NURSES' UNIONIZATION IN MANITOBA:

A HISTORICAL PERSPECTIVE

by

Sue Richmond

A thesis submitted to
the University of Manitoba
in partial fulfillment of the
requirements for the degree of
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ABSTRACT

Utilizing a historical research design, this qualitative study identified and examined the causes of unionization among nurses in Manitoba from 1970 to 1976. The influence of economic concerns, working conditions, professional issues, and societal conditions upon nurses' unionization were explored. The impact of these factors upon unionization was then examined within the context and framework of conflict.

The data for this study was obtained from the oral testimonies of ten individuals who experienced and participated in the formation of Manitoba's nurses' union. These accounts were obtained through a semi-structured interview format. Additional data was obtained from relevant written documents.

Following content analysis of the data, the categories of economic concerns, working conditions, professional issues, and societal conditions emerged as considerations in the unionization of Manitoba's nurses. How these factors influenced unionization was related to work place conflict resulting from perceived discrepancies, unresolved work

place problems and the need for change. Additional conflict related factors which emerged from this study were the quality of work place communication and the need for nurses to obtain an influential voice within the work place.

Based on this study's findings, implications for nursing education, nursing practice and nursing education are offered. Further to this study's findings, recommendations for nurses and their working environment are provided.

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CHAPTER ONE

INTRODUCTION

Currently, in 1992, Manitoba's nurses' union has 11,300 members (Giesbrecht, 1992). Approximately 101 of Manitoba's 150 health care facilities employ unionized nurses (Giesbrecht, 1990). Membership is voluntary with certification dependent upon a 50% + one acceptance vote of the eligible nursing staff within each health care facility. Since its creation in 1975 with a founding membership of 5,800, Manitoba's nursing union, originally known as the Manitoba Organization of Nursing Associations or MONA has amassed a substantial following. Marking its fifteenth anniversary in 1990 with a name change, the Manitoba Nurses' Union (MNU) continues to increase its membership, its strength and its power. Within a relatively short time, the Manitoba Nurses' Union has become a significant institution for this province's nurses. The speed and extent to which unionization has permeated Manitoba's nursing profession signals an enormous shift of emphasis among nurses.

Problem Statement

"Unions are organizations designed to protect and enhance the social and economic welfare of their members" (Tannenbaum, 1965, p. 710). Low salaries and poor working conditions are cited by practicing nurses and in the literature as common causes of unionization (Chernecki, 1986; Cormick, 1969; Rowsell, 1967). Although these sources are undoubtedly correct, the possibility remains that there may have been other significant contributing factors in the unionization of Manitoba's nurses. Whether or not wages and work conditions influence unionization depends upon what employees perceive as fair and deserved rewards for their contribution to the work place (Schriesheim, 1978). Employee satisfaction with existing work conditions and compensation are additional considerations in the unionizing process (Salutin, 1986). For nurses, union action requires the resolution of professional standards, personal determination of self-worth, employee-employer relationships, and conflict (Erickson, 1971; Miller, 1980; Rotkovitch, 1980). How these complex and powerful elements have influenced the development of Manitoba's nurses' union remain largely unstudied and unknown.

The compatibility of unionism and professionalism has

been a persistent debate within the nursing profession (Erickson, 1971; Gideon, 1980; Gilchrist, 1987). As unions are considered synonymous with militant action in the form of strikes and demonstrations, they are highly stigmatized and controversial (Colangelo, 1980; Douglas, 1981; Tannenbaum, 1965; Wynne, 1978). Within the health care setting where patient care is paramount, unionization initiates an abundance of personal conflicts and dilemmas for nurses (Miller, 1980). Committed to the ideal of service to others, nurses struggle with conflicting professional and personal beliefs when contemplating union representation (Douglas, 1981; Gideon, 1980; Herzog, 1980). Individual gain and improved working conditions are difficult rationalizations for the professional nurse (Sullivan & Decker, 1988). For nurses to challenge their traditional ideals of service, self-sacrifice and obedience, the conditions which perpetuated union representation must have been powerful.

Management and union groups are viewed as natural adversaries (Wynne, 1978). Many health care managers believe unions possess far too much power and are detrimental to the productivity of the facility (Jacox, 1971). Peace and tranquility are not the visions which come to the minds of managers who deal with unionized staff.

Unions threaten authority, power, autonomy, loyalty, and commitment (Schanie, 1984; Sloane & Witney, 1972). According to Greenberg (1983) and Schanie (1984) some managers contend that following unionization of employees, the atmosphere and productivity of the work place is forever changed.

Despite the controversial nature of unionism, membership in the MNU has steadily increased (Giesbrecht, 1990). In pursuing union representation, nurses have encountered powerful obstacles. Unionization requires the resolution of competing values such as personal belief, self-interest, professional ideals, public attitude, and management acceptance (Gilchrist, 1987; Jacox, 1971).

For nurses, union action has not been a frivolous or effortless endeavor (Jensen, 1984). It has been a powerful, and unprecedented occurrence in the history of Manitoba's nurses. Discovering and examining the causes of unionization should reveal valuable information about nurses, their jobs and their employers. This knowledge will provide insight into why the "caring" profession sought union representation.

Purpose of the Study

This study proposes to identify, examine and explain the major contributing factors which determined the unionization of Manitoba's nurses. The economic, social and environmental conditions which existed at the time of nurses' unionization will be investigated. In addition, the concerns of nurses regarding wages, work conditions and professional integrity will be reviewed. Further analysis will examine the impact of conflict upon the context and content of union activity.

In order to achieve a thorough examination of why nurses in Manitoba unionized, the research study will entail an investigation of the underlying factors or events which contributed to unionization. These factors will be revealed by means of the analysis of various intricate and influential factors which determined union activity among nurses in Manitoba. The following exploratory questions related to the unionization of nurses in Manitoba will be utilized in this study:

1) How did social factors influence unionization?
2) How did economic factors influence unionization?
3) How did environmental, work place conditions influence unionization?

4) What professional issues influenced unionization?

5) How did conflict influence the initiation of unionization?

Significance of the Study

This study will provide identification and understanding of the factors which compelled nurses to unionize. Examination of union determinants will clearly define powerful issues and concerns encountered by nurses. These issues relate to how nurses interact with their profession, their environment and their employers.

Identifying the concerns which precipitate unionization affords insight into how nurses see themselves, their jobs and their role in society. Union activity signifies a desire for change and reveals important issues. Job expectations, future change and the direction of the nursing profession are areas which can be understood through the identification of union determinants.

Exposure of what factors caused unionization will also enhance increased awareness of nurses and their work by employers. Managers who are willing to address staff

concerns will enjoy productive working relationships within their organizations (Throckmorton & Kerfoot, 1989; Young & Hayne, 1988). With the identification and documentation of common unionization precipitators related to job dissatisfaction, repetition of past employer-employee maladies can be averted (Schanie, 1984). Managers who are familiar with past mistakes may then discover creative new strategies in order to revive weak staff relations and improve work productivity (Freeman & Medoff, 1984; McConnell, 1984).

Finally, this research may promote further study regarding the concerns of nurses within the work place and the consequences of these concerns. As the employee's environment changes, so too does the perceived job value to the employer and society change (Baumgart, 1983). In times of perpetual economic, professional and health care change, the importance of the factors which caused the unionization of nurses cannot be underestimated (Zwarun, 1984).

Assumptions

In exploring and describing the determinants of unionization among Manitoba's nurses, the following assumptions are acknowledged:

1) Acceptance of union representation is an individual and highly personal event (Hopping, 1976; Gideon, 1980).
2) Nurses' perceived value to the work place is determined through comparison with other workers (Cormick, 1969; Gideon, 1980).
3) Unionization among employees is a reactionary process. Union action does not occur without a reason, it is in response to some perceived inequity or injustice (Werther & Lockhart, 1976; Young & Hayne, 1988).
4) The existence of conflict indicates the need for change to prevailing conditions. Conflict inspires growth, challenge, diversity, and change (Robbins, 1974).

Definitions of Terms

Within this study, the following terms will be utilized as defined below:

Certification - legal recognition by a provincial Labour Relations Board which ensures that only one union is authorized to represent a certain group of employees, the mechanism that gives the bargaining group legal status and the rights accorded by labour legislation (Sullivan & Decker, 1988, p. 429).

Collective action - a method of informal bargaining occurring between the employer and a loosely structured group of employees who share similar concerns. Agreements are usually unwritten and not legally binding (Gideon, 1980, p. 1206).

Collective bargaining - any procedure by which representative groups of individual sellers of labour combine to participate in the determination of the terms which are to govern the provision of that labour (Crispo, 1963, p. 944). An activity whereby the employer and representatives of the employees attempt to resolve conflicting interests (Holley & Jennings, 1984, p. 164).

Conflict - a struggle over values and claims to scarce status, power, and resources in which the aims of the opponents are to neutralize, injure or eliminate their rivals (Stern, 1982, p. 12). An interactive state manifested in incompatibility, disagreement, or differences within or between social entities, i.e., individual, group, organization, etc. (Rahim, 1986, p. 13).

Local - a formal structural organization within an employment setting (Beletz, 1980, p. 43). The basic entity within the union organization, the initial point of contact between the union and the employee, the unionized membership within each separate health care facility (Holley & Jennings, 1984, p. 103).

Nurse - the word nurse shall be understood to mean Registered Nurse, (RN).

Representation - standing or acting for another through delegated authority; for nurses, group action by formal representation involves the professional association and/or unionization (Throckmorton & Kerfoot, 1989, p. 612).

Unionization - the development of an organized, legally recognized group of employees that uses formal procedures to negotiate with an employer to determine the conditions under which the employees perform their jobs (Throckmorton & Kerfoot, 1989, p. 613).

Conceptual Framework

According to Kerr (1986), conceptual frameworks direct the researcher toward possible sources of evidence that can support or contradict a theory and provide guidelines for research which suggest issues and questions to be investigated. Use of a conceptual framework increases research objectivity and controls potential bias (Wilson, 1985).

Historically, monetary and work place issues have been cited as initial determinants in nurses' unionization (Chernecki, 1986; Rowsell, 1982). These are broad generalizations which tend to obscure the interactive

process of employee/employer relations. Unionization is a complicated process which makes identification of common elements difficult (Badgley, 1978). One must look beyond general categorizations and frequently negotiated items in order to ascertain the intricate but profound causes of collective action. Elements of interaction such as perceived discrepancies, unmet expectations and controversial decisions within the work place contribute heavily to job dissatisfaction and interest in unionization (McConnell, 1984: Schanie, 1984).

In reviewing the literature, several prevalent terms became obvious regarding the interaction between employees and their working environment. These terms were: participation, cooperation, confrontation, perceived discrepancies, and conflict. Therefore, a model of conflict and conflict resolution is considered an accurate framework by which to study the process of unionization. Rahim (1986) defines conflict as "an interactive state manifested in incompatibility, disagreement, or differences within or between social entities, i.e., individual, group, organization, etc." (p. 13). Conflict "exists when two or more parties differ with regard to facts, opinions, beliefs, feelings, or values" (Scalzi & Nazarey, 1989, p. 587). Fundamental sources are needs, goals, beliefs, and

interests (Thurkettle & Jones, 1978). "Opposition is viewed as a way of life among members of both small and large groups-through interorganization and intraorganization conflict" (Robbins, 1974, p. 11). Divergent values between employees and their environment or employers related to the conditions of work will create conflict. Contributing to this divergence is conflict related to the employees' perception of what conditions actually exist and what conditions the employees believe should exist.

Methods of conflict management which employees' perceive as not satisfying their needs will result in the pursuit of alternative methods of resolution. One alternative is unionization. For employees, unionism represents the perceived solution for ineffective problem solving methods and conflict within the work place. "The relationship of dependency and conflict with management is the core of union action" (Tannebaum, 1965, p. 710). Conflict is inherent in many union activities. Union negotiations, grievance hearings and arbitration hearings all possess elements of conflict and conflict resolution. This study will utilize the concept of conflict as a framework for examining the unionization of Manitoba's nurses.

Conflict Management

The result of conflict, dependent upon its source and its management, can be diverse. "Conflict *per se* has no positive or negative connotations; it is the use or misuse of conflict that determines its positive or negative effects" (Thurkettle & Jones, 1978, p. 19). Scalzi and Nazarey (1989) state that conflict is an inevitable part of everyday life.

An abundance of theoretical approaches for conflict have spanned the spectrum from pathological to normal (Stern, 1982). The pathological or traditional concept of conflict advocates avoidance as a means of handling what is considered a destructive and negative force (Marriner, 1982). The traditionalist's approach to conflict is basic and singular, it requires elimination. "All conflicts are seen as destructive and it is management's role to rid the organization of them" (Robbins, 1974, p. 12). Pathological conflict within an organization can lead to such adverse effects as decreased morale, high turnover rate of personnel, disorganization of ongoing daily activities, neglected long-range goals, and reduced quality of patient care (Stern, 1982). According to Robbins (1974), organizational apathy and stagnation are the result of traditional or dysfunctional conflict strategies. Such

conflict is non-productive, detrimental to the facility's operation and difficult to resolve (Sexton, 1980).

The adaptive or positive concept of the interactionist approach views conflict as a natural, inherent, constructive, and essential element that signals the need for change (Robbins, 1974; Thurkettle & Jones, 1978). Interactive, knowledgeable conflict management distinguishes the adaptive or positive concept from the pathological or traditional position (Marriner, 1982). Adaptive conflict resolution can create such positive outcomes as collegiality, cohesiveness, innovative thinking, increased communication, and avoidance of stagnation (Stern, 1982). Robbins (1974), states that functional, constructive conflict is both valuable and necessary. Moderate conflict can be positive by precipitating change to environmental, political and social mores (Marriner, 1982). Without conflict, there would be few new challenges and no stimulation to think through ideas; it is the vital seed which germinates growth and success (Robbins, 1974). Conflict then becomes an inevitable precursor to change.

Continued conflict will eventually precipitate change. The strength and quality of change is dependent upon the method of conflict management (Marriner, 1982). The

commitment of those individuals affected by the conflict dictate the magnitude of change. High job dissatisfaction and employee unrest resulting from persistent work place conflict could initiate union activity. Stern (1982) states that nurses have only recently begun to perceive collective bargaining as a viable alternative for resolving conflict between themselves and the hospital administration.

Conflict Model

Sexton's (1980) model of interpersonal conflict has been adapted to accommodate the unionization process (Figure 1). Lewis (1976) states that interpersonal conflict may arise between two or three people or within a group and that one example is conflict between a supervisor and a subordinate. Scalzi and Nazarey (1989) suggest that interpersonal conflict may become intergroup conflict. Lewis (1976) states that intergroup conflict occurs between the members of two groups. The evolution of the individual concerns of nurses into group concerns and collective action is compatible with the progression of interpersonal conflict to intergroup conflict. Using Sexton's model of interpersonal conflict as a basis for intergroup conflict, the research questions of this study will examine the process of unionization among nurses in Manitoba.

CONFLICT MODEL

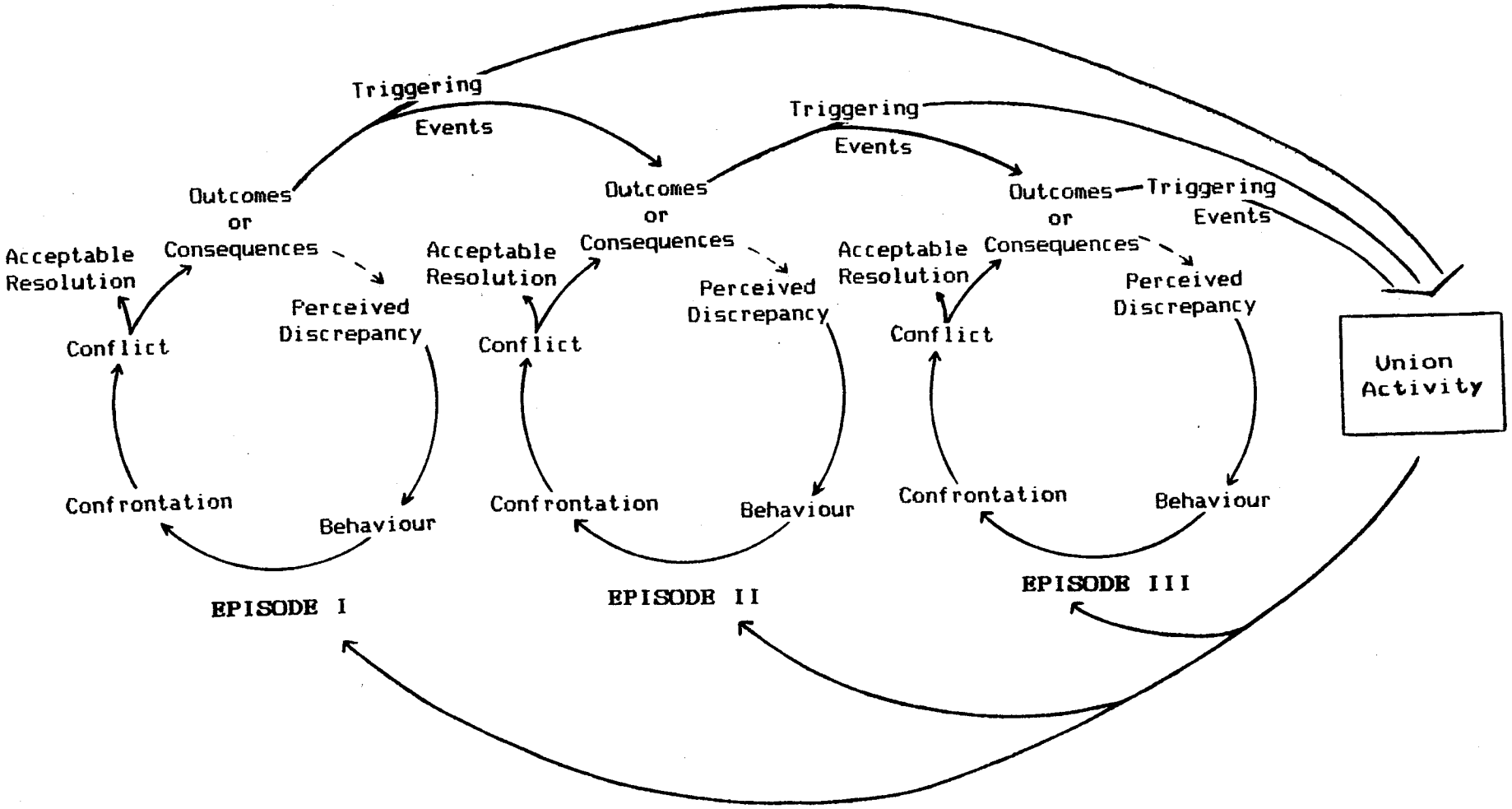

Figure 1

Adapted from:
Sexton, D. (1980). Organizational Conflict: A Creative or Destructive Force. "Cyclical Model of Conflict"

Sexton's conflict model depicts the progressive, cumulative nature that conflict may assume. According to Sexton (1980), indirect conflict management expends less energy in the short term but will result in conflict which has a long life expectancy. Within the episodic cycles, the original stages identified by Sexton were behaviour, consequences and issues. In accommodating the unionization process, the modified conflict model utilizes the episodic stages of perceived discrepancy, behaviour, confrontation, conflict management, and consequences or outcomes.

The model displays the phases of interaction which transpire between employer and employee. It accommodates the precipitating factors which directly and indirectly influence or culminate into unionization. The evolutionary and escalating nature of conflict can be appropriately outlined within each episode or cycle of the model. The triggering events can be followed through the perceived discrepancy, resultant behaviour, confrontation, and conflict resolution phases to the relevant outcomes or consequences. Unresolved work place conflict in any one or all of the episodes could initiate union activity.

In applying the conceptual framework to this study, the research questions have been designed to identify the relevant triggering events (Appendix A). The specific union

initiating issues such as money and work conditions become the triggering events. Employee belief of an inequity related to the triggering events constitute the perceived discrepancy phase. Reaction to the perceived discrepancies will occur in the behaviour stage of the model. Marriner (1982) identifies rationalization, withdrawal, projection, displacement, repression, and attention-seeking as common behavioural actions related to conflict. The behaviour or reaction to the perceived discrepancy may eventually lead to confrontation between the employees seeking a solution to the perceived discrepancy and their employers considered capable of alleviating the inequity. At this point, the perceived discrepancies will have been openly identified or defined.

Precipitated with the identification of existing work place conflict, the confrontation phase involves the various methods of conflict management. "In confrontation the parties directly engage each other and focus on the conflict between them" (Sexton, 1980, p. 19). The critical point within this phase of the model is that the method of conflict management must be considered by the employees as satisfying their perceived discrepancies (Marriner, 1982). How the conflict is handled in this stage will determine the final outcomes or consequences of the triggering events

and the perceived discrepancies. Conflict management or problem solving techniques which do not satisfy employees' concerns will become triggering events for another episode cycle or lead directly to union activity. The determinants of unionization can be followed through the interactive, dynamic components of the conflict model enabling the researcher to examine and understand why nurses in Manitoba unionized.

CHAPTER TWO

REVIEW OF THE LITERATURE

The Evolution of North American Unionization

Employer and employee relationships have existed for centuries. Presumably, these interactions were not always peaceful. Throughout the years, one could expect that several diverse methods of handling work place problems and conflict have been attempted. Gradually, unionism has been perceived by employees as the most effective method of confronting and solving their work place problems.

According to Fossum (1985), the Federal Society of Journeymen Cordwainers (shoemakers) of Philadelphia organized in 1794 and is the first documented American union. By the turn of the century, other skilled tradesmen such as printers, bakers and tailors had formed local unions throughout the country (Fossum, 1985). Bargaining issues for these early unions were wage increases, reduced work hours and job security (Herman & Kuhn, 1981). Although workers enjoyed gains, these initial organizing activities were to be short lived.

The depression which followed the War of 1812 weakened workers' bargaining power and eliminated the young unions

(McKendy, 1975). During this time, initial union gains disappeared. Fourteen to sixteen hour work days were standard, bankruptcy common and employees expendable (Fossum, 1985). No functioning union survived the depression but the experience and knowledge of union benefits remained with the workers.

Dependent upon the economy, American unions experienced many fluctuations of growth and decline (Herman & Kuhn, 1981). Depressions severely damaged emerging union strength. The Industrial Revolution of the 1840's finally saw the growth of unionization which was to become permanent and national (Fossum, 1985).

The first national union in the United States, the Knights of Labor, was founded in 1869 (Herman & Kuhn, 1981; Smith, 1985); membership was diverse, open to any gainfully employed individual (Fossum, 1985). The only exclusions were those individuals classified as "professional gamblers" such as lawyers, saloonkeepers, bankers, and stockbrokers (Herman & Kuhn, 1981; Smith, 1985). The diversity of membership contributed to the American demise of the Knights in 1887 (Herman & Kuhn, 1981).

In 1886 the American Federation of Labor formed. This group soon became the dominant labour organization in the United States (Herman & Kuhn, 1981). After lengthy debate

at the 1935 annual convention and vote to uphold craft unionism, a group of dissenters organized the Committee for Industrial Organization which was later renamed the Congress of Industrial Organizations (Fossum, 1985). In 1955, a merger created a combined AFL-CIO federation, which still exists today (Fossum, 1985). Throughout the evolution of American unionism, the emphasis of bargaining has remained on salaries and work conditions.

Unionization in Canada

Although the first unions in Canada reflected some British influence, the growth and development of unionization in Canada was heavily determined by the United States (McKendy, 1975). Early unionization in Canada appears to have paralleled the United States in both time and type of worker (Jamieson, 1973). A few labour unions existed in the early 1800's. According to Forsey (1974), there is sufficient evidence to believe that some craft unions existed in the Maritimes prior to the War of 1812. Organized in 1827, a group of Quebec City printers has the distinction of being Canada's first documented labour union (Jamieson, 1973). Three years later in 1830, shoemakers in

Montreal organized (McKendy, 1975).

In 1875, the Knights of Labor established a Canadian assembly in Hamilton, Ontario, which by 1880 was non-existent (Forsey, 1974). In 1881, a second attempt to form a Canadian assembly in Hamilton resulted in a stronger existence for the Knights of Labor (Forsey, 1974). In 1883, a group of Winnipeg telegraph operators became the first Manitoba workers to join the Knights (Smith, 1985). In 1902, following years of declining membership and strength, the Knights were expelled from the national body they had helped form, the Trades and Labour Congress (Smith, 1985).

"In 1886 the Dominion Trades and Labour Congress was established, and in 1893 this became the Trades and Labour Congress of Canada until 1956 when it merged with the Canadian Congress of Labour to become the Canadian Labour Congress" (McKendy, 1975, p. 110). Since its formation, the Canadian Labour Congress has become the major entity within Canada's labour movement (Jamieson, 1975). Throughout the development of Canada's labour unions, the emphasis of bargaining has been improved salaries and working conditions for the membership.

Professionals and Unionism

While unionism achieved gains in both numbers and employee benefits, early membership remained concentrated among blue-collar workers (Goldenberg, 1975). "Unionization of professionals and white-collar employees lagged behind that of the industrial worker" (Hobart, 1980, p. 6). Those workers who considered themselves professional dismissed unionism as a violation of their professional status and code of ethics (Erickson, 1971). Although unionism was unacceptable to the majority of professionals, collective action was not. "Professionals traditionally have used their collective strength to achieve certain kinds of professional goals" (Jacox, 1980, p. 23). Physicians, engineers, lawyers, dentists, and architects utilized their professional associations to provide a collective voice in such areas as fee setting and control of practice (Goldenberg, 1978).

Historically, the traditional professional was self-employed, charged clients directly for services rendered and did not require union representation (Kleingartner, 1967). Changes in business trends transformed the professional's position of self-reliance to that of salaried employee (Epstein & Stickler, 1976). The

traditional professional's autonomy became threatened by an employer and the diverse organizational framework of the work setting (Eldridge & Levi, 1982). As it was a vehicle by which professional interests could be protected within the work place, unionism gradually gained acceptance among salaried professionals (Contra, 1972; Kleingartner, 1967).

Meanwhile, occupational groups such as teachers and nurses struggled to attain professional status and recognition (Alutto & Belasco, 1974). According to Etzioni (1969), a sociologist, nurses were semi-professionals because their training was shorter and they lacked true autonomy. Additional terms which defined the nursing field were quasi-professional, sub-professional and evolving profession (Etzioni, 1969; Kleingartner, 1967). Jacox suggests that "to call nurses unprofessional has been a powerful means of control, since their desire to be professional is so strong" (1971, p. 240). In the quest to achieve professional status, professionalizing occupations such as nursing and teaching adopted the traditional model of professionalism (Jacox, 1971). Nurses were eager to attain professional distinction but embracing the ideologies of specialized expertise, autonomy and service would complicate the process of unionization.

Unionism has been associated with conflict, greed,

militancy, and strikes, and consequently has endured frequent negative connotations (Denton, 1976; Rinneard, 1975; Tannenbaum, 1965). These characteristics were considered detrimental to the image of the professional nurse (Hopping, 1976). For nurses, the unionism doctrines of standardization, egalitarianism, economic gain, solidarity, and security for membership threatened the professional values of individualism, autonomy, expertise, self-regulation, and service to client (Conroy & Hibberd, 1983).

In addition, widespread use of collective bargaining by blue-collar workers was a strong motivator in nurses' aversion to unionism (Badgley, 1978; Conroy & Hibberd, 1983; Jacox, 1971). As union membership has been perceived as totally unprofessional and undignified, professional and white-collar employees have long viewed themselves above even considering the possibility of joining a union (Stanton, 1974). While professions such as medicine, law and engineering gradually embarked upon union action, nurses, ever so intent upon stringent professional standards, were reluctant to participate in collective bargaining (Grand, 1973; Kleingartner, 1967).

Professionalism and Unionism Conflicts Within Nursing

Acceptance of unionism for nurses has been a turbulent journey hindered largely by nurses themselves (Gideon, 1980; Seidman, 1970). "Most nurses welcome higher salaries and better working conditions, but many reject collective bargaining and collective action as a means to attain them" (Grand, 1971, p. 289). For nurses, unionization presented several dilemmas (Miller, 1980). Debating and resolving these dilemmas impeded the progress of collective bargaining (Cormick, 1969). The nursing profession was divided by opposing positions on the compatibility of professionalism and unionism (Baumgart, 1983; Gilchrist, 1987). Central to the debate were the issues of commitment to the patients, strike action, ethics, and autonomy.

Incompatibility

Hopping (1976) views unionism and professionalism as conflicting ideologies and questions whether a "nurse can be both a professional and a member of the union without violating the tenets of either" (p. 373). For some nurses, collective bargaining contradicts the altruistic ideals of selfless devotion to duty, patient priority, minimal

economic gain and professional commitment (Seidman, 1970). Professionalism is more than belonging to an occupational group, it is a way of life, a mind set (Hopping, 1976). The professional nurse is expected always to give primary consideration to the welfare of the patient (Kruger, 1961). The nurse's obligation and duty to the patient supersedes a commitment to the employer and self (Rotkovitch, 1980). Attempts by registered nurses to influence the terms and conditions of their employment were hampered by the general feeling that to bargain about such matters was somehow unprofessional (Cormick, 1969; Seidman, 1970). For nurses, an element of self-sacrifice appeared to be vital in establishing professional status (Grand, 1973).

Rotkovitch (1980) contends that unionism diminishes self-image, public image and threatens standards of care. Weighed against the image of nursing and public support, interest in union action definitely waned. In order to prove and demonstrate their professionalism to the public, nurses fiercely avoided collective bargaining (Kleingartner, 1967).

Erickson (1971) and Hopping (1976) maintain that unionism lacks respectability and is based on power. According to these authors, collective bargaining is a conflict-based process that threatens the service

relationship between clients and the integrity of the professional nurse. Coercion rather than confrontation is utilized as a method of resolving differences (Hopping, 1976). Erickson states that unionism introduces a struggle between adversaries attempting to maneuver into positions of obvious advantage over the other, the result of which is to weaken management. "Labor organization activities put a wedge between the nursing staff and its director" (Rotkovitch, 1980, p. 16). Another bureaucracy is created which further jeopardizes professional autonomy (Hopping, 1976). In addition, unionism must always maintain the philosophy of never being satisfied (Erickson, 1971). Unions justify their existence through continued conflict and controversy within the work setting.

One frequently utilized argument supporting the incompatibility of professionalism and unionism focuses on the issue of seniority versus merit (Douglas, 1981; Rotkovitch, 1980). Unions endorse the use of seniority for staffing concerns such as promotion, retention and leaves of absence. Seniority is a "difficult concept for professionals who believe that education, advanced training, and merit should be the criteria for reward and success" (Douglas, 1981, p. 2). It has also been suggested that as seniority is substituted for merit; unionism

restricts the manager's ability to reward nurses for clinical excellence or to terminate incompetent employees (Hopping, 1976). Rotkovitch (1980) contends that patient care suffers as a result of diminished rewards and sanctions within the health care facility. According to Erickson (1971), the egalitarian principle of unionism does not endorse incentives for creative, individual thought. The argument of seniority versus merit maintains that both excellent and incompetent employees become equal within the tenets of the union.

Obviously, the strongest repellent for nurses unionization has been the use of strike action (Lindabury, 1968). Deserting patients for self-interest was not professional behaviour and therefore, repugnant to nurses. Interrupting services to clients for economic self-interest was inconsistent with the goals and values of a helping profession (Conroy & Hibberd, 1983; Douglas, 1981). For nurses, initial acceptance of collective bargaining was alleviated through a no strike policy (Lindabury, 1968). However, the inability to strike was viewed as a violation of basic unionism and received criticism (Cormick, 1969). Among the critics, Crispo (1963) described collective bargaining without the ability to strike as collective begging. An eventual shift from striking for self-interest

to striking for patient welfare has alleviated nurses' aversion to the doctrines of unionism (Beletz, 1980; Zwarun, 1984).

Compatibility

Arguments which support the compatibility of professionalism and unionism revolve around what the profession can gain through unionism. Those who espouse collective bargaining by nurses envision unlimited benefits for the profession, its members and its clients (Herzog, 1980). Jacox (1980) states that organizing for the purpose of collective bargaining does not decrease professionalism. "To the contrary, it is one of the strongest mechanisms by which nurses can achieve professionalism" (Jacox, 1980, p. 24). Contra (1972) maintains that unionism provides nurses with a voice in establishing policies that affect both employment and practice. Nurses are realizing that their employment setting prevents them from providing the service they know a competent and responsible professional is obligated to give the client (Contra, 1972). A poll conducted by *RN Magazine* in 1982 revealed that 59% of the staff nurse respondents believed that there was no conflict between unionism and professionalism (Lee, 1982).

In view of deteriorating patient care and increased workloads, unionism becomes a professional necessity. Within the bureaucratic organization, the professional loses direct control over practice and income (Cleland, 1975). Employers dictate the payment, scope and content of the professional's practice (Miller, 1980). Jacox (1971) argues that in order to regain control over practice and salary, the professional must be prepared to deal collectively with the organization.

Baumgart (1983) and Jensen (1988) state that unionism is a method of subsidizing the professional association in attaining and maintaining professional integrity within the work place. Gilchrist (1987) contends that the association and the union can provide alternative power sources to each other which enable nurses to build formidable coalitions. While groups such as physicians and lawyers successfully augmented their professional associations with collective bargaining, nurses remained entrenched in their debate about professional behavior (Kleingartner, 1967).

Jacox (1971) suggests that the incompatibility controversy has been fueled by physicians and administrators as a method of control in order to keep nurses passive and subservient. Collective bargaining by nurses threatens the unilateral control of administrators

(Colangelo, 1980). As a result, "hospital administrators, physicians and nurse administrators are often among the loudest to proclaim collective bargaining unprofessional" (Jacox, 1971, p. 241). Nurses who are preoccupied with establishing their professional integrity are not likely to become a disruptive union force (Gideon, 1980).

Crispo (1963) and Jacox (1971) contend that collective bargaining, or any kind of collective action is not in itself professional or unprofessional. "The use made of collective action determines whether or not it is appropriate behavior for professionals" (Jacox, 1971, p. 255). The method and content of collective action will either strengthen or weaken the professional's status (Crispo, 1963). Membership conduct rather than unionism defines professional distinction.

In the debate of professionalism and unionism, Gideon offers the most pointed argument. "If you're worried about whether professionalism and unionism are compatible, you are not professional" (1980, p. 1205). In short, worrying about professional behaviour demonstrates a lack of confidence in professional status. Professionalism is a false god which distracts nurses from more pressing issues (Gideon, 1980). Colangelo (1980) supports Gideon's position by suggesting that nurses should stop wasting time and

energy with their professional status and address more urgent issues such as control of practice.

Colangelo (1980) and Gideon (1980) contend that collective bargaining provides a method of determining destiny rather than awaiting it. Unionism offers active participation within the employment setting and control over practice (Baumgart, 1983). Potential nursing shortages can be averted through competitive salaries (Chernecki, 1986). Presumably, unionism is the vehicle by which nursing can solve many problems, increase appeal and strengthen the future.

Canadian Nurses and Unionization

In 1943, concern over the recruitment and retention of nurses prompted the Canadian Nurses Association (CNA) to endorse collective bargaining for its members (Beith, 1944; Connor, 1948). Presumably, collective bargaining would result in improved salaries and working conditions for nurses; thereby alleviating the severe nursing shortage which existed in Canada at the time. In addition, reports of nurses' affiliation with trades and labour unions strengthened the association's interest in collective

bargaining (Beith, 1944). As a result, the Labour Relations Committee of the CNA was formed in 1943 for the purpose of investigating the collective bargaining needs of its members.

Prior to 1943, collective action by nurses had been unstructured and sporadic, occurring privately between individual hospitals and the nursing staff (Raab, 1985). According to Raab (1985), concern about long hours and unrealistic working conditions led the Roman Catholic church to negotiate employment agreements with nurses in the early 1900's. Sullivan and Decker (1988) contend that the clergy's only interest was to restrict employment to Roman Catholic nurses. Regardless of the exact reasons for initiating collective action, Quebec City claims the first nurses' bargaining unit which was formed in 1928 (Raab, 1985; Rowsell, 1980).

In 1946, the CNA passed a resolution that opposed strikes by nurses at any time for any reason (Cormick, 1969). Initial collective bargaining by the nursing associations was a progression of trial and error. Provincial associations circulated salary and personnel policy recommendations to members and employers (Jensen, 1988). As these guidelines were not binding and frequently ignored by employers, this peculiar method of collective

bargaining was totally ineffective (Jensen, 1988; Sullivan & Decker, 1988).

Manitoba's first unionized nurses appeared in 1953 when registered nurses employed by the City of Winnipeg were inadvertently deducted union dues and became members of the Federation of Civic Employees bargaining unit ("15 Years," 1990). Determined to fulfill the objective of bargaining for nurses by nurses, the Winnipeg Civic nurses sought representation by their professional association. Legal restrictions rendered collective bargaining by the Manitoba Association of Registered Nurses (MARN) impossible (Rowsell, 1980). The Winnipeg Civic nurses' objective was finally realized in 1965 when they formed their own association, received Labour Board certification and began to bargain independently on their own behalf with the City of Winnipeg ("15 Years," 1990). This persistent and distinguished group of nurses would later become Local 1 of the provincial nurses' union.

An important impediment to organized collective bargaining in Canada has been the restrictive framework of legislation (Sullivan & Decker, 1988). Both federal and provincial laws dictate the extent of collective bargaining, with provincial laws having the greatest strength (Cormick, 1969; Rowsell, 1980). Under the British

North America Act, matters of health were the responsibility of the respective provinces (Bentley, 1979). The variation of legislation among the provinces has resulted in the differing historical backgrounds of the provincial nurses' unions. As professional bodies, the provincial associations were initially deemed responsible for collective bargaining (Jensen, 1988; Rowsell, 1980). Therefore, the related Labour Relations Acts and Registered Nurses Acts became the vehicle by which lawful certification could occur (Cormick, 1969). Recognized in 1946, the Registered Nurses Association of British Columbia (RNABC) became the first provincial nursing association to conduct collective bargaining on behalf of its members (Cormick, 1969; Hood, 1961).

Instigated by Alberta in 1965, the remainder of the provincial associations began to develop labour relations departments for the purpose of collective bargaining (Jensen, 1988). In 1970, following an amendment to the Registered Nurses' Act of Manitoba, the MARN formed the Provincial Staff Nurses' Council (PSNC) which conducted collective bargaining on behalf of interested locals (Chernecki, 1986). The large proportion of nurse managers as members in the provincial associations soon ignited a debate. Managers would be on both sides of the bargaining

table and, as a result, negotiations could be perceived as employer or "company-dominated" (Baumgart, 1983; Rowsell, 1982). In addition, nurse managers who bargained for the wages of association members and subordinates risked conflict of interest allegations.

The origin and direction of formal unionization for Canada's nurses was determined within the space of one year, 1972. Three events dramatically influenced the destiny of unionization for nurses in Canada and Manitoba. First, the CNA stand which prevented nurses from striking was rescinded (Sullivan & Decker, 1988). Second, the federal government removed all professional exclusions to collective bargaining in 1972 (Jensen, 1984; Rowsell, 1980). Amendments to Manitoba's existing labour legislation in 1972 granted all professionals collective bargaining rights (A guide, 1986; Smith, 1985). As these changes included traditional professionals, prior debates among nurses regarding the compatibility of unionism and professionalism became irrelevant. No longer solely dependent upon the related provincial labour laws, the legal basis for collective bargaining within Canada became consistent and indisputable.

The final and most powerful incident which occurred in 1972 was a legal challenge to the involvement of

professional nursing associations in bargaining activities. The Service Employees International Union contested the certification of a bargaining local in Saskatchewan on the basis of company domination (Baumgart, 1983; Jensen, 1988). The case was eventually settled in 1973 by the Supreme Court of Canada with the decision to deny certification to the provincial association (Sullivan & Decker, 1988). The events of 1972 became monumental landmarks in the history of unionization for Canadian nurses.

In order to avoid similar legal challenges, the remaining provincial nursing associations began the process of creating bargaining units outside the framework of the professional organization (Jensen, 1988). As a result, Canada's first distinct and independent nurses' unions became reality. In addition to professional association fees, nurses began to pay union dues (Sullivan & Decker, 1988).

By 1981, when the National Federation of Nurses' Unions was formed, all of the Canadian provinces except Prince Edward Island had separate nurses' unions (Rowsell, 1982; Sullivan & Decker, 1988). Approximately 75 per cent of Canada's nurses are now unionized (Hibberd, 1992). Manitoba's nurses' union, the Manitoba Organization of Nursing Associations (MONA) was formed in 1975 (Giesbrecht,

1990). Of the current 11,300 membership of the Manitoba Nurses' Union, 8,500 are registered nurses (Giesbrecht, 1992).

Despite formidable obstacles and controversy, nurses have persisted in the quest of union representation. The long and turbulent journey encountered by Canada's unionizing nurses suggests powerful, unrelenting reasons for unionization. Although Werther and Lockhart suggest that "the motivations of workers are so diverse that there is no single way to explain why people join unions" (1976, p. 31), the process of unionization does display commonalties. Within the categories of context and content, the specific determinants of unionization will be reviewed.

The Context of Unionization

Several contextual or environmental elements have affected the process of nurses' unionization. Changes in society, economics, the nursing profession, health care, and the organization have combined to create a shift in the nurse's perception of self-worth and value to the work environment.

Societal Issues

Baumgart (1983) suggests that societal value shifts strongly influenced the union movement. According to Eldridge and Levi (1982) the fact that most nurses are women has been a major factor in the failure to achieve significant gains and change within the profession. Phillips and Phillips (1983) state that a traditional role in the home severely hindered women in the pursuit of union representation. Women were considered short term workers who were passing time until they found husbands and started raising families (Hughes, 1980; White, 1980). As a result, a career was a waste of time and not necessary for women in the work force (Phillips & Phillips, 1983). For women, nursing was ideal work as it involved inherent nurturant and educational tasks which were easy to replicate with minimal training (Eldridge & Levi, 1982). Jacox (1971) contends that this was a belief which was reinforced primarily by a male dominated work environment.

Nurses bore the social burdens of "ideal ladies," devotion, passiveness and servitude (Coburn, 1974). Nurses themselves believed that they "should be feminine, motherly, devoted to their patients, willing to make sacrifices, and more concerned with the quality of their work than with their economic welfare" (Grand, 1971, p.

296). This was a well developed perception which permeated society. "A nurses' union would be almost, if not quite, as absurd as a mother's union" (Miller, 1980, p. 1196).

"Perhaps more than any other professional group, nursing is overwhelmingly a female profession" (Douglas, 1981, p. 5). Naturally, the prevailing value of women in the work place also applied to nurses. Considered temporary workers whose major contribution was in the home, women and nurses who pursued recognition, affirmative action and competitive monetary rewards encountered powerful resistance. Several traditional beliefs hindered the advancement of women's value within the work place. Douglas (1981) cites four common restraints to union organizing among large groups of women such as nurses. These problems are:

1. many nurses are not the sole breadwinners of their families and will work for less pay than their male counterparts,
2. many nurses enter and leave the profession at times coinciding with family responsibilities, thereby causing instability in the work force,
3. many nurses enter the profession for the short term and will thus accept a lesser compensation,
4. and, successful and ambitious nurses advance to

> supervisory and managerial positions and are therefore exempt from union coverage (p. 5).

According to Eldridge and Levi (1982), nurses have been able to shed their traditional roles through an alliance with a broader women's movement. Collective action became a successful method of influencing decisions and achieving goals (Chernecki, 1986). Ignited by the Women's movement, nurses began to demand recognition, respect, control, and independence (Simms & Dalston, 1984). Attitudes and expectations within nursing changed. Among nurses, these changes in perception included the view that collective bargaining and unionism were excellent power resources (Eldridge & Levi, 1982).

While women and nurses gradually achieved increased recognition and status as a result of the Women's movement, the nursing profession experienced serious consequences. New opportunities for occupational and professional aspirations became abundant. "Women have more options, so they are going into other professions, not just the traditional fields of nursing or teaching" (Schultz, 1987, p. 7). Nursing recruitment suffered as women entered new, previously forbidden fields (Simms & Dalston, 1984). Nursing could not compete with the career advancement and monetary gain of other occupations or professions such as

management, medicine and law. Collective bargaining resulting in competitive salaries and benefits became a method of regaining nursing recruits (Chernecki, 1986). For nurses, self-preservation became a vital and powerful motivator in the consideration of collective action and unionism.

Societal change was a major instigator of nurses' unionization. For nurses, unionism became a method of expressing discontent with former mores, initiating change and assuring self-preservation. "The slow build up of job frustration has been fueled by a fresh awareness of women's rights, by the impact of inflation and by disenchantment with traditional prestige symbols" (Badgley, 1978, p. 7).

Economic Issues

Canada's economic climate also influenced nurses' unionization. Inflation increased living costs but nurses' salaries remained unchanged. "Nurses have watched considerable salary gains made by workers in industry and other professions" (Rowsell, 1967, p. 26). Nurses' salaries were lower than salaries of individuals with comparable training and responsibility such as X-ray technicians Cormick, 1969). Other professionals, technical and blue-

collar workers who were unionized enjoyed wage increases and cost of living adjustments (Gideon, 1981). Apparently, collective action was the most successful method of achieving financial recognition.

Baumgart (1983) suggests that an evolving division of labour eroded nurses' financial worth. Determining and justifying their financial worth was completely foreign to nurses who had devoted themselves to an altruistic ideal (Bloom, O'Reilly, & Parlette, 1979). As a result, nurses were totally inept in competing with other workers for financial compensation (Jensen, 1988). Unionization offered a stronger bargaining position and ensured recognition of work force contributions by nurses.

Nurses had increased roles in the delivery of health care but reaped few rewards in terms of money, respect and status (Simms & Dalston, 1984). Health care was the only institution where social and economic inequality was so marked and yet so generally unacknowledged (French & Robinson, 1960). Workers at the top of the hierarchy gained income and social prestige while middle echelon workers such as nurses suffered regressive consequences (Chernecki, 1986). "Nurses' salaries were sometimes raised not through their own efforts but only because the top of the salary scale of nursing assistants was approaching that of the

registered nurse" (Cormick, 1969, p. 669). Such economic inequities increased dissatisfaction and militancy among nurses. When pay scales or fringe benefits of an institution are below that of similar organizations, collective action often corrects the inequity (Werther & Lockhart, 1977).

Changing Health Care

Changes in the delivery of health care services directly affected the educational preparation and practice of nurses. Nursing education emphasized idealistic values while the work environment viewed nurses as "... elements of production, rather than intelligent, dedicated professionals" (Simms & Dalston, 1984, p. 118). Increased educational levels produced highly sophisticated, intelligent and self-confident nurses who frequently discovered that their expertise was ignored in the work place (Bloom et al., 1979). In pursuit of professionalism, nurses became trapped in a conflict of role expectation and perception. This role conflict brought greater career pressures, more job stress and a growing divergence between expectation and reward (Baumgart, 1983). Control of practice became essential as nurses began to realize that

they were responsible for the future of their profession (Rowsell, 1967). Unable to directly influence their work place as individuals, nurses sought assistance through union representation. If nurses believe that they are not accepted as professional by their employer, they will seek alternative methods of commanding respect such as union representation (Lee, 1982).

Changes in methods of health care delivery resulted in an enormous expansion of nurses' roles within the work place. "Advances in technology have resulted in the need for higher skilled personnel who, in turn, want correspondingly higher wages" (Rakich, 1973, p. 9). Nurses' contribution to the provision of health services increased dramatically (Chernecki, 1986). With these changes came increased responsibility and accountability. Nurses soon became immersed in new technology, bioethical issues, transfer of function obligations and higher patient acuity (Baumgart & Larsen, 1988). However, comparable recognition and rewards for nurses were not as forthcoming as increased job functions and responsibilities (Chernecki, 1986).

Changes in health services influenced the administration and management of health care organizations (Young & Hayne, 1988). The introduction of patient classification systems, workload indices, quality

assurance, and fiscal restraint programs have all had their effect upon nurses. "As hospitals become more orientated to business practices and the measurement and recording of performance, there is the ever present danger that concerns for efficiency and rationing nurse services will outweigh those of quality" (Baumgart & Larsen, 1988). With nursing labour costs constituting a large proportion of hospital budgets, nursing services become popular targets for improved hospital efficiency (Smith, 1988). In recognizing their vulnerability to budget cuts and increased responsibilities, nurses began to view union representation as a method of averting increased workloads, assuring quality patient care and obtaining recognition for their expanding contribution to the work place.

Organizational Issues

Rapid change in demand and complexity of hospital operations requires sophisticated managers with advanced administrative preparation. A perpetual scarcity of knowledgeable and articulate leaders within the work place has contributed to discontent among nurses (McConnell, 1984). Mulcahy and Rader (1980) state that the future of unionization in health care lies in the hands of

management. Stanton (1974) states that the emergence of a union is a symptom suggesting that in some way management has failed in its basic function. If employers will not appease employees, the union certainly will. Unionism endorses a democratic rather than authoritarian process whereby nurses obtain a voice not previously heard within the work environment (Contra, 1980; McConnell, 1982).

Inherent to any employer/employee relationship is the process of interaction. Types of issues between the two parties and the quality of interaction will have significant consequences. A tradition of adversity rather than cooperation creates an atmosphere of mistrust and resentment (Schanie, 1984). Throckmorton and Kerfoot (1989) state that unions need a reason to exist and that it is virtually impossible to organize a satisfied, happy group of people. "Nurse managers should understand that it is poor relations between employer and employee that open the door for union activities" (Young & Hayne, 1988, p. 367). In a study involving hospital administrators, 87.5% of the respondents believed that management shortcomings such as lack of quality performance increased union activities (Samaris, 1978).

Lockhart and Werther contend that "when employees believe there is responsive management, there is no need

for collective action" (1980, p. 163). The authors suggest that employee unionization is a reactive process. "Unions do not merely happen, their formation is caused by management treatment of personnel more than any other single element in the organizational setting" (Werther & Lockhart, 1980, p. 163). Holley and Jennings (1984) state that "if employees perceive that a union will satisfy their job related goals and needs, they will likely vote for union representation" (p. 130).

Stanton (1974) maintains that a well-managed, perceptive and progressive organization will make labour activities by its personnel totally unnecessary. "In virtually every instance, the administration's lack of perception and response to the legitimate needs of their employees gives rise to an organization drive" (Rakich, 1973, p. 12). In a survey of more than 18,000 hospital employees over a span of ten years, Hacker (1976) identified several reasons why workers unionize. Among the management related causes were: "lack of leadership which ensured employee rights, inconsistent application of departmental personnel policies, and irregular and substandard performance appraisal procedures" (Hacker, 1976, p. 45).

McConnell (1982) cites five common management actions

which can drive employees closer to unionization. They are:

1. introducing major changes in organizational structure, job content, equipment, or operating practices without advance notice or subsequent explanation,
2. giving employees little or no information about the financial status of the institution or about its plans, goals, or achievements,
3. making key decisions in ignorance of employees' true wants, needs, and feelings,
4. using pressure (authoritarian or autocratic leadership) rather than true leadership (consultative or participative leadership) to obtain employee performance,
5. and, disregarding or down-playing instances of employee dissatisfaction (p. 193).

When employees join a union, management is the primary motivator (Schanie, 1984). Managers who act capriciously, dispense discipline unfairly, fail to inform subordinates of important organizational changes or otherwise threaten the security of workers are the principal cause of collective action (Werther & Lockhart, 1976). McConnell (1982) identifies unfair or unsympathetic treatment, lack of confidence in management, no pride or affiliation with

the institution, and poor overall attitude as determinants of health care unionization. Stern (1982) states that dehumanized and impersonal treatment by employers initiates collective action among employees. Rutsohn and Grimes (1977) identify lack of input into decision-making, lack of upward communication, poor job assignments, lack of security, and poor personnel policies as major employee complaints which precipitate unionization.

Salutin (1986) contends that poor treatment by a supervisor or anger about favouritism and unwarranted promotions are significant factors in employee unionism. In addition to favouritism, Rakich (1973) identifies inconsistent management performance, lack of communication, blocked promotional mobility, perception of helplessness, and overall deterioration of human relations as causes of unionization among hospital employees. Holley and Jennings (1984) maintain that initial interest in unionization is usually based upon employee dissatisfaction with some work-related situation coupled with the belief that there is no opportunity for change. "It could even be a matter of being taken for granted, and so you want to stand up, and be noticed, to speak up and be heard" (Salutin, 1986, p. 161). The belief that the organization's hierarchy is unreceptive to employee concerns only strengthens the attraction of a

union. "Unions become necessary when the principles of open communication, participative management, respect, and fairness are perceived as absent" (Throckmorton & Kerfoot, 1989, p. 610).

Unable to significantly influence management style, employee dissatisfaction will eventually be expressed in the form of financial demands. A specific financial package can be negotiated. "As yet there is no contractual way to obtain less tangible items such as sympathetic listening, open communications, respect, and humane treatment" (McConnell, 1982, p. 292). Ganong suggests that the "union organization route may seem to be the only way for frustrated employees to secure what they see as their needs - equitable wages, benefits, recognition, and changed working conditions" (1973, p. 61). Unionization becomes the vehicle by which nurses can be assured an active role within their work environment.

Within the organizational setting, the supervisor's position is crucial. The immediate supervisor has the greatest contact with the staff. The worker's opinion of the organization is largely determined by the quality of the supervisor. As employees view the supervisor, so are they likely to view all of management and the organization (McConnell, 1984). If the supervisor is unconcerned,

uncaring, insensitive, distant or indifferent, so too is the image of management (Schanie, 1984). The supervisor's behaviour becomes the basis upon which employees evaluate the organization's management.

"First level supervisors are usually the weakest link in management's resistance to unions" (Werther & Lockhart, 1976, p. 41). The ascending and descending communication link inherent to the supervisor's position is pivotal to the facility's atmosphere. Often nobody at the top of the organization has any solid idea of what is really troubling the ranks of the non-managerial employees (McConnell, 1982). According to Rakich (1973), downward communication should supply information concerning the policies and practices of the hospital to the employee. An incompetent supervisor exacerbates employee dissatisfaction. Throckmorton and Kerfoot (1989) maintain that among the common characteristics of organizations that are at low risk for employee unionization are well established upward- and downward-communication channels which acknowledge and utilize employees' input in decision making. Stanton (1974) suggests that effective upward and downward communication should be initiated in order to identify specific areas of employee dissatisfaction which require management action. "Usually management organizes employees, not the union"

(Schanie, 1984, p. 73). Managers who fail to acknowledge staff concerns increase employee interest in unionization. "Unions are poor substitutes for bad management" (Mulcahy & Rader, 1980, p. 112). Throckmorton and Kerfoot (1989) state that the risk of unionization among employees increases when administrators are "unavailable, distant, aloof, and set themselves aside as 'better than everyone else,'" (p. 610).

French and Robinson suggest that "if their needs are met within the present framework of their employing organization, workers are not likely to turn to unions or collective bargaining" (1960, p. 909). Throckmorton and Kerfoot (1989) state that administrators who are perceived by the nursing staff as being genuinely concerned about employee job satisfaction will experience less union activity. Managers who fail to deal with employee relations doom their organizations to impaired efficiency and union pressure. "Turnover, absenteeism, tardiness, and half-hearted work output are all symptoms of poor employee relations, unionization is just one of the more evident symptoms" (Schanie, 1984, p. 74).

Unions can equalize the power between administration and subordinates. Unionism espouses fair and equal treatment for all employees (Giesbrecht, 1990). The

individual employee may be expendable, but a group of employees present a greater obstacle (Chernecki, 1986). Collective action rather than individual bargaining increases the strength of all individual members (Sullivan & Decker, 1988). There is obvious insight in the union adage of strength in numbers and power through solidarity (Preston & Zimmerer, 1983).

The Content of Unionization

Related to the contextual factors are specific, tangible factors which have contributed to unionization. Viewed as content issues, these frequently negotiated items comprise the broad categories of salary and benefits, work conditions and professional issues.

Salary and Benefits

Initially, monetary advantages were the most compelling reason for nurses' unionization. Rotkovitch (1980) suggests that salaries are an important consideration. Traditionally, nurses' wages were low and disparity with other members of the work force was

increasing. "Hospital wage scales have been low because, for years, hospitals were looked upon primarily as semi-charitable enterprises, staffed with volunteers, women, and minority groups" (Mulcahy & Rader, 1980, p. 109). Nurses received little compensation for long hours devoted to patient care. Achieving wage gains in order to create competitive salaries became a matter of necessity. "Wanting more money isn't always a matter of greed. It depends on how much you already have" (Salutin, 1986, p. 161). The magnitude of nurses' wage disparity was demonstrated the year MONA was created, 1975, when members were awarded a 42% wage increase over two years.

Chernecki contends that "unionism has permitted us to achieve remuneration commensurate with our professional status" (1986, p. 10). For nurses, economic bargaining power by the union is more equally balanced with the employer. Negotiated contracts have "guaranteed salary increments with cost of living adjustments and barrage of benefits that might not have been otherwise secured" (Stern, 1982, p. 17). Mulcahy and Rader (1980) suggest that in order to avoid unionization of health care workers, employers must remain competitive in the area of wages and benefits. Attaining and maintaining competitive salaries for nurses is a major advantage of unionization.

Gideon (1980) states that nurses do themselves and their profession a disservice if they allow the public to think that nurses are not worth more money. The author contends that as the result of a strong union, grocery store clerks have higher incomes than nurses. Nurses will not be paid more until they demand more and the most effective method of acknowledgment is a union. According to Gideon (1980), union workers earn 10-17% more than their non-union counterparts.

Union membership ensures standardized, equitable and fair salary scales. According to Phillips (1981), two factors which promote frustration and lead to collective action are the perception that wages are below an acceptable standard and the perception that wages are inequitable with similar job classifications. Overcoming perceived wage disparities and achieving appropriate financial recognition for services rendered continues to be a strong objective of the nurses' union and an advantage to its members.

Work Conditions

Although common belief and contract content would suggest that economic factors are strong unionizing

determinants, research comparing salary and work conditions has supported the latter. Several studies suggest that money has not been the primary cause of nurses' unionization. Nurses appear to have strong feelings about a variety of non-economic job facets.

Roberts et al. (1985) found that salary did not emerge as a significant pro- or anti-union determinant. Responses to the American survey revealed that pay was not the primary concern of nurses seeking union representation. While, no doubt, salary is important, issues such as continuing education and work conditions elicited a higher rate of union support. The authors hypothesized that working conditions influence a nurse's propensity or willingness to join a collective bargaining unit. Like all workers, nurses are searching for a work environment where they feel satisfied and fulfilled. If their expectations are unmet, they will seek collective power in order to make changes within the related work place. The significant pro-union factors which emerged from the study were work conditions, co-worker treatment and role perception. Specifically, there was a strong relationship between congeniality and union interest. Lack of a 'think positive' attitude and considerate behaviour by managers perpetuated a willingness to seek collective action. Respondents

indicated that consultation about work fostered a feeling of satisfaction and the belief that the facility cared about nurses. A work environment which does not promote employee participation and self-esteem increases the need for collective action.

Managers cannot presume that financial compensation alone will diminish the potential for organized labour. "Initial organizing activity usually springs from non-economic matters involving issues that are not nearly as quantifiable as dollars" (McConnell, 1982, p. 292). Schultz (1987) identified quality of work-life, recognition, control over work and work place, lack of job flexibility, and heavy workloads as work conditions which precipitate unionization. Hacker's survey (1976) revealed that lack of job security and seniority, poor opportunity for promotion and inequitable shift rotations were areas of dissatisfaction which would initiate collective action. Metzger and Pointer (1972) identified differences in fringe benefits between departments and across job classifications as major irritants which drive nurses toward unionization. Several fringe benefits of non-monetary value such as decreased hours of work, improved scheduling, grievance procedures, and joint committees have been achieved through contract negotiation (Chernecki, 1986).

Metzger (1980) cites understaffing, no control over shifting nurses temporarily between units and domination of schedule concessions by temporary personnel as work place concerns which perpetuate union representation. Schanie (1984) identified personnel policy applications, job descriptions, performance appraisal methods, supervisory practices, and career pathways as major sources of discontent. Brett (1980) found that chances for promotion and treatment by supervisors were significantly related to union interest. Lack of input and control within the work environment contributed to nurses' unionization.

A union does not create job dissatisfaction but transforms employee dissatisfaction into collective action (Holley & Jennings, 1984). Getman et al. (1976) and Hamner and Smith (1978) discovered that employees who were satisfied with the content of their work but dissatisfied with the conditions of their work were more likely to vote for union representation. In these studies, 80-90% of respondents stated that they were satisfied with the type of work they were doing but not the conditions under which they were expected to work. Brett's findings in 1980 also revealed that most employees enjoyed their work. Interest in unionization was triggered by work conditions, not the work itself. Employees were satisfied with the job content

but not the conditions in which they were required to perform the work. Dissatisfaction with the scope and organization of the job was related to collective action. Unionization would appear to be especially appealing to those employees who like their work but consider work conditions unsatisfactory. Such individuals would display a higher interest in changing the conditions of their current work situation. Conversely, employees tended not to vote for unionization if they believed that the union was unlikely to improve the work conditions which dissatisfied them (Brett, 1980).

McConnell (1982) believes that the union wins because of poor work conditions such as substandard facilities, weak organizational communications and arbitrary or seemingly uncaring management. Mulcahy and Rader (1980) advocate several management strategies in order to avoid unionization. According to the authors, the risk of collective action can be reduced by providing two-way channels of communication, maintaining reasonable working schedules, selecting and training skilled supervisory personnel, and establishing an effective appeal mechanism. Of these recommendations, communication lines are considered essential. "Some employers deserve a union if they do not care enough to communicate with their

employees" (Mulcahy & Rader, 1980, p. 109).

Grievance procedures, specified policies and procedures for hours of work and overtime, and restrictions on management's ability to manipulate job titles are additional benefits achieved through collective action (Herzog, 1980). Hacker (1976) identifies ineffective grievance procedures as an employee concern which increases interest in unionization. Hopping cites "discrimination, grievance procedures, inconsistent and indefensible scheduling, depersonalization and routinization of jobs" (1976, p. 375) as union determinants. In some instances, obtaining a formal grievance procedure has been the primary motive for unionization (Mulcahy & Rader, 1980). Dissatisfaction with existing methods of resolution has necessitated the implementation of a structured forum by which to express concerns and suggestions. Problems are inherent to any work environment. "All employees need a person to go to in order to resolve problems" (Mulcahy & Rader, 1980, p. 111). If the work organization does not ensure a sympathetic hearing, the union certainly will.

Unionization has provided nurses with a sense of security and a feeling that there is a skilled organization to help them cope with the daily struggles of the work place (Baumgart, 1983). Disillusion with management

performance and treatment causes employees to seek support elsewhere. Results of a survey by Beletz (1980) revealed that 61% of nurses viewed collective bargaining as a means of protection against arbitrary actions by management. A perceived lack of management support within the work setting has propelled nurses to union action.

Professional Issues

Unionization also offers the advantage of confronting professional work issues on behalf of concerned employees. According to Rakich (1973), one contributing factor of increased unionization among hospital employees has been "the changing mores of our society in which professionals are not adverse to organizing for the purpose of bargaining collectively" (p. 10). Nurses have "... grown discontented with increased workloads and poor working conditions in hospitals and their effect on patient care" (Rowsell, 1967, p. 26). Through collective action, nurses can effectively address the ideologies of patient care and control of practice. "The formal mechanisms of collective bargaining provide professional employees with a voice in determining the conditions of their practice and an ability to participate in management decisions" (Beletz, 1982, p. 48).

Input into the decision making process that pertains to patient care has taken priority over economic demands. "The 'bread and butter' issues of wages and fringe benefits more often than not are overshadowed by what nurses consider to be professional standards and concerns" (Metzger, 1980, p. 106). Requests for additional support staff, rights, privileges, and continuing education can be achieved through collective action. Unionism has provided a voice in nursing assignments, increased participation in continuing education and control over replacing nurses with paraprofessionals (Herzog, 1980). Through collective action, nurses are able to confront work conditions which inhibit the achievement of professional obligation and integrity.

In addressing and negotiating professional issues, the 1982 Alberta nurses' contract contained clauses which provided advance scheduling of shifts, elimination of a nurse working a ward alone and safety measures for both nurses and patients (Zwarun, 1984). The 1984 contract extended professional responsibility further to include ethical considerations by introducing Professional Responsibility forms for use in work situations which violate a nurses' ethics or even hospital policy (Zwarun, 1984). Diminished quality of patient care as a result of

understaffing has become a serious matter for nurses. In an attempt to alleviate the perpetual concerns of understaffing and patient care, MNU has negotiated the introduction of Workload Situation forms which document unsafe work conditions (Chernecki, 1986).

The significance of professional issues cannot be neglected. In comparing economic and professional concerns, Beletz found that "slightly more than 60% of grievances were classified as professional, whereas 37.5% were identified as economic" (1982, p. 53). Further examination of the strength of professional concerns revealed that the majority of respondents would vote to strike in the event of an impasse over professional issues while less than half would strike in the event of a dispute over economic issues. Maintaining professional standards and improving patient care delivery constitutes a major advantage of union action.

Kleingartner's expansion of bargaining hypothesis identifies and demonstrates the strength of professional issues among employees. According to Kleingartner (1973), union members will not be content to bargain solely over the traditional issues of wages, hours of work and work conditions, but will expand their scope of negotiations to include professional concerns. This expansion of bargaining

hypothesis accommodates the concepts of professionalism and the unionized worker within a large bureaucratic organization.

According to Rakich (1973), today's employee seeks increasing amounts of responsibility, recognition, sense of achievement, and advancement opportunities. Kleingartner states that for most professionals, work is more than "just a job." "They expect to give a good deal of effort to their work and careers, and they expect to obtain a high level of reward for their efforts" (Kleingartner, 1973, p. 166). In presenting the expansion hypothesis, Kleingartner separated collective bargaining issues into two categories comprised of Level I, short-run job or work rewards and Level II, longer-run professional goals.

In 1981, Ponak investigated Kleingartner's expansion of bargaining hypothesis among nurses. The professional, Level II values which were examined were expertise, autonomy, commitment, identification, ethics, and collegial maintenance of standards. The author assumed that if professional goals are important, they will eventually be pursued at the bargaining table. Following an initial round of bargained contracts, negotiations will begin to reflect professional concerns.

Ponak's (1981) sample was comprised of registered

nurses in Ontario. Nurses expressed a clear preference for goals that reflected professional ideals rather than those of a traditional nature. Goals that addressed concerns about inservice education, orientation programs, continuing education opportunities, performance of non-nursing duties, physician-nurse working relations, and clinical evaluation mechanisms were considered more important than goals aimed at improved salaries, shift premium and more time off (Ponak, 1981). Ponak's results would suggest that the expansion of bargaining hypothesis is supported by the nursing profession. Collective bargaining and unionization offer nurses the ability to achieve professional goals.

In applying Ponak's findings to future union action, increased negotiation of professional issues can be expected. Although professional goals are important and starting to appear at the negotiating table, Erickson's (1971) contention that unions can never be satisfied may explain Ponak's findings. Having settled the basic economic and work place conditions, union emphasis shifts to professional issues. While Ponak's research does offer insight into the evolution of union negotiating interests among nurses, it remains limited and requires replication.

Summary

The preceeding review of the literature displays the diversity of unionization causes among employees. As suggested in the literature, low salaries, professional concerns, work conditions, management treatment, and societal issues have been powerful motivators in nurses' unionization. However, the impact of these factors upon nurses' unionization in Manitoba remains largely unstudied and unknown.

Common to the frequently identified union determinants is the interactive process between employees and the prevailing environment in which they work. While many studies have investigated the impact of salaries and work conditions upon unionization, few have examined the interactive process which occurs between the employee and the environment as a result of these issues. The impact of perceived inequities and inadequate resolution upon the unionization process remains largely unstudied and unknown.

CHAPTER THREE

RESEARCH DESIGN

Oral history was utilized in order to investigate the research questions of this study. Gibson (1979) states that oral history is the recording of the reminiscences of persons who have participated in or observed events of historical interest. As oral history involves personal recounts of memory, it inevitably is recent history (Maggs, 1983). According to Safier (1976), oral history is a technique for collecting information about events by interviewing knowledgeable people. Oral history provides a valuable human dimension to what otherwise would be a boring chronological account of events (Barnett, 1982). In addition to illuminating official records, oral history can provide a mass of information which is not available from the official data or other readily available sources (Barnett, 1982, Roberts, 1979). Kerr (1986) states that while oral history compliments existing data, it can also present a unique perspective regarding the information.

Historical research is defined by Wilson (1987) as a "study design intended to explain the present or anticipate the future using methods for collecting and evaluating evidence from the past" (p. 567). Polit and Hungler (1978)

state that historical research is the systematic and critical evaluation of data relating to past experiences. This research design emphasizes people, human activity, and the multiple variables that influence human thought and activity (Austin, 1958). Matejski (1986) contends that the life, times and critical elements that influence people and society can be accurately examined with historical research. History is the record of human behaviours, actions, thought and beliefs (Ashley, 1978). According to Wilson (1985), historical research designs investigate questions concerning causes, effects or trends relating to past events which may shed light on present behaviours or practices. In investigating why nurses in Manitoba unionized, it is imperative that past environmental conditions, beliefs, values, and human interaction be examined.

While historical study and oral testimony have enjoyed longevity and credibility in the social sciences, their popularity within nursing has been limited (Keddy, 1989; Kerr, 1986). Historical studies have focused on the lives of major nursing personalities such as Florence Nightingale, Adelaide Nutting and Ethel Johns (Kerr, 1986; Notter, 1972). Historical notoriety has come to specific groups of nurses such as American army nurses (Kalisch,

1976), Canadian war service nurses (Nicholson, 1975), as well as provincial nursing bodies in Alberta (Cashman, 1966), and Ontario (Coburn, 1974). The majority of oral history testimonials have been devoted to the experiences of nursing leaders. Among these works are Safier's (1977) examination of American nursing leaders, Keddy's (1960) investigation of Canadian nurse administrators and Alderson's (1976) study of nursing education. Despite a rich and colorful past within Canada's nursing profession, historical research and oral testimony remain largely unrecognized and under-utilized.

Although description is a common purpose of historical investigation, Kerr (1986) states that additional uses are explanation, interpretation and comparison. Enlightened portrayals of past events constitute a major component of historical research (Austin, 1958). Such insight permits the examination of the impact of changing economic, social and professional values upon nurses unionization. Further analysis can then reveal the importance of employer/employee interaction and work place conflict upon the unionization process.

The historical researcher collects and evaluates evidence from the past (Wilson, 1985). Based on the results of a search for new meaning and perspective, an integrated,

written record of past events can be formulated (Austin, 1958). According to Wilson (1985), historical designs provide a prescribed approach to examining and interpreting data contained in historical sources such as diaries, letters, documents, and journals. The data of historical research are events, situations, or statements made in the past (Polit & Hungler, 1978). In studying the past phenomenon of unionization among Manitoba's nurses all relevant existing details must be investigated. Meticulous analysis of the obtained information can then be followed by thorough reporting of the results and interpretations (Austin, 1958).

There are several reasons why historical design is applicable to the investigation of nurses' unionization. Historical research possesses the ability to substantiate common belief and/or reveal new information regarding a past occurrence (Kerr, 1986). "Nurses searching for an identity relating to their roles perhaps through history can gain insight into themselves and their profession" (Treece & Treece, 1982, p. 210). The application of historical research to the question of why nurses unionized provides new insights or evidence about old ideas and events. Exposure of such information can then identify the impact of conflict upon initial unionizing activity.

In order to effectively work with unionized staff, employers must first understand why the staff unionized. Kerr suggests that historical research can "reconstruct and/or describe past events in order to present an analysis which may serve to explain situations and relationships and create meaning" (1986, p. 31). Through identification of past causes of unionization, employers can better understand how unresolved work place concerns and issues influence employee behaviour. "Perhaps the greatest intrinsic value of historical research can be summed up in one word -appreciation" (Newton, 1965, p. 25).

Data Collection

Written Documents

In applying historical research to the question of why nurses in Manitoba unionized, the data was compiled from a variety of sources. Relevant documents created at the time of the event and oral history, eye-witness accounts of those individuals who were instrumental in the unionization of Manitoba's nurses were the major sources. The purpose of this evidence was to provide the insight necessary to explain why nurses in Manitoba unionized.

Historical research requires the analysis of all available records related to the specific occurrence (Christy, 1975). For this reason, a variety of written documents were analyzed. The review was limited to the period of time which corresponded to the initial unionization process; 1970-1976. Several primary documents were obtained. Wilson defines primary sources as "firsthand information which includes letters, diaries and eye-witness accounts" (1987, p. 354). Additional primary sources identified by Matejski (1986) are public documents such as laws, court decisions, and committee reports. These items existed or were created at the time of the event. Primary works cannot be edited (Safier, 1976). Unaltered personal correspondence and unedited minutes of meetings constitute primary sources (Matejski, 1986).

Written records pertaining to the collective bargaining experiences of Manitoba's nurses were utilized as primary sources of data for this research. These included the minutes of the Winnipeg Civic Nurses' Association meetings, minutes of PSNC meetings and MONA meetings. They detailed the original priorities and objectives of collective bargaining by Manitoba's nurses. The minutes of the PSNC and MONA meetings, located at the MNU office, were accessed with the approval and assistance

of the MNU president. The minutes of Winnipeg Civic Registered Nurses' Association meetings were located at the Manitoba Provincial Archives and did not require approval for access. Other primary sources such as personal journals or letters belonging to participants were not discovered.

Secondary written documents were also utilized as sources of data for this study. These sources were "second- or third-hand accounts which include reference books and newspaper articles" (Wilson, 1987, p. 356). Secondary documents are not authored by those who created the historical event but by those who provide an interpretation of the occurrence based on their observations of the event. These sources included local publications relevant to the specific historical period. Review of the *MARN Nurscene,* a quarterly publication, contained regular PSNC updates on the status of the collective bargaining process. Copies of pamphlets entitled *PSNC Newsletter to Staff Associations* and *Collective Bargaining for Registered Nurses in Manitoba* were also obtained. Investigation of initial *MONA Newsletter* publications provided additional insight into the early objectives of the nurses' union.

Review of local newspapers, the *Winnipeg Free Press* and the *Winnipeg Tribune* contained evidence of certified locals, nursing shortages, salaries and collective

bargaining negotiations. In utilizing newspapers, errors in reporting as well as bias in stories and reports are a consideration (Shafer, 1970). While these sources can only provide a partial picture of the unionization process, they are useful in tracing the course of events (Matejski, 1986).

All written documents related to the formation of Manitoba's nurses union were examined prior to conducting the oral history interviews (Reimer, 1984). This facilitated initial identification of potential oral history participants. Individuals considered eligible for the study were those who authored documents or were referred to within the documents.

Oral Histories

Interviewer Preparation

Interviewer knowledge of relevant written documents enhanced the accuracy and value of interviews. The interviewer must do preliminary research in order to conduct a successful interview (Barnett, 1982; Thompson, 1988). The time spent by the interviewer inspecting the written record is the key to a successful interrogatory (Raphael, 1977). Barnett (1982) states that background

information presented by the interviewer can provide clues and memory jogs which stimulate the narrator's discussion. Familiarity with existing written material during the interview can eliminate needless replication, allow clarification of vague entries and reveal new perspectives for examination (Thompson, 1988).

In order to provide interview data of value, the interviewer must be well prepared prior to conducting interviews (Ives, 1974). Examining the topic of unionization among nurses increases the necessity for thorough, reflective and honest interviewer preparation. This preparation involved resolution of preconceptions, self-analysis regarding the purpose of the study, the role of the interviewer and the rapport established with participants (Reimer, 1984). As well, knowledge of written documents, familiarity with relevant literature and strong interview skills are vital ingredients which determine the value of the study (Edson, 1988).

This research was conducted by a nurse who, at the time, was a university student. However, past employment as a nurse manager was a possible threat to the objectivity of the study. Management positions create an abundance of negative perspectives in respect to the topic of unionization, many of which are based on hearsay or third-

party testimony rather than direct personal experience. Of paramount importance was the ability to conduct the research and the oral history interviews from the perspective of a researcher rather than that of a manager (Field, 1989). Continual self-analysis through identification and resolution of preconceptions became necessary during the study (Egan, 1975). New information can only be acquired with objective, open-minded enquiries which respect another individual's point of view (Thompson, 1988). The capacity in which the interviewer was presented to the participants was as a nurse and a graduate student. A shared background in nursing between the researcher and participants increased acceptance of the interviewer and decreased the necessity of determining the participant's frame of reference (Reimer, 1984).

The relationship between the interviewer and interviewee influences the quality and value of the interviews (Reimer, 1984). Objectivity within an interview can be enhanced when the interviewer is unknown to the participants (Edson, 1988). The interviewer was unknown to the majority of the participants. MNU staff members who were participants were familiar with the interviewer as a result of eighty hours of practicum experience related to study in this graduate program. In addition, the researcher

had no recollection of the creation of Manitoba's nurses' union and had minimal participation as a member.

Essential to this study was the ability to conduct concrete, illuminating interviews which stimulated communication and revealed information. Olson (1980) states that poor interviewing techniques can affect the validity and reliability of the information given by the narrator. According to Thompson (1988), the value of the information obtained through interviews is threatened by interviewers who dominate the discussion, impose personal opinions, contradict, interrupt or argue with participants.

Reimer (1984) suggests that a neutral stance toward participants' ideas strengthens the development of an honest rapport with participants. Good rapport encourages candor, minimizes reticence and promotes enjoyment for the participant (Raphael, 1977). Thompson (1988) identifies several interviewer qualities which are vital to successful interviews. They are: flexibility toward people resulting from interest and respect; the ability to display understanding and sympathy for other points of view; and, above all, the willingness to sit quietly and listen (Thompson, 1988). Knowledge and experience in regard to interview techniques strengthens the quality of the interview. Interviewer preparation for oral histories has

involved instruction and practice in helping-skills interviews, employee selection interviews, as well as the oral history workshop conducted by the Manitoba Provincial Archives.

Sample

For this study, oral history interviews were conducted with ten individuals who were eye-witnesses to, or participants in the creation of Manitoba's Nurses Union. Ten participants were considered sufficient in order to provide verification among the written and verbal statements. Details provided by the oral history participants can be compared to each other and used to identify patterns of regularities (Keddy, 1989). As well, the utilization of ten participants provided a variety of employment backgrounds and experiences which increased the probability of obtaining a representative sample. The preliminary listing of potential participants contained approximately fifteen names in order to provide substitutions in the event of participant refusal or absenteeism. Dependent upon the information obtained, oral history interviews involved a minimum of one meeting per participant with the option of a second interview.

The sample was composed of those individuals who had special knowledge of the specific occurrence of union development (Thompson, 1988). Former members of the Provincial Staff Nurses Council, the first MONA locals and the inaugural MONA executive were interviewed. The sample included prior executive directors of MONA, former presidents of MONA and MONA locals, as well as Labour Relations Officers who were involved in the certification of early union locals. Participants recounted their memories of the unionization process. Of particular interest were statements regarding the social, economic, and professional climate at the time of the initial unionizing activity. Evidence of employee dissatisfaction with conflict management and employer treatment was also examined during the oral history interview.

As it was anticipated that some of the eye-witnesses would have authored primary source documents, preliminary participant selection resulted from the analysis of written documents. Individuals mentioned in the written records also qualified as potential participants. In addition, the sample was completed by individuals referred by other participants and current union members.

The criteria utilized in order to determine eligibility and acceptance of participants was as follows:

1. Registered nurses who were actively involved within the profession in Manitoba during the time frame of 1970-76.
2. Registered nurses who were instrumental in establishing the MONA office or a MONA local during the time frame of 1970-76.
3. Eligible individuals who were residing in Manitoba at the time of the interviews.

Although Registered Psychiatric Nurses (RPN), Licensed Practical Nurses (LPN) and Operating Room Technicians (ORT) are valuable and credible members of the MNU, they were not considered eligible for this study. As a result of initial collective bargaining activities by the PSNC of the MARN, only registered nurses were utilized for this research. In addition, use of registered nurses provided research results more compatible with the literature review which was based solely on registered nurses.

All ten of the participants satisfied the criteria of the study. The employment backgrounds of the participants varied. At the time of unionization, eight worked in urban facilities while two worked in rural facilities. Their clinical areas of work consisted of four in acute care general duty, one of which was a rural facility; two in privately owned urban nursing homes; one in a government

funded rural personal care home; two in teaching positions, and one in public health.

Initial contact of participants was in the form of a letter which introduced the researcher, the study, its purpose and the potential value of the individual's participation within the study (Thompson, 1988) (Appendix B). One week after the mailing date of the letters, the researcher contacted the participants by telephone in order to determine their interest in the study and to arrange interview times. For the convenience of the participants, interviews were conducted at their residence or place of work. One individual, claiming minimal recollection and involvement regarding the unionization event, wished to be excluded and was excused from participation in the study.

All participants were informed of the study's purpose and their role within the study prior to obtaining written permission (Safier, 1976) (Appendix C). With the participant's permission, the interviews were taped (Gibson, 1979). Exclusions and/or restrictions were documented and respected (Reimer, 1984). The final disposition of the tapes was discussed with the participants.

In order to avoid misrepresentation or misuse of information obtained through interviews, participants were

informed that they would be contacted and asked for clarification of any confusing or vague statements. Further clarification of participant's involvement in this research was enhanced with an explanatory statement which was left with each participant (Appendix D). Participation in the study was voluntary and no incentives were utilized.

Interviews

A partially or semi-structured interview format was utilized for the interviews (Wilson, 1985). The questions presented were open-ended. A semi-structured, open-ended interview format permits the examination of additional avenues of interest regarding the topic of inquiry which may be revealed during the interview (Reimer, 1984). Oral histories provide the unique opportunity to ask questions and to delve in greater depth into some of the areas being discussed (Kerr, 1986). Flexibility within interviews was maintained in order to relax participants and enhance expansion of responses.

Within the interview, six major questions were presented to each participant in order to provide basic continuity of obtained information (Appendix E). The content of the questions focused on the primary reasons why

nurses unionized and the prevailing atmosphere within the nursing profession. The interview questions were derived from the research questions, the conceptual framework and the review of the literature. In order to avoid subject confusion, the design of the inquiries was simple, concise and direct (Olson, 1980; Raphael, 1977).

During the interview, inquiries remained objective and respectful of the participant's point of view. Clarification of questions was conducted with the intent of increased understanding rather than persuasion. Interviewees should not be led or directed toward responses which the interviewer wants to hear (Thompson, 1988). Many questioners provide the participants with subtle cues which keep the answers within the frame of reference the interviewer has established (Raphael, 1977). Interviews which provided open, illuminating and useful evidence necessitated control of interviewer verbal and non-verbal behaviour.

"The goals of research often conflict with the goal of preserving the privacy of individuals, and the reporter is responsible for some intricate decision-making" (Ramos, 1989, p. 60). The wording of interview questions and interview techniques avoided the disclosure of highly personal or confidential responses. Occasionally a

participant's statement would conclude with a comment that their name would not be used or that the tapes would be destroyed. Such statements were then followed by a discussion of whether or not the information was relevant and/or required exclusion.

Gibson (1979) states that the average length of an oral history interview is between one and one-and-a half hours. Dependent upon how thoroughly the questions were answered, the length of the interviews for this study were compatible with Gibson's statement. According to Thompson (1988), participant exhaustion or apathy can be avoided by limiting the length of the interview and scheduling additional interviews. Better results are achieved when interviews are conducted over a number of days rather than concentrated in one long day (Gibson, 1979). Each interview provided substantial information and additional interviews were not arranged.

In order to increase the accuracy of the data obtained, brief notes were taken during the interview. The notes focused on the participant's non-verbal activity, reaction and intensity of responses. These notes were later integrated with the interview transcripts (Gibson, 1979). Use of interviewer notes strengthens the value of the data (Swain, 1965).

Henige (1982) and Ramos (1989) state that terminating interviews and relationships with participants is a necessary challenge for even the most seasoned interviewer. As the interview and contact time with the participants of this study was minimal, the relationships which developed were not too difficult or unpleasant to terminate. However, as a common courtesy and in view of the rapport, trust and honesty which was encouraged and cultivated within the oral history interviews, some degree of closure was required. Participants were informed that a transitional time frame of one month would follow the final interview. This period of time was utilized by the researcher and participant as an avenue for submission of new information and clarification of existing information. Upon the expiration of the month, contact with participants was considered terminated and no new information was sought or received. As a method of leaving the field or terminating relationships, Henige (1982) and Thompson (1988) suggest sending letters of thank you to participants. Following the one month transition or exiting phase of this study, brief hand-written notes of thank you expressing the participant's valuable contribution to the study and the researcher's appreciation were mailed to all participants.

Transcription of Tapes

Clarity and accuracy of the oral history data was achieved through prompt, meticulous transcription of tapes. According to Ives (1974), the transcript should be made as soon after the interview as possible so that the clarity of statements on tape can be verified by the interviewer's memory of the interview. The transcripts were written accounts of the interview tape contents (Reimer, 1984). Transcription of tapes was verbatim, thereby presenting an exact record of tape contents along with explanations of difficulties, noises and interruptions (Ives, 1974). From these transcripts the researcher then began to identify and examine the major contributing factors in the unionization of Manitoba's nurses.

Data Analysis

In order to establish validity and reliability of this historical research, it was necessary to satisfy the conditions of external and internal criticism .

External Criticism

Shafer (1970) states that external criticism authenticates evidence and establishes the validity of existing documents. According to Christy (1975), control of external criticism can be achieved through the use of as many original or primary sources as possible. Written data sources must be genuine and authentic (Matejski, 1986). The validity of the data obtained was increased by the use of oral history participants who had authored and verified the genuineness of the relevant documents (Keddy, 1989). External criticism eliminates the possibility of using false evidence (Shafer, 1970). Intentional and accidental errors in the text of sources are a consideration (Christy, 1975). As this study focused on recent history, use of external criticism was minimal. Shafer (1970) maintains that external criticism is limited to the domain of specialists and historiographers.

Internal Criticism

The content of evidence that is deemed authentic must then be evaluated for honesty and accuracy (Matejski, 1986). Internal criticism eliminates the possibility of misleading information and determines evidence credibility

(Shafer, 1970). It can be achieved through the careful comparison of oral statements and printed documents (Barnett, 1982). Cross-referencing of written and oral history data among primary sources occurs in order to satisfy internal criticism or reliability (Christy, 1975). Credibility of the data obtained can be achieved through corroboration of participants's eye-witness accounts and written documents (Keddy, 1989). As stated by Matejski (1986), confirmation among sources provided the researcher with a precise, objective understanding of the facts and diminished the possibility of bias, misrepresentation or fraud.

Content Analysis

The data obtained for this study was subjected to content analysis. Carney (1972) states that content analysis is a technique for making inferences by objectively and systematically identifying specified characteristics of messages. Communication and documentary evidence are the primary sources of data (Kerlinger, 1973; Polit & Hungler, 1978). Content analysis always aims to compare the data it extracts against some norm, standard or theory (Carney, 1972).

Analysis or synthesis of obtained information is the most difficult part of the historical researcher's task (Keddy, 1989). "Synthesis is the procedure of selection, organization, and analysis of the collected data" (Christy, 1975, p. 192). Researcher objectivity, judgement and creativity are vital elements in the interpretation of historical data (Kerr, 1986). In synthesizing the data, all obtained information was reviewed and examined for recurrent themes. The verbatim interview transcriptions were integrated with the corresponding interviewer notes in order to obtain a complete interview experience. The resultant interview data was analyzed for specific, individual reasons for unionization. These specific perceptions or themes were then arranged into broad categories based on similarity of responses such as monetary issues, job dissatisfaction, patient care, and working conditions. The intensity of responses was also analyzed. The oral interview data was then compared to the written data from available documents. All data sources were analyzed and integrated.

Following content analysis of all obtained data, the hypothesis or inference related to the original research questions was validated. The statement entailed previous beliefs and/or new information about why nurses in Manitoba

unionized. Barnett (1982) states that in the end it is the researcher's duty to validate the data, point out inconsistencies and present differing versions or opinions. Related to this study, the statement reflects the influence of conflict upon the unionization of Manitoba's nurses.

Limitations of the Research Design

This study can only be as valuable as the information or data discovered. That is, the success of this study remains totally dependent upon the sources available and the expertise of the interviewer. As Manitoba's nurses' union has only been in existence for fifteen years, the existing written documents were complete and intact. Limited access to information and unwillingness to participate did not hinder the study. Alternative sources were not required in order to obtain completeness.

The research did not require difficult decisions as a result of conflicting evidence, large gaps in the data or unsupportive sources. Conflicting information was resolved through further investigation of available written document evidence and oral history testimonies. Edson (1988) states that "because we can never know the whole truth about the

past, historical interpretations will always be partial and incomplete (p. 48). It is unrealistic to expect to obtain every last bit of information on the subject of nurses' unionization in Manitoba. However, in order to achieve a study of any significance, one must still strive to obtain as much information as possible.

"In the historical approach, the researcher plays an active role in integrating and interpreting the data" (Fox, 1970, p. 188). Researcher bias is a potential problem of this design. Objectivity was controlled through the identification and control of personal biases (Raphael, 1977). Satisfaction of personal preconceptions through selective interpretation of data was not the intention of this research. While this research may not reveal any new insights into the union process, its intrinsic value is the identification and documentation of the determinants of unionization among nurses in Manitoba.

Subject bias is a major consideration of this study. The historian must study human activity in terms of how the actors themselves interpreted the situation in which they found themselves, how they used their environment, and how they demonstrated their values, attitudes, and beliefs (Matejski, 1986). Eye witness accounts are always a personal experience and involve not only perception but

also emotions (Vansina, 1985). The possibility that participants may have changed their position on unionization existed. This required identification and comparison with previous ideals. As the obtained data contained the author's or interviewee's perspective, the criticism of subjectivity in historical research is valid.

Related to the subject content of this research, subjectivity strengthens the potential results. By the very nature of unionization, one expects to discover a personal and subjective component. Oral histories and written documents can be laden with personal perceptions, opinions and points of view (Christy, 1975). Unionization was, undoubtedly, a personal decision for many of the founding members. Only by identifying the original beliefs and expectations of those instrumental in the unionization process, can one truly appreciate the significance of unionization.

Due to the multitude of personal perspectives regarding unionization and high degree of subjectivity in historical research, there may be limited ability to replicate or generalize the results. "The historian must, to greater degree than other researchers, be cautious in generalizing the results of the research" (Polit & Hungler, 1978, p. 229). While still possible, generalization and replication

of this research must accommodate the personal perspectives and experiences of those individuals who initiated the formation of Manitoba Nurses' Union.

Strengths of the Research Design

In considering the research questions for this study, the design chosen has several strengths. Historical research has the potential for illuminating current questions through intensive study of carefully selected material that already exists. "Interpretations of the present are derived from an understanding of the past" (Newton, 1965, p. 25). Historical research provides knowledge and understanding of contributions by individual nurses and groups of nurses about significant events or forces which have shaped the character of the profession (Kerr, 1986). The role and impact of those individuals instrumental in nurses' unionization is too valuable to be neglected.

An additional strength of historical research is flexibility. "There is no need to adapt the rigid and inflexible parameters which are necessary under experimental conditions" (Kerr, 1986, p. 32). The

flexibility of the historical research design, in addition to the personal interviews provides increased richness and depth of information.

Finally, historical research of the unionization process may provide a basis or foundation which may lead to further research on the subject. Additional research could support prior findings or reveal new perspectives. This information may finally answer the recurrent questions about the origin, development and impact of unionization within the nursing profession.

Ethical Considerations

In conducting research which involves collecting information from participants, investigators must be cognizant of the rights of human participants. The protection of participants requires diligent adherence to a number of research considerations (Wilson, 1985). Of major concern is the accurate portrayal and documentation of information obtained during this research (Austin, 1958). In achieving scientific objectivity, the research includes all points of view, including those that are unsupportive (Christy, 1975). Personal values, biases and preconceptions

regarding the outcome of the study can be controlled through continual self-analysis (Wilson, 1985).

The required cooperation of duly authorized review boards and institutional policies control the parameters of study (Wilson, 1985). Initiation of this research occurred with the approval of the Ethical Review Committee of the University of Manitoba School of Nursing. Permission for access of pertinent written MNU documents from the time frame of 1970-76 was obtained. The purpose and intent of this study was discussed with the MNU president as a means of clarifying how the researcher would utilize the written records. This study commenced upon receipt of approval from these facilities.

The purpose of the study and the participants' role within the study was thoroughly reviewed with the participants (Safier, 1976). A verbal and written explanation of the study was presented to all oral history participants (Appendix D). Participants were advised of their role and rights within the study. All questions and concerns were addressed prior to obtaining consent for participation in this study. Individuals who appeared hesitant, uneasy or reluctant to participate were excused and not coerced (Safier, 1976). Participants were allowed to withdraw from the study at any time.

Written consent was obtained from all oral history participants (Appendix C). The consent stipulated any desired exclusions of statements contained within the tape recording as well as the disposition of the tapes following the completion of the research (Reimer, 1984). The wishes of individuals who made statements and then requested omissions were respected (Thompson, 1988). In order to prevent misrepresentation or misuse of obtained information, participants were aware that they would be contacted for clarification of any vague or confusing statements (Safier, 1976). Participants were advised that upon the completion of this research, interview tapes would be erased and all written materials, notes, transcriptions related to the interviews would be destroyed. The eventual destruction of interview tapes enhanced openness and honesty in responses.

In order to further encourage candor and frankness of statements regarding unionization among Manitoba's nurses, participants remained anonymous. Anonymity was maintained by designating each participant a code number known only to the researcher. The code number was applied to all information related to the oral history interviews. Audio-tape cassettes, interview notes and transcriptions were all coded by number. Further control of participants' identity,

which received unanimous acceptance, involved the exclusion of the names of people and places. During the study, all of the materials were secured in a locked container. Related to this study's oral history interviews, only the investigator and the thesis committee members had knowledge of and access to the raw data.

CHAPTER FOUR

FINDINGS

Each of the ten participants of this study were asked to recall what existing conditions or factors prompted nurses in Manitoba to unionize from 1970-1976. The questions presented to each participant focused on economic conditions, work conditions, professional concerns, and conflict. Based on the participants' responses and the analysis of the information provided, this chapter is presented under the five major headings of: the Evolution of Nurses' Unionization in Manitoba, Economic Issues, Working Conditions, Societal Influence, and Conflict.

The Evolution of Nurses' Unionization in Manitoba

Each oral history interview commenced with participants' recollection of nurses' collective bargaining in Manitoba prior to the formation of the PSNC in 1970. Within this discussion, the participants voiced their personal beliefs and experiences regarding the development of a nurses' union in Manitoba. Contained within these statements was evidence of nurses' strong desire to

represent their own interests. This was the objective of the nurses employed with the City of Winnipeg who withdrew from the Canadian Union of Public Employees (CUPE) and formed the Winnipeg Civic Nurses' Association in 1955. One participant stated that the purpose of this action was to achieve greater self-representation at the bargaining table.

According to one participant, there were approximately five groups of Manitoba nurses conducting independent collective bargaining with their employers between 1965 and 1970. These locals consisted of three Winnipeg units and two Brandon units. One participant stated that, as a result of individual bargaining, there was no "coordination or consistency" between the various negotiated contracts. One participant contended that the only available information for collective bargaining by the early associations was recommendations for salaries and working conditions of Registered Nurses issued by the Social and Economic committee of the MARN. The participant suggested that employers "picked and chose" what they wanted from the recommendations and "threw everything else in the garbage." "Getting a standard" among the bargaining nurses' units became an original objective in the formation of the PSNC.

The participants maintained that there was "no active

soliciting of members," however, the rate at which nurses in Manitoba were organizing increased during the existence of the PSNC, 1970-1975. One participant stated that PSNC staff "were travelling all over the province organizing groups." At that time "central bargaining did not exist" and "each local negotiated its own contract" with the employer or hospital board. According to one participant, each contract was "separate from the others" and, in "patterning" one contract after another, consistency was provided by the PSNC staff member who negotiated the contracts.

All of the participants discussed the conflicts that emerged within the provincial licensing body, the MARN, and the PSNC as a result of collective bargaining. According to the participants, the salary guidelines and negotiations pertained to all MARN members, including nurse managers. One participant recalled that "there was concern regarding a possible challenge by an employer that the MARN was an employer's organization and should not participate in collective bargaining." Anticipating that "it was only a matter of time" until the 1973, Saskatchewan "company dominated" collective bargaining court ruling was tested in Manitoba, the membership of the MARN voted to sever all ties with collective bargaining in 1975. Representing the

former locals of the PSNC, MONA was created in 1975 with the sole purpose of conducting collective bargaining for the general duty nurses of Manitoba.

While all of the participants were cognizant of how collective bargaining by the MARN was a conflict of interest, two of the participants maintained that there were additional conflicts within the MARN that caused the formation of MONA. These participants maintained that the MARN did not appear to be "representing the general duty nurses." According to these participants, prior to the creation of MONA, "the MARN was speaking for management nurses" and had "forgotten" that the greater majority of the members were general duty nurses. As a result of a management dominated hierarchy within the MARN which did not appear to be effectively representing their interests, the general duty nurses believed that they "needed somebody else" to be concerned about the "everyday problems" they were encountering in the work place. Increased understanding and representation of the day-to-day concerns of general duty nurses was an additional consideration in the formation of the separate collective bargaining entity, MONA.

Upon recalling their introduction to collective bargaining, all of the participants described themselves in

terms of "naive," "babes in the woods" and "green." In expanding upon their unfamiliarity with unions, participants used such phrases as, "unionism of any kind was not in my background," "I had previously been against the union," "a stranger off the street," and "fish out of water." One participant recalled that nurses did not know "what to ask for" when bargaining. This was evident at an early proposal meeting where some members thought they were supposed to bargain for better wages and considered it "odd" that other members wanted a proposal which would improve the lunches for the night staff. Even though some believed that a proposal meeting was "not the place" to discuss the quality of staff meals, the eventual solution was to include the request and "let management throw it out." This participant provided further evidence of how "naive" their bargaining group had been:

> To researcher: We had no idea how complicated it would be. After we negotiated our first contract, we thought we were the smartest people in the world and we thought that was it, we could just sit back and relax. Little did we know. That was just the beginning. (Fieldnotes: November 7, 1991)

Several of the original participants of collective bargaining claimed to have had "no idea what the union was all about" or no knowledge of "what all the benefits would be," but recalled that they "learned fast" and "soon saw

the light coming." These participants stated that although they were "too dumb to say no" and "did not know a lot about unions," they were "willing to work hard and learn."

Despite their lack of knowledge regarding unionization, the participants described their participation with such phrases as a "great experience" or a "real learning process" where they met "terrific people" and "had a lot of fun." The participants spoke frequently of the strong comraderie which developed among the union membership. One participant contended that the union became "another avenue of interest and involvement for many general duty nurses, outside of further education." Another participant claimed that there was "honesty in the union not often found anywhere else."

Participants described how their dedication compensated for their naivety. As proof of their dedication, participants discussed the hours of volunteer work that were involved in the development of the union. According to the participants, union representatives received minimal financial reimbursement for mileage when attending meetings and there was no salary for the early presidents. As one participant stated, "it was a labour of love."

The introductory phase of the interviews detailed the

participants' early involvement with and the progressive development of nurses' unionization in Manitoba. Following this preliminary discussion, the participants then responded directly to the interview questions presented to them. These questions examined the economic issues, work conditions, professional concerns, and societal issues which existed for nurses from 1970 to 1976 and how conflict related to these factors influenced Manitoba's nurses in their consideration of union representation. The participants' responses to the specific questions presented to them comprises the remainder of this chapter.

Economic Issues

A significant portion of the interviews entailed participants' discussion of nurses' monetary conditions during 1970-1976. Economic concerns were detailed in statements involving low nurses' salaries, wage disparities among nurses, other workers' salaries, and financial compensation of nurses' education and responsibility. Other economic considerations were identified in comments regarding benefits such as paid vacation, overtime pay, increments, long service compensation, responsibility pay,

shift differential, and recognition of past experience. In addition, nurses' increased perception of financial value related to changes in self-esteem and self-worth was viewed as an economic factor in unionization.

A major concern for nurses contemplating unionization was increased financial compensation for services rendered. According to one participant, economic issues "played a tremendous role" in the unionization of nurses employed in privately owned facilities. As a result of economic concerns, the preliminary objective of collective bargaining by nurses was salaries and benefits. One participant stated that while nurses initially knew very little about negotiations, "they did know that they were to bargain for better salaries." Participants stated that early bargaining was progressive; the first priority of which was to increase nurses' salaries to a reasonable level. Once the salary issue was settled, other items such as scheduling and hours of work were addressed.

Salary

One participant could not recall that economic concerns influenced nurses' unionization in Manitoba, stating that "there was no big money crunch at the time."

The remaining nine participants believed that economic conditions, during the time period of 1970-1976, played a major role in unionization. Three of the participants contended that money was the sole cause and "biggest thrust" of unionization. According to one of these three participants, nurses unionized because they were not able to achieve salaries that were "fair, just and equitable." Another participant stated that, although the reasons were "clouded" with improved working conditions and improved patient care, money was the main reason why nurses unionized.

Frustration with the current situation and the need for change influenced nurses in their decision to unionize. Contributing to this frustration, participants cited the inability to achieve raises in their pay scale. According to one participant, unionization was a worthwhile endeavor because it was an assurance of higher wages.

One participant conceded that "money went further in those days," but still maintained that nurses were working for "peanuts." An old pay stub recently discovered by one participant revealed that two weeks of work as a staff nurse was worth $100-$125, prior to unionization. Another stated that in 1968, four eight-hour shifts were worth $75-$100. The participants maintained that nurses were "badly

paid" and that salaries were low before unionization.

According to the participants, prior to unionization, nurses were not paid for the role they played in the health care facility, particularly in view of their education and responsibility. Despite low salaries, the participants stated that they were expected to possess and maintain a level of knowledge which would enhance an optimum quality of life. In considering the life and death situations which nurses frequently encountered, the responsibility was deemed great and the financial compensation inadequate.

Wage Comparisons

Financial recognition for education and responsibility became a greater issue when comparisons were made with other workers. According to one participant, other workers' salaries were always "a bone of contention among nurses." The participants stated that early organizing meetings inevitably involved inquiries about what other workers were paid. Nurses were discovering that, at the time, they made less money than other workers. One participant maintained that nurses' salaries should have been comparable to other professionals; however, there was minimal evidence that this was a common practice. Rather, participants frequently

cited grocery clerks and Safeway workers as evidence of wage disparity with other workers. The participants maintained that for less responsibility and education, Safeway workers were receiving a salary equal to or more than a registered nurse. One participant contended that wage disparity with other workers was the reason why, following unionization, nurses received a substantial salary increase (42%, in 1975). One participant provided an example which demonstrated nurses' wage disparity with other workers:

> To researcher: In 1974, with twelve years of experience, I was making $3.75 per hour while people filling sand bags at the time of a threatened Red River flood were making a few cents more. The economic discrepancy was frustrating and played a major role in why I became active in unionization. (Fieldnotes: December 5, 1991)

The participants stated that another consideration in nurses' unionization was wage consistency for nurses among the health care facilities within the province. Lack of communication and coordination among nurses was considered a major reason for variations in salaries. According to one participant, one of the early priorities of the union was to achieve comparative nurses' salaries among the facilities in Manitoba. Another participant stated that as a result of a rural allowance, wage inequities existed between city and rural nurses. The participants maintained

that collective action was a method of achieving consistency and control over nurses' salaries and benefits.

Wage disparity between privately owned and government health care facilities was also viewed as a contributing factor in nurses' unionization. According to one participant, the perceived wage policy in private facilities was the "less money spent on nurses' salaries, the more money there was for profit." As a result of this business practice, "the salary of nurses in privately owned facilities was much lower than the going rate." Working within the confines of what money was available resulted in precarious incomes for part-time nurses.

> To researcher: Whenever there was a problem with money, the director would come along and erase part-time hours. I can still see our supervisor at the schedule with an eraser. If you were part-time, you lost the security of a continual income. (Fieldnotes: December 5, 1991)

Another participant stated that because of low salaries, privately owned facilities had difficulty recruiting and retaining "better nurses who were devoted to achieving and maintaining high levels of nursing care." For nurses in privately owned facilities, unionization was a method of creating higher salaries and alleviating patient care concerns.

Within each work place, parity of nurses' salaries was uncertain. The participants could not identify wage

disparities between nurses employed within the same facility as a contributing factor to unionization. The participants stated that nurses "did not compare salaries" among themselves and "no one knew what anybody else made."

> To researcher: We were not aware of salary discrepancies between nurses. We believed that the managers were following a set salary scale or policy, but it was not bargained for collectively. When it came to salaries, it was all a big secret. So who knows if the favourites got a higher wage. (Fieldnotes: October 4, 1991)

According to the participants, the salaries of other unionized employees within the work place such as nurses' aides and maintenance workers influenced nurses' unionization. One participant claimed that the salary of the general duty nurse was "getting down to that of the cleaning woman." Other participants concurred with statements relating how other health care workers' salaries were increasing, overtaking nurses' salaries. One participant was succinct, "salaries were very low in comparison to anything and getting lower."

Competitive Salaries

The participants cited recruitment and retention of nurses as an additional factor in nurses' unionization. Competitive nurses' salaries were considered an integral

component of ensuring a substantial nursing force. As one participant explained:

> To researcher: People were not coming into the profession. In order to recruit proper people into the profession, you have to pay proper salaries. And then to retain them, you have to pay proper salaries. You don't want to educate them and then have them leave the profession. (Fieldnotes: October 8, 1991)

The participants had differing recollections as to whether or not the need for competitive salaries by means of unionization was related to a current nursing shortage in Manitoba. Some participants clearly believed that there was a nursing shortage at the time. Others were uncertain, claiming they did not know, but then upon further reflection would make comments such as "we always seemed to be short of nurses" or "we could have always used an extra pair of hands." One participant questioned the use of the phrase "nursing shortage."

> To researcher: I have no idea what a nursing shortage is. Rather, it was a misuse of nurses. Nurses had too many non-nursing functions. (Fieldnotes: October 10, 1991)

Although participants had varying recollections of a nursing shortage, all were in agreement that nurses were leaving Manitoba to work elsewhere in the early seventies and that higher salaries was the cause. Ontario and the Unites States were cited as areas where young Manitoba nursing graduates relocated in order to receive higher

wages for their work. One participant stated that "Manitoba wasn't the lowest paying province in Canada, but it was close to the bottom." Higher salaries as a result of unionization was considered a method of retaining Manitoba's nurses.

According to the participants, achieving increments and improved salary scales were additional considerations in nurses' unionization. The participants stated that prior to unionization, there was one step on the salary scale, the start rate, and that everybody stayed at that level. One participant claimed that salary raises were awarded when "the manager felt like it." Another participant discussed how, previous to unionization, increments had been based on merit. The introduction of increments based on length of employment, did not receive that respondent's total support:

> To researcher: You used to be rewarded for a good job, now everybody is the same. Workers who sit on their duff all day get the same pay as those who do all the work. (Fieldnotes: October 16, 1991)

The participants stated that nurses did not receive much recognition for past experience and long service prior to unionization. According to the participants, although nurses were still contributing to the work place, the length of time they worked in the facility was not rewarded

with increased salary, increased vacation, or pre-retirement benefits. One participant described how negotiations with privately owned facilities always presented problems regarding long service recognition and benefits:

> To researcher: Some employers didn't see long service or past experience as valuable. These employers preferred to pay everybody at the start rate wage and didn't want people there for a long time. Staffing was viewed only as an expense. (Fieldnotes: October 8, 1991)

Benefits

The participants stated that paid benefits were also a major concern of nurses who began to consider unionization. One participant believed that interest in unionization involved "waking up to the fact that we didn't have any benefits, no pension plan." The realization that other health care facilities provided employee pension plans strengthened interest in unionization.

According to the participants, nurses were paid a flat salary prior to unionization. The participants maintained that shift differential, responsibility pay or weekend allowance were non-existent. One participant stated that privately owned facilities never did receive shift differential payments because granting permanent shift

scheduling was considered "good enough."

Other benefits of importance cited by the participants were paid statutory holidays, sick time pay and compensation for emergency "on-call." One participant stated that, "in the early seventies, privately owned facilities did not provide sick pay. If you were sick you lost a day's pay." Upon discussing emergency call-back benefits, another participant retorted:

> To researcher: There were no call-back benefits. That was the privilege of being a nurse. (Fieldnotes: October 4, 1991)

According to the participants, overtime pay was an additional concern which influenced nurses' consideration of unionization. One participant stated that overtime was a common occurrence which was seldom acknowledged.

> To researcher: We worked lots of overtime and did not keep track of it. If we tried to leave work five minutes early for an appointment we were hit over the knuckles. They (the managers) forgot about the three or four hours of overtime. (Fieldnotes: November 7, 1991)

This participant contended that union representation resolved overtime disputes.

> To researcher: When there's a contract you cannot leave work five minutes early, but you will be reimbursed for extra time you put in. (Fieldnotes: November 7, 1991)

The participants claimed that prior to unionization, there was no financial recognition for charge duty. One

participant stated that "rather than money, getting weekends off was considered sufficient and satisfactory compensation." As relieving the head nurse was not financially recognized, one participant discussed the advantage of independent collective bargaining. Upon agreeing to assume head nurse responsibilities, this individual's response was "you're going to have to pay me." This person was compensated for charge duty. When the pay scales were reviewed at the time of unionization, it was discovered that this nurse "was making the same part-time as the assistant head nurse."

The participants maintained that the length of paid vacation was an additional factor in nurses' unionization. One participant stated that vacations were whatever was stipulated by law (the Employment Standards Act), two weeks, with the occasional increase after ten years of service. One participant who had been a CUPE member recalled that "we had wanted three weeks vacation for a long time but we were always told that the union would have to ask for the same for everybody and our request would be turned down." The participants contended that vacation increases did occur as a result of unionization.

One participant maintained that employee health coverage was an additional advantage of nurses'

unionization.

> To researcher: I thought it was silly that health professionals had to fight to get health benefits. Other workers had better coverage, we should have been the first to get those types of benefits. (Fieldnotes: October 16, 1991).

Nurses' Perceived Self-worth

The participants voiced differing positions regarding how a change in nurses' perceived financial self-worth and value influenced unionization. One participant believed that changes in self-worth were a result of unionization, claiming that nurses "stood a lot taller after unionization" and "after we organized, we were never stepped on again." With such comments as "nurses were beginning to respect themselves" and "we realized that we had skills that were worth a half decent salary," the other participants maintained that nurses' unionization was a result of increased self-worth among nurses. One participant related changes in self-worth with long-standing oppression. "Nurses had felt undervalued and underpaid within the work place and health care system for too long." Self-worth was also equated with the traditional perception of a nurse. "It was difficult with the image of charity, but we still needed the necessities of life, you

have to have the dollars." One participant described the prevailing atmosphere and transformation among nurses as follows:

> To researcher: Nurses at that time were not supposed to organize or go on strike to increase their salary and benefits. It indicates how depressed conditions were, to go to the extent of unionization. (Fieldnotes: October 8, 1991)

Working Conditions

The greatest proportion of time within the interviews was devoted to participants' discussion of nurses' working conditions prior to unionization. This discussion entailed statements regarding how management treatment, communication, grievance procedures, staff scheduling, and job security influenced unionization among Manitoba's nurses during the time frame of 1970-1976. As a result of the participants' numerous comments relating safe nursing care and standards of care to such conditions of work as staff coverage, professional concerns have been included in the category of working conditions. Statements regarding quality of care, staff coverage, continuing education, technological change, evaluations, and unionism comprise the discussion of professional concerns.

All of the ten participants stated that working conditions played a major role in nurses' unionization. Three of the participants contended that working conditions were the greatest cause of unionization. Four other participants spoke specifically of how managers and Directors of Nursing were the major cause of unionization.

Manager's Influence

Four of the participants stated that the major cause of unionization among the nurses at their facilities was not poor salaries or working conditions. According to these four participants, nurses unionization was initiated with the encouragement and the support of either the administration or the Director of Nursing (DON). One participant stated that the nurses at their health care facility unionized as a result of a general staff meeting which had been organized by the administration. The purpose of the meeting was to solicit the support of the various classifications of workers in lobbying against proposed government cutbacks. In supporting this cause, the various groups of workers, including the nurses, began to contemplate collective action.

According to the other three participants,

encouragement by the Director of Nursing was the primary reason why nurses at their health care facilities unionized. These participants claimed that their Directors of Nursing were "active in the MARN" and the "association was important to them." In addition, the participants stated that the nursing staff considered their Directors of Nursing to be "credible" individuals whose suggestions were worthy of serious consideration. Two of these nurse managers were described as "open-minded," "progressive," "up and coming," "highly respected" individuals who had "good staff rapport" and were "concerned about the welfare of their nurses."

One participant believed that unionization was encouraged by the Director of Nursing in order to provide "guidelines" and "something to go by" which would then "make the job of managing easier." Another participant described how their nurse manager encouraged nurses' unionization:

> To researcher: Our Director of Nursing (DON) kept saying: "You nurses should get organized. Get an association going and do some collective bargaining, to improve nurses lot". I guess the DON thought the nurses were dragging their feet and needed a push in the right direction. (Fieldnotes: November 7, 1991)

The remaining participant recalled how union participation originated with the Director of Nursing:

> To researcher: It was very strange how I got involved. The boss, the DON came up to me one day and said: "We've got this notice that they are having this meeting in Winnipeg and you are going to it." So I blinked my eyes and said: "Okay".
> Researcher: What kind of meeting was that?
> To researcher: The union meeting. (Fieldnotes: October 16, 1991).

In discussing unfavourable treatment of nurses by management as a cause of unionization, participants cited inconsistencies in hiring, firing and promotion practice. One participant stated that the union "made managers accountable for their actions," specifically in the area of "proper hiring practices" such as "job postings" and "determining who should get the job." Two of the participants believed that "favouritism" was a major factor in nurses' unionization. One participant stated "the person who talked the loudest got the best deals, the best hours" and "different people got different things." According to this participant, prior to unionization, promotions were determined by "being friends with the right people" and "coffeeing together." Unionization was considered a definite advantage for those who were not "favourites" and could not "speak up."

> To researcher: So the poor little weak nurse who did the job and all the grubbing stayed in the same position forever. Individuals had to represent themselves. You had to be strong and just not take it. (Fieldnotes: September 10, 1991)

Unionization became nurses' perceived method of achieving fair and impartial treatment by managers.

> To researcher: There would have been no union if employers had treated nurses the way they should have been treated, with respect. Not misused and trampled over. If employers are good to their employees, there is no need for a union. (Fieldnotes: November 4, 1991)

The participants stated that changes in management personnel influenced nurses' unionization. One participant claimed that the need for a "legalized union" was increased in instances where a "poor manager followed a good manager." According to the participant, "if managers change, the contract will still be there." Other participants cited cases of a "miserable manager who managed by threat" or a "wicked manager" replacing a manager who had "good rapport" or had been "idiolized by staff." Another participant stated that "managerial harassment" and a progression of managers ranging from "not too good" to "totally impossible" contributed to unionization at their facility. In considering the variations of management styles, the participants saw the union as constant and protection for the employees.

Inconsistent treatment of staff members by head nurses was viewed by the participants as an additional factor in nurses' unionization. According to one participant, unionization was a method of counteracting the

discrepancies between head nurses who were "flexible" and those who were "rigid" by ensuring that staff members would "all be treated the same." Specific actions by supervisors which were believed to have contributed to unionization were "inequities in work assignments," "unreceptive to questions" and "going around screaming all day."

According to the participants, impartial decision-making was an advantage of unionization. As a result of a union contract, management decisions were considered less subjective and personal. One participant claimed that the union provided "great guidelines" and was "something to fall back on, for both members and management." As a result of having "things written down" stating "this is what we do," "everybody knew where they stood" and "what to expect."

Job Security

Related to management policy, job security or protection was perceived by all of the participants as an additional benefit of unionization. According to the participants, unionization increased employee job security and diminished the possibility of losing your job for "any little thing," or as one participant suggested: "because

the supervisor did not like the way you had your hair that day." Dismissal on the grounds of "just cause" was considered a powerful and necessary advantage of nurses' unionization; an advantage, according to one participant, that nurses' had over their managers.

The provision of maternity leaves was cited by participants as a contributing factor in nurses' unionization. Prior to unionization, pregnancy meant "giving up your job." The common response regarding maternity leaves was "you had to quit your job and start over." According to the participants, quitting the job and starting over again frequently resulted in disrupted salary scales, benefits and seniority.

Scheduling

Seven of the participants stated that hours of work and shift scheduling were major concerns of nurses' prior to unionization. The remaining three participants maintained that scheduling and getting days off were "no big problem" in their facilities. Those participants who believed scheduling influenced unionization cited instances of "working evenings for three to six weeks at a time with one weekend off." One participant claimed that common

scheduling concerns among the nursing staff were "getting the right vacation, rotating between two shifts instead of three, and improved days off." Scheduling inequities between full-time and part-time employees were cited as additional considerations in nurses' unionization:

> To researcher: Full-time nurses were working two out of three weekends. Part-time nurses were working every third weekend. The full-time nurse took the brunt of things. (Fieldnotes: September 9, 1991)

Working long stretches, "more than seven in a row," and "short-changes" such as days to nights were identified as scheduling concerns which influenced nurses' unionization. Two of the participants maintained that shift "scheduling in their facilities had improved due to collective bargaining." Following unionization, nursing schedules provided alternate weekends off and rotations between two shifts. Stating that "shift schedules used to be put up only one or two weeks in advance," one participant credited unionization with increased notice of work schedules.

Part-time working hours were an additional concern. According to one participant, nurses were scheduled to work as either "full-time or others." Part-time and casual nurses constituted the category of "others." As a result of this ambiguous scheduling classification, part-time nurses were not assured of consistent shift assignments.

One participant stated that "nothing was in writing" and "part-time schedules would be changed at any time." Referring to "the problems with employers playing around with hours," one participant recalled:

> To researcher: It was hard for part-time nurses. Shifts were added and taken away on a whim. There was no stability to part-time working hours. (Fieldnotes: October 8, 1991)

According to the participants, unionization ensured advance notice of shift changes and mutual agreement. In addition, negotiations provided for signed agreements which stipulated the number of hours a part-time nurse was committed to work. Participants maintained that unionization provided an avenue whereby many of the work place problems related to scheduling and hours of work could be resolved.

Communication

According to seven of the participants, communication was a factor in nurses' unionization. Three of the participants maintained that, at their facilities, there was "no problem with communication," that there was "good rapport with employers" and that managers were "very approachable." These participants believed that a "small" nursing staff compliment enhanced open, productive

communication within their facilities. As the nursing staff of one of these facilities numbered approximately twenty members and remaining two nursing staff compliments numbered approximately one hundred and fifty individuals, the perception of "small" varied dramatically among the participants. Those participants who believed communication influenced unionization, stated that prior to unionization, "nurses would talk, but not be heard," and that "nurses had no input into what was happening to them in the work place." According to one participant, lack of communication within the work place was a long-standing problem that had existed for "years and years and years."

In recalling the difficulties encountered in communicating with employers, participants cited instances of "being told from the top down," "the occasional staff meeting," "no major input by nurses" and "no way to voice concerns." One participant described the proceedings of staff meetings:

> To researcher: We had management by authority. There was never any consideration given to staff input or how staff felt. We had general staff meetings where the management would say: "we want to hear from you", but nothing ever changed. It was frustrating. (Fieldnotes: December 5, 1991)

In discussing the final outcome of nursing concerns voiced at staff meetings, one participant responded: "in the end

management still did what they wanted to anyway."

One participant stated that even though their employers "prided themselves on harmonious employee relations," the quality and outcome of communication was uncertain. According to this participant, the employer was "receptive to staff concerns" in "providing an audience," but "whether or not you were heard was another matter." One other participant maintained that unionization was a useful third-party intervention for discrepancies in supervisory communication skills between "a pig-headed administrator you could not talk to" and "a DON who would listen," One participant stated that as a result of "poor communication and follow-through, problems in the work place were not resolved."

According to the participants, a major advantage of unionization was increased communication and knowledge for the members. The participants claimed that the union was very efficient at informing members of their rights as employees and keeping members appraised of the status or outcome of their concerns. The participants maintained that, within the union, information was freely and efficiently distributed among the membership.

Grievance Procedure

Seven of the participants maintained that the lack of an effective grievance procedure within their work place influenced nurses' unionization. Three of the participants stated that their facilities had effective channels of problem resolution either through an "informal" grievance or "complaints" procedure. Those who considered a grievance procedure an advantage of unionization claimed to have had "no grievance procedure whatsoever" or a grievance procedure "that was only as good as the administrator." One participant maintained that nurses had "no assurance, outside of the union, that any grievance procedure would upheld." In instances where "in-house grievance procedures" existed, nurses had concerns about "consistency of resolutions," "being at the whim of management" and "access to arbitration."

One participant stated that, prior to unionization, "nurses did not realize their rights, did not think to grieve and did not know who to grieve to." Another participant maintained that, as the non-union grievance procedure required strong individual representation, resolution of concerns was minimal. As a result, "few complained, everybody put up with things" and a "lot of things went by the wayside." According to the

participants, a clearly defined and formalized grievance procedure which was considered fair for all members was a welcome advantage of unionization.

Professional Issues

Five of the participants stated that professional concerns had minimal effect upon nurses unionization from 1970 to 1976, while the remaining five participants stated that professional concerns definitely influenced nurses' unionization. The participants who believed that professional concerns did not influence unionization included the participants from rural facilities, as well as those urban participants who had stated that their staff compliment was "small." The five participants who believed that professional issues did influence nurses' unionization voiced concerns related to professional standards for care, staff coverage, heavy workloads, and safe patient care. Continuing education, staff evaluations and orientation were perceived as having little effect upon unionization. All of the participants maintained that technological advances in patient care had minimal effect upon nurses' unionization in Manitoba.

Patient Care

In discussing how professional concerns influenced unionization, the participants recounted instances of serious patient risk due to limited staff coverage. These participants stated that as professionals they had standards set out which they were expected to meet. However, heavy workloads prevented them fulfilling their obligation to the patient. As proof of the limited staff coverage, these participants described common occurrences where "one RN was responsible for ninety-nine residents," "the only RN assigned to an acute care ward was also responsible for the Emergency department" and "no RN coverage in the Nursery." According to the participants, prior to unionization the workload was phenomenal and nurses became frustrated because they were "not able to give the care they wanted to" or to "look after patients properly." One participant recalled becoming "really concerned about the care that the residents were not receiving."

Professionalism and Unionism

In discussing professional concerns, all of the participants recalled the dilemma nurses encountered

regarding the compatibility of unionism and professionalism. According to the participants, there was some resistance among nurses regarding collective bargaining for professionals. The participants had differing views regarding how the issue of professionalism and unionism was resolved. For those participants who had DON encouragement, professionalism was of minimal concern. One other participant stated that as, the "head nurses were the first ones to get involved" at their facility, "the others found it easier to be part of the union." Another participant contended that their group had no problem with professionalism because the "MARN was not representing us anyway." Other participants maintained that, as collective bargaining had originated with the MARN and the PSNC, concerns of compatibility between professionalism and unionism were diminished because nurses "still felt that the MARN was representing them."

The participants stated that, in the early seventies, organizing meetings frequently entailed discussions of professional status and union membership. Several of the participants cited the prevailing MONA motto of "to care for nurses is to care for patients." In confronting the issue of professionalism and unionism among potential members, a common strategy was to refer to nurses'

professional obligation:

> To researcher: Is it not professional to negotiate a salary that will allow us to recruit the right type of people into the profession? Is it not professional to negotiate a salary that will allow us to retain good people? Is it not professional to implement shift scheduling that will decrease "burnout" and improve patient care? (Fieldnotes: October 8, 1991)

One participant did not believe that conflict existed between professionalism and unionism, maintaining that whatever conflict existed "was in people's minds." Contending that the "union helps nurses be better professionals," one participant frequently contradicted any consideration of conflict between professionalism and unionism.

While the concerns of Manitoba's nurses regarding professionalism and unionism were eventually resolved, all of the participants stated that the controversy over "calling themselves a union" was never settled. The participants frequently commented that there were many "heated debates and discussions" regarding the use of the word "union." As one individual stated, "union was a dirty word to the membership" and the word association was "easier to live with."

Some of the participants attributed nurses' aversion to the word "union" to blue collar worker affiliation and militant action. One participant suggested that to nurses,

"union meant labourers." One participant stated that nurses "saw themselves as white collar workers" and that somehow "white collar workers were better that blue collar workers." Another participant maintained that the nurses "were not going to be like the other unions" (e.g. the Teamsters) and "looked at the other unions to decide what they were not going to do." In recalling nurses' stance regarding blue collar workers and unionism, one participant concluded:

> To researcher: Mind you, they (nurses) would marry them, but they (nurses) would not associate with them in the union. They (nurses) did not realize that the two groups were more in common than (they were) separate. (Fieldnotes: October 10, 1991)

All of the participants maintained that, as union members, nurses had never been overly "militant in their actions."

According to the participants, the issue of strike was a major concern of nurses' in their consideration of unionization. One participant recalled that "strike was a terrible word"

> To researcher: We originally gave up the right to strike. We considered striking unimportant. As professionals, we did not think we should be striking. (Fieldnotes: November 7, 1991)

One participant stated that "striking was a stumbling block that came up at every meeting" and was "the main deterrent to organizing." Another participant recalled that "nurses

were deathly afraid of strike." One participant stated that in considering unionization, potential members were reminded that "every avenue would be exhausted" and that a strike would be a "last resort" which would "be decided by a vote of the members themselves." The participants suggested that the "perceived view of striking against the patient, rather than the employer" contributed to nurses' discomfort with strike. One participant described how a threatened strike in 1975 measured nurses' early commitment to unionism.

> To researcher: I never dreamt a nurse would go on strike. None of us wanted to strike. We hoped and prayed that we would not have to hit the streets, but it was the only clout left to us. It was a major step for nurses to belong to a union, then to ask them to go on strike. It certainly tested the membership. (Fieldnotes: November 4, 1991)

Societal Influence

In examining the influence of societal factors upon nurses' unionization from 1970-1976, the participants discussed factors related to women's roles, nurses' roles, expanding job opportunities for women and the unionization of other workers. According to the participants, the impact of these factors upon unionization varied. Eight of the

participants believed that societal concerns motivated nurses toward unionization, while the remaining two participants stated that societal issues had minimal effect upon nurses' unionization.

Women's Roles

In describing how changes in women's roles affected nurses' acceptance of unionization, the participants discussed the prevailing perception of women in the work force. Two of the participants stated that, as women, they were "happy to have a profession," "just thankful or lucky to have a job" and "it did not matter what we were paid." Other participants recalled that women worked "only to supplement their husbands' income," for "pin money" or to save for such "luxury" items such as a "new washing machine." As women's perceived contribution to the work place was considered minimal, they were "under-valued and under-paid." Nine of the participants believed that increasing numbers of women as sole-supporters during the late sixties and early seventies necessitated decent salaries and contributed to unionization among nurses in Manitoba. The prevalence of lifestyles which require two incomes to support the family was identified as an

additional consideration in nurses' unionization. Upon discusing male nurses and salaries, one participant stated that, prior to unionization, "men did not enter nursing" or "left the profession" because their "salary would not support a wife and family."

The participants suggested that the Women's movement gave women and nurses the courage to "speak out more," "stand up and be counted" and "begin to fight for themselves." According to the participants, the subservient role of females and nurses was a major factor in nurses' unionization. The participants attributed nurses' ongoing role of servitude to "male dominance" within the home and the work place. One participant stated that nurses had been "kept in their place by the male dominated professions around them." In describing the prevailing role of the nurse, the participants used such phrases as "Doctor's handmaiden," "servant" and "gopher." As proof of nurses' low status within the work place, participants detailed instances of "getting up to give the Doctor your chair" and "always allowing superiors to go through the door first."

The participants claimed that the unassertive and subservient nurses' role was perpetuated by nursing education programs which instilled self-sacrifice, charity

and dedication. According to one participant, the image of the nurse was an additional obstacle:

> To researcher: It was all charity and self - sacrifice. Nobody ever thought that you would need a weekend off to go to a party, or to make enough money to look after yourself properly. As if polishing your halo was supposed to keep you going. (Fieldnotes: October 4, 1991)

The participants viewed nurses' unionization as the action of an oppressed group which finally rebelled. Common comments among the participants related to how nurses were "fed-up" with "sitting back" and "just taking whatever was handed to them." According to the participants, nurses' unionization was a method of standing up, speaking out and controlling your destiny.

Expanding Job Opportunities and Other Unions

The participants did not believe that increasing job opportunities for women related to the Women's movement influenced nurses' unionization. The consensus among the participants was that expanding career opportunities for women began to occur after nurses' unionization in Manitoba. The participants did not believe that a shortage of nurses resulted from women pursuing other careers. According to the participants, unionization was not major strategy directed at enticing individuals into the

profession of nursing.

All of the participants maintained that the unionization of other workers did not influence nurses in their decision to unionize.

> To researcher: Nurses did not unionize because other workers were unionized. They were more concerned with what was happening to them within their own environment. (Fieldnotes: October 8, 1991)

The participants stated that "blue collar workers had unionized long before us" and that "nurses were slow to move." One participant claimed that, because of "striking," "other unions were more of a deterrent" and "scared nurses."

In concluding the discussion of social factors, the participants frequently commented that "it was just that time in the life of nursing" or "the time was right." As one participant stated, it was "better to stay with nursing and try to work towards bettering our conditions than to leave the profession." Rather than considering unionization solely in the context of a women's or labour movement, the participants preferred to view nurses' unionization as a "nurses' movement."

Conflict

In examining the role of work place conflict in the unionization of Manitoba's nurses, the participants discussed conflict related to openly identified and confronted work place concerns. According to the participants, the impact of work place conflict upon nurses' unionization varied. One participant maintained that DON encouragement negated any influence of conflict. Appearing reluctant to consider the process of unionization in the context of conflict, three of the ten participants stated that dissatisfaction with existing problem solving methods and the need for change were strong motivators in the unionization of Manitoba's nurses from 1970 to 1976. The remaining six participants claimed that conflict definitely influenced nurses' unionization. All of the statements outlining the role of conflict in nurses' unionization related to ineffective problem solving methods within the work place.

The participants contended that the existence of conflict and the need for effective problem solving depended upon the administration and the communication within the facility. The participants stated that while "some problems were solved amicably, others were not." In

instances where problems were not considered "solved properly," the employees "got help elsewhere" and the "vast majority of nurses went the union route." One participant claimed that the "problems finally added up and led to unionization."

In their attempts to achieve satisfactory solutions to problems, the participants stated that nurses had "nowhere to go," "ran into brick walls" and had been "unable to address their concerns for years." One participant claimed that the "only guarantee of any kind of solution" was what the nurses "negotiated for themselves." Disenchantment with the established methods of solving problems was considered a factor in nurses' unionization. According to one participant, "neither management or the MARN" produced favourable solutions to nurses' problems. Another participant stated that CUPE did not satisfactorily represent the nurses. The participants maintained that the nurses' union became an alternate source for "successful solutions to problems" and "effective handling of conflicts." In situations where a manager "does not listen to the employees" or "settle a dispute," the participants claimed that the union certainly will.

The participants stated that nurses' unionization was a reactive process which originated from not having

concerns or problems addressed within the work place or from some adverse condition within the facility. One participant maintained that the "vast majority of nurses" saw the union as "the organization that could help them solve their problems." According to the participants, the union assumed the responsibility of resolving conflicts and problem solving for nurses.

One participant stated that confrontation and conflict was the key reason why union action started among nurses. The participant believed that conflict originated from nurses not having economic, professional or working conditions properly addressed. Another participant maintained that "having problems resolved for them" was "one reason why nurses felt comfortable" with the union and "wanted to unionize." According to one participant, it was "fairly easy to motivate" nurses to unionize in the beginning because they were "fed up with existing conditions" and "wanted a change."

In achieving effective solutions to nurses' problems, the participants stated that collective action was preferable to individual action. The participants contended that individual action had not previously resulted in satisfactory solutions to nurses' concerns. A common statement among the participants was "one voice in the

wilderness versus ten thousand." One participant suggested that nurses were "hesitant to fight for themselves" and that it was "easier to have someone come in from outside to settle disputes." "Representation" and "having someone to support you if you if you had problems at work," were frequently identified advantages of nurses' unionization. According to one participant, the union would "stand behind you" and "not drift you out to the wolves."

The need for recognition, respect and a voice were viewed as important considerations in the unionization of Manitoba's nurses. As women and nurses, the participants claimed that interest in unionization resulted from being "ignored" and "under-valued" within the work place "for too long." Participants frequently stated that with a union "you get someone to speak for you," and a "voice" by which you can "express concerns about workloads and scheduling." With a voice that was heard, the participants believed that nurses began to achieve recognition and respect. According to one participant, the collective voice of a union enhanced credibility when presenting work place concerns.

> To researcher: It was hard to get any changes before we unionized. If you complained about something, you were considered a trouble maker. (Fieldnotes: December, 5, 1991)

Summary

The participants suggested that, to some extent, economic conditions, work conditions, societal issues, and conflict all influenced nurses' unionization in Manitoba. However, the participants did have differing views regarding which of the factors most heavily influenced nurses' unionization. The contributing factors to nurses' unionization and the strength that the participants placed upon those factors, related to nurses' unionization in Manitoba, are presented in Table 1. None of the participants identified any additional factors which contributed to the unionization of Manitoba's nurses from 1970-1976.

In examining how economic, working conditions, societal, and conflict issues influenced unionization, each participant provided a unique perspective which clarified the history of the nurses' union in Manitoba. While each participant's recollection and situation varied, several main concepts emerged. These concepts entailed disparities, inconsistencies, participation, and the inability to create change through existing channels. For nurses in Manitoba, unionization became a method of addressing these problems.

Table 1

Influence of Determinants upon Nurses' Unionization

(Numbers signify the participants who indicated this response.)

	Strongest Influence	Strong Influence	Moderate Influence	Slight Influence	No Influence
ECONOMIC ISSUES					
Salary & Benefits	3	6			1
WORK CONDITIONS					
General	3	7			
Management Support	4				
Hours of Work		7			
Communication		7			
Grievance Procedure		7			
PROFESSIONAL CONCERNS					
Quality of Patient Care			5	5	
Continuing Education				10	
Staff Evaluation				10	
Orientation				10	
Technological Change				10	
SOCIETAL ISSUES					
Sole-support Parenting			9		1
Other Careers					10
Other Unions					10
WORK PLACE CONFLICT		6	3		1

During the interviews, some of the participants voiced a continued concern over the strike action and militancy associated with unionism. However, all of the participants were adamant that collective action and unionization was a worthwhile endeavour and the best thing to happen to nurses in Manitoba. In summing up their experiences regarding the unionization of nurses in Manitoba, the participants stated that they were pleased with and proud of their involvement.

CHAPTER FIVE

DISCUSSION

Unionization for nurses in Manitoba has been a means of correcting inequities related to salaries, conditions of work, professional issues, and the treatment of nurses as workers and women. Unionization appears to have been successful in decreasing the distance between what employment conditions actually existed and what conditions nurses believed should exist. Unable to create change as individuals and through existing avenues, Manitoba's nurses sought union representation. Collective action and unionization offered a higher probability of creating change than traditional organizational channels. Nurses perceived that they had previously been unheard within the work place. Therefore, unionization provided nurses with a much needed voice. With this collective voice, Manitoba's nurses began to acquire recognition and respect within the work place.

This chapter will discuss the inequities and inconsistencies which contributed to nurses' unionization in Manitoba. These disparities involved economic conditions, working conditions, professional concerns, and societal issues. In resolving the conflict regarding these

inequities and creating change, unionization provided a powerful voice for Manitoba's nurses.

Economic Issues

Wages and Benefits

Low wages and the lack of benefits were major considerations in the unionization of Manitoba's nurses. Rotkovitch (1980) and Stern contend that salary and benefits have been significant factors in nurses' unionization. Although increasing wages and obtaining more benefits were important concerns of nurses, they do not appear to be the sole cause of unionization. As only three of the ten participants stated that economic considerations were the major reason for nurses' unionization, it appears that there were other important issues involved in the unionization of Manitoba's nurses.

In considering that collective bargaining by nurses in Manitoba first focused on monetary concerns and then progressed to work conditions and professional concerns, it would appear that the history of collective bargaining by Manitoba's nurses demonstrates Kleingartner's (1973) expansion of bargaining hypothesis. Kleingartner's

hypothesis suggests that professionals initially bargain monetary issues and then, after time, progress to bargain professional concerns. Once wages and benefits were raised to an acceptable level for Manitoba's nurses, then work conditions were addressed. This progression of bargaining issues is compatible with Ponak's (1981) research which examined Kleingartner's hypothesis among Ontario's nurses.

The influence of economic conditions upon the unionization of Manitoba's nurses paralleled Salutin's (1986) statement that wanting money is not always a matter of greed; it depends upon how much you already have. Early collective agreements reflected the emphasis upon increasing nurses' salaries. In 1971, negotiations netted nurses a wage increase that ranged from 10% to 17% over a two year period ("Agreement Signed," 1971). As a result of these negotiations, the starting rate for a general duty registered nurse increased from $500 to $515 per month or from $3.13 to $3.31 per hour in 1972 ("Agreement Signed," 1971). Collective bargaining by the PSNC began to net Manitoba's nurses a steady progression of salary increases. In 1973, general duty registered nurses were starting at $677 per month or $4.34 per hour (PSNC minutes, September, 1973). Following negotiations in April 1975, the starting rate for general duty registered nurses was $900 per month

or $5.82 per hour, a basic wage increase of approximately 33% ("Eleventh Hour," 1975). The settlement was less than the 59% increase originally requested by Manitoba's nurses ("Nurses Seek," 1975). At this time, five increments or steps were also negotiated; the highest of which was a monthly salary of $1075 or $6.95 per hour ("Eleventh Hour," 1975).

Improved benefits began to appear in the early collective agreements negotiated by the PSNC. These benefits included shift differential, on-call compensation, over-time pay, paid sick leave, and increased vacation and statutory holidays. As in nurses' basic salaries, the negotiations of benefits demonstrated a steady upward climb in financial compensation for services rendered. In 1973, the negotiated standby rate ranged from 25 to 30 cents per hour and shift differential was 12.9 cents per hour ("Provincial Staff," 1973). Following the 1975 negotiations, the standby rate was $5.00 per shift with shift premium and responsibility payments of 20 cents per hour ("Eleventh Hour," 1975). With the introduction of a clause stipulating compensation of overtime at a hourly rate of time and a half, the 1973 agreement addressed the concerns voiced regarding overtime ("Provincial Staff," 1973).

As stated by the participants, sick leave, vacation entitlements and statutory holiday compensation did improve as a result of collective bargaining. Following the 1971 negotiations, the annual "paid sick leave benefits were increased to 102 working days from a previous 90 working days, and in 1972 to 114 working days" ("Agreement Signed," 1971). In 1973, based upon full-time service, vacations were three weeks after one year and four weeks after five years with four weeks after four years in 1974 ("Provincial Staff," 1973). In 1975, a five week vacation was provided after twenty years of full-time employment ("Eleventh Hour," 1975). Recognized holidays were ten at time and one half per year in 1973 ("Provincial Staff," 1973).

Financial Compensation of Responsibility and Education

Financial recognition of nurses' work place responsibilities was an important consideration in the unionization of Manitoba's nurses. In 1984, Simms and Dalston identified nurses' increasing roles within health care and lack of monetary rewards as factors in unionization. Improved wages and benefits through collective bargaining began to compensate nurses for their contribution to the work place. Responsibility pay became

another method of recognizing nurses for additional duties. The 1971 negotiated contract included a clause which stated "nurses temporarily assigned to responsibilities of a more senior position will receive a $1.00 per shift allowance after a total of 15 working days in such a position, in a calendar year" ("Agreement Signed," 1971).

Despite minimal financial reimbursement, employers had expected nurses to maintain a level of knowledge which produced optimum quality of patient care. Prior to unionization, the cost of acquiring further knowledge related to changes in patient care and improved patient care was the responsibility of the nurse. Collective bargaining by Manitoba's nurses resulted in additional financial compensation for nurses' educational preparation. The 1975 collective agreement contained academic allowances for additional educational preparation which ranged from an extra $15.00 per month for a Nursing Unit Administration course to $100.00 per month more for a Master's Degree in Nursing ("Collective Agreement," 1975).

Wage Disparities

Wage parity for nurses throughout the province of Manitoba was a factor in unionization. Economic inequality

was suggested by French and Robinson (1960) as a cause of unionization among health care workers. Werther and Lockhart (1977), state that collective action corrects the inequities in pay scales among similar organizations.

Coordinating nurses' salaries and achieving wage parity for Manitoba's nurses was to be an arduous task for the early union negotiators. Eliminating wage disparities among nurses was a slow process. As maintained by one participant, a rural allowance did exist for nurses employeed at rural health care facilities. The rural allowance in 1973 was $15 per month ("Provincial Staff," 1973). However, the existence of a rural allowance did not appear to result in higher wages for rural nurses. In one documented instance in 1975, the basic nurses' salary at a rural facility was $715 per month; while, in Winnipeg, nurses were receiving $900 per month ("Nurses Pay," 1975). Willing to exercise their collective power in order to rectify the wage disparity, unhappy nurses walked out and patients had to be flown to Winnipeg because there was no hospital staff ("Nurses Pay," 1975).

Nursing Shortage and Provincial Nurses' Salaries

Although there were differing positions regarding a

nursing shortage and its possible impact upon unionization, there was total agreement that the recruitment and retention of nurses was an early objective of collective bargaining for nurses. Dependent upon the economic status, the recruitment and retention of nurses appeared to be a major concern across the country and an advantage of unionization. The 1972 position of the CNA regarding the social and economic welfare of nurses which was endorsed by the PSNC was "that the economic status of nurses is an important factor both in recruitment into the profession and in retention of nurses in the practice of the profession ("Collective Bargaining," 1974).

Manitoba's low nurses' salaries were considered the cause of nurses seeking employment in other provinces. Losing nurses to other provinces was the common concern related to a nursing shortage and the need for competitive salaries through unionization. Prior to unionization, nurses' salaries in Manitoba were among the lowest in Canada. At $618 per month in 1974, Manitoba's nurses were the second lowest paid in Canada, while Quebec nurses were the lowest paid ("Are Manitoba," 1974). At $945 and $850 per month respectively, nurses in Ontario and British Columbia were the highest paid ("Are Manitoba," 1974). Unionization did create competitive salaries for Manitoba's

nurses. By 1975, a wage comparison of general duty registered nurses' monthly salaries listed Ontario at $1045-$1245, British Columbia at $1049-$1239, Alberta and Manitoba at $900-$1075, with Saskatchewan the lowest at $798-$927 ("1975 General," 1975),

Wage Comparisons With Other Workers

The higher salaries of other workers was a powerful stimulus which influenced unionization among Manitoba's nurses. Rowsell (1967) states that nurses have been motivated toward collective action by the considerable salary gains of other workers. Mulcahy and Rader (1980), suggest that, in order to avoid unionization, health care employers must provide competitive wages and benefits for employees.

Gideon (1980) states that other workers who are unionized enjoy wage increases and cost of living adjustments. In Manitoba, there were instances of other workers receiving higher salaries than nurses. Averaging $541 per month in 1971, nurses were making less than most mail carriers who were paid $666 per month, as well as police officers and firefighters who were receiving $708 per month ("Employment Income," 1975).

Safeway clerks were unanimously identified as an example of workers with less training and education who were making more money than Manitoba's nurses. Grocery clerks were presented by Gideon (1980) as workers with incomes higher than nurses. In 1971, the majority of grocery clerks in Manitoba were receiving the same monthly salary as nurses, $541 ("Employment Income," 1975). These statistics identify total income earned and do not distinguish income from overtime and benefits; therefore it remains possible that, based on hourly income rates, the argument that Safeway clerks were making more money than nurses is true. Within the work place, the incomes of the support staff were approaching those of the nurses. Cormick (1969), states that nurses received salary raises in order to keep their wage above that of the nursing assistants.

Another consideration in the unionization of Manitoba's nurses was that other workers with similar training and responsibility made more money than nurses. Cormick (1969), identifies X-ray technicians as one higher paid group of workers with comparable training and responsibility. In 1971, the majority of X-ray technicians in Manitoba were averaging $541-$708 per month compared to nurses' $541 per month ("Employment Income," 1975). At $666 per month, most elementary and secondary school teachers

were receiving more money than nurses.

Nurses' Perceived Financial Value

Related to economic issues, a change or shift in nurses' perception of their own financial value to the health care facility contributed to the unionization of nurses in Manitoba. Unionization was influenced by nurses' belief that their value to the health organization was greater than their pay reflected. In measuring their own financial value to the work place, nurses assessed their own low salary and how inadequately it compared with other workers' salaries. According to Phillips (1981), employee interest in unionization is increased by the perception that the wages and conditions of employment are below an acceptable standard and the perception that the wages and conditions of employment are inequitable relative to those doing similar work.

The impact of economic concerns upon unionization displayed perceptual discrepancies between what nurses were actually earning and what they believed they were financially worth. For Manitoba's nurses, this discrepancy was evident in four major conditions which existed at the time of unionization. These conditions were: the low salary

nurses received for their work; the higher salaries other workers received for their work; the disparities among nurses' salaries within the province; and nurses' belief that they were worth more money. In confronting these economic discrepancies and the inability to change them through existing avenues, unionization became an inviting alternative for Manitoba's nurses.

For Manitoba's nurses, achieving equitable and fair financial compensation for their work was a measure of increased recognition and respect within the work place. Accordingly, low salaries meant low value or low recognition and respect. Lack of recognition and respect of nurses created under-value and under-pay. Throckmorton and Kerfoot (1989) identify lack of recognition and respect within the work place as powerful factors which increase the risk of unionization among nurses. However, in increasing their recognition and respect within the work place, Manitoba's nurses first needed to be acknowledged.

Obtaining a voice was a major factor in the unionization of Manitoba's nurses. Prior to unionization, nurses had limited input or control over their working environment. Pross (1986) states that to have a say, you have to have a voice. In order to change their current conditions, nurses had to have a voice which was heard.

Raab (1985) and Zwarun (1984) state that nurses are demanding an equal adult voice and beginning to speak out. According to Baumgart and Larsen (1988), as well as Jensen (1988) and Stern (1982), unionization is one method for nurses to obtain a voice. For Manitoba's nurses, unionization offered a powerful voice whereby nurses could change their employment conditions, including salary, and begin to gain recognition and respect within the work place.

Working Conditions

Working conditions were a major consideration in the unionization of Manitoba's nurses. The work place issues which influenced nurses' unionization were management treatment, job security, staff scheduling, communication, and grievance procedure. Professional concerns such as quality of care, staff coverage, continuing education, technological change, evaluations, and unionism were dependent upon the work environment. Through unionization, Manitoba's nurses could acquire input into their working conditions. With increased input, changes to the working environment could be created.

The strong influence of work place concerns upon nurses' unionization in Manitoba reflects the positions of Hacker (1976), McConnell (1982), Metzger (1980) Mulchay and Rader (1980), and Schanie (1984). Several additional studies identify the impact of work conditions upon unionization. Schultz (1987) identifies quality of work-life, lack of job flexibility and heavy workloads as significant employee concerns which precipitate unionization. Brett (1980), Getman et al. (1976) and Hamner and Smith (1978) found that unionization was higher among employees who liked the content of their work but not the conditions under which they were required to perform their work. Holley and Jennings (1984) state that initial interest in unionization is based upon employee dissatisfaction with some work related condition, coupled with the belief that the situation cannot be changed.

Working conditions appeared to be an important objective of collective bargaining among nurses in Manitoba. According to a position paper released by the PSNC which ranked the collective bargaining concerns of nurses in Manitoba, conditions of work were second to communication and economic issues were third ("Collective Bargaining," 1974). This ranking order is supported by Roberts et al. (1985) who found that work conditions

elicited a higher rate of union interest among hospital employees than economic concerns.

Manager's Influence

Unfavourable treatment by managers or supervisors was identified as a cause of unionization among nurses in Manitoba. Specific management related concerns were controversy over hiring practices, awarding promotions, job security, scheduling, communication, and grievance procedures. Unionization was a reactionary process which was precipitated by inconsistent or unfair management treatment.

Inconsistent hiring practices and favouritism were considerations in the unionization of Manitoba's nurses. Rakich (1973) and Salutin (1986) identify anger over favouritism, blocked promotional mobility and unwarranted promotions as significant factors in employee unionization. Union representation made managers accountable for their actions. Beletz (1980) found that 61% of nurses believed that unionization ensured protection against arbitrary management actions. As a result of collective bargaining by Manitoba's nurses, seniority became the basis for many management decisions, such as vacation requests and

scheduling. In addition, the length of continuous service or seniority of employees became the method of determining promotions ("Collective Agreement," 1975). Schanie (1984) and Throckmorton and Kerfoot (1989) state that interest in unionization occurs when employees believe that fairness is absent. Lack of seniority and inconsistent management performance were identified by Hacker (1976) as factors in employee unionization. Concerned about management decisions that appeared to be determined by favouritism, Manitoba's nurses considered collective bargaining an effective method of achieving fair and impartial management treatment.

Union action among Manitoba's nurses was precipitated by administrative members who appeared to be more concerned with balancing the budget than with employee satisfaction or quality of patient care. Within these facilities, consideration of staff concerns was minimal. Lockhart and Werther (1980) state that collective action is not necessary when employees believe that there is responsive management. The authors also contend that unionization among employees is caused by management treatment of personnel more than any other element in the organizational setting. Stanton (1974) maintains that organizations which are well-managed, perceptive and progressive decrease employee interest in unionization. Rakich (1973) suggests

that administration's lack of perception and response to the legitimate needs of the employees causes union action.

A change in management personnel was a further consideration in the unionization of Manitoba's nurses. A negotiated contract with the employer was viewed as valuable and constant insurance for employees in the event of a new manager or supervisor. The protection of a collective agreement was considered advantageous for workers when confronted with a new manager who did not possess strong human relations skills.

At four of the ten health care facilities, either the administration or a DON encouraged or supported nurses' unionization within the facility. These managers were credited with good staff rapport and concern about staff welfare. Nurses' unionization within these facilities was not in response to some negative action but rather a method of improving nurses' general welfare. Although not stated directly, there were comments which suggested that these managers were experiencing difficulties resolving problems or creating change within their work place, related either to their staff or their superiors.

Beyond what exact issues caused nurses to unionize, the involvement of Directors of Nursing and staff nurses displays a willingness among Manitoba's nurses to work

together in order to change existing employment conditions. In initiating such change and increasing the probability of success, alliances were formed among nurses of diverse employment and backgrounds. Within Manitoba, unionization and collective action for nurses originated with collective support among nurses.

Job Security

Unionization was a method of ensuring job security and protecting Manitoba's nurses from arbitrary dismissal practices. Hacker (1976), Rutsohn and Grimes (1977) and Werther and Lockhart (1976) identify lack of job security as an important consideration in the unionization of employees. Although brief in nature, a clause in the 1975 negotiated contract stated that management had the right to "discipline, suspend and discharge any nurse for just cause" ("Collective Agreement," 1975). With a collective agreement, dismissal of employees required "just cause" based upon valid reasons and comprehensive documentation.

Related to job security, the provision of maternity leaves was an additional concern which contributed to nurses' unionization in Manitoba. White (1990) identifies the provision of maternity leaves as a factor in the

unionization of female workers. Prior to nurses' unionization in Manitoba, extended leaves from work were not provided by employers and pregnancy meant termination of work. Return to work after pregnancy meant re-applying for employment. This method of handling extended leaves caused interruptions in pay scales, benefits, vacation entitlements, and seniority. Collective bargaining provided Manitoba's nurses with a maximum leave of absence of four months with the guarantee of the same occupational classification and the same step on the salary scale upon return to work ("Collective Agreement," 1975).

Scheduling

Hours of work and shift scheduling were factors which contributed to nurses' unionization in Manitoba. The common scheduling issues were: receiving the right vacation, rotating between two shifts instead of three, working shorter stretches and increasing the time off between shift changes. Scheduling inequities between full-time and part-time employees were additional considerations in nurses' unionization. Hopping (1976) and Rutsohn and Grimes (1977) state that inequitable shift rotations, poor job assignments as well as inconsistent and indefensible

scheduling contribute to the unionization of employees. Mulcahy and Rader (1980) suggest that the threat of unionization can be decreased by maintaining reasonable working schedules. Metzger (1980) contends that no control over scheduling by employees increases interest in unionization.

Early negotiated contracts addressed the scheduling and hours of work concerns of Manitoba's nurses. In 1971, the hours of work in a bi-weekly work period for a full-time nurse were set at a maximum of 77.5 ("Agreement Signed," 1971). Further negotiations resulted in a minimum of every third weekend off, rotations of either day and night shift or day and evening shift with the amount of time on nights or evenings not to exceed the amount on days ("Provincial Staff," 1973). In addition, the maximum amount of consecutive work days was limited to eight and a minimum of fifteen hours off between shifts was required ("Collective Agreement," 1975). Other negotiated clauses provided for nurses to work permanent evening or night shift and two week advance posting of shift schedules ("Collective Agreement," 1975). The classifications of full-time, part-time and casual work were defined within the contract, however, at that time, casual nurses were not covered by the collective agreement ("Collective

Agreement," 1975).

Despite the existence of a negotiated contract, scheduling disagreements still occurred between nurses and their employers. During one PSNC meeting, the members in attendance reviewed an attempt by a manager at one health care facility to increase the number of weekends worked by each nurse (PSNC minutes, February, 1971). Other concerns presented to the PSNC involved nurses not being allowed to work permanent night or evening shift (PSNC minutes, October, 1974)

At three of the ten facilities, scheduling was not a concern and not a consideration in nurses' unionization. In these instances, there were no problems with requests for changes to work schedules. The staff of these facilities were perceived as small in number, close and accommodating. At two of the three facilities, encouragement by supervisors had influenced unionization.

Communication

Ineffective communication with managers and supervisors was a factor in the unionization of Manitoba's nurses. The causes of ineffective communication with superiors varied. However, the common two causes of blocked

communication channels were: managers who would not listen to staff concerns; and managers who would listen and then not act on presented concerns. Throckmorton and Kerfoot (1989) suggest that the potential for unionization increases when the principles of open communication are perceived as absent. Rakich (1973) and Stanton (1974) state that lack of communication and ineffective channels of communication contribute heavily to employee interest in unionization. As a result of poor channels of communication, nurses believed that they had minimal input into the operation of the facility and no control over their work environment. Mulcahy and Rader (1980) and Throckmorton and Kerfoot (1989) contend that there is a low risk of unionization among employees if the work place has established two-way or upward and downward communication channels.

It appeared that harmonious staff relations required more than providing a courteous audience. The illusion of interest was not sufficient in appeasing concerns and staff members expected to see results or outcomes from their voiced concerns. Rutsohn and Grimes (1977) identify the lack of input into decision making as a factor which increases employee interest in unionization. Throckmorton and Kerfoot (1989) state that facilities which acknowledge

and utilize employee information in decisions will experience less union activity.

Unionization was considered an effective method of dealing with superiors who had differing communication skills. The common example was an ability to communicate with the DON and an inability to communicate with the administrator. This would appear to indicate either the importance staff members place upon the ability to communicate with all superiors or the importance of communicating with the most senior manager. The possibility of a supervisor blocking the dissemination of two-way information would support the ability of communicating with all of the superiors. As the most senior person within the organization potentially determines the final outcome of staff requests and suggestions for change, there is also support for the ability to communicate with the most senior individual. These possibilities would suggest that both considerations have merit. However, communicating with the administrator or most senior manager was presented as the more important communication factor which influenced nurses' unionization in Manitoba.

McConnell (1982) states that, as a result of weak organizational communication, often nobody at the top has any solid idea what is going on. Ineffective communication

hindered the identification and resolution of problems within the work place. In discussing how communication can influence unionization, Mulcahy and Rader (1980) state that weak organizational communication channels present the impression of seemingly uncaring management. Throckmorton and Kerfoot (1989) suggest that administrators who are unavailable, distant or aloof contribute to employee unionization.

Lack of communication with management was a concern voiced by nurses attending PSNC meetings (PSNC minutes, March, 1972; May, 1974). As stated by one nurse to a local newspaper, there was no provision for management and nurses to sit down and discuss matters of common concern unless there was collective bargaining ("Nurses Plan," 1972). Sullivan and Decker (1988) suggest that the chief advantage of collective bargaining is the opportunity it affords nurses to discuss work problems with the employer.

In confronting the lack of communication regarding work place concerns, the creation of staff management committees was negotiated into the early collective agreements ("Provincial Staff," 1973). Within each facility, the staff management committee was comprised of equal representation of staff and management personnel. Meetings occurred at the request of either party with no

more than one per month ("Collective Agreement," 1975). There was no provision for a minimum number of meetings per year. In recognizing how important communication was to nurses, the PSNC suggested that the creation of staff-management committees was potentially the greatest benefit of collective bargaining ("Collective Bargaining," 1974).

At three of the ten health care facilities, communication was not a problem and did not influence nurses' unionization. Within these work places, managers promoted good staff rapport, were readily accessible and easily approachable. These were the same three facilities with perceived small staff compliments and no scheduling problems.

Grievance Procedure

Lack of an effective grievance procedure within the work place influenced nurses' unionization in Manitoba. Hacker (1976) and Hopping (1976) state that grievance procedures are important to employees and that ineffective or non-existent grievance procedures can precipitate unionization. Claiming that all employees need someone to go to with their problems, Mulcahy and Rader (1980) believe that obtaining a formal grievance procedure is the primary

motive in the unionization of some employees. With unionization and a collectively bargained contract, Manitoba's nurses obtained a formal grievance procedure ("Collective Agreement," 1975).

In three instances, informal grievance or complaint procedures existed within the health care organization prior to unionization and unionization did not occur in order to achieve a structured forum for handling problems. The existing procedures were considered successful in producing satisfactory results. These were the same three facilities where scheduling and communication had not been a problem or a factor in unionization.

Professional Issues

The influence of professional concerns upon nurses' unionization in Manitoba varied. Standards of care, staff coverage, heavy workloads, and safe patient care were professional concerns which contributed to nurses' unionization in some health care facilities. However, professional concerns were not a major influence upon unionization in the urban facilities which were perceived as small as well as the rural facilities. The impact of professional concerns upon nurses' unionization in Manitoba

did not completely support Metzger's (1980) suggestion that professional standards and concerns among nurses often overshadow wages and benefits. Continuing education, staff evaluations and orientation had minimal effect upon unionization. Technological change did not appear to significantly contribute to unionization among Manitoba's nurses. Rakich's (1973) suggestion that advances in technology result in higher skilled personnel who expect higher wages and consider unionization in order to increase salaries was not supported by Manitoba's nurses. The variance in how professional concerns influenced nurses' unionization in Manitoba may be explained through Kleingartner's (1973) expansion of bargaining hypothesis which states that professional concerns begin to surface after a union has been in existence for a number of years.

Patient Care

Safe patient care and heavy patient workloads were considerations in the unionization of Manitoba's nurses. Among the patient care concerns of Manitoba's nurses were too few nurses responsible for too many patients and nurses responsible for too many patient care areas such as charge duty along with the nursery and/or emergency. These

extensive responsibilities were considered detrimental to safe patient care. Rowsell (1967) states that nurses have grown disenchanted with increased workloads and poor working conditions in hospitals and their effect upon patient care.

Patient care concerns were dependent upon professional standards of care and the degree of professional obligation to the patient. Contra (1972) states that the employment setting prevents nurses from providing the service they know a competent and responsible professional is obligated to deliver. Input into the quality of patient care delivered was important to nurses. Beletz (1982) suggests that the formal mechanisms of collective bargaining provide professional employees with a voice in determining the conditions of their practice. Herzog (1980) contends that unionism provides nurses with a voice in nursing assignments, increased participation in continuing education and control over replacing nurses with paraprofessionals.

Within the work place setting, collective bargaining was perceived by Manitoba's nurses as an effective method of satisfying professional standards. Although professional standards for nurses were set by the provincial association, Manitoba's nurses required an additional

source of strength within the work place in order to address the conditions in which they were expected to satisfy their professional obligation to the patient. Collective bargaining became the perceived method of changing the work place conditions which prevented Manitoba's nurses from fulfilling their professional standards; and, as a result of the 1973 Supreme Court ruling which prevented collective bargaining by provincial nursing associations, unionization became the only remaining alternative for nurses who wished to confront their professional concerns by collectively bargaining with their employer.

Professionalism and Unionism

Concern regarding the compatibility of unionism and professionalism varied among Manitoba's nurses. While there was some resistance among nurses regarding union membership, the prevailing position was one of acceptance. Acceptance of unionism for Manitoba's nurses was increased by disenchantment with existing conditions and the desire for change. The acceptance of unionism for Manitoba's nurses is supported in Lee's (1982) findings that indicate that 59% of nurses do not believe that there is a conflict

between unionism and professionalism. Within Manitoba, resistance to collective bargaining by nurses appeared to be lessened through the early involvement of the professional association. In addition, encouragement by the Director of Nursing or other supervisory members appeared to promote credibility in unionization and decrease concerns of unionism violating nurses' professional status.

Collective bargaining was perceived by Manitoba' nurses as an effective method of obtaining and maintaining professional status. Herzog (1980) and Jacox (1980) state that collective bargaining increases professionalism. For nurses, strengthening professional status and satisfying professional obligation was synonymous with having input into the quality of patient care provided. Miller (1980) states that nurses' ability to acquire an influential voice in patient care policies is at the heart of professionalism. Collective bargaining became a successful means of determining patient care and maintaining professional standards. Contra (1972) suggests that unionism provides nurses with a voice in establishing policies that affect both employment and practice.

Obtaining input into patient care and control over practice were serious professional considerations for Manitoba's nurses. Cleland (1975), Jacox (1971) and Miller

(1980) suggest that unionization is a method for professional nurses to regain control over practice. Baumgart (1983) states that unionism provides nurses with active participation within the employment setting and control over practice.

Use of the word "union" was a controversial issue for nurses in Manitoba. Much of this controversy appeared to be related to unionism among blue-collar workers. Badgley (1978), Conroy and Hibberd (1983), and Jacox (1971) suggest that widespread use of collective bargaining among blue-collar workers has been a strong motivator in nurses' aversion to unionism. Nurses appeared to define their own professional distinction in relation to blue-collar workers and labourers which in turn created an aversion to the term "union." Stanton (1974) states that as union membership has been viewed as unprofessional and undignified, professional and white-collar employees have considered themselves above a union.

Related to unionization, the issue of strike was a serious consideration for Manitoba's nurses. Lindabury (1968) states that strike was a major repellent in the unionization of nurses. Striking was not perceived to be compatible with nurses' professional obligation and duty to the patient. Conroy and Hibberd (1983) and Douglas (1981)

state that striking has been considered incompatible with the ideals and image of a helping profession. Within Manitoba, resolution of nurses' discomfort with striking varied. In some instances, no-strike policies were adopted. In others, strike was deemed the final demonstration of solidarity, disenchantment with current conditions and the need for change.

Societal Influence

The prevailing societal perception of women's limited contribution to the work force was a factor in the unionization of Manitoba's nurses. At the time, women's work was considered less important to society than men's work. For women and nurses, standing up and being heard was a major internal and external struggle which hindered the ability to change the working environment. Eldridge and Levi (1982) state that the fact that most nurses are women has been a factor in the failure to achieve significant gains and change for the profession. Motivated by the Women's movement, women and nurses began to pursue their rights. For nurses, unionization became an additional resource for creating change and obtaining fair and equal

treatment.

Women's Roles

Unionization was the vehicle by which Manitoba's nurses could begin to change the traditional societal perception of women as docile, amicable individuals who would work for less money and were not interested in having input into work place decisions. Coburn (1974) identifies devotion, passiveness and servitude as common attributes which characterize nurses. Grand (1971) describes nurses as feminine, motherly, devoted, willing to make sacrifices, and more concerned about patient care than financial compensation. Unionization offered an effective solution by which nurses could begin to eliminate a long-standing societal perception of servitude and obedience.

Supporting Douglas' (1981) statements, Manitoba's nurses encountered many of the common beliefs regarding the instability of women and nurses in the work force. These beliefs were: nurses frequently enter and leave the profession due to family responsibilities, nurses work in order to supplement a husband's income and nurses enter the profession for short periods of time. Baumgart and Larsen (1988) and White (1990) identify increasing numbers of sole

income families and low family incomes as common socioeconomic factors which have increased the number of women in the work force. These changing trends necessitated higher earning power for women and nurses. Among the conditions which influenced Manitoba's nurses were increased numbers of sole-support families and lifestyles which required two worthwhile incomes.

As well as earning less money than other workers, female nurses made less money than their male counterparts. In 1974, female nurses were averaging $6473 per year, while male nurses were averaging $6664 per year ("Women In," 1975). Intent upon changing existing conditions and achieving financial equality with their male counterparts, unionization became the action of an oppressed group which finally rebelled.

Expanding Job Opportunities for Women

Increasing job opportunities for women related to the Women's movement did not influence nurses' unionization in Manitoba. Loss of women and potential nurses to other professions or careers which had traditionally been considered male-dominated was not a common occurrence at the time of nurses' unionization in Manitoba. This does not

support Schultz (1987) and Simms and Dalston (1984) who suggest that nursing recruitment suffered as women had more career options. These varying positions may be due to perspectives which relate to different periods of time.

Conflict

The impact of work place conflict upon nurses' unionization in Manitoba varied. While work place conflict was not readily apparent in some facilities, dissatisfaction with existing problem solving methods and the need for change was evident in all of the facilities. Lewis (1976) and Robbins (1974) identify effective problem solving as an important component in handling conflict. For Manitoba's nurses, work place problems regarding salaries, working conditions and professional concerns had not been effectively handled or resolved through existing organizational channels. Unionization became the perceived solution for nurses' work related problems.

Where effective channels of communication existed and staff compliments were perceived as small, the influence of work place conflict upon unionization was believed to be minimal. This would suggest that either open communication

compensated for the existence of conflict or that effective communication resolved conflict. Lewis (1976) and Thurkettle and Jones (1978) suggest that communication is an important ingredient in dealing with and resolving conflict. Kramer and Schmalenberg (1976) state that the chief concern in handling conflict is to get the problem out in the open so that it can be dealt with. Effective communication appeared to decrease the degree of conflict the staff nurses experienced within the work place.

In instances where supervisors encouraged unionization, the existence of work place conflict was considered minimal. These supervisors were credited with such qualities as good staff rapport and strong communication skills. These supervisor attributes appeared to lessen the conflict experienced by the staff nurses. However, conflict may still have been a factor in the unionization of these nurses. In the facilities where the supervisors encouraged nurses' unionization, it appears that conflict did exist at the DON and management level and that the unionization of the staff was deemed an appropriate method of confronting the conflict and creating necessary change.

There was evidence of instances where work place conflict definitely influenced nurses' unionization. This

conflict was compatible with Scalzi and Nazarey's (1989) and Rahim's (1986) suggestion that conflict exists when two parties disagree or differ in regard to facts, beliefs or values. As stated by McConnell (1984) and Schanie (1984), perceived discrepancies, unmet expectations and controversial decisions were evident in the history of unionization among these nurses. Stern (1982) states that nurses have only recently considered collective bargaining as a viable alternative for resolving conflict between themselves and the hospital administration.

The historical perspective of unionization among Manitoba's nurses revealed a conflict process which is compatible with the stages of Sexton's modified conflict model. The stages of Sexton's modified conflict model are: triggering events, perceived discrepancy, behaviour or reaction, confrontation, and consequences. For Manitoba's nurses the triggering events were the economic conditions, working conditions, professional issues and societal conditions which existed prior to unionization. Manitoba's nurses perceived a discrepancy between what employment conditions actually existed and what employment conditions they believed should exist. Their reaction or behaviour was the recognized need to change their existing conditions in order to diminish the perceived discrepancy. The

confrontation stage involved nurses presenting their concerns to their employers with the intention of obtaining a solution to the perceived discrepancies within the work environment. The outcomes or consequences of the confrontation stage were dependent upon how satisfied the nurses were with proposed solutions to the perceived discrepancies. Within this stage, nurses' realized the increased effectiveness of a collective voice versus individual action. Without satisfactory outcomes to the perceived discrepancies which were presented, unionization became the perceived solution for Manitoba's nurses to effectively correct the inadequacies and create change.

The perception of unsatisfactory solutions to work place problems and the need for change were conflict related concerns which contributed to unionization among nurses in Manitoba. Robbins (1974) and Thurkettle and Jones (1987) suggest that conflict can be a natural and essential element which signals the need for change. For nurses, union representation offered the potential for achieving satisfactory resolution of work place problems related to salaries, working conditions and patient care. Stern (1982) states that union representation provides nurses with some sense of control in terms of their future economic and professional existence with their employers. In achieving a

sense of control and the ability to solve work place problems, unionization was a powerful voice for nurses which was difficult to ignore.

Summary

Prior to unionization, Manitoba's nurses experienced a variety of inequities and inconsistencies related to their working environment. These inequities involved wage disparities, unfavourable working conditions, unmet professional expectations, and lack of input into work place issues. Disillusioned with existing organizational channels which had produced minimal resolution of their concerns and change to their situation, Manitoba's nurses considered alternative methods of solving their existing problems. In obtaining significant input into work place issues and creating the desired change, nurses in Manitoba believed that the collective voice of unionism was the most advantageous alternative.

Implications for Nursing

The findings of this research revealed several unionization factors which may be of value within the realms of nursing education, nursing practice and nursing research. These implications involve the conditions which appear to be important to nurses within the employee-employer working relationship.

Nursing Education

Familiarity with the factors which cause nurses to unionize would permit nurse educators to include the following areas in the preparation of future nurses and potential nurse managers, who may or may not be union members:

1. Educational preparation which identifies the responsibilities, obligations and rights of nurses as employees.
2. Educational content which examines the variety of work place conditions which nurses may encounter as employees, as well as acceptable methods of adaptation or change regarding these work conditions.

3. Related to professionalism, educational content could include information which emphasizes the importance of effective communication within the work place, nurses as contributors to the work place, and the value of nurses' input into patient care and work place decisions.
4. Educational preparation which recounts the historical perspective of nurses' professional status and the unionization of nurses.

Nursing Practice

Within the practice of nursing, the factors of unionization suggest the following considerations:

1. Nurses' recognition of their own value and contribution to the work place. In addition, the need for increased awareness among nurses regarding their potential for input into the work place related to patient care and work conditions.
2. Nurses' realization of the value of effective work place communication in solving problems related to the work place and patient care.
3. Nurses' realization of their potential for changing existing conditions, either through unionization or

effective collective action within their work place.

It appears that nurses in Manitoba are beginning to realize their value and increasing role as employees within the work place; however, there are several strategies which may promote further understanding among nurses of their value and contribution to health care within this province. Such strategies would include:

1. The promotion of nurses' value within the work place by existing nursing groups and nurses' employers.
2. Ungoing information for nurses which identifies the value of the nurse in the work place.
3. Reinforcement of nurses' value to the work place through management techniques which encourage and acknowledge nurses' participation in decisions affecting nurses and patient care.

Nursing Research

The history of unionization among nurses in Manitoba revealed several potential areas of inquiry related to nurses and unions. These potential areas of nursing research are:

1. An examination of the historical perspective and causes of unionization among other groups of nurses, both within Manitoba and other provinces. Unionized federally employed nurses and nurse educators would be other potential groups which could be studied.
2. An investigation of the impact of political, economic, health care, and nursing practice trends upon the unionization of nurses.
3. An examination of the impact of work place communication and conflict management upon nurses' unionization.
4. An investigation of how the various management styles and managers' perception of unions influence unionization among nurses.
5. A comparison of existing unionized and non-unionized nurses' groups with the identification of possible differences between the two groups.
6. An examination of what factors have influenced the unionization of recently organized groups of nurses.
7. An examination of the impact of nurses' increased educational preparation upon nurses' unionization and future negotiating issues.

Recommendations Regarding Nurses and Their Working Environment

Based on the findings of this research which investigated the history of nurses' unionization in Manitoba, there are several recommendations for nursing managers, nurses' unions and nurses themselves. These recommendations are:

1. The need for managers to understand the importance of developing strong nursing staff relations and to realize the impact and consequences of unfavourable working conditions.
2. Managers should recognize the importance of effective communication within the work place. In addressing the significance of communication, managers need to establish and encourage strong lines of communication which utilize nurses' suggestions in work place decisions.
3. Once lines of communication have been established, nurses and employers need to recognize their commitment to maintaining effective channels of communication which produce solutions to work place problems.

4. While the image of the Manitoba's Nurses' Union may be negatively influenced by the issue of strike, the conditions of nurses' work prior to unionization and what changes nurses have achieved through unionization must not be forgotten or minimized.
5. Nurses' unions must continue to recognize and reinforce their role as facilitators of increased communication between nurses and their employers. In addition, the role of nurses' unions as facilitators of change for nurses should be encouraged.
6. Nurses themselves should understand that, while they have professional and work place obligations, they still have rights and expectations regarding their salaries and work conditions which should be satisfied. In instances where these rights or expectations may be limited or absent, nurses need to recognize their potential for correcting or changing their conditions. Among the possible methods for nurses to create change within the work place is unionization.

CHAPTER SIX

SUMMARY AND CONCLUSIONS

Although the reasons why employees consider unionization are diverse and personal, commonalties do exist. Related to nurses in Manitoba, the common factors or triggering events of unionization were low wages, wage disparities, inconsistent or unfavourable management treatment, unmet professional expectations and changing women's roles. Continued conflict or ineffective problem resolution regarding these common factors initiated nurses' interest in unionization as a means of confronting and changing existing conditions.

Unionization for Manitoba's nurses appears to have been the result of perceived discrepancies regarding economic conditions, work conditions, professional concerns and societal issues; the inability to correct these discrepancies; and the need for a powerful voice whereby these discrepancies could be confronted and changed. In changing their conditions and alleviating the perceived discrepancies, nurses considered effective communication a critical component. Unionization for nurses in Manitoba became a method of obtaining a voice and promoting meaningful communication with employers.

Nurses' unionization in Manitoba was the result of a

process which is compatible with Sexton's conflict model. The stages of Sexton's modified conflict model are: triggering events, perceived discrepancy, behaviour or reaction, confrontation and outcomes or consequences. The progressive events which contributed to the unionization of Manitoba's nurses were: the reality of what conditions actually existed for nurses; the conditions that nurses believed should exist; the realization of the need for change; the inability to change existing conditions through work place channels; and, the necessity of obtaining a voice and meaningful communication in order to change existing conditions. This process culminated with the recognition of union representation as a viable method for nurses to achieve a voice and/or create change.

As suggested in currently accepted conflict theories, the need for open communication and the need for change are major components of work place conflict. These two elements were also evident in the unionization of Manitoba's nurses. This would indicate that, to varying degrees and at differing staff levels, conflict and ineffective problem solving methods within the work place contributed heavily to the unionization of Manitoba's nurses from 1970 to 1976.

While the need for a voice and meaningful work place communication has been identified as a major cause of

unionization among Manitoba's nurses, the existence of open communication within the work place did not appear to eliminate the possibility of nurses seeking union representation. In instances where effective communication existed, unionization was not a reactionary process to some long-standing negative stimulus such as unfavourable management treatment of staff nurses and the need to be heard. Unionization for these nurses was encouraged by management and occurred primarily for the purpose of creating change, the intended result of which was the improvement of nurses' welfare in general. In these instances, the ensuing relationship between management and unionized staff nurses was considered positive, compatible and productive.

There appears to be a strong relationship between effective work place communication and the perception of small staff compliments. Where staff numbers were perceived as small, effective communication was present. As the actual size of the staff compliments considered small ranged from twenty to one hundred and fifty registered nurses, there was no differentiation of urban and rural facilities. Of interest and worthy of further investigation would be the determination of whether the perception of staff numbers as small promotes effective communication or

if open communication creates the perception of smallness and closeness among staff members.

The initiation of unionization for nurses in Manitoba was a major occurrence in the history of Manitoba's nursing profession. Frequently overshadowed by the bargaining issues which exist at the time of contract negotiations, the significance and historical perspective of unionization among Manitoba's nurses often do not receive the understanding or appreciation they deserve. The documentation and examination of the events and experiences which precipitated nurses' unionization in Manitoba contributes to the identification, understanding and appreciation of what work place issues have been important to nurses in the past. Those concerns which have not been satisfactorily addressed or corrected will continue to influence the unionization of Manitoba's nurses and the content of future contract negotiations.

This study examined how the causes of unionization frequently identified in the literature influenced the unionization of nurses in Manitoba. Those factors which contributed to the unionization of Manitoba's nurses were: low wages, poor working conditions, professional issues, societal change, and work place conflict. Those factors which slightly influenced nurses' unionization in Manitoba

were: technological change, staff evaluation, continuing education, and orientation. Those factors which did not influence the unionization of Manitoba's nurses were: expanding job opportunities for women and the unionization of other workers.

Further to identifying precipitating conditions, this study has revealed several interactive components which contributed to the unionization of Manitoba's nurses. These components were: the quality of work place communication, the existence of disparities or inequities, the reaction to perceived discrepancies, the influence of communication upon the perception of "smallness" of staff numbers, the support of managers, the existence of conflict within the work place, and nurses' need for a voice. This study also revealed one obvious but often unheralded characteristic of nurses in Manitoba. Commonly recognized as the basic foundation of unionization, but not always attributed to nurses, this characteristic is collective action. In reacting to their conditions of work and identifying the need for a voice, Manitoba's nurses began to work together in order to create change. Seeking union representation, standing together collectively and speaking out about what issues concerned them, Manitoba's nurses began to exercise their collective power in order to change existing

conditions.

The identification and examination of the preliminary unionization factors among nurses in Manitoba reveals several additional areas of interest regarding current and future causes of nurses' unionization. In expanding upon the early causes of nurses unionization, it would be significant to determine if the same factors are influencing the unionization of nurses today. Identification of current causes of nurses' unionization would provide further evidence regarding the triggering events of economic conditions, working conditions, professional issues, and societal influence, as well as the impact of work place conflict involving the quality of communication and the need for change. In addition, the identification of the causes of unionization among nurses today would reveal any new concerns or issues which have become important to nurses in Manitoba. Only through further investigation of nurses' unionization can it be truly determined if the current and future causes of nurses' unionization are similar to the past experiences of the nurses who, from 1970 to 1976, initiated the unionization of Manitoba's nurses.

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Research Questions Applied to Conceptual Framework

A Research Questions (Triggering Events)	B Existing Conditions	C Interactive Forces	D Perceived Discrepancy between B & C	E Method of Conflict Management	F Outcome
1. Social Factors	Job opportunities Status of women Nursing shortage	Women in work force Career competition	Yes/No	Satisfactory/ Not satisfactory	Dissipation/ Further action
2. Economic Factors	Salaries Benefits Inflation	Value to work place Self-worth	Yes/No	Satisfactory/ Not satisfactory	Dissipation/ Further action
3. Environmental Concerns -Work conditions	New technology Work situation Management treatment	Contribution to work place Patient care	Yes/No	Satisfactory/ Not satisfactory	Dissipation/ Further action
4. Professional Concerns	Inservice Orientation Quality of care Standards	Career Patient care Self-perception	Yes/No	Satisfactory/ Not satisfactory	Dissipation/ Further action
5. Conflict Management	Methods of handling concerns Problem solving effectiveness	Work place atmosphere Reaction to situation	Yes/No	Satisfactory/ Not satisfactory	Dissipation/ Further action

Appendix B

Mail Letter for Potential Participants

My name is Sue Richmond. I am a Registered Nurse and a student in the Master of Nursing program at the University of Manitoba. As part of my nursing program, I am conducting a study of nurses' unionization in Manitoba.

In order to gather information on the topic of nurses' unionization, I would like to interview individuals who were instrumental in and experienced the creation of Manitoba's nurses' union. As a result my review of the MONA records related to the development of Manitoba's nurses' union, I believe that you would be a valuable source of information and a potential participant for my study.

The decision to participate in this study is entirely yours. You may withdraw from the study at any time. If you agree to contribute to my study, your interview will be no longer than two hours and arranged for a day and time that is convenient to you. I will ask you for your remembrances regarding the creation of Manitoba's nursing union.

I will contact you by telephone in approximately one week's time to hear your decision about participating in this study.

Thank you for your time and attention.

Appendix C

Consent Form for Oral History Participants

This to certify that I, _____, agree to participate in the history of the Manitoba nurses' union study conducted by Sue Richmond. I have been told that Ms. Richmond is a Master of Nursing student at the University of Manitoba. I have heard the explanation of the study and have read the attached description. My participation is voluntary and will entail a minimum of one hour to a total of three hours interview time. I understand that these interviews will be recorded and that I may choose to exclude certain taped statements from use in the study.

I have had the opportunity to ask questions and have received satisfactory answers. I understand that I may ask Sue Richmond further questions should they arise, at any time.

I understand that all information pertaining to my participation will be identified by code number and that the data and my identity will remain confidential. I understand that the information may be published but that my name will not be associated with the research. I understand that upon completion of the study, all the notes will be destroyed and tapes erased.

I understand that I may receive a copy of the results of this study upon request.

Exclusions and/or restrictions to consent (if any):

_____

_____

_____

Signature of Participant: _____

Signature of Interviewer: _____

Date: _____

If you wish to receive a copy of the results of the study, please print in your name and address below:

Name: _____

Address: _____

Appendix D

Explanatory Statement for Participants in Study on the History of the Manitoba Nurses' Union

My name is Sue Richmond. I am a Registered Nurse and a student in the Master of Nursing program at the University of Manitoba. As part of my nursing program, I am conducting a study of nurses' unionization in Manitoba.

In order to gather information on the topic of nurses' unionization, I would like to interview individuals who were instrumental in and experienced the creation of Manitoba's nurses' union. As a result of my review of the MONA records related to the development of Manitoba's nurses' union, I believe that you would be a valuable source of information for my study.

Your interview will be no longer than two hours and arranged for a day and time that is convenient to you. With your permission, the interview will be taped. I will ask you for your remembrances regarding the creation of Manitoba's nursing union.

Prior to the interview, I will ask you to sign a consent form which will allow me to use the information contained on the tapes in my study. Upon your request, stipulated recorded statements will be excluded from use in this study. Identification of all tapes and written materials related to your interview will be by code number, not by name.

In agreeing to contribute to this project, you can be assured of anonymity. Your tape-recorded interview will be stored in a locked container until the completion of this study. Upon the completion of this study, all tapes and written materials related to your interview will be destroyed. Your name will not be used on written notes or in any public report of this study.

I will be pleased to answer any questions or concerns that you may have about this study. I can be reached at 1-743-2226, collect. If you would like to speak with my study advisor, Professor Christina Gow, you can call her at the School of Nursing, University of Manitoba (474-8297). If you wish, for further reference, this letter is yours to keep.

Thank you very much for your participation and valuable contribution to my study.

Appendix E

Questions Utilized in the Oral History Interviews

1. How did social factors influence unionization? (e.g., Women's movement, other career opportunities).

2. How did economic factors influence unionization? (e.g., salaries, benefits).

3. How did environmental factors influence unionization?
(e.g., work conditions, management treatment).

4. How did professional concerns influence unionization?
(e.g., patient care, inservice education, orientation).

5. How did conflict and methods of conflict management related to nurses' concerns influence unionization?

6. Were there any other important contributing factors to nurses' unionization which we have not discussed?