2007).

There existed an agreement among the leadership interviewed that the ANA, the UAN, and the Center for American Nurses needed to clarify how they would relate to one another in the context of organizational autonomy from and affiliation with the ANA. These relationships were outlined somewhat in the affiliation agreements, however it was explicit in both the interviews and in the ANA records that negotiating the agreements was not easy. Many expressed hurt feelings and feelings of neglect. However it was agreed that maintaining the UAN and the Center for American Nurses under the ANA was important for purposes of demonstrating unity within the profession.

And yet the relationship among the three groups had yet to be clarified. Perhaps here was an example of change as a process. All three organizational leader participants understood the need for clarity in regards to their relationship with one another, and a desire to work through issues with the affiliation agreements. They all also identified that this had yet to be accomplished. Perhaps each was holding out hope for unity while still concerned with their individual identities.

An overarching theme among interviewees from the ANA, the UAN, and the Center for American Nurses was the concern of years of internal focus by the ANA leadership and its membership. The focus on organizational structuring and representation were identified as having negative financial and political consequences. Financially, the ANA had designated in 1999 specific monies for the development of the UAN and the establishment and development of the workplace advocacy program, commission, and eventually the Center for American Nurses. The cost of this was noted in both allocations of cash as well as staff (ANA Board of Directors Meeting, Volume Two, March 2000). As noted before, all ANA program budgets were cut in 2001 except for the UAN budget, which was actually increased with an anticipated 30 percent growth in membership through additional contract negotiations in 2001 (ANA Board of Directors Minutes, December 2000). Money was also redirected in early 2001 to address threatened (and eventual actualization), of member nursing association disaffiliations (ANA Board of Directors Minutes, January 2001). Additional money was provided for charter membership of the UAN in the AFL-CIO (ANA Board of Directors Minutes, June 2001). Grant monies were provided to the Center for American Nurses for its initial start-up, and additional grant monies were allocated to support the establishment of new ANA member state nursing associations in those states where member nursing associations had disaffiliated from the ANA (ANA Interviews, 2006; 2007).

The political consequences paid by ANA's years of internal focus may not yet be realized. Many interviewees expressed concern that with money, time and energy focused internally, fiscal and other human resources were diverted from policy and professional representation. The concern was that ANA's ability to serve as the voice of

nursing in the U.S. may have been jeopardized as the association was unable to be present at certain public policy tables because of a lack of resources. Additionally, if ANA's position as the represented voice of professional nursing in the U.S. was challenged because of the ANA's inability to unify the diversity of interests within the profession, including labor concerns, then its status as the U.S. representative to the International Council of Nursing might have been questioned.

The consensus among all interviewees was that ANA had been successful in upholding the code of ethics for the profession and maintaining the profession's social contract between regarding nursing service contributions to the greater society. It was also uniformly expressed that ANA needed to refocus its work toward the policy arena and in maintaining professional standards. However, this must be done with contemporary articulation of real ethical issues and events and connected with everyday ethical comportment and concerns.

Conflicts

There existed one overarching conflict that drove the ANA change process, the outcry from the ANA's member nursing associations for equitable recognition, organizational involvement, and resource allocation. Without a doubt the ANA was in crises with the disaffiliation of four member state nursing associations in 2001, and others threatening to follow (ANA Board of Directors Minutes, January 2001; February 2001). Membership losses threatened the ANA's ability to claim itself as the representative organization of professional nursing in the U.S.

It was obvious within the ANA that the member nursing association disaffiliations occurred as a result of union member dissatisfaction with the ANA leadership in

addressing the concerns of the staff nurse (UAN interviews, 2007). The union nursing association members desired a greater concentration of the ANA's resources in order to more aggressively organize nurses under union contracts. The rationale for such desire was that by doing so, the ANA membership would grow. However, non-union nursing association members grew concerned that by committing such resources the ANA would in essence become simply a union of registered nurses, overwhelmingly representing the hospital staff nurse (Center for American Nurses Interviews, 2006; 2007). According to the 2004 National RN Survey (U.S. Department of Health and Human Services 2005), 56 percent of nurses were employed in hospitals, and among all nurses employed, only 45.5 percent held the title of staff nurse. Thus recognition as a labor union representing the hospital staff nurse would alienate over half of the nursing professionals who were not employed as hospital staff nurses. Additionally, if one were to consider the population of RNs not employed at all but maintaining licensure and identification with the profession, the total number of RNs in the profession not eligible for union representation would be even greater. Such distinction remains significant for the ANA, the UAN, and the Center for American Nurses in the absence of a shared vision and collaboration among these organizations and their membership.

Interestingly, such logic was never explicitly addressed. Rather, non-union ANA member nursing associations organized themselves in a collective within the ANA. As the union arm of the ANA was granted more legitimacy within the ANA structure, becoming the UAN, the non-union state nursing associations legitimized themselves as equally concerned with nursings' economic and general welfare needs, and identified methods other than unionization in addressing the needs, terming it workplace advocacy

(Center for American Nurses Interviews, 2006, 2007). The non-union state nursing associations further organized themselves within the ANA structure and became the ANA Workplace Advocacy Commission, increasing their organizational legitimacy and permanence in the ANA.

As previously mentioned, although statements made by the UAN leadership during interviews indicated that the UAN leadership was not concerned with the Workplace Advocacy Commission, there was expressed concern that the Commission was using anti-union propaganda and positioning itself as an alternative to the UAN and unionization in addressing nursings' workplace concerns (UAN Interviews, 2007). Conflict between these two groups was apparent. Again, state nursing associations aligned themselves with one of these two groups, the union association members were required by ANA bylaw changes to be members of the UAN, and the non-union association members vocally supported the work of the Workplace Advocacy Commission (ANA Board of Directors Meeting Agenda Item #4b, June 2003).

During this rising member conflict, it was clear that more ANA union nursing association members were threatening ANA disaffiliation, most notably Michigan and Minnesota (ANA, UAN Interviews, 2006; 2007). Although less vocal and less apparent, it was expressed by some interview participants that there also existed some expression among the non-union nursing association membership threats of disaffiliation. This conflict forced the ANA leadership to make changes in order to maintain the association as the U.S. nursing professional society. Equalizing resources and organizational legitimacy was done, creating the separate but ANA affiliated organizations of the UAN and the Center for American Nurses.

Through the creation of two new national nursing organizations, with memberships split between union and non-union state nursing associations, it appeared that the new membership relationship of these two groups with the ANA at best provided the ANA leadership with time to further assess its future as a labor organization and professional society. The conflict within the ANA between these two groups remained as evidenced by the grueling process of creating the ANA affiliation agreements with the UAN and the Center for American Nurses by early 2003 (ANA Interviews, 2006; 2007). And perhaps the confidence of all three organizational leaders in the new arrangement in addressing the conflict was minimal as evidenced by the fact that each affiliation agreement was negotiated to be time limited, providing the opportunity over the years to modify or even discontinue the relationships among the three.

This ongoing conflict was more a matter of philosophy than it was a struggle for organizational power. As mentioned previously, the theoretical perspectives of professions supported the notion of control of the profession within its own ranks (Freidson, 2001). This perspective is beyond the legally regulated elements controlling the profession as these are meant for the protection of the public, not the development of the profession. How the profession organizes and develops its service to the society is within the purview of the profession, through its institutions, including its professional society (Freidson, 2001). This autonomy is critical in allowing the profession to best serve the needs of society. A professional's accountability was to the greater social need, whereas the laborer's accountability was to their employer (Zacur, 1982).

If one embraced this notion of profession and its variance from labor, one can begin to reflect on the conflict that arises when a professional society attempts to serve as

a labor organization. Such a notion becomes more complicated as various professions have emerged and evolved and hold positions of employment within organizations (Freidson, 2001 & Sullivan, 2005). As a collective, RNs have and continued to hold a variety of positions within the healthcare industry, as employees, administrators, and independent practitioners (U.S. Department of Health and Human Services, 2005). Addressing the unique economic and general welfare needs of the entire RN population through one institution was challenging, and the ANA attempted to do just that.

The agreements of the ANA leadership, including the leadership of the UAN and the Center for American Nurses were overshadowed by the conflict between the UAN, representing union state nursing associations, and the Center for American Nurses, representing the non-union, workplace advocacy state nursing associations. And although each group shared values and interests, the methodology in addressing these greatly varied between the UAN and the Center for American Nurses. As these two organizations with differing functions in addressing nursings' workforce and workplace issues could easily identify their function in the ANA strategic goals, the function of the ANA in regards to these goals was less articulated.

Conclusion and Recommendations

The change in the ANA organization from 1999-2004 demonstrated change as a process with interplay between internal and external influences, and included the experiences of organizational players. Over a four year period, the ANA reorganized its membership structures in order to address the needs of its constituent member associations, specifically the state nursing associations, in an effort to manage the increasing conflict between union and non-union interests. Additionally, the structural

changes ended the trend of union state nursing association disaffiliations from the ANA, and increased ANA membership opportunities for individual RNs and specialty nursing organizations.

Although there appeared to be a resolution to the conflict of equity in the ANA resource allocation to both the union and non-union member interests by creating two independent but ANA affiliated organizations representing each of these interests, conflict remained regarding how these two organizations would relate to one another and address national nursing issues. Without these conflicts resolved, resources would continue to be focused inward to address the affiliation and agreements and further delineate organizational functions. Spending time, money, and human resources inward had an opportunity cost to the profession. The ANA's continued use of resources internally jeopardized opportunities for the profession to fully engage in national public and health policy processes. Diversion of resources from programmatic activities to the UAN and the Center for American Nurses resulted in the ANA concentrating resources to two programmatic activities, both addressing the single issue of nursings' economic and general welfare needs. As the professional society for nursing in the U.S. the ANA was expected to represent and commit resources to the totality of needs of the profession in an effort to address the healthcare needs of the society it serves. This did not happen from 1999-2004, and without the resolution of internal conflict, likely remains a concern at this time.

Representation of the profession also remained at risk for the ANA as individual membership numbers had decreased by approximately 5,000 over a ten year period beginning in 1995. With the majority of lost membership resulting from state nursing

associations disaffiliations from the ANA, it was apparent that maintaining a federated model of organizational membership did not support growth in ANA membership. This not only contributed to a loss in revenue opportunities, but also challenged the status of the ANA as the most comprehensive representative of the nursing profession in the U.S. Such a challenge then also threatened ANA's ability to participate in the national arena as their membership in the International Council of Nursing (ICN) depended on their ability to remain a comprehensive representative of the profession.

Other organizational structures needed to be reexamined for their contribution in the survival of the ANA. Years of internal conflict had lead to distrust resulting in the development of an overwhelmingly complex organization. Stakeholders in too many decision-making processes had utilized several organizational entities such as task forces and workgroups in an effort to assure open communication and representation (ANA Interviews, 2006; 2007). Unfortunately this only created more organizational complexity and contributed to confusion and to concerns of lack of organizational transparency and distrust on the part of the ANA staff, leadership, and membership. Minimizing organizational entities would not only lower costs, but by creating a shared understanding and clarification of roles and functions between entities greater efficiency is achieved, and organizational complexity is lessened. The ANA membership needed to find a way to once again trust its elected leaders to do what was best for the organization, and the elected leadership needed to clarify its role to staff and members while finding more efficient ways of guaranteeing open, clear, and honest communication and build trust without creating organizational complexities.

Since it was now understood that the ANA leadership had decided to not renegotiate its affiliation agreements with the UAN and the Center for American Nurses, there was an opportunity for the organization to concentrate on its core mission and vision as the professional society of nursing in the U.S. This was also an opportunity to end the federated model of representation and membership as state nursing associations needed to determine the cost benefits of maintaining membership in more than one national nursing organization. An opportunity to redefine itself and its role as the U.S. nursing professional society was present.

Thus the process of change within the ANA from 1999-2004 was viewed as necessary, costly, time consuming, and potentially beneficial. Change was necessary to immediately end the tide of membership loss from state nursing association disaffiliations from the ANA, and necessary to force the association to address the long standing issues of serving as both a professional society and a labor organization. It was costly in both dollars lost to single focused programmatic development and lack of membership growth, and in years of internal focus neglecting external professional and public policy involvement challenging the association's status as the professional society representing nursing in the U.S. Change was also time consuming due to rising conflict and polarization of concern around the single issue of addressing nursings' economic and general welfare needs. This led to increased distrust among the membership, the leadership, and the staff that created overwhelming organizational complexities that contributed to increased time needed to address the issues.

And finally, the change was perhaps beneficial. Institutions and organizations are a reflection of the people who create and maintain them; these are the members and the

leaders. Organizations can only continue and grow through experiences as lessons are learned, studied, and understood. The ANA experienced a time when its organizational members and leaders have had to deal with the long standing debate of whether the professional society can serve the interests of the profession and also serve as a labor organization engaged in union activity. That time has come, and perhaps the experience of the ANA from 1999-2004 and beyond will now serve as a single case study for other professional organizations to learn from as they too may struggle with the issues of addressing their professional member economic and general welfare concerns. Additionally, if the leadership of the ANA, the UAN, and the Center for American Nurses were to have a shared vision of nursing as a civic profession, focusing the organizational efforts on the greater social contribution of the profession as a whole, in addition to addressing the needs of profession, there then may be created an opportunity for collaboration and unity.

Reflections from the Researcher

Because the author of this work recognized his more than twenty year experience with both the ANA and the state nursing association struggle with serving as both a labor union and a professional society in both Pennsylvania and California, it is important to recognize the contribution of such experience to this study. As described by Ellis and Bochner in Dezin and Lincoln (2000), "In reflexive ethnographies, the researcher's personal experience becomes important primarily in how it illuminates the culture under study" (p. 740).

Throughout the interview process I began to recognize that I was indeed in a very fortunate position. Reflecting on the comments and discussions between the leaders of

the ANA, the UAN, and the Center for American Nurses, I became acutely aware that I had placed myself in a position to hear the concerns of these participant interviewees. There was a collective understanding of the issues and a shared perspective among the leaders within each organization; however, as identified in the dissertation writing, there were conflicted issues and perspectives between the groups. Of greatest interest to me was that although there were conflicted perspectives, each was presented logically by the interviewees. I had become a trusted listener who would tell the story from each organizational perspective.

Each interviewee logically presented a case for their organizational perspective. However, each perspective focused on organizational legitimization and fear of control by the other organizations. For example, the ANA leadership feared a loss of their representation of the U.S. nursing profession in its totality to the interests of the UAN with a union perspective representing the hospital staff nurse. In turn, the UAN leadership feared a loss of control in representing the staff nurse interest if they lacked legitimate representation within the ANA organizational structure and its leadership. This fear was also reflected among the Center for American Nurses interviewees who feared an unbalanced representation of union staff nurses by the UAN in the ANA organizational structure and thus also sought legitimate representation of non-union nursing interests within the ANA. As a member of the ANA, a current member of the ANA California nursing association, and a former member of the Pennsylvania Nurses Association (a union), I began to understand and sympathize with the fears of these leaders.

With this newly found understanding, I began to think about the actions of each organization throughout the time frame of this study. As the aforementioned fear grew among the membership within each organization, fear-based behavior of distrust and protection of organizational interests dominated the organizational processes throughout ANA's restructuring. Although the organizational leaders talked openly and freely to me for the purposes of this study, they seemed at worst unable to talk with each other, and at best unable to fully understand the logic of the concerns expressed among the leaders and members.

Although I began this research process with concern for the survival of the ANA as my professional society, I know share with the reader a new perspective. This process of organizational change was a necessary evolution of the ANA, the UAN, and the Center for American Nurses. As these organizations move forward in redefining their relationships with one another, I am hopeful that they will begin to recognize that the process experienced throughout this initial restructuring served to help the leadership and membership within each organization to gain greater insight into the function of their respective organizations. The previously mentioned fears are no longer necessary as each organization has fully legitimized itself. What remains is defining the relationship each will have with one another and its constituency. Perhaps now, these organizational leaders can begin to dialogue with mutually shared goals and trust that will better serve the profession and its special interest needs.

Limitations of Study

This study was a case study of a specific organization, the ANA, and its organizational structural changes and process from the years 1999-2004. It provided a

time specific snapshot of an analysis of the ANA's structural changes through the perspective of its most recent leaders, including living past presidents and current officers and members of the Board of Directors of the ANA, UAN, and Center for American Nurses. Also included in this study was an analysis of ANA organizational documents and records reflecting the process of change in the goals and objectives of the ANA leadership and organizational structure and activities between the years 1999 - 2004.

This study was limited to the perception of the ANA leadership and thus did not include the perspectives of the ANA membership at large. Also, the time frame was limited to five years, reflective of recent changes in the ANA's structure, activities, and processes. The unit of analysis was the ANA as a professional society and focused on the organizational changes of the designated time. It was not an analysis of organizational effectiveness, but rather a study of the change process within the organization from 1999-2004. The analysis of the change process relied heavily on ANA leadership opinions and perceptions, and thus was meant to provide a glimpse at the organization in its efforts to serve as the professional society of nursing in the U.S. Although this study did not provide generalizable information for other professional societies, it did provide documentation of events and analysis of data from semi-structured interviews of organizational leaders and records and documents of organizational activities to allow current and future ANA leaders to reflect on their most recent past and plan for the future.

Future Research

To fully understand the change process of the ANA in serving its dual organizational role requires a continuation of this study beyond the end point of March 2004. Evidence has already surfaced that the process of organizational change within the

ANA is continuing with the announcement of no longer continuing the affiliation agreements with the UAN and the Center for American Nurses. Additionally, it has been announced that nearly 40 bylaw changes are to be addressed at the June 2008 meeting of the ANA House of Delegates. Continuing this research will provide an opportunity to better understand the full process of organizational change and its influence on the ANA.

In focusing on the ANA, other professional societies will benefit. As the healthcare industry continues to change, and physicians become increasingly employed within healthcare organizations, the American Medical Association (AMA) is likely to experience similar processes within its own organization. Other professions with representative professional societies and labor organizations, such as social workers and teachers may also benefit. And finally, by focusing on the issue of managing professional and labor interests within a single professional society might help contribute to the evolution of new theoretical prospective of professions and labor process.

ANA's Future

Other developments in ANA's organizational structures that occurred after March 2004 were beyond the scope of this study. Of particular interest was the re-negotiation of the affiliation agreements between the ANA and the UAN and the ANA and the Center for American Nurses, which were for five years and two years respectively (ANA, UAN, Center for American Nurses Interviews, 2006, 2007). Renegotiation of the affiliation of the ANA with the Center for American Nurses was successful in 2005. In 2008 the initial autonomy and affiliation agreement between the ANA and the UAN expired. Of special note, in the March/April 2008 issue of *The American Nurse*, the official bimonthly publication of the ANA, the ANA president announced in her message that the

ANA Board of Directors had decided to not renegotiate their affiliation agreements with either the UAN or the Center for American Nurses, and that more than 40 bylaw proposals were anticipated to be brought to the June 2008 meeting of the ANA House of Delegates.

Thus the future of the ANA continued to evolve in 2008. With the UAN and the Center for American Nurses affiliation agreements with the ANA not renegotiated, ANA resources were no longer utilized in maintaining organizational structures for management of these relationships. The specifics of the proposed bylaw changes addressed at the 2008 meeting of the ANA House of Delegates likely addressed membership categories once again, and eliminated language pertaining to the AOM relationship with the UAN and the Center for American Nurses. Given the federated models of each of these organizations, each state nursing association will have needed to reexamine its own membership in the ANA, and or the UAN and or the Center for American Nurses. What that means for the future of these national nursing groups and their relationship with one another remained to be seen.

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Appendix A: Letter of Introduction to Study Participants

Date:

Dear Nursing Leader:

I am a doctoral candidate in the Department of Social and Behavioral Science, School of Nursing, UCSF conducting a dissertation case study of the processes of organizational change at the American Nurses Association (ANA) during the years 2000-2005. I will be focusing specifically on the internal and external influences that contributed to the structural changes of the ANA during this time. I am writing to ask you to be interviewed regarding these influences and the process of change in the ANA structure.

I will be contacting you in the next several weeks to learn of your willingness to participate or not participate. Your participation in this study is entirely voluntary and there are no direct benefits to your participation. By participating in this study, however, you will be making an important contribution to registered nurses and their professional society in the United States. Whether or not you choose to participate will have no effects on you in your relations with UCSF and no one will know who agrees to participate, or not participate, except the researchers.

Although all research risks loss of confidentiality, all interview materials will be carefully protected. For this study, no individual participant names or individual quotes will be utilized. The interview will be taped recorded if you permit, otherwise I will take notes. At any time you may ask questions, refuse to answer a question, or stop the interview.

If you have any questions now or at any time about this study, you may call me or the Principal Investigator, Dr. Charlene Harrington, at UCSF at 415-476-4030, or you may email her at Charlene.Harrington@ucsf.edu. Or you may contact the UCSF Committee on Human Research, which is concerned with the protection of volunteers in research projects. The Committee's office hours are between 8:00am and 5:00pm Monday through Friday Pacific time. The telephone number is 415-476-1814, and their mailing address is: Committee on Human Research, Box 0962, University of California, San Francisco, CA 94118.

Sincerely,

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Appendix B: Interview Guide

1. Describe the changes in ANA's organizational structural changes between 2000 and 2005.
   - Why were these changes made?
   - What have been the major challenges in this change process?
   - What strategies were utilized in addressing these challenges?
   - How have these changes influenced the work of the ANA?

2. What were the influences that contributed to the recent structural changes that occurred within the ANA?
   - How did membership influence the changes?
   - What alternatives to restructuring were considered?
   - How has the ANA restructuring addressed these external challenges?

3. How have these structural changes in the ANA addressed the overarching goals and objectives of the ANA?
   - Have these changes contributed to any changes in membership numbers?
   - What changes in membership has the organization seen since the restructuring?
   - What changes in membership are anticipated as a result of the restructuring?

4. What issues has the ANA faced over the years in serving as both the professional society of nurses and as a labor union?
   - What influence has this had on the recent structural changes?
   - How have these issues changed with the restructuring of the ANA?

5. What was the reason for creating a membership category for organizational affiliates?

6. What was the reason for establishing an ANA affiliate organizational membership with the United American Nurses (UAN)?
   - What are the goals and objectives of the UAN?
   - What activities does the UAN utilize in meeting their goals and objectives?
   - What does it mean for the UAN to be affiliated with both the ANA and AFL-CIO?
   - What have been the challenges faced by the UAN over the past five years?
   - How does the work of the UAN differ from other national unions who represent registered nurses in labor contract negotiations (AFSCME, SEIU)?

7. What was the reason for establishing an ANA affiliate organizational membership for the Center with American Nurses (CAN)?
   - What are the goals and objectives of the CAN?
   - What activities does the CAN utilize in meeting their goals and objectives?
   - What have been the challenges faced by the CAN over the past five years?

8. How do the services of the UAN and CAN fit with ANA's organizational goals and objectives?

9. If ANA is to continue as the professional society for nursing in the United States, what priorities does the organization need to have?
   What major issues do you believe the ANA needs to address in the next five years?
   How will these issues be managed through the organizational structure?
   How would you evaluate the ANA's performance and effectiveness since the reorganization?
   - In addressing membership needs?
   - As a professional society?
   - As a labor union?

   What recommendations would you give to other professional societies regarding their organizational structure in addressing their member's economic and general welfare needs?

Appendix C: Interview Themes by Organization

ANA Interviews	UAN Interviews	Center for American Nurses Interviews
The Futures Task Force	Impetus to the ANA structural change	Historical development of the Center for American Nurses
ANA as a labor organization	Historical development	How the Center for American Nurses sees their work
By-laws considerations	Management domination of volunteer leadership positions	Parity with the UAN
Affiliate Organizational Members participation in ANA Board of Directors	Views on need for contracts in employment setting	Union states vs. Non-union states in ANA
Influence of Constituent Member Association disaffiliations	Perception of staff nursing	Membership – numbers remain unchanged, but different ways to become a member
Leadership perspectives	ANA federated organizational model	UAN and Center for American Nurses as new organizations independent of the ANA
Need for UAN affiliation with AFL-CIO	UAN leaving ANA	Challenges in restructuring
Union vs. nonunion Constituent Member Associations	Affiliation with AFL-CIO – raid protection	Workplace advocacy - An alternative to collective bargaining or just different
Dues	Ability of collective bargaining to increase ANA membership	Challenges of identity and public relations
ANA goals and federated organizational model	When views on issues differ from those of the ANA	Perspective on future of ANA
Member views influencing structural changes	Niche – work of ANA, work of UAN (labor organizing)	Profession society vs. labor organization
Organizational model/structure options	Affiliation agreements and internal focus – addressing professional issues and staff nurse feeling disenfranchised.	AFL-CIO affiliation
ANA goals and need to create Affiliate Organizational Members	Center for American Nurses requiring more ANA resources than the UAN as they lack a revenue generating membership base.	
Continuing challenges with restructuring		
Internal organizational focus		
Affiliation agreements		
ANA staff changes		
Organizational affiliates		
Defining economic and general welfare		
Professional vs. labor issues		

Appendix D: Chronology of Events from ANA Public Documents

• BOD proposing bylaw changes for structural changes concerning commission structure and further establishing the UAN and the Federated Nurses Association (FedNA) • UAN organizing in states where SNAs do not engage in Collective bargaining. Working Group on Crossing State Boundaries established • Decision to begin exploration of UAN affiliation with other national union: Affiliation Task Force established.	• Decision to further explore affiliation with AFL-CIO • HOD establishes the FedNA, the UAN, the WPA program, and CNPE in bylaw language • HOD requests ANA examine membership options for SNOs	• Workplace Advocacy Task Force request BOD to define WPA and Collective Bargaining and propose bylaw changes to create the Commission on WPA • Initial meeting of new Congress on Nursing Practice and Economics • Massachusetts Nurses Association (MNA) requests a seat on Affiliation Task Force: No action taken by BOD • Workgroup on Crossing State Boundaries defers to the Constituent Assembly (CA).	• Task Force on Membership Options established to explore ANA membership options for Specialty Nursing Organizations (SNO) • WPA program moved to the ANA Constituent Affairs Department with a full time staff member	• Special Meeting of House of Delegates (HOD) called for June 2000 to address bylaw proposals • Concern from CA, SNA Labor Coalition, WPA Coalition, SNA regional groups, CNPE, and UAN Ex. Council that WPA structure will parallel UAN and compete with them for resources. • BOD accepts proposed bylaw amendment and the purpose and function of the Commission on WPA
February 1999	June 1999	October 1999	November 1999	December 1999

Appendix D: Chronology of Events from ANA Public Documents (cont.)

• UAN requests a designated seat on ANA reference committee: BOD approves UAN non-voting liaison to the committee, non voting liaison seat on the ANA BOD, and membership of the ANA BOD Committee on Legislation • Working Group on Crossing State Boundaries: "divergent views" on purpose of group impeding progress. BOD reaffirms support of Group • Noted the MNA will AGAIN vote on ANA disaffiliation • UAN in affiliation discussion with AFL-CIO • UAN seeks involvement in ANA policy making, including a non-voting seat by the UAN chair on the ANA BOD • Task Force on Membership Options presents 2 models for SNO membership in ANA including pilot program • Noted cost of establishing FedNa, UAN, WPA, and CNPE was $400,000.00; staff reductions made in Sept. 1999 occurred in all ANA areas except UAN and WPA Program • BOD approves use of Knowledge-Based Strategic Governance Model by Tecker Consultants, L.L.C. for use in decision making • NOLF and NFSNO meet and establish working group to examine SNO needs and organizational structures	• ANA E.D. hires UAN E.D. • Discussions with MNA continue regarding potential disaffiliation • SNAs in Virginia, Nebraska, and Utah establishing WPA programs • WPA presents proposed operating guidelines for WPA Commission • Nine commissioner appointments to the WPA	• Business Arrangements Task Force (BATF) submits recommendations for membership on Futures Task Force (FTF) and hiring of consultant • UAN reports Maine and Massachusetts disaffiliation campaigns. • BOD announces five goals to focus all work: Professional Practice Advocacy, Public Policy, Knowledge & Research, Inclusive Membership, Workforce & Workplace Advocacy • BOD affirms the meaning of "organizational insulation"	• ANA president announces MNA vote to remain with ANA • 18 individuals from state WPA programs meet with ANA Pres. And E.D. over concern of BOD lack of interest in WPA • BOD approves nonvoting seat on the BOD for the WPAC • UAN Director announces potential affiliation with other unions if AFL-CIO affiliation fails: Minnesota Nurses Association suggests UAN sever ties with ANA – suggestion is "resoundingly rejected by the Labor Coalition"	• Maine State Nurses Assoc. (MSNA) voted Oct. 2000 to remain united with ANA • BOD approves $1.675 million deficit budget for 2001 providing for 30% growth of the UAN • BOD directs $600,000.00 increase in 2001 UAN budget • BOD affirms ANA member as SNA, but continues to serve individual RN member • BOD requests FTF to propose strategic plan by 3/01 & operational plan by 12/01 • Finance report indicates increase in programmatic expenses for the UAN expected to increase for 2000, and proposed to be budgeted for 2001; all other programmatic expenses are to decrease
March 2000	June 2000	September 2000	November 2000	December 2000

Appendix D: Chronology of Events from ANA Public Documents (cont.)

• MNA schedules 3rd disaffiliation vote for March 2001 • BOD allocates $127,000.00 in response, $50,000.00 from 2001 UAN budget with remaining from other programmatic budgets.	• UAN Director announce MSNA expected to address disaffiliation in April 2001	• Draft proposal for merged NOLF/NFSNO to Alliance of Nursing Organizations • Membership Satisfaction Survey of ANA's most valued services n=5298 ○ 57% - Nursing Practice and Policy ○ 33% - Workplace Advocacy ○ 17% - Collective Bargaining • Bylaws proposals submitted by UAN and by the MSNA considered "controversial" by the Committee on Bylaws • Futures Task Force submits to BOD a draft strategic plan • BOD reviews proposed bylaw amendments for 2001 HOD • Tecker Consultants present final draft of ANA strategic plan to BOD	• Maine and Massachusetts vote to disaffiliate from ANA, vacating 48 HOD seats	• Meeting of ANA BOD, SNA Labor Coalition (SNALC) and WPAC – remove all bylaws proposals except Article VIII, Section 5 – UAN membership • Massachusetts Association of Registered Nurses becomes ANA constituent member • Proposed ANA-UAN affiliation charter with AFL-CIO approved by ANA BOD, sent to UAN's National Labor Assembly for action: • Draft strategic plan approved for presentation to 2001 HOD
January 2001	February 2001	March 2001	April 2001	May 2001

Appendix D: Chronology of Events from ANA Public Documents (cont.)

• Full AFL-CIO charter sought for raid protection from AFL-CIO affiliated unions • First two months funding for affiliation approved, ≈ $50,000.00/month • Awareness of "conflicting demands for limited resources among internal constituencies" – identifies collective bargaining and workplace advocacy strategies • Federation model noted as a periodic barrier to organizational effectiveness • Futures TF set timeline for presentation of structural changes to a special HOD meeting in June 2002 • Review of professional vs. trade association and discussion of open association model • HOD refers all bylaws proposals back to bylaws committee for single set of proposals for HOD in 2002	• ANA membership ≈ 156,000 • Membership losses noted from disaffiliations • 70% of revenue is dues generated • Goal set of 200,000 members within the year	• Consultant Tecker presents revised document of 6 possible ANA structures	• CNPE operating guidelines reviewed – 15 members, 10 elected by HOD, 5 BOD appointments	• Joint NOLF/NFSNO meeting held – 43 nursing organizations attend • Nursing Organizations Alliance (NOA) formed with specified relationship with ANA • NOLF/NFSNO dissolved • Constituent Assembly meets – 106 representatives from CMA, BOD, CNPE, Futures TF, WPAC, UAN Ex. Council, ANA Committee on Bylaws, and E&GW program directors, and SNA Labor Coalition in observance • Bylaws proposals to be presented to the 2002 HOD
June 2001	July 2001	August 2001	October 2001	November 2001

Appendix D: Chronology of Events from ANA Public Documents (cont.)

• Legal counsel recommends allowing cross state labor organizing – concern over insulation issue and challenges • In response, Communication issues arise • Tecker Consultants presents six potential organizational models to the BOD	• BOD reviews chart comparison of current ANA structure to a Model 1 and Model 2 structure, examining key features, governance, finance, and workforce as they would relate to bylaw changes • BOD explores the following: ○ Direct membership ○ Identification as a labor organization ○ UAN and WPA as autonomous organizations ○ NSO membership ○ "competing interests" and internal conflict • Review of feedback from stakeholders r/t bylaw proposals • Proposed Strategic Planning Goals for HOD approval: ○ Professional Practice Excellence ○ Healthcare and Public Policy ○ Knowledge and Research ○ Unification ○ Workforce and Workplace Advocacy	• HOD adopts 2002-2003 Envisioned Future and Goals	• Strategic Plan revised and adopted by BOD	• Strategic Plan again revised by BOD
December 2001	March 2002	June 2002	August 2002	November 2002

Appendix D: Chronology of Events from ANA Public Documents (cont.)

• BOD reviews the draft *Autonomy and Affiliation Agreement between ANA and UAN/AFL-CIO* • UAN identified as "wholly autonomous" • UAN identified as only Associate Organizational Member (AOM) of ANA for collective bargaining	• UAN Special National Labor Assembly overwhelmingly supports autonomy/affiliation agreement with ANA	• BOD signs *Affiliation Agreement* with the ANA and the American Nurses Coalition for Workplace Advocacy (ANC\WPA) • ANC\WPA identified as ANA AOM	• ANA strategic goals focus on: ○Nursing Shortage ○Staffing ○Workplace rights, health & safety, patient safety/advocacy ○ Other ▪ CWPA identified as key organizational component responsible for many areas under these topics • Glossary of Terms define Associate Member Division, Labor Organization, Member at Large, Professional Practice • BOD affirms its designation as a labor organization • Committee on Bylaws receives feedback on proposed amendments from 23 CMAs, ANA BOD, ANF, CWPA, UAN Ex. Council, 4 Missouri and Ohio individuals • New dues policy established to incorporate CMA membership in ANA and AOMs • BOD receives final bylaw proposals from Committee on Bylaws	• 29 CMAs raise concerns pertaining to bylaws proposals: ○ Move to Biennial HOD meeting ○ Individual/ direct membership
December 2002	January 2003	February 2003	March 2003	May 2003

Appendix D: Chronology of Events from ANA Public Documents (cont.)

• BOD begins discussion of AOM presidents seat on BOD. Issues: ○ Transparency ○ Reciprocal representation ○ Distinguishing business and policy agenda items ○ Competition • Individual membership category designated as optional on a pilot project requiring agreement between ANA and CMA for RNs from the CMA • Internal policies are negotiated among ANA and AOMs. Documented as "painful" Conflict apparent. Meetings among ANA, UAN, and CAN generate 77 action or information items to be addressed after approval of bylaws • Report from Bylaws Strategy Work Group regarding concerns with new structure: ○ Conflicting positions among ANA and AOMs ○ Perception that WPA was "treated badly" during negotions ○ Dues flow and impact on CMAs • Workgroup meeting weekly via conference calls • First meeting of Governing Council of the Center for American Nurses held • 35 CMAs declare intent to belong to CAN • UAN National Labor Assembly delegates overwhelmingly ratify Autonomy and Affiliation agreement • HOD delegate changes with approved restructuring as follows: ○ 600 delegates – unchanged ○ ANA BOD ↑ for UAN and CAN ○ ↑ for Individual Member Division ○ 8 seats for Organizational Affiliates ○ 4 seats for anticipated OAs • Bylaw proposals approved by ANA HOD	• Center for American Nurses (CAN) passes bylaws for incorp.	• Natl. search for CAN E.D.	• CA expresses concern of ANA's relationship with CMAs • Discussion of expressed threat from CNA and MNA campaigning in Arizona, Missouri, and Hawaii • ANA membership lost since 1995 from disaffiliations ≈ 50,000 • ANA membership at 151,000	• BOD affirms AOM presidents participation on the ANA BOD, establish policy from bylaws that excludes participation any meetings of business matters or confidential matters regarding ANA's strategic position with other organizations • Task force established to explore criteria for possible future AOMs • Individual members pilot program under way • Task force on Future AOMs present draft of Criteria for Consideration of Organizations as Future AOMs that specifies concern regarding competing PACs • Draft matrix examined on ANA-AOM Policy Coordination Process • Task Force on Organizational Affiliates recommends dues for OAs at $5,000.00, and specifies representation in HOD, CA, and ANA BOD
June 2003	October 2003	Nov. 2003	Dec. 2003	March 2004

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