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AN ANALYSIS OF CONFLICTS EXPERIENCED BY NURSES 
DURING THE 1989 NURSES' STRIKE

by

Georgina Dingwell

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF 
THE REQUIREMENT FOR THE DEGREE OF 
MASTER OF EDUCATION 
in the Faculty 
of 
Education

C Georgina Dingwell, R.N. 1991 
SIMON FRASER UNIVERSITY 
August 1991

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ABSTRACT

The purpose of this study was to examine the issues that caused unionized nurses in British Columbia in 1989 to take job action (which included striking) and to explore the nature of conflicts that nurses experienced before, during, and after job action. Similarly, nurse administrators were also studied after job action to explore their opinions on the issues and on some of the conflicts administrators experienced during the job action.

The study was carried out between March 1989, before a strike vote was taken and continued throughout the job action until October, 1989 after the strike was settled. The study included interviews with over 500 nurses throughout the whole job action. A questionnaire was distributed post strike to 680 unionized nurses. Seventy-seven per cent of the questionnaires were returned completed.

The study found that nurses chose striking as a way to send a message that nurses had serious professional concerns. Nurses especially wished to be recognized and valued within the health care system. Money was a lesser issue.

The study outlined reasons why nurses were critical
with the way their union executed the job action to the extent that they rejected a contract offer recommended by their union. Other study findings that were cause for reflection included conflicts surrounding professionalism and unionism, gender-related issues, nurse-employer relationships and nurse-physician relationships.

The impact of labor strife in nursing can be profound and devastating to the health care system, since nurses are the largest group of health care professionals and since they provide direct care to patients. This study shows the need for governments, unions, professional associations, physicians and employers to identify and explore contentious issues with nurses and to find ways to resolve areas of conflict.
DEDICATION

To the nurses of British Columbia who were courageous and who taught me a new perspective on caring.

To Norman Robinson who was patient and who taught me about new possibilities.

To Don who was also patient and who taught me about doing what you have to do.
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CHAPTER 1

THE PROBLEM

Introduction

In British Columbia, nurses avoided using the strike weapon until 1989. On May 17, 1989 however, nurses in British Columbia voted overwhelmingly (94%) in favour of striking. Subsequently, nurses began strike action in which hospital nurses withdrew all except essential nursing services. Seventeen days into the strike, a settlement was negotiated by an elected union bargaining committee. The settlement was highly touted by union executive, staff, senior labour officials, the business community and government. Yet, rank and file nurses were disgruntled with the settlement. Nurses publicly agonized, protested and organized into "Vote Yes" and "Vote No" factions. Dissident nurses championed a province wide campaign to reject the negotiated offer stating that "the package was not attractive enough to solve the critical nursing shortage and improve the health care system". The settlement offer was strongly rejected by the membership despite union officials' efforts to encourage nurses to support the offer and despite increasing fear of government intervention.
A confused public watched and attempted to understand and to support nurses while the health care system limped along without full nursing service until mid-August when binding arbitration ended job action.

The purpose of this study was to examine issues which brought nurses to job action and conflicts which nurses experienced related to that job action. The study was divided into three phases: pre-strike phase, job action phase (including striking), and post-job action phase. Subproblems differed for each phase.

Pre-Strike Phase

Statement of the Problem

The purpose of this phase of the study was to explore what the nature of the issues were, how nurses anticipated voting and/or actually voted in terms of striking, the type of experience nurses had with strikes before, the feelings of conflict that nurses had related to the possibility of withdrawal of service, and generally how nurses felt about their union and their professional association.

There were subproblems which evolved from the main problems of issues and conflicts related to striking.

Pre-strike Subproblem 1.0 - The Issues

What were the issues for which nurses would/had vote(d) to strike?
Pre-strike Subproblem 2.0 - HLRA Settlement
Did nurses anticipate a settlement by HLRA without having to strike?

Pre-strike Subproblem 3.0 - Previous Experience with Strikes
What were nurses' previous experiences with striking either personally or with family members?

Pre-strike Subproblem 4.0 - The Strike Vote
Would/did nurses vote to strike?

Pre-Strike Subproblem 5.0 - Anticipated Concerns
What concerns did nurses have in anticipation of strike action?

Pre-strike Subproblem 6.0 - Union Involvement
How much involvement did nurses have in the BCNU?

Pre-strike Subproblem 7.0 - Union Feelings
How did nurses feel about their union?
Pre-strike Subproblem 8.0 - Professional Association Involvement

How much involvement had nurses had with their professional association?

Pre-strike Subproblem 9.0 - Professional Association Feelings

How did nurses feel about their professional association?

Pre-strike Subproblem 10.0 - Relationship BCNU/RNABC

Did nurses feel that the BCNU and RNABC should work more closely together?

Pre-strike Subproblem 10.0 - Head nurses and Union Involvement

How did head nurses feel about the union and their role as a head nurse in potential strike action?

Job Action/Strike Phase

This phase occurred when nurses withdrew their services either through strike action or by refusing to carry out nonnursing duties and to work overtime. The job action phase occurred from June to August 1989.
Statement of the Problem

The main problem at that time focussed on the types of conflict nurses experienced while carrying out job action and maintaining essential services.

Post-Job Action Phase-Unionized Nurses

Statement of the Problem

This portion of the study occurred in the immediate post job action phase. The study analyzed how nurses felt about strike action; why a majority of unionized nurses were willing to vote for and to participate in strike action and to subsequently reject an offer which had been recommended by their union executive and bargaining committee. The study also explored conflicts that nurses experienced when involved in a labour dispute that involved withdrawal of patient care service, yet maintenance of what was designated as "essential service".

Since the main problem focussed on issues and conflict, a myriad of subproblems arose from the study's main problem.

Post-Job Action Subproblem 1.0 - Nurses and Striking

To what extent did nurses feel they should have the right to strike?
Post-Job Action Subproblem 2.0 - The Strike Issues

To what extent:

2.1 did nurses feel that this strike was about wages;

2.2 did nurses feel the strike was a message to government about recognition of value of nursing?

Post-Job Action Subproblem 3.0 - Striking and Professionalism

To what extent:

3.1 were nurses concerned about public opinion;

3.2 did nurses feel that the public were supportive during the strike;

3.3 did nurses believe that there were more important matters for nurses to be concerned with than public image;

3.4 did nurses believe that the strike tarnished the professional image of the nurse;

3.5 did nurses have the impression that nurses on the picket line dressed and acted unprofessionally;
Post-Job Action Subproblem 4.0 - The Professional Association

To what extent:

4.1 were unionized nurses involved in their professional association before the strike;
4.2 did nurses desire to have involvement in the professional association after the strike;
4.3 were nurses satisfied with the support of their professional association during job action;
4.4 did nurses feel that their union and professional association should work more closely together?

Post-Job Action Subproblem 5.0 - Nurses and their Union

To what extent did nurses:

5.1 have involvement in their union before the strike;
5.2 wish to have involvement after the strike;
5.3 feel that they did not want to become more involved in either the union or the professional association after the strike;
5.4 consider themselves to be trade unionists;
5.5 feel that the BCNU was justly criticized;
5.6 feel that the BCNU enlightened the public regarding the role of the nurse in health care;

5.7 did nurses feel satisfied with the way nurses were represented and informed by the union during the strike;

5.8 feel that they understood the decisionmaking process in the union;

5.9 feel satisfied with their union leadership;

5.10 feel satisfied with BCNU stewards' conduct during job action;

5.11 feel that nonnursing trade union leaders had a right to comment on nurses' contracts;

5.12 feel other unions were better prepared and informed than the BCNU;

5.13 feel that BCNU did not respect the trust of nurses;

5.14 feel that the BCNU was justly criticized?

Post-Job Action Subproblem 6.0 - Job Action and Conflict

To what extent:

6.1 did nurses feel that there was equitable shift sharing during the strike;
6.2 did nurses feel that they pushed themselves to the limit during the strike;
6.3 did nurses feel they adhered to job action;
6.4 did nurses feel upset that other nurses continued to carry out nonnursing duties;
6.5 did nurses feel that it was easier to do nonnursing duties than to ask others;
6.6 did nurses feel that other nurses watched to see if they broke union rules?

Post-Job Action Subproblem 7.0 - Post Job Action and the Negotiated Offer
7.1 What caused participants to vote "no" to reject the negotiated contract?
7.2 What caused participants to vote "yes" to accept the negotiated contract?
7.3 What best predicted how nurses would vote for the contract offer?
To what extent did nurses feel:
7.4 that BCNU should not have publicly recommended an offer without a vote;
7.5 that the Bargaining Committee should have done better with HLRA;
7.6 that BCNU needed more expert negotiators to do their bargaining for them;
7.7 that they gained confidence from the "no" campaign;

7.8 dissention within the union was a negative aspect of the strike?

Post-Job Action Subproblem 8.0 - Nurses and Gender

To what extent did nurses feel:

8.1 that trade unions were generally not attentive to women;

8.2 they considered themselves feminists?

8.3 that the occupational problems of nurses are related to those of women generally;

Post-Job Action Subproblem 9.0 - Nurses and Physicians

To what extent did nurses feel:

9.1 that physicians understood and respected nurses' issues and concerns;

9.2 that physicians were verbally supportive, but were not supportive in their actions during the strike;

9.3 that physicians who were financially affected by the strike were the least supportive to nurses?
**Post-Job Action Subproblem 10.0 Nurses and Their Employers**

To what extent did nurses feel:

10.1 that their administration worked with nurses to improve conditions;

10.2 that administration exploits nurses' commitment;

10.3 that administration was justified in their concern for patient safety;

10.4 it unfair that their employers receive privileges for strike work;

10.5 nurse administrators valued and respected nurses during the strike;

10.6 nurse administrators were more committed to the organization than to nurses;

10.7 committed to their employing hospital?

**Post-Job Action Subproblem 11.0 - Personal Conflict**

To what extent did nurses feel:

11.1 powerless and lacking control during job action;

11.2 that striking was a difficult moral decision;

11.3 they had become a more powerful group since the strike;
11.4 that meeting and talking with other nurses was a positive experience?

11.5 that they were uncomfortable being a source of conflict rather than one who resolves conflict?

Post-Job Action Subproblem 12.0 - Stress

Experienced by Nurses

During the strike to what extent did nurses feel stress related to:

12.1 decreased public service;
12.2 heavy workloads;
12.3 nonnursing duties;
12.4 picketing;
12.5 union disorganization;
12.6 uncertainty of strike time length;
12.7 decreased income;
12.8 conflicting expectations of employer and union;
12.9 collegial stress;
12.10 their family;
12.11 friends and social attitudes;
12.12 physicians' attitudes;
12.13 attitudes of hospital administration;
12.14 other unions;
12.15 back to work legislation?
Post-Job Action Subproblem 13.0 - Stress experienced by Head Nurses

During the strike to what extent did head nurses feel stress related to:

13.1 being declared "nonessential";

13.2 conflicting expectations between administration, union and their staff;

13.3 feeling ignored, disrespected by their union;

13.4 returning to direct patient care?

Post-Job Action Subproblem 14.0 - Head Nurses: and their Union contract

To what extent did head nurses wish to be out of union contract after the strike?

Post-Job Action Subproblem 15.0 - Demographic Data

15.1 To what extent did selected nurse characteristics relate to various issues and conflicts in nurses' job action?

15.2 To what extent did selected characteristics such as size and type of facility and region relate to various issues in job action?
Post-Job Action Subproblem 16.0 - Selected Characteristics and the Strike

16.0 How did selected demographic aspects relate to how nurses voted during the strike?
16.1 To what extent were there regional differences between nurses;
16.2 To what extent were there differences between nurses employed in different types of hospitals?

Post-Job Action Phase - Nurse Administrators

Statement of the Problem

The primary purpose for the study of nurse administrators was to gain their perspective on the nursing job action. There were several subproblems.

Post-Job Action Administrators Subproblem 1.0

What did nurse administrators believe were the issues for which unionized nurses took job action?

Post-Job Action Administrators Subproblem 2.0

How did nurse administrators view job action which included striking by unionized nurses?
Post-Job Action Administrators Subproblem 3.0
How did nurse administrators feel about unionized nurses' image during job action?

Post-Job Action Administrators Subproblem 4.0
Were nurse administrators concerned for public safety during job action?

Post-Job Action Administrators Subproblem 5.0
How did nurse administrators view their relationships with unionized nurses during job action?

Post-Job Action Administrators Subproblem 6.0
What were sources of stress experienced by nurse administrators during job action?

Post-Job Action Administrators Subproblem 7.0
How did nurse administrators feel about the BCNU during the strike?

Post-Job Action Administrators Subproblem 8.0
Did nurse administrators expect unionized nurses to reject the negotiated offer? If so, why? If not, why not?
Post-Job Action Administrators Subproblem 9.0
What gender issues were apparent to nurse administrators during job action?

Post-Job Action Administrators Subproblem 10.0
What effect did nurse administrators believe the dissention between nurses had?

Post-Job Action Administrators Subproblem 11.0
What impact did nurse administrators feel that the job action had on nonnursing administrators?

Post-Job Action Administrators Subproblem 12.0
How did nurse administrators feel about physician support and understanding of unionized nurses during job action?

Post-Job Action Administrators Subproblem 13.0
How did nurse administrators view the RNABC during job action?

Post-Job Action Administrators Subproblem 14.0
How did nurse administrators feel about receiving compensation/privileges for their work during job action?
Significance of the Study

This study has significance at many levels. At a broad level, the Canadian health care system is experiencing growing tensions from a variety of sources; one of the main sources is that of efforts being made to restrain costs. Baumgart (1988) describes the conditions as "volatile" and "confusing" for both consumers and professionals. Of those professionals, 400,000 of them are nurses and the nature of their work is indisputably essential for the care of 25 million Canadians in "pressure cooker" conditions (Inglehart, 1986). Baumgart (1988) points out that change in the system will depend on how well the problems are analyzed and the issues understood, including those of nursing.

If there is to be positive change, then there must be examination of the professional associations and unions of nursing. This includes their responsibilities, not only to the public, but to their membership.

Both professional associations and unions have grappled with the problems of nursing, albeit in different fashions. Professional associations have focussed their energies and resources primarily on attaining professional status by setting standards and
increasing the educational entry for nursing to the baccalaureate level. At the same time, nursing unions have been struggling through the collective bargaining process to gain improved salaries and working conditions. Despite their work, nursing is eroding its resources - young people are not attracted to nursing in sufficient numbers and nurses who are experienced practitioners are leaving the profession.

Nursing is fraught with conflict, and for nurses, change is perceived as too slow in coming. Nurses have demanded that their their conflicts be placed on the bargaining table, in turn the unions promise that their inequities will be changed at the bargaining table, or, if not there, by withdrawal of service. An examination of the types of demands by nurses and promises by unions is a worthwhile exercise. Those demands which become bargaining objectives are not easily translated or attainable at a bargaining table. The potential for labor strike and rebuffed settlement offers is great when nurses have not had their expectations met and when they perceive that promises to them have been broken.

The increased frequency of withdrawal of services by nursing has caused conflict for professional associations and unions alike. Some of those services
withdrawn merely cause inconvenience to the public; however, many services are considered important. While professional associations know their primary mandate is to ensure that a safe standard of service will be provided to the public, they are well aware that some desperately needed changes will require some drastic measures such as job action.

On the other hand, while unions know their primary responsibility to ensure that their members achieve their bargaining objectives, they are not unaware of potential risks that occur when service is withdrawn from the public.

It is undeniable that hospital managers and nurse administrators play a key role in contributing to the liberation of the front line nurse's ability to practice. Nurses' frustration with lack of recognition and lack of educational and administrative support in their hospital work environment have repeatedly been cited as reasons why nurses have suffered stress, burnout, and have left their jobs and even the profession. How much these issues relate to job action is worth examining. Conversely, the role of the nurse vis-à-vis the employer in context of job action merits review.

Even on a general level, the labour scene is ever-
changing and both management and unions are examining ways to redefine their relationships, particularly those surrounding job action.

In order to address the deep conflict that membership feel based on a potent sense of responsibility for safe care of the public versus the desire to improve their lot, these ethical issues must be analyzed by both unions and professional associations. The issues should be examined in light of the type of responsibilities that these governing bodies have for their membership, for the public, and to each other particularly during labour disputes.

The occupational features of nursing comprise a microcosm of the world of working women. Analysis of any issue related to occupational problems of nursing must be recognized as being relevant to information on the experience of working women as a whole.

Finally, personal and professional growth can evolve from a conflict situation. Studying the roots of professional, political, and personal conflict can provide insights into some fundamental questions of concern perhaps most important of all, to nurses as individuals.
Organization of the Study

This study is organized into nine chapters. Chapter 1 includes the introduction, a statement of the research problem and subproblems which are to be investigated as well as the significance of the study.

Chapter 2 presents a review of recent literature on professionalism and unionism in nursing, nursing strikes, collective bargaining, and conflicts within nursing. The chapter also discusses the BCNU withdrawal of services in 1989 in some detail.

Chapter 3 describes the procedure and methodology employed in the study.

Chapter 4 contains the pre-strike study results.

Chapter 5 contains a the results of the strike/job action study.

Chapter 6 contains the results of the pilot study and the post-strike study including a brief analysis and discussion of each sub-problem.

Chapter 7 contains the results contains the results of post-strike interviews with nurse administrators and a brief analysis and discussion of the results of those interviews.

Chapter 8, the final chapter, offers the writer's conclusions and speculations on the implications of the findings for future practice.
Definition of Terms

**B.C.N.U.** - British Columbia Nurses' Union. It is the organization in British Columbia that is responsible for collective bargaining for registered and graduate nurses.

**R.N.A.B.C.** - Registered Nurses' Association of British Columbia. This organization is the professional arm of nursing in British Columbia. The organization is the licensing body for nurses that ensures that the public received safe, competent care by nurses.

**H.L.R.A.** - Health Labor Relations Association. This is the organization that conducts labor negotiations behalf of the hospital employers in British Columbia.

**Essential Services** - Essential services are those services which, during job action, are provided at a minimum level to assure the survival of patients. The union commits itself to seeing that no job action interferes with adequate staffing for:

- a) crisis intervention for nurses for preservation of life; b) ongoing care for those who are unable to care for themselves; c) nursing care for therapeutic services without which life would be jeopardized; and d) nursing involvement necessary for urgent diagnostic procedures required to obtain information on potentially life-threatening conditions." (BCNU Policy...
Statement, March 27, 1984) Two assumptions are implicit in this: first, BCNU must maintain all emergency services and critical areas and second, qualified persons will assure that the policy guidelines are met.

**Nonessential Work** - Services that do not involve matters of life and death but which may be necessary to the health and well being of the people whom nurses serve.

**Job Action** - refers to any action taken by nurses which may mean reduction or withdrawal of services by nurses. In this case, a ban on working overtime shifts, refusal to carry out nonnursing duties and a withdrawal of all except essential services.

**Nonnursing duties** - refer to those tasks which are not directly involved in nursing care of the patients and which can be carried out by members of other unions. These tasks involve situations in which nurses usually inappropriately carry out clerical, cleaning, and portering duties, none of which require nursing knowledge and skills.
CHAPTER 2
BACKGROUND TO THE PROBLEM

Introduction

This chapter examines the literature on aspects of nursing conflicts, professionalism and unionism, collective bargaining and nursing strikes in recent years. The chapter begins with the general examination of sources of conflicts within nursing in recent times. Next, the current status of professionalism and unionism in nursing, with a Canadian focus, are reviewed. Various aspects of collective bargaining are explored. Finally, the 1989 nursing strike in British Columbia is reviewed in some detail.

Nursing Conflicts

Growe says nursing is misperceived as a "second-string, semi-profession" and cites the 1990's as a "point of no return for nursing" (1991, 240). In her journalistic view on nursing in the Canadian health care system, titled "Who Cares?", Growe points out that there have been significant changes in health care. Those changes have put nursing services at a premium but they have "not translated into control, money or respect" for nurses.

Corley and Mauksch (1987) compare the unjustifiable
position of nursing with that of the housewife and mother.

The nurse sees herself in an occupational and organizational position in which the freedom, power, and support needed to perform her functions is simply not accorded to her. Restrained within her own hierarchy, trivialized by the physician, taken for granted by the administration, and romanticised by the public, the nurse is excessively strained to be an integrator and direct ministering agent of patient care (p.147).

Characteristics of nurses such as warmth, sensitivity, and nurturance have always been viewed as negative compared to those of the dominant culture (medicine and administration); "intelligence, decisiveness and lack of emotion" (Miller, 1976, 74).

In our culture Miller says, serving others is for losers; it is "low level stuff" (P.60). Others have eloquently pointed out that the caring part of human experience has been devalued (Benner, 1984; Benner and Wrubel, 1989).

Greer (1971) calls nurses work the most depressing phenomenon in the pattern of women's work. She finds that nurses are "victimized" into accepting a shameful remuneration because of the essential aspect of their work. Greer designates this a crime of society because it dares nurses to "abandon the sick and dying, knowing they will not do it" (136).

Nurses have become Jills of all trades, undertaking multiple tasks related to clerical, cleaning and
maintenance. Nurses feel that performing these "nonnursing duties" further compromises valuable patient care time already shortchanged because of staff shortages and patient volumes. Yet, in the past, nurses have felt that the only option available to them was to do tasks themselves, since other actions may further jeopardize patient care.

Greer (1971) points out that in relation to tasks performed even "domestic staff" would not consent to the way nurses, as professionals allow themselves to be "bullied" (p.30).

Priest, a journalist and a former nurse, notes that the problems of nursing goes much deeper than the piggy bank. (Vancouver Sun June 17, 1989) She says nurses are caught in a three way vise between the public, the physicians, and the hospital administration.

Women in general and nurses in particular, Roberts (1983) argues, have exhibited characteristics of oppressed groups. The consequences are low self esteem, self-hatred and dislike for other nurses. This aspect of nursing, Grissum and Spengler (1976) say, is subtle to recognize and becomes evident in divisiveness and lack of cohesiveness in nursing groups.

Roberts (1983) suggests that this passive aggressive behaviour is ineffective in negotiations since the oppressed person becomes submissive and
cannot express their frustrations when confronted with the powerful figure. Roberts posits that fear of aggression against the dominant group develops when the subordinate group realizes they could be destroyed if they were attempt to revolt and a secondary fear develops related to fear of change itself and of alteration of the status quo regardless of how oppressive.

Leroux (1978) believes that, more than ever before, nurses must work to change their image, but to do that they must also become aware of the effect or influence of social conditioning on them. Others suggest that changing nursing education and its environment will shake the status quo.

The impact of nurses' dissatisfaction with their professional lot has been documented in every nursing journal as well as other important nonnursing literature. Studies on nursing shortage are nearly as plentiful as are articles containing theories on nursing shortage (Layton, D. 1988; Meltz, N. & Marzetti, J., 1988; Corcoran, 1990; Iglehart, 1987; Prescott, P.A., 1987; Schultz, 1987). The recurrent theme, however, is that nurses receive inadequate compensation for working in intolerable conditions.

**Nurses and Hospitals**

"Nightingalism" and employeeism first described by
Grand in 1971 is still alive and flourishing in nursing (Growe, 1991; Baumgart, 1988; Colvin, 1987).

Colvin (1987) describes the nature of the relationship between hospitals and nurses as one of dependence and of conflict. Hospital nurses, Colvin believes, cannot eliminate or fulfill the conflicting demands of allegiance to the bureaucratic organization or to their profession and clients whom they serve. Colvin also adds that nurses are involved in labour relations clashes because of the "history of indifference and benign neglect" (p. 47) by the organizations in which nurses work.

Roberts (1985) agrees that most of nurses' problems are caused by hospital administration. They describe the fear on the part of management to be bordering on paranoid when the subject of unionism was broached. Another study by Wetzel, Gallagher and Maxey (1985) found that popular perceptions of unionism tended to overlook the positive impact of unionism.

Corley and Mauksch (1987) have found that while nurses' commitment to patients was the major motivating factor to nurses, nurses' commitment to the organization was contingent on perceived commitment of the organization to the patient. These researchers evidenced that awareness of nurses' commitment "served as a basis and justification for neglect and reduced
responsibility on the part of other hospital workers regardless of occupation" (p.141). Nurses' commitment reduces pressure on others to fulfill their tasks and responsibilities; those in a position of power are absolved from a sense of guilt or failure. Nurses' commitment is romanticized and counted on and is thus exploited rather than being rewarded (Corley and Mauksch, 1987; Growe, 1991).

Mallinson (1987) challenges hospital chief executive officers to increase their understanding of the work of nurses and to face nurses' priorities which is their practice of caring. Mallinson (1987,) and others call on hospital management to invest in and respond to nurses or, they warn, nurses will among other things will "break your business" (p.591).

Wilson, Hamilton and Murphy (1990) prescribe that management start dealing with nurses rationally and responsively to nurses or nurses will seek the "crutch of a union" (p.39) to solve their professional woes.

Colvin (1987) believes that the answer to labour strife lies in prevention since and she and others (Cleland 1978, Scott and Mitchell 1976; Ganong 1972) believe that shared governance models will help address the disparate views of management and nurses.

Nurses and their Leaders

Roberts (1983) suggests that it is not surprising
that leaders of oppressed groups often have characteristics and beliefs that resemble those of the dominant culture. Oppressed groups view their "own kind" with skepticism, criticize them for their inability to improve their lot, and point out that they too, would get ahead if they would only try.

Cleland refers to nursing leaders as "Aunt Janes", the female term for "Uncle Tom" because of their position between the powerful administration and medical forces and nurses. Nursing leaders have represented "an elite and marginal group and are promoted because of their allegiance to maintenance of the status quo" (p.23). Grissum and Spengler (1976) note that these leaders are also called "queen bees" or successful women who are antifeminist, and are often removed from other nurses and view them as second class citizens.

Roberts (1983) points out that this type of leadership leads to divisiveness and competition among nurses and does not foster united efforts to change the system. Bowman and Culpepper (1974) call for the group to make a change in the power alignment with the dominant group to promote unity and to avoid "horizontal violence". Roberts notes that nursing may have to avoid an elite leadership and develop a leadership from the "grass roots" (p.29).
Nurses and Physicians

Christman, 1965; Darbyshire, 1987; Holkelman, 1975; Hite, 1977; and Morgan and McCann, 1983 have recognized that differences in educational preparation between physicians and nurses result in vital differences in their health care values and perceptions of each other. Morgan and McCann (1983) posit that these differences can cause discord not only between physicians and nurses but within the profession itself.

Gross economic disparity exists between a nurse who spends approximately one half the time of a physician in educational preparation, yet can expect only one fifth the return in income (Oparnica, 1978).

Nevertheless, researchers still report strong feelings of commitment to medicine and loyalty to the physician by nurses (Corley and Mauksch, 1987).

Darbyshire (1987) points out that the sexist domination of nursing by medicine was neither an accident nor was it haphazard, rather it was structured, and institutionalized; designed to reflect the power relationship within society. Nurses often mistakenly assume they will be accorded respect simply by asking for it. Darbyshire foresees little change in that relationship until changes are made with respect to notions of what is valuable in society: the esteemed male, high technology, illness-focus versus the
stereotypical female-caring orientation.

However, expressions of independence and assertiveness are becoming more frequent as a reflection of the profound changes in the role of women in society (Corley and Mauksch, 1976). Nurses are demanding a new deal from physicians, seeking more respect and recognition.

Mauksch (1981) says that the physician needs to change his or her view to allow significant roles besides his own to be featured and valued. Mauksch also points out that economic disparity between physicians need to be examined. The public has noticed how much smaller the earnings of nurses are in relation to physicians; and physicians face a challenge of having their income deflowered.

Closing the educational and economic gap would make a difference in increasing respect and decreasing status and value differences (Morgan and McCann, 1983).

Nurses: their Unions and their Professional Associations

Nurses have had long-standing ambivalence towards unionization. (Beletz, 1988; Wilson, Hamilton, and Murphy, 1989). Short and Sharman (1987) suggest that nurses neither fit the trade union model, nor do they fit the professional model since nursing is neither
primarily male, nor is it homogeneous in class. Professions, they note, are male middle class and upper class strategies and trade unions are masculine working class strategy.

Short and Sharman (1987) list several significant factors which inhibit nursing from utilizing full trade union power: a tradition of selfless devotion to the sick, continuing influence of "lady-nurse" (p. 199) types in education, professional nursing association and hospital hierarchy, majority of nurses working in the nonprofit public sector, rapid staff turnover because of family responsibilities, and working class women entering nursing to achieve upward social mobility. Short and Sharman note that the "Cinderella occupation of the health care sector has finally run out of patience" (p. 197).

Abel Smith (1960) posit that nurses may find that identification with other sectors of the working class within trade unions may be incompatible with their social aspirations.

Many believe union and professional ideologies are fundamentally conflicting and professional unionism is a contradiction in terms (Beletz, 1988; Hopping, 1976). According to Beletz (1988), unionism diminishes nurse power because it is divisive and creates discourse for the profession and for the public.
Although nurses have been ambivalent about unionism, Wilson, Hamilton and Murphy (1989) believe that the potential is high for nursing to be driven to greater unionization. Not only will nurses' professional woes drive them to unionism, so will indirect factors such as high health care costs and high costs of health care personnel, especially nursing (Wilson et al, 1989; Connors, August, 1989). Others believe that the only way to achieve control of their practice is through professional bargaining (Eldridge and Levi, 1982; Flanagan, 1983; Sheridan, 1982; Zimmerman, 1981).

Gardner and McCoppin (1986) argue that there is a new trend emerging in white collar unionism that combines industrial action with professionalizing tactics primarily in response to feminist issues.

The whole issue of membership domination by management in professional associations is a recurrent one. Ongoing conflict prevails about the perceived lack of representation of the issues of the front line nurse by the professional association (Luttman, 1982).

The question of "turf"; that is, who should bargain for professional issues has been raised more in the American literature (Miller, J. 1981). In Canada, jurisdictional issues are just now beginning to surface as a contentious issue as nurses demand that their
bargaining expand from wages into the realm of professional issues (Slattery, 1988).

Unions and professional associations plea for nurses to fulfill their professional obligations to become better informed about collective bargaining and to take a more active role in shaping their profession (Savage, 1989; Stern, 1982). Inducing members to participate in union activities is one of the most difficult tasks of union organizations as well as other member organizations (Dean, 1985).

Roberts (1983) feels that lack of participation in professional organizations can be seen as evidence of lack of pride in ones group and a desire not to be associated with it. Aligning with other powerless persons (such as nurses) has been shown to be unwise.

While the literature supports collaboration between unions and professional associations working together for common goals, at times of labour unrest the relationship can be an uneasy one. The association with the trade union movement, Kerr (1988) points out, may be difficult, if not abhorrent for the professional association and some of its members.

In British Columbia, the Executive Director of the professional association, Pat Cutshall explained the Board's support for nurses' right to collective bargaining, but drew the line at taking a position on
the merits of employers or nurses' bargaining goals, offers or strategies (RNABC News, July-August, 1989). BCNU President McPherson (BCNU Report, June 1991) still demanded the professional association take sides of staff nurses for the union's collective bargaining stance on Bill 82 and encouraged nurses to demand their fees back if no support were forthcoming.

Kerr (1988) explains that professional associations cannot be expected to provide support during labour unrest because the statutory mandate of professional associations is to serve the public before professional interest.

While the paradoxical issue of how nurses remain as patient advocates while they execute an effective strike is argued in the literature (Muyskens, 1982), there are some related issues that have not been challenged to any degree. The question of who assumes responsibility for negligent practice caused by a nurses' failure to provide care during a strike in which essential services were negotiated between the representatives for the hospital employers and the union has not been raised in the literature.

**Collective Bargaining and Nurses' Strikes**

Whether it is right for nurses to strike has been debated extensively (Miller, 1975; Connelly, Evans,
Dahlen and Wiekner, 1979; Muyskens, 1982). What has not been documented clearly in nursing strikes, is why nurses actually engage in strike action.

For teachers, according to Munton (1987) strikes are a "complex combination of circumstances related to rational and irrational behaviour" (p. 22). Munton's study found that certain personal characteristics will predispose teachers and there are regional differences with respect to issues. Munton notes that most strikes occur over economic issues and those relating to learning conditions of students and working conditions of teachers: issues related to "basic human needs" as Munton cites Yerkovitch (1967, 459).

In nursing, strikes have been explained as a last resort measure. Strikes occurred after lack of respect for and responsiveness to conservative actions by nurses (Chernecki, 1988; Connors, May, 1989; Rawson, 1988; Savage, 1989; Slattery, 1989).

The effects of nurses' strikes on patients and hospitals have been severe in some cases (Rothman, 1987) including the admission of sicker patients because of the effects of restricted admissions and early discharge. In some areas physicians have changed their practice and do more in the way of surgery on an outpatient ambulatory basis.

Whether nursing strikes are right or wrong, the
lack of resolve or even responsiveness to these factors have increased the militancy in nursing union membership (Chernecki, 1988; Slattery, 1988, Connors, 1989). This militancy has been exhibited by recent provincial strike actions, political demonstrations, and by union/professional association conflict (Gilchrist, 1987; Baumgart, 1988). When strikes do happen, pressures prevail; for nurses, it is to not cause harm to their patients and for government negotiators, it is to responsibly avoid confrontations which will disrupt health care to the public.

Rowsell (1982) believes that collective bargaining for nurses is "fascinating" because it addresses a fundamental and timely issue in society and yet it is "controversial" because established goals of the profession and the trade union movement are divergent.

Metzger et al (1984) remark that "Nightingalism" (the image of self sacrifice without concern for economic reward or job conditions) still exists and is an important factor that distinguishes nurse from other employee groups.

Furthermore, Metzger et al (1984) point out that collective bargaining in nursing is complex and fraught with the danger of impasse and ensuing strikes. Concerns are different from those of other employees
Metzger believes and they "spill over" (p. 98) into collective bargaining.

Literature on professionals and collective bargaining document that contradiction between professional value systems and organizational demands produces distinctive professional concerns versus goals that reflected professional concerns then being emphasized at the bargaining table. Ponak's study (1981) emphasized that professional bargaining goals were more important than the traditional bargaining goals that also had relevance. Professionals are not content to bargain solely for wages, hours and working conditions but they will expand the scope of negotiations to include a category of issues reflecting what are referred to as professional concerns. Kleingartner (1973) refers to this as expansion of bargaining.

Bloom, Parlette, and O'Reilly (1980) found that management's view of striking nurses' concerns were markedly different from those of striking nurses. Nurses' real concerns related more to communication with management and participation in organizational decisionmaking while management felt that wages and job security were critical issues for the nurses.

Management in the health care industry may need to reconsider their approach and behaviour to job action,
that focusing on economic issues rather than on fundamental issues will increase probability and duration of a strike (Bloom et al. 1980, Metzger et al. 1984). Alutto and Belasco (1974) revealed that the more the bargaining unit is seen to represent professional issues, the more likely nurses will take militant action. This finding is reinforced by a study by Beletz (1987) in which nurses tended to associate more closely with the professional model of collective bargaining, yet they had an ideological commitment to militance.

Metzger (1984) feels there is a inability of nurse union leadership "to translate the real concerns of nurses into acceptable settlements and that has played a role in the proliferation of strikes by nurses" (P.100). Issues such as shared governance cannot be resolved in the collective bargaining process and must, in the end, seek resolution through institutional channels. Metzger reminds us that few contracts are resolved and few strikes are surrendered as a result of legal decisions.

In terms of solutions, the overall emphasis in the literature focussed on the importance of an assertive, united front by nurses to make to make changes through collective bargaining (Sheridan, 1982; Savage, 1989; Connors, 1989) as well as well as to make the public,
as consumers of health care, aware of nursing.

Nursing Strikes in Canada

In the fall of 1988, nearly 6,000 nurses in Saskatchewan went on strike in 93 hospitals; and repeated their strike efforts again in May of 1991. In January of 1988, 11,000 nurses in 104 Alberta hospitals launched their fourth province-wide strike. Nurses were tired of being compensated for the sole reason of providing a worthwhile service/contribution to society (Hibberd, 1988). In three Alberta strikes between 1977 and 1982, Hibberd (1988) described the common features as being an enormous economic demand in relation to a fiscal constraint policy, increasing complexity of demands on nursing services, and failure to compromise leading to impasse. In 1982, Alberta nurses lost their right to strike.

However, in 1988, the real strike issues fused into a more basic argument: Alberta nurses were angry that their right to strike had been replaced by binding arbitration in 1983 (Banning, 1988; Cook, 1988; Hibberd, 1988). Hibberd (1988) points out that since "neither government or employers are listening to nurses...and neither legal strikes or disobedience has produced a settlement with honor", therefore, some movement must take place in terms of attitudes, behaviours and/or players in the scene.
British Columbia Nurses' Strike - 1989

In British Columbia, nurses had used striking as a way of settling differences with their employer on two occasions: in 1939 (St. Joseph's Hospital in Comox) and briefly in 1976, before the eventual separation of the BCNU from the RNABC in 1980 (Goldstone, 1972; 1985).

Events of 1989

In January, 1989 BCNU presented their bargaining package to the HLRA. The package was enormous, containing close to a hundred proposals around ten union priorities: higher wages, creation of a professional responsibility clause, pension improvements and early retirement, upgrading shift and other premiums, stronger health and safety language, expansion of casuals' rights, upgrading hours of work and scheduling provisions, better educational leave, job classification improvements, and contract language to strengthen the union.

BCNU asked for a 33 per cent wage increase and other monetary items worth approximately 43 per cent more. HLRA also had other contracts besides BCNU to be concerned with: the HSA and HEU contracts expired at the end of March. After 16 days of negotiations, at the end of April, an impasse had been reached.

Nurses were outraged when the HLRA placed a full
page advertisement in local papers throughout the province in early May stating that in B.C.'s excellent health care system, nurses were the highest paid in Canada. The BCNU calculated salaries to be sixth highest in Canada.

In a letter to the Editor of the Vancouver Sun on May 15, the BCNU President informed the public that they must understand and deal with the consequences of a profession "which is deteriorating beneath our feet". BCNU believed that they would receive a strong strike mandate from their members and set the strike vote date for May 17. They recommended that their members vote "yes" to strike. BCNU supported the labour movement's boycott of the Industrial Relations Council (IRC) and thus the IRC's observers. From the government's position, this placed the legal status of the vote in question. The B.C. Federation of Labour exemption; however, permitted the BCNU to use the IRC to observe the vote. On May 17, 81 per cent of the 17,000 in contract nurses exercised their vote; 94 per cent of them voted emphatically in favour of striking.

Strike notice was served to the employers. A May 20 editorial (Vancouver Sun) reminded the HLRA that they should be neither "surprised nor incensed" since the situation had been coming to a head for such a long time. Rescheduling of negotiations was to happen on
May 23. A mediator, Stephen Kelleher, was appointed to make binding decisions regarding essential services disputes.

Job action began two days before negotiations were scheduled to resume, but it was limited to nurses' refusing to carry out duties which were not directly related to patient care (called "nonnursing duties"). In the next eleven days of negotiations, only items which were considered to be "non cost" agreements were mediated. Nurses, hospitals, and the public were uninformed about the progress of the negotiations due to a news blackout.

In early June, the BCNU held rallies throughout the province. Deborah McPherson, told an energized nursing crowd that "this is a sign that we have awakened a sleeping giant" (Vancouver Sun, June 5). On June 10th, HLRA proposed a three year contract at 5.5, 6.0 and 6.5 percent. BCNU negotiator Judith Jenkins told nurses at another rally on June 16 in White Rock, "What they (HLRA) are saying is that you are worth nothing."

Negotiations continued for 22 days with BCNU finally countering the offer with 20, 7, and 7 percent. HLRA rejected BCNU's offer saying that further discussion would be pointless. BCNU immediately reacted by adding to its current job action a ban on overtime. The next day, June 14, BCNU came through with their
promise to strike: they embarked on a graduated withdrawal of all but essential nursing services from 12 hospitals employing more than 6000 nurses. Denny Boyd reported (Vancouver Sun June 15, 1989) that there is "something disturbingly inappropriate about a picket line around a hospital. It is like seeing armed soldiers around an embassy, policemen in a school yard. The juxtaposition is jarringly wrong, telling you that trusted systems have jammed up."

The provision of "essential services", however, meant that 70 per cent of nurses were still working inside hospitals to provide services. The two other health care unions, HEU and HSA, honored BCNU's picket lines except for essential services; their essential service level was much lower than that of BCNU's. Although it varied between facilities, some say the level was closer to 20 per cent. Because of low essential service levels, members of HEU and HSA lost proportionately more salary than did nurses (BCNU Report, 1989). A familiar dispute throughout the strike was that of what constituted the definition of "essential".

Bernadette Stringer in New Directions, (September-October, 1989) wrote that because of BCNU's inexperience as a union, the "bureaucratic chickens came home to roost...a battle ensued at every hospital
over numbers of nurses who would continue to work during a strike". Stringer noted that where effective rank and file nurses organized essential services, levels were set at about 50 percent of normal; where rank and file organization was "weak or ill-informed by poorly functioning regional committees, management got their way... and staffing levels were up to 85% of normal". One hospital, Stringer reported, had essential service levels designated at 110 percent of pre-strike staffing.

Employers were blamed for not discharging patients whose care did not, to BCNU, seem to be essential and nurses were told that they must provide essential services which also included non-nursing duties. Peter Walton, a Vancouver General Hospital spokesman, noted on June 14 that nurses were providing essential services and pointed out to the Vancouver Sun that in some areas such as intensive care unit staffing levels were "close to full complement".

By June 20, job action reached its peak: essential services were the only care maintained at 80 locations employing 15,000 nurses; 69 of those agencies were behind picket lines. At 64 other agencies throughout the province, 2500 more nurses maintained overtime and nonnursing duty bans. "Smiles faded" and were replaced by a grim determination among nurses (Globe and Mail,
June 17). Nurses settled in for a long strike. Hospitals cancelled more surgery and sent patients home early or stopped admitting them.

"Frayed tempers and aching backs may affect management's efforts to keep hospitals going... things are getting a little testy," said hospital administrator Bruce Harber (Vancouver Sun, June 19, 1989). Management struggled to make and deliver meals, clean wards, do laundry and perform clerical duties. A union steward at that same hospital reported, "Nurses are working like dogs" to provide basic care, "management's expectations are unrealistic. They want exactly the same level of care as before the strike, and they are not picking up enough of the slack to make a difference".

Members from other unions, such as truck drivers for suppliers of food and supplies, refused to cross BCNU picket lines. Premier Vanderzalm said that while he was "extremely concerned about the strike and while people are suffering under the stress and strain", he would not interfere. "Collective Bargaining has a price." (Vancouver Province June 18, 1989)

The body and soul of nursing was exposed and debated everyday in a public forum. Everyone had a say. BCNU and HLRA battled it out in full page ads in local papers. Media monitored public support daily in
the newspapers, on television and on the radio. Generally, money was the focus of articles and interviews.

Reporters sought input from construction, industrial, forestry and food plant workers. Workers felt nurses deserved to make more money, but to the dismay of many nurses, responses would resemble those of this meat-cutter: "They (meat-cutters) are dealing with animals that are dead. They are not dealing with live bodies." (Vancouver Province, June, 20, 1989)

"It is easy to cost out the expensive machinery in a hospital. But how does one measure the value of the ministering services? Of what worth is the touch that brings healing life?" (Sam Roddan, Vancouver Sun, June 28, 1989)

Canadian Nurses' Association President Judith Ritchie said in an interview that "Nurses are baffled because governments and hospitals can't find enough money to pay nurses better....there is tremendous wastage elsewhere in the health care system." (Vancouver Sun June 19, 1989).

The strike became more heated. One hospital closed its Emergency Department saying that the union dropped its essential service level and there were "unsafe staffing levels". BCNU countered that the hospital had violated the essential services agreement. "They
turned out the lights in the Emergency Ward and left nurses sitting there in the dark," said BCNU spokesman, Jerry Miller (Vancouver Sun, June 22, 1989).

HLRA announced that it was taking BCNU to the Supreme Court arguing that nurses were not working to previously agreed to essential service levels. BCNU subsequently withdrew temporarily from the Kelleher essential service process after insisting that the essential service obligations were being met. B.C. Labour Minister Lyall Hanson then ordered IRC to rule on essential services by bypassing the Kelleher process. BCNU insisted that it did not get proper notice of the hearings (BCNU Report, July-October, 1989). HLRA attended the hearings alone. All other health care unions boycotted the IRC. A series of injunctions called for the provision of essential services; they were in keeping with the Kelleher decision.

Arbitrator Stephen Kelleher ruled that three more operating rooms at Vancouver General Hospital be opened. Vancouver General nurse Debra McPherson noted that the two operating rooms opened and staffed were not being used around the clock. Labour Minister, Lyall Hanson appointed IRC Commissioner Ed Peck to monitor hospitals for maintenance of essential services, thus bypassing the Kelleher process. BCNU
President Savage responded by saying that "Mr. Peck knows nothing about nursing. Nurses know about nursing. We will continue to provide essential nursing services to our patients." (Vancouver Sun, June 24, 1989)

The strike escalated as Hospital Employees' Union joined striking nurses on the picket line June 22. HEU represents nurses' aides, cleaners, cook, ward clerks, orderlies and practical nurses. HEU Spokesman Sean O'Flynn told a rally "From today on, everything is changed. We intend to make sure the hospitals are sealed up tight and only essential services get through them....We intend to wipe the smiles off management's face." (Vancouver Sun June 23, 1989)

On June 22, Pat Savage told a rally on the steps of the province's legislature, "We are making progress in turning up the heat. So keep it up." (Vancouver Province, June 23, 1989). Public support remained relatively good throughout the strike. A Vancouver Province poll surveying 1,141 people found that 70 per cent of British Columbians supported nurses in their dispute. A nationwide poll asked whom the public sided with and found that 54 per cent of participants nationwide sided with nurses, 17 per cent sided with the government, 20 per cent were undecided and 9 per cent supported neither. A provincial poll showed that
69 per cent favored the nurses and 16 per cent backed the government. (Vancouver Province June 23, 1989).

Media also focussed on patients and families who found themselves caught in the middle. Cancer and heart surgery patients were victims in their delayed surgeries. Patients were diverted or transported to other provinces. "The situation is a travesty...it's mayhem. The government must step in and provide the dollars to settle this," one family member said. "I don't blame the nurses on this one - the government is responsible. Families are so fearful for their relatives in hospital." (Vancouver Province, June 20, 1989). Many patients had surgeries cancelled or were unable to have surgeries booked. Little attention was paid to the longstanding pre-strike surgeries cancelled in all facilities throughout the province because of nursing staff shortages.

The British Columbia Health Ministry received telephone calls that three deaths resulted from the nurses' strike. "The longer the strike goes on," British Columbia Medical Association President David Blair said, "the more likely that something will happen to someone" since hospitals were not operating at optimum levels and decisions had to be made about which patients were classified as emergency and which were urgent (Vancouver Sun, June 24, 1989). B.C. Medical
Association's President, David Blair, who would himself soon be negotiating with the government over physicians' contracts, said the government "has deliberately chosen confrontation over successful negotiations... someone has obviously realized the resulting strike would save the government some health-care costs." (The Province, June 21, 1989).

Talks resumed with mediator John Kinzie for a weekend and ended June 26 with a tentative settlement: a three year package of 29.5 per cent and other benefits coming to 8 per cent. A back to work agreement called for BCNU picketing to end at facilities where HEU is not on strike. The settlement was touted highly by employer, government, and the business community. Peter Dueck, Minister of Health, commented, "I suppose the hospital administration boards are very enthusiastic about the tentative agreement... the problem we have now is HEU." (Vancouver Sun, June 27)

The excitement and optimism of a settlement gave way to anger on the picket lines. The tentative contract agreement, nurses said, was insulting and many nurses felt that they deserved better than the offer. Immediately, signals were clear that nurses would not be supportive of the agreement. Nurses in Victoria voiced that their nurses union had let them down and was "hoodwinked by a more organized and politically
attuned bargaining agent for the hospital" (Times Colonist, June 27, 1989). Vancouver nurses echoed the concerns saying they "wouldn’t endorse the deal and we want our union to know that". Another Burnaby nurse said, "I don’t know what’s happened to our negotiators. They were mesmerized or hypnotized or something."

Past President of BCNU Colleen Bonner said, "We are not overjoyed". Vernon nurse Mary Malerby demanded, "We want the bargaining committee to justify its decision" to recommend that nurses accept the offer (Vancouver Sun, June 28).

Mitzi Arthur of Nanaimo said "There’s no way they’re going to settle for it and we’ll stay out all summer if we have to." (Nanaimo Free Press June 29). Union spokesman Jerry Miller tried to rationalize nurses’ response to the offer as "negative reaction to a preliminary report that does not reflect the complete package" (Vancouver Sun, June 27, 1989).

Meetings were held in rooms filled to overflow with nurses wanting to hear details of the tentative agreement from President Savage and other union officials. "Loud boos greeted Pat Savage" and nurses stomped out of a "heated" meeting at the Sheraton Hotel chanting "Say No!" to the contract (Vancouver Sun, June 28). Savage, in the heat of the moment, agreed to withdraw the executive’s recommendation to ratify the
deal and agreed to advance the voting date. She offered her full support if nurses chose to continue the picketing. After the meeting, Debra McPherson, a Vancouver regional representative, said "It's (the offer) not what we want. They (nurses) are saying nurses will continue to feel undervalued." (Vancouver Province, June 28, 1989).

The day following the meetings in Vancouver, BCNU president, Pat Savage retracted her words of support for nurses who were displeased with the contract. Savage said she "got caught up in their emotions and agreed to their demands". Savage acknowledged that "only the provincial bargaining committee has the authority to take such actions. The members may reject the proposed settlement, but that decision belongs to all of them - because every nurse will have to live with the consequences." (Vancouver Province, June 29).

This "backpedalling" infuriated nurses who were further incensed by the comments of labour officials.

Senior labour officials including Ken Georgetti, President of the B.C. Federation of Labour called the offer "by far one of the best contracts negotiated in B.C. in the last two or three years and its probably one of the best in the country in the last year." "I think it shows that the employer recognized a number of the arguments advanced by the union...The strike and
the deal have made the BCNU stronger and given nurses a greater sense of their worth and their power", Georgetti pointed out (Vancouver Sun, June 28, 1989.

Jack Munro, Canadian IWA president said, "You can't sneeze at a 29.5 per cent wage increase...maybe that criticism is being measured against some expectations and that maybe some expectations get a bit out of whack with reality." (Times Colonist June, 29).

"It's like Father Knows Best," a nurse said. "If this had been a union made up predominantly of men, Munro would not make those comments." (Vancouver Province, July 2) Another nurse said "It's okay for Jack Munro to say it's a good offer when his guys are getting more to pull logs off the greenchain than we are to save lives." Judith Ogilvie member of the bargaining committee said that the ramifications for rejecting the deal are tremendous, "If we are going to reject this deal we would not have the support of organized labour." (Vancouver Sun, June 30)

On June 29, 150 nurses stormed the Boardroom at BCNU headquarters where Chief executive officer Glen Smale, Bargaining Committee President Annabelle Dyck, BCNU Vicepresident Marsha Forrest and Treasurer Linda McCannell-Smith were meeting. When Smale told nurses he would meet with ten of them, they filled the boardroom and tore up President Pat Savage's press
releases. Bernadette Stringer, representative of
Vancouver nurses, described the executive as "arrogant"
and "I think there's a really good chance that the
executive will be defeated... We are tired of seeing a
bargaining committee that does not take seriously what
the members say." (Vancouver Sun, June 30, 1989)

In the meantime, HLRA president, Gordon Austin said
a "NO" vote would "create a very unpleasant situation
because it's difficult to look at the union and see
who's really in control." (Vancouver Sun June 28).
Premier Vanderzalm said when told nurses were upset
with the deal, "It's unbelievable." (Vancouver
Province, June 29). Nurse Lyn Walters expressed,
"Compared to other unions we're like Mary Poppins going
out to meet Rambo". Another nurse commented, "You
better believe I've got some sharp words for our union
executive. This strike was to get nursing up to a
professional level, beyond the blue-collar worker.
Well, this offer isn't going to do it." (Vancouver
Province June 29)

Nurses continued their ban on overtime and non-
nursing duties as they awaited the ratification vote.
But on July 1 the picket lines came down including
those at the turbulent Vancouver General Hospital.
"Nurses want to focus their efforts on defeating the
contract," said Deborah McPherson, "They felt going
was the wisest strategy because the media is determined to paint us as weird radicals." (Vancouver Province, July 2).

As hospitals tried to get back to normal, union leaders began a blitz throughout the province to sell the package to members before the July 12 vote. By July 3, Vancouver nurses had collected $3000.00 for two nurses, Debra McPherson and Bernadette Stringer, Vice-chairs for the Vancouver Region to take the "no" message on the road. The expectation was that these nurses, who became known as the "dissidents", would present the negative side of the contract. "Nurses don't have to be lulled into accepting this deal," said McPherson, "they are being told there is no alternative, but that is just not the case." (Vancouver Sun, July 5). Pressure from within BCNU Council was placed on both Stringer and McPherson to tow the party line. Stringer's response was "...discussion is healthy..there's nothing wrong with dissent as long as you encourage people to take it through the appropriate actions, such as at the polls when we vote on ratification." (Vancouver Sun, July 5).

The "No" campaign, as it became known, gained momentum. Attention focused on release of information which revealed that hospital administrators in some facilities had been given dinners, cruises, $1000
bonuses as rewards for strike work, the cost of which was borne by hospital budgets. Hospital administrator Wayne Keddy referred to it as "small recognition for the tremendous hard work they did in very trying times." (Vancouver Sun, July 7).

On July 8, as Quebec nurses overwhelmingly rejected their agreement, Pat Savage predicted a high turnout for the B.C. vote saying, "I think it will pass, although I think it will be close." (Globe and Mail, July 8). The general belief was that nurses should cool their anger, vote yes and get on with life. Terry Morley warned in the Times Colonist the day before the vote:

Woe to the nurses of this province if they turn down the contract offer now before them. They will be flayed by the little stings of editorial censure, they will taste the bitter draught of public venom. Their friends in the labour movement will abandon them to their fate. Their enemies in the hospital will snigger at the gaudy spectacle of a union leadership left naked and defenseless. The government, stuffed with leering ministers will happily arouse itself to take advantage of their plight.

On July 12, 77 per cent of eligible voters voted 65 per cent against the pact. The majority of nurses at 11 Lower Mainland hospitals voted "no" as did Vancouver Island, Sunshine Coast, West Kootenay, 8 Fraser Valley Hospitals, Cariboo, Okanagan and Northeast hospitals. Those voting to accept the contract were the East Kootenay bloc and scattered throughout 66 facilities,
mostly small hospitals such as Tahsis, Port McNeill and some long term care and diagnostic centres. In Victoria, hospitals were split in their vote: Victoria General Hospital voted against and Royal Jubilee Hospital voted to accept the contract.

Bargaining Committee representative Judith Ogilvie said, "Nurses have to be pretty angry to vote 65 per cent against a contract." Gordon Austin, President of HLRA, expressed disappointment saying that reopening the contract issues would be a mistake and that "the reaction to that might get quite sudden and quite violent" (Vancouver Sun, July 14).

The "no" group raised pressure for the Bargaining Committee to resign with Debra McPherson saying that the "no" group was no longer a 'subgroup', it was a majority. "The government was not taking us seriously and our Bargaining Committee had lost touch with the membership". Savage restated her position that neither she nor the bargaining committee would resign even though this had been a "setback". (Vancouver Sun July 14).

In an unprecedented move, BCNU Bargaining Committee and Council had joint meetings on July 17 and 18 to discuss new strategies. Both groups agreed to hiring a consultant to "assist in negotiations" and that a representative of the "no" group (Deb Filleul) would be
added to the Bargaining Committee.

Health Minister Peter Dueck called nurses' work to rule action as coming "close to anarchy" as the impact of strict enforcement of overtime bans and non-nursing duties hits hospitals (Vancouver Sun, August 1). Waiting lists for surgery became unmanageable, wards closed, emergency departments become next to closed except to all but "true" emergencies and critical patients were sent out of the province. Kirk Mitchell, a hospital administrator admitted that the BCNU's overtime ban was not at the root of the problem, "it is simply an adjunct." (Richmond Review, August 6)

Deb Filleul, the "no" group's negotiating committee member echoed Mitchell's comments saying that the overtime ban only highlighted the effects of the nursing shortage. "It's up to the hospitals to manage...they have the number of nurses they have, who are working a normal week like most other workers in the province do...the people of B.C. cannot expect nurses to work 45 to 60 hour work weeks to maintain services." (Vancouver Sun, August 1)

On August 8, BCNU agreed to resume negotiations with HLRA. After four hours, talks failed when mediator Vince Ready decided the two sides were too far apart to continue. HLRA had "no new proposals which would address the critical situation in health-care
delivery arising from the nursing shortage", said Pat Savage. (Vancouver Sun, August 9). HLRA's Gordon Austin reported to be "frustrated" said that while nurses are decent people, "they have a weakness in their leadership and they've allowed themselves to be directed by what we would call a fringe radical group."

Government cabinet met and on the same day, Premier Vanderzalm issued an ultimatum: settle within the week. As a Vancouver Sun editorial pointed out, he had "written the prescription for the medicine. It's bitter." To settle using the Industrial Relations Act or Bill 19, the Sun contended, would be to "throw among the pigeons the largest and most ornery cat on the block. The nurse would be bullied, organized labour's unity strained by a dubious cause on which to make its stand, and the public ill-served by a grumpy settlement that didn't resolve the issues" (Vancouver Sun August 11). A frustrated Chairman of the HLRA related that government may have to intervene since union leadership was in "total disarray."

On August 12, 1989 talks with mediator Vince Ready resumed at Ready's request with nurses and HLRA in separate quarters. Talks carried on for 12 hours the first day and for 13 hours the next day. On August 15, Ready made a proposal which would authorize him to end the nurses' job action. Wage increases and length of
contract were not resolved but both sides agreed they would be settled by binding mediation. The vote was a split one by the BCNU provincial council. "I don’t think the nurses of this province are going to be happy," Pat Savage said. "Nurses can use their own decision to refuse overtime, if they wish", Savage said. Stringer said in future "we will have to be firm from the outset, have a new plan of action, and have some new leadership, people who are willing to stand their ground." (Vancouver Sun, August 16, 1989).

On August 16, 1989 binding arbitration was handed down by mediator Vince Ready. The decision included a two year settlement with a wage increase of 20.9 percent; other items were unchanged. Savage’s responded to the settlement saying, "nurses will accept it under duress" and added that "when family members or friends can’t get hospital care because more and more beds are closed for lack of nurses, remember who’s responsible." (Vancouver Sun, August 18, 1989)

Summary

This chapter has reviewed aspects of nursing conflicts, collective bargaining and nursing strikes. It has also reviewed the events of the British Columbia Nurses’ Strike in 1989. The review served as a frame of reference for the analysis and discussion of this study’s results and a statement of conclusions.
CHAPTER 3
RESEARCH METHODOLOGY

Introduction

The initial intent of the study was to examine the issues which might bring nurses to job action and the roots of conflict which nurses might feel during job action if and when it were carried out. The study was to be done pre-strike, during the strike, and after the strike. Sources of conflict were derived from information in the literature and from the nurses themselves. Initially, it was hoped that the study would be supported by the BCNU so that with their endorsement and assistance, a questionnaire could be distributed to members and that interviews could be carried out. It return, the BCNU would have had input into the types of issues they would like to explore and have firsthand knowledge of nurses' feelings about strike, unions, employers and conflicts which nurses might experience during job action. For the union, it would be advantageous to know where the membership stood before any potential job action took place.

Gaining Study Clearance

In March, 1989, prior to the event of job action
and the strike vote of May 17, the BCNU President, Pat Savage, was approached with a research proposal to take to the BCNU Council. The proposal contained an outline of a study and included a draft questionnaire. A covering letter (Appendix I) explained the researcher's interest as well as educational needs. It also identified the nurse researcher as a member of both the RNABC and the BCNU.

The request was for BCNU to endorse a study on "Job Action - Attitudes and Actions of Nurses". The letter explained that the purpose of the study would be to obtain information on the roots of conflict that nurses feel before/during job action. It would also provide valuable information about how nurses felt about issues such as strikes, unionism, professionalism and job action that they might carry out.

A similar study, the letter said, had been carried out on teachers by a master's student with the same advisor in the past and that the British Columbia Teachers' Federation (BCTF) had endorsed the study. The BCTF had gained invaluable information about issues related to striking teachers. The letter further noted that there would probably be differences between nurses and teachers, some of which related to interruption of the caring process, other health care providers, nursing image and gender issues.
The study was presented to BCNU as an opportunity to gain information since there were almost no studies done on labour disputes in nursing and this study would provide the union with insight into their memberships' views on a variety of issues. The researcher addressed the potential sensitivity of the timing of the study in relation to the bargaining process and expressed appreciation that the BCNU would not want to demonstrate that their intent was to not bargain in good faith and to take job action. The researcher was willing to prepare for the event of job action yet to take a "wait and see" approach. No funding for the study was requested.

The BCNU President brought the study forward to the Council in April, 1989 after which the President notified the researcher that the Council had felt that the study would be a worthwhile one. She pointed out that while the Chief Executive Officer, Glen Smale had also agreed to the study in principle it would be necessary for the researcher to contact the Director of Member Services, Pat Fraser for agreement. Here the study was halted. As a manager, Ms. Fraser pointed out, there was no time for her staff to assist and the work of the study was bargaining unit work. "How would you feel if someone came in and took over your job?" Ms. Fraser did not want nurses interviewed on the
not want nurses interviewed on the picket line, she believed that carrying out the proposed study would be taking away bargaining unit work of the employees of the British Columbia Nurses' Union.

Another attempt to negotiate the study with the President of the British Columbia Nurses' Union by the researcher was unsuccessful.

Shortly afterward, the professional arm of nursing was approached. The Executive Director, Pat Cutshall, and the President, Sue Rothwell, of the Registered Nurses' Association of British Columbia were approached (Appendix II). Both agreed in principle that the study should be done.

Ms. Cutshall expressed reluctance for the RNABC to endorse or assist in distribution of the study since it might seem to nurse administrators that the Registered Nurses' Association of British Columbia was not being supportive of them during this time of labour strife.

Ms. Cutshall did not feel the Board would be supportive of a strike study. However, Ms. Cutshall also pointed out that if mailing would be paid for by the researcher, that the Board of the Registered Nurses' Association of British Columbia might consider that the RNABC might mail the questionnaires.

Unfortunately, the next Registered Nurses' Association Board meeting would not happen until early
September, too late for a prospective study.

In the meantime, while the researcher negotiated with both organizations to achieve approval for the study, the researcher began to talk to nurses and the study took on a life of its own.

Data Required

In order to assess the attitudes of nurses towards the withdrawal of services and the conflicts experienced by nurses surrounding the 1989 strike, data was collected during all phases of the job action: before the job action, during job action (including the strike), and after the job action.

Consultation on each aspect of the study was done with an informal advisory committee. Nurses who were employed in a variety of areas of nursing: practice, administration, education and research were consulted. The Executive Director and some Board members of the RNABC, as well as the President of the BCNU and members of the Union Council were consulted during the study.

All data was obtained by the researcher, a nurse as a participant-as-observer (Gold, 1958). The role of a participant-as-observer Gold notes, is a delicate balance between "going native" and maintaining objectivity. Care must be taken, Gold says, to retain sufficient elements of distance to maintain intimate content, but to avoid intimate form.
Pre-Strike Data

The pre-strike study was a qualitative study in which the purpose was to explore what nurses perceived the issues of the potential strike were and aspects of conflict that nurses were feeling in regard to potential job action. An initial questionnaire was developed as a framework on which to base interview questions. This evolved from the questionnaire used in the 1987 teacher's study by Patricia Munton. The interviews were also open-ended so as to elicit data which could be categorized and later used to develop a questionnaire which could be used if strike action were to take place later.

Procedure. The study was explained to one nurse known to the researcher in each of four hospitals. The researcher requested that the four nurses approach a variety of nurses in their employing hospitals to explain the study and to determine if those nurses wished to be interviewed by telephone. If nurses were interested, they would leave their telephone number and name with one of the four nurses who would, in turn, provide the researcher with the contact information.

Participants were either called by the researcher or called the researcher themselves and after having the study further explained to them, agreed to be audiotaped while being interviewed by telephone or in
interviewed by telephone or in person. Only one of the twenty-five nurses wished not to be interviewed after the study was explained to her. The interviews took place on the week previous to or after May 17, the day of the strike vote before any job action took place. Interviews lasted approximately one hour each and were conducted by the researcher, a nurse.

Procedure. A draft questionnaire was prepared (Appendix III). Demographic information was requested from each nurse as were contextual factors such as position held, specialty, type of contract, experience with collective bargaining. Nurses were asked open ended questions concerning issues, feelings about their union and professional association, their employers, and conflicts they were experiencing.

When participants had a limited period of interview time, the focus was limited to issues surrounding the potential strike and the participant’s vote.

Participants. Twenty-five nurses from four different hospitals (three community and one teaching hospital) in the Lower Mainland and Interior of British Columbia were interviewed. The nurses were all hospital nurses practicing in a variety of units. Participants had varying levels of responsibility within contract i.e. head nurse, assistant head nurse, and staff nurse. Educational level varied from diploma
preparation to baccalaureate preparation. Marital status varied as did employment status (i.e. full time, part time and casual employment) and age.

Data Treatment. Once the interviews were completed, the audio tapes were transcribed and the questionnaires were tabulated examined to determine the similarities and differences in responses, themes and overall perceptions. Responses were grouped according to the categories of inquiry and were summarized. These responses were used to guide the next stage of the study: the strike phase.

Job Action/Strike Data

In order to more deeply grasp the issues and the conflicts surrounding the issues during the actual job action, nurses were observed and interviewed throughout the strike and job action. The research was aimed at discovering what the issues were as the strike evolved and which situations produced the greatest conflict.

Picket Line and Meeting Data

Procedure. The researcher approached the picket line, introduced herself as a nurse and identified herself by BCNU and RNABC membership card (if there were no nurses present who knew the researcher), explained the study, and asked if the picketers would agree to being interviewed while walking the picket line. Nurses on the picket line often volunteered to be
interviewed individually later both in person and/or by telephone. Nurses expressed discomfort with being audiotaped on the picket line in the presence of other nurses and other unions therefore interviews on the picket line were rarely audiotaped. Most nurses responded verbally to questions that had been used on the pre-strike questionnaire (Appendix III) or discussed their feelings on the picket line as the researcher transcribed. Interviews varied in length from 10 minutes to 2 hours on the picket line. All nurses who were interviewed off the picket line agreed to audiotaping. Their interviews lasted from one to three hours. The questions were based on the previous categories of data acquired during the prestrike study. This, however, was not rigidly adhered to since the main objective was to give the participants opportunity to express matters of central significance to the participants rather than those presumed to be important by the interviewer.

Only two nurses who were approached on the picket line did not wish to give an interview. These nurses had voted against the strike.

Union meetings were attended in which nurses were observed. Nurses were randomly selected and interviewed before and after meetings to ask what they felt the issues were and about their overall feelings
related to striking, picketing, unions, employers and personal and professional conflicts surrounding the withdrawal of patient services.

The data collection was interpretive and descriptive in order to capture the feelings of conflict nurses were experiencing. As much as possible, natural transitions were used to sequence the main areas of inquiry.

Participants. The researcher interviewed over 200 nurses on the picket lines of fifteen hospitals and in union meetings in the Fraser Valley, Lower Mainland, and Vancouver Island. The hospitals were of all types and sizes: tertiary care, teaching hospitals, community hospitals and specialty centres. Nurses practiced in a variety of hospital specialty areas and were staff nurses, head nurses, assistant head nurses, educators, clinical nurse specialists, occupational health nurses, clinicians and others.

"No" Vote Data

This portion of the study took place after nurses voted to accept ("Yes" voters) or to reject ("No" voters) the contract recommended by the union. The aim was to explore what the reasons might be for nurses to vote against the union's recommendation to vote to accept the negotiated offer.
Procedure. Union representatives were contacted from each of the agencies. The study was explained to the representatives and they were requested to approach nurses and explain the purpose of the study to those who they thought had voted either "Yes" (if they were employed in a "Yes" facility) or "No" (if they were employed in a "No" facility). Participants interested in taking part in the study would agree to provide their names and phone numbers to the hospital's union representatives who would, in turn, provide the names and phone numbers to the researcher.

Interviews were conducted by telephone and in person. The researcher used an interview guide to ask participants open ended and closed questions (Appendix IV). Interviews were audiotaped with the permission of all participants.

Participants. A purposive sample of 20 nurses were selected from four hospitals. Five participants were selected from each of two hospitals in which high percentages of nurses voted to reject the offer negotiated by the union ("No" facilities) and five nurses from each of two hospitals in which high percentages of nurses voted to accept the offer negotiated by the union ("Yes" facilities).

Post-Job Action Study

The Pilot Study
This phase of the study took place after the strike but during the job action of refusing overtime work. The purpose of this phase was to test the questionnaire for content and comprehensiveness.

Following the many interviews of nurses before and after the strike and before and after the settlement ratification vote, a pilot questionnaire was developed (Appendix V). The final questionnaire was developed in consultation with the writer’s supervisor, Dr. Norman Robinson, Professor of Educational Administration at Simon Fraser University. Then final questionnaire was comprised of 101 items relating thematically to the seven areas of conflicts outlined in Chapter 2 (Appendix VI). A study that was used as a resource in developing questions was that of a study done in 1964 by E.J. Ingram, Executive Assistant of the Alberta Teachers’ Association and a subsequent study done in 1987 by Patricia Munton, in a Master’s of Education Project at Simon Fraser University. In particular, subproblems developed from questions used in those two studies were subproblems 1.0; 2.1; 2.2; 3.1; 3.2; 3.3; 3.4; 4.1; 4.2; 4.3; 4.4; 5.1; 5.2; 5.3; 5.5; 5.7; 5.9; 5.14; 7.3; 10.5; 12.9; 12.13; and all questions related to subproblem 15.0.

Subproblem 5.4 evolved from the literature on nurses and trade unions (Alutto J.A. and Belasco, J.A.,

Subproblems 10.1 to 10.6 were derived partly from Bloom, J.R., Parlette, G.N., and O'Reilly, C.A. (1980); subproblem 10.2 on the nurses' commitment and its exploitation was derived from Alutto, J.M. and Belasco, J.A. (1974) and Corley and Mauksch, H.O., (1987).

Subproblems 3.5; 5.6; 5.10; 5.11; 5.12; 5.13; 6.1; 6.2; 6.3; 6.4; 6.5; 6.6; 7.1; 7.2; 7.4; 7.5; 7.6; 7.7; 7.8; 9.2; 9.3; 10.1; 10.3; 10.4; 11.1; 11.2; 11.3; 11.4; 11.5; and all of 12.0; 13.0; 14.0; and 15.0 were primarily developed from recurrent themes of the nurses' interviews before, during and after the job action. These issues raised were also supported to varying degrees in the literature described in Chapter Two; however, some specific questions pertained to this particular strike.
Procedure. Twenty nurses from a Lower Mainland teaching hospital were requested to take part in the pilot study. Eighteen nurses who were provided with a draft of the questionnaire responded. The researcher requested the participants to analyze the draft and then to answer questions about the draft with respect to format and comprehension (Appendix V).

In a covering letter accompanying the questionnaire, nurses were requested to appraise the questionnaire for content, for comprehension and for style. Envelopes were provided with numbers on the outside so that the union representative would be able to account for which participants had returned the questionnaires. After critiquing the questionnaire and answering the questionnaire, participating nurses were asked to place completed questionnaire in a the numbered envelope and to return a sealed envelope. The researcher collected the envelope the contents of which were confidential to the representative. The researcher was unaware of who the participants were and could not identify participants by the envelope.

Overall, the comments were positive regarding the questionnaire. The questionnaire was lengthy (ten pages); however, only one respondent thought that the questionnaire was too long. All other respondents indicated that all the questions were essential and
none should be removed. Some respondents suggested additional questions which had been previously been considered but had been rejected because the focus was not appropriate to the study. Many of the respondents expressed that they were pleased that a study was being done. Some nurses wrote about their feelings about nursing or of incidents that happened to them during the strike.

After review of the comments, the final revisions were made and the questionnaire was then reproduced and made ready for subsequent distribution.

Participants. For the pilot study, a hospital was selected in which nurses had not previously been interviewed. A purposive sample of 20 nurses were selected to test the post-strike questionnaire. A union representative was requested to approach 20 nurses some of whom could be considered by the union representative as being supportive of strike actions as well as those who were unsupportive of strike action.

All units within the hospital were represented. Nurses were from all levels of responsibility (e.g. head nurse, staff nurse, instructor) and with a variety of contracts (full time, part time, casual).

Post-Job Action: The Nurses' Questionnaire

Procedure. In September 1989, two dissident council members (McPherson and Stringer) brought forth the
issue of distribution of the study questionnaire to the BCNU Council. The BCNU agreed to release a bulletin throughout the province outlining the background and purpose of the study and suggested that nurses interested in participating should contact the researcher (Appendix VII). Union representatives contacted and/or were contacted by the researcher to distribute the mailed questionnaires (Appendix VIII).

Six hundred and eighty questionnaires were sent to nurses in 28 facilities throughout nine regions of British Columbia. Larger hospitals were given more questionnaires and small facilities were given proportionate numbers of questionnaires to distribute.

The questionnaire was developed, as previously described, from information obtained in previous interviews before, during and after the strike and in the pilot study. Accompanying the questionnaire was a covering letter and a self-stamped envelope with the only identification being a letter code indicating the facility from which the questionnaire returned.

Of the six hundred and eighty questionnaires sent out, 521 participants or 77 per cent returned their questionnaires completed. Many of the questionnaires had pages of comments attached.

Nurses were anxious to discuss their feelings about the job action. A high return rate and many pages of
written comments substantiated this.

I wanted to tell you that I was in the "bush" when I completed this study...I was a bit panicked as to how I'd get it to the mail on time as it meant a day trip out to the local post office and then finding the time between hauling water and cutting wood. I was amazed how quickly I actually organized my time to sit down and do it and how up I felt when finished. Thank you for doing this study and good luck!

Participants. Union representatives were requested to distribute questionnaires only to those nurses who were interested in participating and to nurses who had been both active and inactive in the union. The nurses were of various ages, from all levels of responsibility (i.e. staff nurses, head nurses, educators, clinicians) and practicing in a variety of units in their hospitals.

Tables 41, 42 and 43 shows that the majority of nurses were married (70.0 per cent), female (94.2 per cent) and had one or more dependents (55.8 per cent). The most common age group responding was between 41-50 years (37.3 per cent) with the 31-40 age group (36.7 per cent) closely behind (Table 40). This profile is similar to the Statistics Canada (1986) information which revealed that married women made up 70 per cent of the nursing work force, were female (97 per cent) and that two thirds of nurses were aged 30 and over with the fastest growing component between 30-44 years. Table 45 shows that the majority of respondents had
graduated between 1960-1980. 37.4 per cent had more than 15 years of practice, only 15.7 per cent had less than 5 years (Table 46).

Of the responding nurses, 71.9 per cent were employed full time (Table 48). Again, similar to the Statistics Canada studies which showed that 33 per cent of nurses were employed on a part-time basis, this study showed that 28.2 per cent were employed on a part-time or a casual basis.

The respondents were employed in tertiary (36.7 per cent), medium size (35.2 per cent), small (19.2 per cent) and long term care (8.7 per cent) facilities (Table 51). Table 50 shows that nurses had practiced for long periods in their facility. 27.5 per cent of nurses had been employed for 5-10 years; 32.4 per cent of nurses for over 10 years in their agency.

Nurses came from all specialty areas, primarily from Medical-Surgical areas (27.7 per cent), then critical care and Emergency (23.9 per cent), and geriatrics (11.7 per cent) as shown in Table 52.

Table 47 reveals that 89.9 per cent of nurses had an RN diploma preparation. 16.9 per cent were enrolled or prepared at the BSN level; 5.1 per cent were enrolled or prepared at the Master’s level (only 1.5 in Nursing). Nurses with post basic preparation were 22.9 per cent; 11 per cent had other preparation. These
statistics show a higher level of preparation that those obtained by Statistics Canada in 1986 in which only one third of nurses had obtained qualifications beyond the basic diploma training.

Table 44 shows that the majority of respondents were staff nurses (76.0 per cent). Head Nurses were 11.7 per cent, Assistant Head Nurses 3.1 per cent, Supervisors, 2.9 per cent and others such as staffing coordinators, educators, clinicians (6.0 per cent) responded.

Table 49 points out that 75.4 per cent of nurses noted they would be uncomfortable or distressed if salary were withdrawn. Table 53 shows that participants' source of income during the strike was mainly through working essential shifts (68.8 per cent), while 31 per cent of nurses were supported by husbands/families. Nurses who were not paid tallied to 4.4 per cent, 4.4 per cent borrowed money; 25.8 per cent used savings.

Data Treatment. The data was coded on to an column code sheet accommodating one question per line. The responses were coded using zero for -2 through to five for +3. Blanks were left on the computer coding sheets if no response were given to a certain question. Whenever a response was omitted, the "n" was adjusted accordingly.
The statistical package for the Social Sciences (SPSS) was used to obtain frequency distributions, one way analysis of variance, chi square tests, Pearson product moment correlations, and t tests.

Post-Job Action Data

The Nurse Administrators' Study

The purpose of this research was to explore what nurse administrators felt were the issues of the strike and to explore the conflicts they experienced during the strike since the literature suggested that nurse administrators would have a different idea about the reasons for nurses' striking (Bloom, Parlette, and O'Reilly, 1988; Colvin, 1987; Metzger, Ferentino, and Kruger, 1984. The researcher made the decision to include nurse administrators in the study based on a request to the writer by a nurse administrator for an interview to discuss the considerable conflict experienced by herself and peer administrators during job action. An interview format was developed based on similar questions to those asked in the striking nurses' questionnaire that was distributed to them after the job action (Appendix IX).

Procedure. Letters were sent to nurse administrators in ten hospitals in the Lower Mainland and Fraser Valley requesting interviews with nurse administrators (Appendix X). Interviews were conducted
individually, in person, and all participants agreed to be audiotaped. An interview schedule was followed using open-ended questions were asked of the participants. All questions related to strike issues and conflict experienced during the strike. Audiotapes were subsequently transcribed.

**Participants.** Twenty-nine nurse administrators agreed to be interviewed. Participants included twenty-two Directors of Nursing and seven Vice-Presidents of Nursing.

**Data Analysis.** The data collected were analyzed in an interpretive manner and categorized into similar areas such as the data of the striking nurses'.

**Summary**

In this chapter, the research methodology employed in the study was reviewed. The data required for the study, the procedures and the instruments used to measure the variables under study have been described. The sample chosen was a purposive sample of British Columbia nurses. Finally, the statistical treatment of the data for these nurses has been outlined.
CHAPTER 4

RESULTS, ANALYSIS, DISCUSSION AND CONCLUSIONS

Pre-strike Study:
Issues and Conflicts Experienced by a
Random Sample of Nurses In
Four Hospitals in British Columbia

Introduction

In this section the results of the pre-strike study are summarized. Since the study was exploratory in nature, multiple issues were explored which related in part to theory and in part to the concerns raised by the participants in the study.

Twenty-five nurses from four different hospitals (one teaching hospital and three community hospitals) in the Lower Mainland and the interior of British Columbia were interviewed. Nurses practiced in a variety of units: Emergency, Critical Care, Psychiatry, Medicine, Surgery, Obstetrics, Pediatrics, Ambulatory Care, and Long Term Care. Three participants were head nurses, one was an assistant head nurse, and 21 were staff nurses. Twenty-two nurses were diploma prepared and three had baccalaureate preparation. About half had post basic specialty preparation. Twelve nurses
were married, eight were single, four were separated or divorced and one was widowed. Twenty-one were employed full time, three were part time and one was employed casually. All were female.

Analysis of Problems

Analysis of Pre-strike Subproblem 1.0 - The Issues
What were the issues for which nurses would/ had vote(d) to the strike?

Findings. While most nurses mentioned that wages were one of the issues, the majority of nurses identified many other issues.

Nurses with lengthy nursing careers strongly believed they should be compensated better. A nurse with 20 years experience said:

I would like to be paid more for my experience. If I were in another career, I would be paid more. I think I am worth it.

Experienced nurses had frustrations about the lack of change in nursing as well as the lack of compensation for their work. One nurse with 28 years experience put it this way:

I am frustrated with the fact that I am doing the same sort of work that I did 10 years ago. I am frustrated that doctors and administrators don’t value us. Also, I started nursing at $11 per hour and after all these years, I get $17 per hour. If money were the thing that made me most unhappy, I wouldn’t have stayed in nursing, but it isn’t good.
Nurses with career longevity did not always express their concerns in financial terms. The majority of nurses interviewed had professional concerns. One nurse with 13 years experience described her concerns this way:

I love what I do so I may be different from the younger girls. But the nurse-patient ratio, the safety factor, is a real issue for me. I have 16 patients to give care to. The level of care I am able to provide is frustrating to me.

Another nurse with 10 years experience:

Sure wages are an issue - plus working conditions. The government reduces the money allowed to hospitals so they cut here and there and nurses pick up the slack - all this gets added to nursing duties where we are already pushed. Housecleaning cuts, supply cuts, and who makes do? Nurses. The medical profession doesn't see us on an equal basis as a profession in our own right, as a member of the team. We have the same rights as doctors have.

A nurse with 25 years experience believed that the main issue related to who would ultimately control nursing practice:

I think the issue is concerned mainly with control over nursing especially in the area of management issues. I have a bias in that I think that unions also want more say in nursing issues in areas where nurses work. I also feel nurses are looking at other salary settlements throughout the country and they want parity.

Another nurse with lengthy experience (22 years) identified the issue of nurse recognition and pointed to nursing administrators for lack of support:
Certainly wages are a factor but I don't see them as being the whole issue. I think nurses want recognition of what the value of nurses is. And...administrative support. In most cases, administration looks after itself and not after issues that concern the nurse. They don't pay attention to nurse advocacy and patient rights. In theory they agree, but they won't go out on a limb for nurses.

When wages were mentioned as an issue, nurses frequently commented on their discomfort with comparison to other nonprofessional wage earners.

I don't particularly like when nurses look at what Safeway clerks make. I think we are worth more than what we are getting because we deserve more not compared to others but compared to ourselves.

Nurses who were relative newcomers to the profession would assign priority to their issues with wages following other issues. This nurse with three years experience outlined her priorities:

In priority for me, the issues are job perks: first; second: wages, benefits, sick leave and vacation and education. Safety is a big issue for all of us.

A nurse with one week experience agreed:

I think the professionalism issues are the most important, after that comes education, time off for professional development and then wages.

Discussion. The majority of nurses interviewed believed that the main issues centered on professional issues: maintaining standards of care, working conditions, administrative support, recognition and value for experience and work. Wages were secondary
with the majority of nurses. This finding is in agreement with Metzger (1984) and also Beletz (1988) who argue that nurses are less concerned about industrial-sector bargaining issues such as wages and job security and more concerned with respect from other professionals, administrative support, and other professional issues.

Analysis of Pre-strike Subproblem 2.0 - HLRA

Settlement. Would nurses anticipate a settlement by HLRA without having to strike?

Findings. None of the nurses interviewed felt that the contract would be negotiated by HLRA without a strike vote mandate in the least, or a strike at the most. Most nurses who voted to strike described themselves as being influenced by the HLRA advertisements in the newspapers telling the public that nurses in British Columbia were "the highest paid in Canada" (Vancouver Sun, May 8, 1989).

I was influenced by the advertising of the HLRA - they misrepresented us to the public and it triggered me into voting to strike. The HLRA is going to use nursing as an example to other health care providers that government will not bow to demands.

Most nurses who were interviewed had similar comments:

The thing that made me more angry was the HLRA ad in the paper - they spent my tax dollars to blatantly lie about our wages and conditions.

I think I was a little influenced by the advertising HLRA had done - the misrepresentation of benefits and salaries. I
think that was why for the first time I voted to strike. I couldn't believe that a bargaining agent would do this. I couldn't believe it. I don't think they would come up with a package without a strike vote.

Even a nurse who voted "NO" to striking said:

They are absolutely firm in their offer - they have a warped view of the situation.

Another nurse had a similar indication that nurses were not going to have an easy time with bargaining.

I think the government is making a political statement; they are unwilling to give nurses that much - especially after the Alberta strike.

This nurse had a sense of what was to come:

HLRA are not prepared to spend a cent more than they have to. They will push us as far as we can go before they make a real move. Their objective is to run hospitals and save money. They will even make money on a strike.

Some nurses felt that a strong strike vote would foreshadow the strength of nurses' conviction regarding the issues and would cause the government negotiate less stringently:

I think a strike will be necessary. A strong strike mandate will make the government think about it - they think now that we are just whiners and are crying about nothing.

Nurses frequently felt they would have to be brought to striking to resolve the problems.

Our problem with nursing as in teaching is that when we negotiate we try to be reasonable. I think as a profession we attract types of individuals who tend to be nurturing and accommodating and who tend to comply. If nurses are aggressive it is usually for their
patients or in terms of their professional development. And the nursing figureheads do not stand out as impressive or well known as in labour, for example. So without a strike no one will effectively vocalize that we are not happy. It doesn't work that way.

I think this vote will help HLRA act a little more quickly. If we don't get a strong mandate or if we don't get a clear cut vote saying we don't have strong support then they won't act. If we get a strong mandate, they will have no choice but to have to negotiate. They will have to do something.

I think everything up to the strike vote was grandstanding on the part of the government and the union - they have done no real negotiating. I hope we don't go out too soon since neither have negotiated in good faith.

This nurse was one of many who included the public stakeholder in the strike message:

I don't think the strike vote will do it, but it will impress upon the negotiators that nurses are serious about why they are and that they have the support of their fellow colleagues and the public will become aware too. The thing is that with hospital care - once the patient leaves it, they don't do too much more thinking about how unfavourable conditions are. And people don't get into hospital all that often. Some people never do and that is great but they should be aware that there are issues that need to be addressed.

Discussion. Nurses believed that without a strike vote, their negotiators (and the public) would not hear them. Many were falsely hopeful however, that with a message of a strong strike vote, there would be a settlement. Beletz (1988) says that it is difficult to assess the degree to which nurses' militant attitudes matches that of actual militant behaviour since many
nurses have not accepted the concept of the strike.

Analysis of Pre-strike Subproblem 3.0 - Previous Experience with Strikes

What were nurses' previous experiences with striking either personally or with family members?

Findings. Most nurses interviewed had no experience with striking either personally or with family members. Nurses who had previous experience with striking, either personal or with family members were not looking forward to the experience of a strike. Experiences were primarily negative.

Four of the interviewed nurses however, had experienced strikes in other provinces:

I was involved in the 1975 strike in Alberta and since I was a student, I had to cross the picket line. We were escorted by police and security. It was an awful experience, there were tires slashed and people were struck with picket signs.

In the Alberta 1979 strike I worked in a small hospital and we agreed to vote NO to strike since the results would have a devastating impact on such a small, isolated community. It was a chicken way out, we got benefits and our friends suffered. I didn't feel good about it at all.

Some nurses had relatives who were involved in strike action in another line of work. Three nurses were married to teachers who had been on strike previously.

A nurse who voted "NO" to striking:

My husband was on strike and I feel ambivalent
because of his experience. There was a great deal of peer pressure from his peer group, it changed the whole relationship between them. The picture was a strained one - they all felt enormous pressure.

A nurse who voted "Yes" to striking:

My husband is a principal who was not considered to be management at the time. He had to cross the picket line to keep the schools secure. It was a funny sensation to be one of them and yet not. In his case they were supportive, but in many others, the strikers were not.

Other nurses had experience with nonnursing unions' striking.

HEU struck and we weren't supposed to cross the picket line. I was in an Intensive Care Nursery and the babies needed nurses, so I could cross the line and it didn't bother me. I did laundry and cleaning - the place was never so clean!

Discussion. In nursing, there are generally no studies that explore the effect of previous striking and experiences with striking on strike votes. Most of the literature pertains to attitudinal and participation in collective bargaining as it correlates to marital status, age, religion, education and union membership of spouse. Baird (1968) studied variables such as occupation of and labour union membership of father, and occupation of spouse as variables in determining attitudes toward collective bargaining and found that favourable attitudes were held by nurses whose husbands were members of unions.
Analysis of Pre-strike Subproblem 4.0 - The Strike

Vote. Would/had nurses vote(d) to strike on May 17, 1989?

Findings. 24 of the 25 participants indicated that they would/or had voted to strike on May 17, 1989. The participant who did not vote to strike said:

I struggled with the whole thing and ended up voting the way I felt because I don't like strikes. However, if we do strike, I will accept it and support it. I respect the choice of the majority. I can understand why people voted to strike and I will go as far as I can personally live with. If I am called upon to picket, I will. But I am NOT a public statement.

Whether nurses voted to strike or not, they had difficulty with their decisions:

A staff nurse related:

I voted yes, but I have to say I wrestled with that. Basically, I am not a militant, it isn’t my makeup. I don’t like strikes, I don’t want to be on strike. I wanted to send a message that these issues nurses are asking for are legitimate, and that they needed to be attended to.

Discussion. 96 per cent of nurses interviewed voted to strike. This figure is relatively congruent with the actual vote in which 94 per cent of nurses voted to strike.

Analysis of Pre-strike Subproblem 5.0 - Anticipated Concerns

What concerns did nurses have in anticipation of strike
action?

Findings. Voting to strike was one thing, but actually having to take strike action was another. Much anticipatory anxiety was expressed. Nurses were clearly uncomfortable in their decision to vote for striking. The concern focused not only on their potential withdrawal of care, but on their image if they did withdraw care. Not all nurses had the experience of striking before, so for most it was a first time experience of working through their feelings on their personal ethics related to striking. The other frequently raised issue which should be of interest to nurses' unions and other health care unions, was that of nurses' feelings about picketing. When nurses felt strongly about patients' not receiving the needed care, nurses expressed a strong desire to cross the picket line. Nurses recognized that they were different from other trade unions in that respect.

An emergency nurse described her anxiety this way:

I hope I will be declared essential service. I am worried about violence, name calling and co-workers missing shifts and not getting paid. I would be afraid of having conflict with my coworkers afterward if I don't withdraw my service. But I will have more conflict if I do withdraw service.

A head nurse spoke of a common concern among other head nurses interviewed:

The stewards told me to put on my head nurse
hat for getting an essential service plan together for my department. Then they said take off your head nurse hat and think like a staff nurse for the strike AND they told me I would not be considered essential service during the strike. Head nurses are essential - someone needs to be at the helm. This is causing me conflict.

Another head nurse could not face a strike in her position.

I am going to take holidays during the time that I think they might strike. Who needs it?

Some nurses felt that this was not only a significant event in terms of career, but also in their lives:

I feel like this decision or event if it comes to that, will make a change in my life. I have heard about other strikes having strong pulls on other nurses' social and work lives so I have anticipatory stress.

Anticipation of picketing was of highest concern to most nurses before the actual strike took place.

Even when I voted yes, I thought I won't picket. But now it looks like a reality. I can't just send a symbolic message. It would not feel OK to not picket, but the idea of it is foreign to me - the power of it. I just don't know what I will do, I feel in such conflict about it.

I think picketing is a useless exercise. There are always other things you can do for the cause.

I said no when they asked for picketing volunteers. I am against it. Seeing picketers make comments and the hostility of picketers towards their peers and the public -I couldn’t stand it. It makes the whole thing seem like a money issue, and it is unprofessional. I chose nursing to help people and I would not be helping people.
Many other nurses expressed concern about the image of the professional nurse on strike.

It isn’t congruent with the image of the nurse. It doesn’t fit with the idea that you are trying to project, you know, the caring nurse.

I will picket but I feel about a 6 out of 10 like a teamster. I guess it doesn’t bother me.

All nurses interviewed agreed that under special circumstances that they would cross a picket line:

If there were an urgent or emergent situation I wouldn’t have any problem with crossing a picket line. I think that is the difference between nurses and other trade unions on strike; nurses don’t get as heated about that type of issue as they do about patient care issues and the work part of it. They are as much after patient good as they are for their own good. That is where you can’t compare Supervalu and the road crew to us.

The essential services plan for our department may be ludicrous - but I don’t know anything about it since the union won’t tell us what is going to be essential. So I can’t tell if I would need to cross or not. If there are problems with maintaining safe patient care, I still feel they come first. I don’t know if I will cross.

I may have to cross the picket line if the strike goes on for a long time. I have bills to pay, and I have to eat.

Discussion. None of the studies on nurses examine the concerns that nurses feel about striking itself. Munton (1988) studied strike propensity and strike compliance in teachers and found that when a teacher is in favor of striking and the teacher has strong issues surrounding the strike, the teacher will go out on
strike. When a teacher is opposed to striking and has strong opinions on the issues surrounding the strike, the teacher will cross the picket lines and continue to work. Whether nurses would be comparable to teachers in this respect is not known. Alutto and Belasco (1974) examined attitudinal militancy among teachers and nurses and suggested that teachers may have different militancy predispositions since their employing organizations are so different from nurses. In this strike, compliance was not tested, since most nurses crossed the picket line to perform essential services.

Analysis of Pre-strike Subproblem 6.0 - Union Involvement

How much involvement did nurses have in BCNU?

**Findings.** Two nurses of the 25 had attended union meetings on a regular basis. Another nurse was a member of a BCNU committee. Two nurses said they would not belong to the BCNU if they had a choice.

**Discussion.** Twelve per cent of nurses interviewed had activity in their cohort group just under the average cohort group activity of 14 per cent (Cutshall, personal communication, 1990).

Analysis of Pre-strike Subproblem 7.0 - Union Feelings

What were nurses' feelings about their union?
**Findings.** No nurse expressed that they like an integral part of the union. Many nurses who were interviewed felt that having a nursing union was "a necessary evil" in order to obtain their rights and entitlements. Whatever the feelings of nurses about unions, they were strongly held one way or the other.

I see why we have a union and it does keep us well informed and I think it is working in our best interest.

A few nurses had ambivalent feelings about belonging to a union:

Unions are blatant, outspoken and aggressive. All the things that I am not. But they are good advocates.

Nurses expressed positive feelings about the BCNU in this way:

I feel comforted and protected when I think of the union.

I feel that unions have to be very good because of my husband's experience. When we lived in Ontario Stephen Lewis got his job back for him.

Many of the participants had negative feelings about the union:

Unions look more at issues only and they are hardline. They take your money and do this for you - like a contract. I think they aren't as concerned for the little guy as they say. I never use the union.

The general public image of the big labour unions influence my feelings about our union. I suppose there are some people in those unions who are alright, but I just find unions cold and unapproachable.
I don’t trust the union. It is asking too much and we may not benefit in fact we may lose in the long run.

I feel the union is forced on us.

Only one nurse was able to relate an experience which made her feel negative about the union.

I was a member of the bargaining committee. When I applied for this position, I got the job so I quit my other one at another hospital. This position got grieved so I wasn’t sure I would have a job. The BCNU did not respond, nor did they send a letter to explain as they had promised. I asked them what are you going to do for me - but they just left me hanging.

One nurse expressed concern about union leadership:

I have mixed feelings about the leadership in the BCNU. Some of the staff leaders in the BCNU are not nurses - unlike the RMABC. They have no nursing credentials and it is wrong for them to be in that position.

Discussion. Nurses who self-selected to participate in this study may have had a longing to discuss their conflict surrounding the issue of striking and concerns of a professional nature.

Pat Cutshall, Executive Director of the RNABC suggests that there are basic philosophical differences between those nurses who are attracted to the ideals of the union are and those nurses who are attracted to the ideals of the professional arm and that they are perhaps unmarriageable (personal communication, 1990). Others have suggested that professionalism and unionism are incompatible as well (Hopping, 1976; Beletz, 1988;
Kerr, 1988; Luttman, 1982).

Analysis of Pre-strike Subproblem 8.0 - Identification with BCNU and RNABC

Did nurses identify more closely with their union or their professional association?

Findings. Although the majority of participants identified more closely with the RNABC than with the BCNU, none indicated that they felt an integral part of the RNABC. Only one nurse of the 25 attended local RNABC chapter meetings on a regular basis, one was a member of an RNABC committee and four were members of an RNABC professional practice group. Eighteen of the 25 nurses said they were satisfied with the leadership of the RNABC. Fifty percent of the nurses felt that their level of interest in the local RNABC was high however they did not express an interest in attending meetings.

Generally, nurses understood that the professional association had a place and the union had a place in their career.

I feel equally toward the professional association and the union. The union looks after working conditions and the professional association, the standards. It is that basic.

It is interesting that the two arms of the nursing organizations have conflicting images according to the nurses interviewed. The RNABC was seen to be "human", "caring", "helpful", and "available": all words which
would be in keeping with the caring ideals of nursing. Other words such as "visionary", "resourceful", "insight", "health promotion" could be associated with the professional ideals of nursing. Positive words used for describing the union were "protected", "advocate", "comforted". These can be associated with the protection of the worker part of the union ideals. However, the words "hardline", "cold", "blatant", "aggressive", "self-centered", "trust", "alien", and "restrictive" are words which connote negative images which are possibly not congruent with union ideals and would not be considered to be professional ideals of nursing.

Some nurses felt more familiar with the RNABC than the BCNU:

I identify with the professional association more than with the union probably because I have no previous experience with the union. I feel alien to the union. I, at the moment, feel more like a teamster than a professional.

Two characteristics were frequently described by nurses when they described a more close association with the RNABC than with the union. First, they felt that the RNABC was more visionary in their approach to nursing and that the RNABC was more responsive to their practice concerns.

More with the professional association. The union is militant with one perspective. They have no global picture. They don't see things on a higher level or have all the pieces to the
puzzle. The professional association has more skills and training and have a broader spectrum, broader horizons.

The professional association was labelled as more "caring":

The RNABC has been more caring, fairly responsive in that if I call with a problem, they are helpful, resourceful. I don't think the union represents me very well and they don't go back to their members to vote enough or to get feedback.

The professional association is more human, not just looking at issues, but they have more insight into how nurses really feel and are supportive. If I needed counselling or guidance I would go there. The union looks more at issues only and is hardline and cold. They take your money and do this for you - it is like a contract.

Some nurses believed that the union restricted their growth.

Although I don't have much experience with the RNABC, I identify more closely with them than the union. The RNABC attempts to expand and to build credibility whereas the union concentrates on holding back and restricting nurses from development.

A professional image was important to others:

I like the idea of the professional association's image which is that it tries to portray promotion of health, the health care system and the PATIENT'S condition. The union is militant and aggressive and self centred.

Some found benefits in both:

I identify with the professional association because they are idealistic, they are available and they offer so much. They support the benefits that we get. But I do think of the union as a comfort, a protection, and for better wages.
Although some felt more comfortable with one or the other; the desire to participate was low:

I feel more familiar with the professional group, but I have low interest in participating. I should make more effort. As it is I just make an effort to read the journal. I feel alien to the union. It has never been unresponsive to me or anything. I just feel that the union takes my money and I don't have much trust in it.

There were those who were pessimistic about the ability of either organization to make change, nor their employer.

I think the professional association should deal with professional issues - and the union should not. The trouble is the professional association is not doing it very well so far. And the union can’t do it.

One nurse in her fifties was not positive about the RNABC because she felt that the aim to have baccalaureate prepared nurses was not a good one.

It is not convenient for me to get a degree at this time in my life or career. University degree nurses have a different outlook. They don’t want to give the physical care, they just want to talk to the patient. Who is going to clean up the messes?

Discussion. These nurses have described characteristics of professionalism versus those of unionism one of which may be more compatible with the nurse’s basic philosophy. For example, the professional association’s tendency to respond to the needs of varying sectors of membership and to take stands that will not only enhance standards of care,
but will address needs of different categories of members differs from the union whose basic philosophy is that of egalitarianism (Kerr, 1988).

Analysis of Pre-strike Subproblem 9.0 - Relationship BCNU/RNABC

Did nurses feel that the BCNU and the RNABC should work more closely together?

Findings. One hundred per cent of participants believed that the professional association and the union should work more closely together. Nurses had no suggestions as to how these two organizations should do this; but it was a strongly held view by all.

Discussion. Gilchrist, (1987) and Kerr (1988) both discuss the relationship between unions and professional associations. Kerr suggests that the conflict may be symptomatic of the maturational stage of the relatively new union organizations and that in the end, professional associations and unions will work out ways to carry out their mandates and that compromise will be necessary. Gilchrist suggests that a mix of "common and divergent interests" will allow nurses to "share power and create a virtual interdependence", but only after "greater and more honest communication, commitment, motivation and individual involvement of the people concerned" (p.33).
This means that the nursing body themselves must elect leadership with commitment to these goals if they wish reduced conflict between the groups.

Analysis of Pre-strike Subproblem 10.0 - Head nurses and Union Involvement

What were head nurses' feelings about their role in relation to the union and strike action?

**Findings.** Three head nurses were interviewed before the strike. They expressed concern about how they were represented in normal times, and this became an issue with them during the period surrounding job action and negotiations. All head nurses who were interviewed speculated as to how they would be represented in the union negotiations and commented that other head nurses felt similarly. Ironically, head nurses expressed as much, if not more than staff nurses how undervalued they felt, from all sides - management and union.

They should have a staff nurse level and a management level. I like the idea of strength in numbers and that I would be protected from wrongful dismissal. But they don't represent me very well.

Head nurses felt strongly about their leadership. They did not feel part of the "herd mentality" as one head nurse put it:

I see myself as a mover and shaker, not as a follower or a sheep.

The issue of being neither fish nor fowl (management or
staff) was the most frequently mentioned conflict that head nurses related.

Being a head nurse you are of no use to management during a strike and one gets the feeling that the union doesn't want you either. You are not on either side. During a strike time you need people there who know the area and can make decisions with both the union and management and yet this person, the head nurse, has been totally ignored.

Discussion. Union philosophy is based on that of egalitarianism; the collective is looked upon as a uniform entity (Hopping, 1975). Paradoxically, head nurses, although union members, were not treated equally by the union. All head nurses were considered to be nonessential by virtue of their position (considered by the union to be "management" within the bargaining unit) rather than by the nature of their work; unlike all staff nurses who were for the most part judged by the nature of their work and their position of nonmanagement.

Summary and Conclusions of Pre-strike Study

Nurses in the pre-strike period, had strongly held views on the issues for which they would vote overwhelmingly to strike. The issues focussed on those of recognition, value and working conditions and wages were of secondary importance.

Among the conclusions which emerged from the pre-
strike interviews were:

1. Nurses hoped that giving a strike mandate to their union would be enough to convey to the government, their administrators and the public a message that nurses were serious about negotiating a contract which would demonstrate that nurses were valued.

2. Nurses equated "recognition" not only with monetary aspects of the contract, but also with improvement of working conditions and acknowledgement of their value in the health care system.

3. Nurses wished their contract to be settled in a fair and nonadversarial manner but believed that the government negotiators would push them as far as they could before negotiating a contract which they would find "reasonable".

4. All nurses identified working conditions and resulting patient care concerns as the most significant issues causing them to vote to strike. Wages were not unimportant, but they followed the other issues.

5. Nurses found HLRA newspaper advertisements inflammatory since they incorrectly represented the issues and focused primarily on money, thereby discounting nurses' concerns. The ads appeared to galvanize nurses' conviction to vote in favour of striking.
6. Most nurses had no direct experience with striking.
7. Nurses experienced a high degree of anticipatory anxiety and conflict before the strike.
8. The majority of nurses had not been involved in union activities before the strike.
9. Nurses felt a lack of communication with and preparation by their union before the strike.
10. Although most nurses were not active in either their professional association or their union, nurses felt more philosophically aligned to the ideals of professional association than they did with their union. However, many found the protective aspect of the union comforting.
11. Nurses wanted their professional association and their union to work together, but had no suggestions as to how this should happen.
12. Head nurses were unhappy with their union designating them as "nonessential".
CHAPTER 5
JOB ACTION AND THE STRIKE

Introduction

On June 14, 1989 nurses staged a phased withdrawal of their services beginning at 12 hospitals in British Columbia. The researcher attended picket lines and union meetings, and interviewed nurses in their homes and other sites for the purpose of eliciting nurses' feelings and behaviour in relation to taking job action and picketing from June 14 until August 2 when job action discontinued.

The questions posed to the nurses were similar to those posed in the initial interviews preceding the strike and described in Chapter 3. Since there were not previous studies available describing interviews with nurses on picket lines and in union meetings during previous strikes, the six categories of potential conflict that had been described in the literature (nurses and striking, nurses and unions, nurses and job action, nurses and physicians, nurses and employers, and nurses and their personal life) were raised with nurses to elicit personal accounts of conflict in these areas related to their current job action experience.

Approximately 300 nurses were interviewed
throughout the 17 day strike and the job action that followed. Part one of this Chapter will provide results and discussion obtained by interviews of nurses on picket lines, in rallies and in various other places from the first day of the strike through to the day on which a contract offer was made. Part Two of the Chapter will provide results and discussion obtained by interviews, newspapers and in meetings after the contract offer was made on June 27, 1989 until the day of arbitration on August 22, 1989.

Part One: Before the Contract Offer

On the first day of the strike, the picket line of three striking hospitals in the Lower Mainland were attended. 12 nurses were interviewed on picket lines of the two tertiary care agencies; eight on the picket line of the smaller community hospital. Nurses described experiencing considerable anxiety about revealing personal thoughts and opinions to others' (family members, friends, social contacts and colleagues). On picket lines, nurses gravitated towards other nurses who were similar philosophically to themselves.

The conversations on the picket line could be categorized into professional issues, union issues, physician-nurse issues, administration-nurse issues, and
stresses associated with actual picketing.

On the first day of the strike at a tertiary care hospital, nurses were determined and positive: "We are ready to go the distance." Generally, nurses cited the issues for which they were walking the picket line were lack of understanding and recognition by their employer and working conditions.

Nurses worried about their professional image would become tarnished by their strike action.

I am a reluctant person in doing this strike business. It is a shame to have to go to this extreme. We are not blind militants such as, say, teamsters.

If I had wanted to be a teamster, I could have. I want to be a nurse.

I am embarrassed and shocked by some nurses' behaviour on the picket line. Yelling and rallying.

Many nurses on each picket line referred to the problems as being a "feminist issue".

We are not pillow fluffers. We are women and people don't understand the medical system and the changes in it. Women are supposed to be kind and conscientious and make everything 'right' as their duty, but get no monetary gain. We need to be recognized as women coming into our own. We need more input. The trouble is, women are scared of the consequences.

Nurses took turns blocking entrances to the hospital, and nurses who were blocking the entrances were frightened: physicians had tried to "run them down", the
public were mixed in their response to the blockades.

A nurse commented on physicians:

> The psychiatrists are supportive, they listened to us, discharged their patients and didn't cross the picket line. Surgeons and anesthetists are losing money. Dr.____, the thoracic surgeon went bonkers and drove a 4 wheel drive through the picket line shaking his fist. If he hadn't squealed his tires, we would have been hit.

Another nurse described conflict that she had experienced with another nurse on the picket line.

> A station wagon pulled into the driveway and drove through. This nurse with a foghorn voice came up to me and started screaming that we were supposed to search all cars going into the public lot - I thought she was crazy. I wasn't about to search the public!

One nurse had graduated three weeks earlier and had just been orientated to a hospital. She stood alone on a corner outside the hospital:

> I don't know anyone here. I haven't even had a paycheck yet and I know they aren't going to give me any work inside because I have no experience and they need experienced nurses to carry the heavy loads. I feel scared and worried.

Confusion reigned in all three hospitals, little or no information came from headquarters of the union to the strike headquarters, thus little information was provided to nurses on the strike line. Lack of information was the major complaint. "The NOT knowing is what makes me up tight" said one nurse. Another
One head nurse who walked the picket line was angry with the union for waiting so long to strike after the strike vote:

We voted to strike, not to do nothing for a month and lose momentum. We have had no communication from them during that time.

The picket line on a smaller hospital was quiet and the nurses were even more uncertain as to what picket line behaviour should be; that is, how to block entrances and what to admit and what to refuse entry; what to say to people approaching the picket line.

At this picket line, nurses explained the situation to many elderly people who were visiting friends and family telling them that they would have to park elsewhere. The reactions from these people ranged from bewilderment to anger.

The older people are the worst. I think they have the attitude that nurses are servants and that we should just be thankful for what we have.

Nurses angrily discussed which physicians were
unsupportive as they admitted non-emergent patients for such surgeries as hysterectomies and bowel resections. As the strike wore on, nurses experienced a variety of responses from physicians. On the surface, it seemed to nurses that the majority of physicians were supportive. However, when physicians were opposed to strike action, they were not subtle about their feelings. Some physicians ignored nurses on picket lines.

I can tell that they are not supportive when they don't look us in the eye, and they won't speak - period. They act like we aren't here. They drive through the picket line with their windows up. If you wave to them, they ignore you. Others are excellent. The non-support comes from the minority.

There were close calls with physician's cars.

There are some surprises. Some of the guys who were super nice and helpful on the wards would have mowed us down on the picket line. A few of the doctors are whipping through the picket lines going faster than they should when there are groups of people standing around.

Some nurses believed that physicians who had never before seen nurses in strike/job action, were frustrated because of their loss of income during the strike. And the issue of gender bias was frequently raised.

Many of them are talking to us and wishing us luck. The interns put up a pop stand. Doctors are inconvenienced, they are losing money and patience. Some are annoyed and "uppity". There is a lot of sexism in this.

The physicians were verbally supportive. But
they said that patient care was jeopardized.
Surgeons were belligerent and wouldn’t
withdraw their nonurgent cases. The directors
kept a strict line on the O.R.’s though.

Everything Dr. ______ ordered was STAT. And
he ordered everything he could think of. Wait
until they want support from us. Of course,
they won’t need our support. The government
will give them what they want. It’s the old
boys club, you know.

Some nurses believed that physicians had lost their
manners and in turn nurses lost theirs.

In the plaster room there was a sign that
read, 'PICK UP AFTER YOURSELF'. Some
physician wrote on the sign, 'NO WAY, IDIOT'.
Then someone wrote, 'YOU S.O.B.'.

There were nurses who were more generous in explaining
why physicians were unsupportive. Some posited that
physicians had not been prepared for this situation and
so were not comfortable with the strike action and did
not have the picket line “etiquette”.

Maybe they don’t know what to say, maybe they
don’t know how to approach us, maybe they have
never seen a picket line before.

Nurses themselves had difficulty with picketing. One
nurse described her first time on the picket line:

My heart sunk to the floor when I knew we
would be picketing. I thought, 'Oh I can’t do
that, I will feel like such a fool. What if
someone I know sees me'. But after the first
time, it wasn’t so bad. It felt good to see
nurses finally crawling out from under a rock.

On day two nine more hospitals struck. One nurse on the
picket line demanded,
Where is the union’s P.R.? What is all this focus by the media on money and not about patient care and shortages?

On day three at another community hospital in the Lower Mainland a nurse described the strike there.

There is bedlam going on here. The picket list is a mess and everyone is still going to work. We are out here at their beck and call more than we ever were.

Disorganization best described the strike action in all hospitals - inside and outside.

They jumped in there before they were ready. All they had to do was ask someone else like Alberta how to set it up and carry it out, but they didn’t. When you are union, you are expected to have no family, no home life, nothing.

Organization of picketing and essential service staffing came largely from head nurses and educators.

We, as educators, have ended up doing a lot of the strike organization stuff. Educators are perceived as doing nothing during the strike so therefore they ended up doing union work so they were seen as rabble rousers - it was a fine line to treat on. A lot of the discussion on the picket line by educators was about salary negotiations because twice now, educators have been demoted while head nurses have gone up - within our union, we devalue the importance of education.

A head nurse said:

I am finding out that a lot of people are prepared to squawk but are not prepared to take the final stand. Anyone with leadership skills are shoved to the forefront and left to manage. They say, YOU go talk to the doctors.
Some nurses experienced a drastic loss of income since the areas in which they worked were not considered by the BCNU's Essential Services Committee to be essential to life or limb. Those nurses, for the most part, were head nurses, educators, ambulatory care nurses and psychiatric nurses. There was great inequity between nurses with respect to loss of income. There were a few nurses who had planned ahead.

I have prepared myself for this. I worked a lot to save up for the strike, if there should be one.

Some nurses had serious financial concerns.

I will borrow from my parents. I have too many financial commitments to go any longer than a few days without income.

One single mother worried about how she would manage financially during the strike.

I have no money to do this. Yet I can't manage on what I make. Working as a nurse is a grueling experience these days with no rewards as there once were. So I believe we have no choice. This whole thing is a humiliating experience for me.

"Humiliation" was an emotion expressed frequently by nurses on the picket line.

I feel monumental stress. It is humiliating to be placed in the position of having to strike as a professional. I feel extremely angry that there are not other options.

A prevailing topic on the picket line between nurses was the relationship with their employers.
They (the administration) always have an answer. An excuse. But things never get better.

We are not valued, there is no recognition. They don’t stand up to the doctors. There is no commitment to deal with our issues.

One nurse said of the Vice President of Nursing,

Last year she worked hard at improving conditions for us. She set up some committees - their goals were to improve communication. But those committees turned out to be out to lunch - there is no ACTION, no CHANGE!

A nurse with 30 years experience described her administrative situation blaming the lack of educational and experiential preparation for her administrator’s poor management style.

I think that our Director feels intimidated or unsure of herself. She came to us with little management experience out of contract. She doesn’t have much preparation for the job. She doesn’t have a degree. When you try to talk to her about a problem, she averts her eyes. If someone upsets her, she never calls anyone into the office to discuss it in a professional manner, she just sort of makes comments about them to some people. There is no response whatsoever about incident reports. It is like they disappear into a black hole. It is because administration is so weak here that everyone else pulls together.

One hospital had a picket line of nurses who were very happy with their management and felt guilty for going out. We have job autonomy, we have chances to participate in decisionmaking, we have control over our practice and we do feel that we are listened to and our needs are addressed. Our administrator says we must support other nurses who do have problems in
their workplace and she supports us for doing so.

Frequent comments on the picket line were directed to the union and to how nurses believed the union should be representing them.

I came away from a union meeting thinking I am in the wrong church, in the wrong pew. It was an us against them ROAR. It should not be an adversarial type of think(ing), it should be posting and informing, and staying within our rights.

I have really lost confidence in the union. It is like they are on the side of management.

Disappointment in the leadership of the BCNU was expressed by many nurses. The President, one nurse said, is like Jack Munro, there is little about her that is professional.

The BCNU was not alone in receiving criticism. Nurses who had previously felt an alliance with their professional association, the RNABC, found fault with the organization for their role during strike action. There were many suggestions as to how the RNABC should have acted - none of which recommended silence.

The RNABC could have done some public education about what we do or about nursing shortage.

Where was the RNABC? They should have said something. They mostly support administrators anyway. They could have got across the issue of shortages.

At least they (RNABC) could have written us a letter.
I don't have much faith in the RNABC. They should say something - give some information or support. We just get silence.

Nurses who were unsupportive of their professional association previous to the strike believed they had more fodder to add to their discontent.

They (RNABC) are buying real estate and going for three hour lunches. I have not receiving any information from the BCNU either since the strike started. They haven’t got their act together either.

The policy of "Entry to Practice" in which nurses who enter nursing after the year 2000 will all have a baccalaureate degree was an issue brought up by many nurses. Many nurses questioned the issue; typical comments related to monetary aspects, patient care and recognition.

Why should nurses spent $10,000 for a BSN for $100.00 a year more than we earn?

The biggest problem that I have with everyone having a degree is that no one will want to do the dirty work. Who is going get in there and roll up the sleeves of their expensive silk blouse to wash someone's backside?

I didn’t realize how separate the RNABC was until the strike. I don’t really read my RNABC News. How out of touch are they? Go and get your degree they say. If we think we have problems now, wait until things are really grim and there are no nurses.

I have come to the point where the money doesn’t really matter. I go to work and like my job. But there are a lot of other nurses and women who can go to other jobs where they
don't have to go to university for four years to work as a nurse, to be treated the way we are treated, to be salaried the way we are salaried, and to have no recognition for the work that they do.

On the third day of the strike, a rally was held at Vancouver General Hospital. Approximately 200 nurses attended. Spirits were generally high and striking nurses had many questions. Union organizers for that hospital, Bernadette Stringer and Debra McPherson, had much information to share with the nurses. They pleaded with nurses who were getting "essential shifts" to volunteer to share their paychecks with those nurses who were "nonessential" such as clinical instructors, ambulatory clinic nurses, recovery room nurses, psychiatry nurses. Nurses were requested to picket six hours for eight hours of work and eight hours for every eleven hours of shift. Novices who expressed concern that they were "over their head" in terms of patient management were told to "identify your skills and do your best - but only what is essential". Other nurses struggled with how to not carry out nonnursing duties. Tips were provided to nurses as to how to delegate these duties to management. "Let management work THEIR asses off!", one organizer said.

Other nurses in smaller hospitals watched the
activities at Vancouver General Hospital and commented:

The militancy at VGH was not professional. Giving people the finger. I am not going to act like a teamster and a bully. It is degrading. Let's be ladies about this.

On June 19, the picket line of one hospital visited consisted mainly of HEU picketers. Nurse "picketers" sat under a tarp outside the hospital grounds drinking coffee and talking. A nurse here pointed to three nurses who politely and good naturedly "policed" one entrance to the hospital. The job, she said, had been relegated to these nurses since they were "comfortable" with telling the public and physicians about the picket line.

The rest of us are uncomfortable. Let me take you around to the other entrance where the HEU are, and you will see militancy. THIS makes me cringe. And look at the camper with all the nurses huddling inside while HEU takes over.

One hospital steward said of nurses who were unsupportive of picketing efforts:

Some of the girls were called to picket but didn't come - I don't think they could come to grips with the whole thing. Most are realizing finally that no one is going to hit them with a baseball bat. Some nurses come to work and drive through the picket line - one nurse went through, no slowing down - 15 m.p.h. Everyone got out of her way. She was older. People who are knowledgeable about things can accept things a lot more. When people have previous contact with a union, and have been more involved, they feel more comfortable about what is going on.
Another union steward explained her leadership this way:

I feel obligated to support the staff around me. It is a demanding thing. But it is an inner thing that I feel. It has nothing to do with the union. I find people needed to feel that you were with them. I would drop around on the picket line at 6 in the morning with food; if not a lot of people show up, I stay until one or two in the afternoon. If my husband was out of town, I go back again for a few hours in the evening - take some muffins and just go have a little chat with everybody. There is an awful lot they don’t teach you in labour school and in management school. But my leadership background really helps me.

There were a small number of picketers compared to the numbers of nursing staff.

People who come off duty are nailed to picket. They are exhausted. A lot of people are just not showing up. Some just took off on holidays and didn’t leave a number. The small percentage - 15 to 20 percent of nurses who picket are the same people. Some nurses who work at other hospitals may have picketed there.

Another nurse was dismayed at the apathy by nurses regarding picketing at this hospital, "Where ARE they (the nurses)?"

75 per cent of nurses here are working. Most nurses aren’t going without salary. Picketing and working together are hard on nurses. It is hard to walk that picket line and try to make cheery, when you would lie to be anywhere but.

Many nurses felt that their actions were scrutinized by their colleagues.

You know if you don’t show up people are going
to be keeping an eye out for you.

According to many nurses, however, there were many discrepancies between hospitals in terms of shift sharing and allocation of picketing duties. One nurse who worked in two agencies noted that there were many differences between the two. One agency had:

very poor rapport among the striking nurses and many loyalties. Head nurses and clinical instructors would get into these organizing positions and book shifts for themselves and their cohorts. I filed a complaint with a steward, but no one followed it up. If you were prebooked you were cancelled. There was no casual work or sharing.

The remedy for not picketing, most picketing nurses believed was obvious.

If you don't picket, you don't work - it should be as simple as that.

Lots of people decided to take their vacation and still get paid while all this goes on. Vacations should be cancelled when strikes happen.

Great peer pressure existed for nurses to picket; however, many nurses picketed very little. Bill McDonald, President of the HEU said that the HEU would be "going out soon and that will fix a certain lack of discipline on the picket line." (CBC Radio, June 20, 1989). One nurse verified this:

I hear the HEU saying to nurses, 'Where are your members - if you aren't going to picket can you expect us to support you?'

Concern expressed on the picket line mainly related to
the families of patients. Public support was important
to nurses and they got lots of it.

I think public support helps tremendously. If
the public were opposed (to strikes) and
against nurses, it (picketing) would be more
unpleasant. Excluding my feelings of fear of
picketing, if the public were not supportive,
I would walk away from picketing.

Neighbours have brought us goodies and showed
so much support by honking, talking and
especially by listening and understanding our
position.

Some say nurses lost their innocence in the strike and
in that regard, the picket line certainly caught some
nurses by surprise.

Two men in their twenties drove by in a moving
van. The passenger shouted, "You make good
money!" I would have liked to have talked to
him. It made me angry because I knew he was
comparing my wages to his. He doesn't have my
education, he doesn't have to save lives and
he doesn't have his family life disrupted -
it's got to be worth more.

Another night a car of young men drove by two
R.N.'s and threw eggs at them.

Two nurses on my picket line were struck by a
car. I usually find that men between 20 -30
(no exaggeration) are abusive verbally.

Nurses had difficulty understanding why there were
negative reactions to their job action when they
believed that they were "guardians of public interests"
(Times Colonist, July 11, 1989).

Being called a communist bastard" by a person
of the public really hurt. An older couple in
a big car hit a girl on the picket line, they
did not slow down and she was walking not stopping them. She was not hurt but if she had been standing still, she would have been. Here we are trying to preserve life, to protect life and prevent injury and here is the public coming to attack you.

One nurse rationalized the negative public reaction this way:

The public was psyched up to be abusive. They swear, they run at us with their vehicles. It just blows you away. I guess we have to deal with their frustration, the anger and their fear.

Another community hospital visited on June 19 had a "flat" picket line. Nurses here seemed apathetic. When questioned on this, a nurse on the picket line agreed and pointed out that the staffing inside had only decreased to the level it had been in nonstrike times on weekends. The hospital had sent its request for essential services to Victoria with weekend and holiday rotations and not for strike. Victoria had accepted the staffing levels and it was grieved but nurses were told they must work at the weekend level before the outcome of the grievance. "So there have been no cutbacks, just confusion and frustration", the nurse said. "It has discouraged us."

Another nurse had been on strike previously in Alberta.

I think people here are unhappy about the employer/employee relationship. It will boil
down to who can last the longest. I know from before that money is the issue for nurses after two weeks. And at our hospital there will be less employer/employee conflict because we are a smaller hospital.

Stress dominated the lives of nurses for the summer on 1989. This nurse described her feelings which were similar to many others who were interviewed.

It snuck up on me. It affects my personal life. I can't focus on anything else no. My whole life is on hold.

Some stress about public opinion would be generated at family gatherings and at social functions.

I went to a barbecue at a friend's. A fellow I know socially was there. At first he begged the topic asking innocent questions. Then for two hours he commented non stop, when I was in ear-shot of him, on how nurses make enough money and what do we do anyway and that the public purse can't stand to pay RN's more. His wife was there. She is a cashier in a major supermarket.

At my parents two men took me on. I was intense about it. One might have been playing the Devil's Advocate by asking questions, the other was complaining about how much nurses earn and how they didn't deserve more. I felt like I was being played with. I felt more intensely about that than any other thing in my life. It was an emotional time.

The majority of nurses had family support.

When it first started, I wasn't sure how my husband would react. I could sort of imagine that my spending all my time on the picket line would really bug him. I used his camper truck as our strike headquarters. He was out of town some of the time so he wasn't inconvenienced a lot. He realized why I was doing it.
We went to a social event...someone had seen me on T.V. and said, 'Oh, you’re one of those militant nurses'. I expected my husband might be embarrassed but I could see then that he wasn’t that bent out of shape by it all.

Some nurses were surprised and disappointed that their families who lived with nursing issues on a day to day basis did not appreciate or support their stand.

My husband isn’t hindering this, but he isn’t helping either.

Interestingly, some nurses’ spouses saw them in the Nightengale role.

My husband has no understanding of what I do. He thinks I am Nightengale.

My husband is management so we try not to talk about it. We are both from the old work ethic. We had salaries that are peanuts. Our daughter is a critical care nurse. Your life hangs in her hands. Even though my daughter and I talk to him and tell him the responsibilities and skills that we use on a day to day basis, he still sees me as a bedpan handler, and soother. The high tech stuff and the other changes, he can’t understand - he’s still thinking like the public, that patients lie in bed and we feed them chicken soup.

One nurse who was interviewed in her home in the evening while her husband was out, described her husband and his family as being very unsupportive of this strike. "If I start talking about this (the strike) being a feminist issue, he goes wild." After the interview was finished, as the participant walked the researcher to the door, the participant noted that her husband’s car was in the
driveway, indicating that he had arrived home, but was nowhere in sight. This induced panic in the woman, who immediately began searching the house and yard with the primary concern being that her husband may have overheard her.

Another nurse was afraid to meet at her workplace, in her home or in a public area. After many secretive telephone calls, in which she would not reveal her identity, the nurse agreed to meet with the researcher in the basement of a community ice arena to be interviewed. She explained that her husband had chronic severe medical problems and that he held many opposite opinions about nursing and unions than she. He felt very strongly that she should be striking for more money. This nurse was employed in a long term care hospital and was opposed to striking because of reduction of services to patients.

We were supposed to not answer the phone and to not serve the patients coffee in the morning after getting them up. I did it anyway. I work nights and my enjoyment comes from getting those patients up and serving them coffee and having a chat with them in the morning. I know this caused a lot of friction but I don’t care.

The strike had a direct effect on some nurses’ own families.

I am torn between my feeling for what we are
doing and for what is happening in my family. A family member of mine broke her hip and keeps getting cancelled and put on a waiting list for nonurgent surgery. I feel it is urgent. She is being kept as comfortable as possible, but that is no great consolation.

The issue of patient safety was raised, but most nurses believed that not the service had not been cut back enough to make a difference from normal times.

It is unsafe in there at times, but it usually is anyway, it’s just worse right now.

Decisionmaking about safe levels of care was questioned by some.

There are people working in there who don’t know what is safe and what isn’t.

As the days wore on, much conflict occurred on the picket line and in the workplace between nurses.

The conflict is creating a lot of stress. I would be easier for head nurses to be out of contract. The afternoon float nurse didn’t show up. The supervisor stayed and worked as a float from 3 until 11 p.m. They could have called in a management supervisor, but this supervisor worked overtime. Three people called the union about that and she felt really badly that some of her colleagues actually did that to her.

I feel anger and frustration at a system when you are called in from the picket line and then others look at you with animosity for being called in.

When you aren’t informed, you are left hanging and it is hard to keep up the spirit.

Nurses’ working to rule was also angering support workers who had to pick up some of the extra tasks.
Clerks, a nurse reported, are calling us "prima donnas". Nurses, on the other hand, were experiencing conflict mainly with the HEU.

They don’t have a clue as to what nurses do. I find this incredible especially since some of them work right beside us.

If you ask a practical nurse to do something, she will not refuse because of principle, she will refuse because the union said so.

There was much conflict over what was perceived to be a lack of organization and a lack of fairness by those union organizers. "The stewards are not dealing with the issues and the conflict", a nurse with 25 years experience said. "Besides that, management is wearing down and we (striking nurses) are in the middle again - or should I say still - being punished."

Discussion. There is little if any, evidence of the information uncovered during the strike on the picket line, in the rallies, in meetings, in the social environment in the nursing literature. The profound sensitivity and discomfort that nurses displayed when discussing strike related issues on the picket line and in the company of those who were of different opinions and those who were not well known to them has not come to light. Evidence of abuse on the picket line by physicians and the public has not been exposed in the literature.
In keeping with the literature on reasons why nurses strike, nurses throughout the strike were deeply focussed on the issues of professionalism (Bloom, Parlette and O'Reilly, 1980). During the picketing and rallying, nurses were demanding recognition by the public, administration, physicians. This was reminiscent of study results obtained by Roberts, Cox and Baldwin's study in 1985 in which they found that nurses were "screaming" for recognition of their value, not in a "monetary sense, but instead the value of the position and job duties" (p.28). They point out that from the time of the Hawthorne studies to the present, it has been found that paying attention to people and their needs "pays high dividends" (p.29).

Part Two: After the Contract Offer

HLRA tabled what they said was their final offer. The BCNU bargaining committee came out of negotiations on June 27, recommending that nurses accept the offer. The offer was praised by Ken Georgetti, President of the B.C. Federation of Labour who called the pact the best contract negotiated in B.C. in the past two or three years and likely the best in the country in the past year.
International Woodworkers Affiliation (IWA) Jack Munro said,

You can't, in 1989, sneeze at a 29.5 per cent wage increase. For the people on the lower end, they did a hell of a good job. I understand there is some criticism being measured against some expectations, but maybe some expectations get a bit out of whack with reality. (Vancouver Sun, June 29, 1989)

Nurses were incensed with comments made by the leaders. Munro's comments particularly irked nurses.

The bargaining committee got pressured from the BC Federation of Labour. They are dictated to and controlled by them. We should fight for our rights. This makes me madder than ever.

I don't think Jack Munro knew what he was talking about. He should mind his own business. In view of the fact that he spoke out, I think someone should contact him when all this is settled, and tell him to mind his own business. Loggers out there are one thing, nurses another.

He (Jack Munro) doesn't even know what nurses do.

Jack Munro and his condescending male chauvinism - ha!

He is ignorant. He doesn't know. But we need his support.

Who asked him, anyway?

Do we have to be affiliated with Jack Munro? Is it any of his business?

Generally, nurses did not like to be associated with the trade union movement.

It is not the place of Jack Munro to comment.
He represents a labour force that I don't want to be associated with. I feel the dissident nurses represent that kind of teamsters' mentality. That misrepresents what I feel as a professional.

B.C. Federation of Labour president Ken Georgetti told nurses that if after careful consideration of the factors with respect to the proposed contract nurses still find it difficult to support the agreement, they should weigh the consequences of turning it down.

Nurses were defiant. Some nurses believed that the labour movement leaders would not want to challenge the government if legislation should force nurses back to work.

Ken Georgetti was fully behind us at a rally. But then he started backtracking. He didn’t want Bill 19 challenged. He didn’t want to face it.

Nurses were unhappy with a proposed contract that did not seem to be a great deal different from the initial contract and did not appear to contain the components that would make a contract palatable for them. While BCNU told their members to accept the contract since it was "the best they could get" from HLRA, dissident nurses from Vancouver began a province-wide campaign to reject the deal on a ratification vote. Nurses stormed BCNU headquarters to demand that union leaders reject the offer.
Meetings were held in towns throughout British Columbia. Vancouver nurses raised funds among themselves to support union dissidents to travel the province to crusade their message to vote "no" to the contract in the same way the BCNU would travel the province to encourage nurses to vote "yes". The "no" campaign frequently met with nurses minutes before or after the "yes" campaign from the union. In "Yes" meetings the members of the bargaining committee tried to defend and sell the contract that they had negotiated to members. These meetings often had tense atmospheres of "intimidation and threats that a lot of us found unsettling" (Vancouver Province, July 7).

I went to a meeting conducted by union executives. The attitude portrayed was 'we know better'. Power should come from the bottom up, not the top down. I don't like being told 'we will not answer your question - we have irons in the fire that we can't talk about.' These people should be responsible and answerable to those who employ them.

At one meeting attended by the researcher on July 5, in Nanaimo, union representatives presented the package to members. The contract was outlined by bargaining committee member, Judith Ogilvie in detail. During the presentation, and during question period afterward, nurses found the manner of union officials to be condescending.
Union officials appeared generally disinterested. Members were told to "Shush" and "Be quiet" as they tried to discuss aspects of the contract among themselves.

The membership group was told they would lose more by voting no than by voting yes. The officials warned them that sources at the government level had informed the union that legislation was being prepared as they spoke. They also warned that the B.C. Federation would not be able to "rescue" nurses should there be legislation.

When nurses expressed concern that not enough information was given to nurses before being given to the media regarding the contract, union officials challenged the members, "What would YOU suggest we do with the press?" When another member asked why a salary grid was placed in the paper a union official asked if she were ashamed. One nurse wept as she told of being laughed at by management because there was a high level of essential service staffing and thus the strike action had not been effective. "This has been a bloody waste of time - the employer didn't suffer, we did."

The punitive tone changed somewhat at the point where a nurse asked "Why are you treating us like naughty children? Will you (the bargaining committee)
support us or not?" The union official responded that if nurses refused the offer, the union would have to do "damage control".

"I can hear all the things you are saying about the offer," one nurse put forth, "but tell me, do you personally believe - is the offer FAIR?" After a lengthy pause in a very quiet room, the union official replied, "No".

Further questions challenged BCNU's management of the image of nursing. "Why aren't you telling the public that it isn't just money that we want?" "Why didn't BCNU counteract negative publicity?" The union official responded:

We operate by constitution and bylaws. When you have two members of the council taking a different opinion this will cause negative press. Your meetings have caused your president some embarrassment. It is really too bad that there are all these other activities (the "NO" campaign) going on. They (dissidents) are not on the negotiating committee. At a meeting in Vancouver, your President could not walk through the contract without being shouted down repeatedly.

The meeting was followed by the "no" campaign meeting with Bernadette Stringer and Debra McPherson. They presented good and bad aspects of the contract and detailed the rationale of their opinions. Stringer and McPherson presented the possible options that might
change the contract. Unlike the presenters in the former meeting, they also discussed nurses’ fears related to voting no and what some of the consequences might be, responding to the union’s concern about legislation as "fear-mongering".

The two nurses said that this was an issue of power and they asked the group to consider what kind of message nurses wanted to give in terms of contract negotiations three years down the road. McPherson asked the group if they were saying ‘Yes, this is good enough – I am satisfied’? McPherson asked what message nurses wanted to take to the bargaining committee and to the Minister of Health. Stringer called the bargaining committee “inexperienced, naive, and incompetent” and described the bargaining committee as “patting nurses on the head while being manhandled by Munro and Georgetti!”. Debra McPherson reminded nurses that “Our fight for fair wages and benefits is also a fight for our patients and for the health care system as a whole.”

While nurses waited to vote on the contract, battles raged in public meetings, in the media, and in hospitals. A province wide uproar was heard over a “$1000 bonus, a dinner at the hospital president’s home and a boat cruise” given to administration and management of University Hospital as a “small
recognition for the tremendous hard work they did in very trying times." (Vancouver Sun, July 7, 1989)

Threats to nurses prevailed from the government, from employers, from the trade union movement. The media warned nurses

Woe to the nurses of this province if they turn down the contract offer now before them. They will be flayed by the little stings of editorial censure. They will taste the bitter draught of public venom. Their friends in the labour movement will abandon them to their fate. Their enemies in the hospitals will snigger at the gaudy spectacle of a union leadership left naked and defenseless. The government, stuffed with leering ministers, will happily arouse itself to take advantage of their plight. (Terry Morley, Times Colonist, July 11, 1989)

Threats originated from the nurses own union. The BCNU told nurses that they had "real concerns that a settlement imposed by legislation or binding arbitration would be less than the one before" them (BCNU Bargaining Report June 28, 1989). BCNU spokesman Jerry Miller told the Vancouver Sun on July 7, 1989 that his "understanding is that there is draft (back to work) legislation in a computer in Victoria, and our source is confidential."

The dissident nurses retorted defiantly that "We have been offered a deal that falls far short ... of a collective agreement that rectifies years of injustice...we will be voting to reject it."
Nurses were energized by having their views on the contract represented by the dissidents.

They (the dissidents) are doing the job the union should be doing. I am proud of them.

Not everyone was happy with the dissident nurses.

I don't like the 'mob' thing. I am an individual and private. I don't like imposition.

I had mixed feelings about the dissidents. I didn't like the militancy. They sounded a bit rough and not diplomatic. I agreed with what they said.

The BCNU assured the trade union movement that the nurses who would not accept the contract was a minority, that the union could sell the offer to their membership.

HLRA was believed to have conducted a poll to determine if nurses would go back to work if there should be legislation ordering them to do so. One nurse echoed the thoughts of many others.

They can't legislate me back to work. I would go to jail for this.

Public support remained supportive, but there were some pockets in which the support was wearing thin.

After a 17 day standoff, nurses returned to work on July 2, 1989. Many wore their vote on their uniforms as "Vote NO" buttons. On July 8, 1989, Quebec nurses, undoubtedly buoyed by their defiant sisters in British Columbia, overwhelmingly (77 per cent) rejected an
agreement reached on June 22.

On July 12, B.C. nurses went to the polls to decide the argument. 65 per cent of voting nurses told people in the province of British Columbia that they had not yet been heard - their answer was NO to the contract. Nurses who voted "yes" then became the identified minority and became defensive and quiet. It was difficult to locate nurses who would admit to voting to accept the contract; the majority of nurses who had voted "no" became more adamant than ever and vocal in their stand. Nurses who voted to accept the contract offer had two reasons for doing so: they felt that they could not get a better offer, and they wished to have the conflict over with.

I voted to accept the offer. I felt that we were not going to gain anything more financially. The HLRA said that was it and it was a matter of priorities. I would say that this government does not value nurses.

I voted yes. The money was a legitimate conflict. But I had a desire to get rid of the strike issue. I didn’t like the dissident group ostracizing anyone who wouldn’t wear a strike button.

I voted yes. I didn’t want to go on strike again. I couldn’t stand the workload, the hell and confusion inside the hospital, and the conflict.

By the time they reached an agreement and they recommended our taking it, I said yes. Because I was exhausted, and besides which I recognized in a very short time that this was
not going to improve everything. There is no way that a settlement is going to settle all the problems that we have.

I voted yes. I wanted to end the conflict. I was going through a separation at home and I couldn’t stand anymore than I already had.

We are brainwashed to take anything that is given to us. We tend to be faint of heart.

A nurse with three years experience said:

The people who voted no must have it really bad, if they are that adamant. Maybe I have not been in nursing long enough. I will just go with the flow, I’m not an activist.

Theories abounded about why the majority of nurses at some hospitals voted to accept the offer.

Our hospital is unique and conservative - very religious. They (the nurses) do it for God’s will.

There were nurses who voted yes but wished afterward that they had voted against the offer.

I voted yes. My heart of hearts wished I had voted no.

I wish I had voted no. I am so mad about money for administrators after the strike. They are absent day and night. We worry day and night about patients.

Some nurses who voted yes in various parts of British Columbia resented the dissident nurses who originated from the large hospital in Vancouver. They were vocal and unkind in their indignation.

We all have to work together here after this. I was under the impression that we were going to accept the offer. That is why I was very
angry with the big slobs at VGH. I felt they represented the teamsters' union which I have always considered the scum of the unions in B.C. I was really angry that they only showed people on T.V. that were at least 150 pounds overweight and not what I consider to be representative of nursing.

Whether they voted yes or no, the issues had become focussed on money. Nurses who voted yes believed that there was no more money and that none of the issues that else was going to come out of the contract. Nurses who voted no could not see the "soft" items in the contract either, so many decided that money would have to make up for it. The most commonly stated reasons for voting no was that it was time to take a stand, to tell the government, the union and the employers that nurses had not been heard yet. So 68% of nurses told the worried public, an apathetic government and their negotiators, their employers that they had had enough, that the government had not yet recognized their value in the contract, that their employer had not agreed to change their working conditions and attitudes about their value, physicians continued to discount them, their professional association remained silent and withdrawn, and their own union "betrayed" them. Nurses told them in the only concrete way they had - on the ballot.

I voted no. Someone had to stand our ground.
It's now or never. I feel less fearful because of them (the dissidents). I was so PROUD that we stood up for our rights. It is the PRINCIPLE of the thing now.

We burn out, we need early retirement. A nurse is a nurse, you know, we area supposed to lift 250 pounds of patients until we are 65 years old, and keep going.

At first I thought I would accept it. But then I sat down with a calculator and then realized I wouldn't.

I was going to vote yes to get it done and over with but I talked to my patients who explained to me that there will be no nurses in ten years if I vote to accept the contract. I felt like I had been given permission then.

Nurses cited the bargaining committee as one of the main reasons why they believed that they could not accept the offer.

Whether you are a staff nurse, an educator, highly educated with a Master's degree or an diploma, you are still perceived that you should just do good for society an nun's wages.

I voted no. The bargaining committee sold out. They were out-manipulated and outgunned. Don't send in the girl guides to deal with the state troopers!

I voted no. I was offended by the offer. I don't think the bargaining committee were experienced enough. They missed the boat. They had blinders on and lost credibility.

The bargaining committee have wimped out. I resent getting a glossy package with an insulting deal. I voted no because the union tried to snow us. They were treating us with disrespect. They wanted the glory but none of the hard work - the grind of leading nursing in an unpopular conflict. They didn't have
what it takes.

I voted no. The bargaining committee had no integrity.

After the strike ended on June 1, 1989, job action continued. A ban on overtime was instituted and a continuation of refusal to carry out non nursing duties. The ban on overtime was particularly effective, since most hospitals depend heavily on nurses to do extra shifts since they do not have enough nursing staff to work the extra hours to fill sick time, vacation and workload. Refusal to do non nursing duties was another matter. Nurses had a variety of opinions of what constituted "nonnursing" duties. One nurse described the situation,

Even the great white papers from the RNABC as to what the nurse is responsible for and not can be written in very broad terms, I suppose, but it doesn’t say that nurses shall not mop the floors, it doesn’t say that nurses shall not porter, it doesn’t say that they shall not do clerk’s work for four hours a day. I think these are a lot of the issues that can’t be written in a contract.

A nurse in her fifties described her consciousness-raising experience with nonnursing duties.

There is a housekeeping room on the third floor. It has a bucket and a mop and there is a sign above it and it says 'Nurses’ Mop'. In other words, housekeeping does routine cleaning, but they won’t wipe up ‘spills’. So, if somebody dumped a flask of water off a bedside table and I was in the middle of giving out medications or bathing a patient, I
would have to stop and wipe up that water....they won't clean up vomitus or anything else that 'spills'.

Some visitor spilled a can of coke the other day and asked me to clean it up. I said there are paper towels in the room would you mind cleaning it up. I have never said anything like that in my life before, but it is not my job to clean up coke that a visitor slops on the floor. I thought, 'Good for me'.

Making a decision about what would be appropriate for nonnursing duties and what would not was sorted out in some staffing circles in a manner similar to this:

The RNABC are doing nothing, especially about nonnursing things - they were fearful that we were going to be unsafe. We had the unwritten rule that anyone who went from the Recovery Room or ICU or Emergency would have a nurse. It just made sense. We shouldn't be returning stretchers back and forth to the OR. Everytime we are going to coffee and a meal we are pushing those damn stretchers around - why doesn't housekeeping do that? Someone said, if we don't do it - who will do it? Who cares? I think we will be a long stronger and a lot smarter after this.

Nurses who were adamant in their refusal to carry out nonnursing duties were thought of as "militant" in some circles. This nurse gave her version of a typical nonnursing situation and how she handled it.

Some people think that not pushing a stretcher and emptying linen is militant. I used to think so, but not now. Now I call housekeeping staff. The other day there was barf all over they floor in the Emergency Department. I dealt with the people at risk. I put a sign on the floor 'CAUTION: WET FLOOR' I have never done that before.
Some nurses saw what an impact that being relieved of nonnursing duties would have in terms of their patient care and their worklife.

Here we are in this labour thing. All of a sudden we are just coming to grips with it. If I just did my nursing things, I could do my patient job. If someone else answered the phone, did the requisitions, my life would be different. People would get their vital signs, their teaching, their meds. on time. It would make such a difference.

As job action went on, nurses expressed delight with their newly found empowerment.

I think the public will learn not to take us for granted again.

We are a new generation, a new breed of nurse - we are not going to put up with this anymore.

On August 21, 1989, Vince Ready negotiated a binding arbitration between nurses and their employers. A two year contract with a total wage increase of almost 21 per cent was imposed. Nurses agreed to stop job action. Some nurses were hesitant about the success of their strike.

I think people are concerned to some extent and surprised that we were so adamant but I have a cynical virus about the public - they will support the same government again and again.

Other nurses found the experience of striking one in which they hoped never to repeat.
It is my first strike and my last. I will not strike again because it is a personal conflict of values. We are supposed to be caring for patients. I think there are other ways to go to negotiate salaries instead of going on the picket line for nurses and I think it dams us as a profession to equate us with steelworkers.

Discussion. The professional issues that nurses identified as reasons for striking soon became distorted in the media, so that wages were defined as the primary reason for nurses' striking. Bloom, Parlette and O'Reilly (1980) posit that bargaining in health care is relatively new and has been affected by reliance on those outside the public sector; this has influenced the view of striking nurses. Traditionally, collective bargaining outside the public sector is seen as a means to improve the economic situation of the worker; issues that do not have fiscal implications are not seen as important. Bloom et al also point out that the traditional model of management also makes the assumption that "work is inherently distasteful...what one earns is more important than what one does, and few want or can handle work that requires self-direction or self-control" (p.26). Therefore, nurses' assessment of reasons for striking will differ from those who come from a perspective of the traditional model.

Beletz (1988) warns, "nursing is replete with
attempts by various groups seeking to control the profession" (p.147) and argues that nonnurse trade unions could not have insight or understanding of the profession. The majority of nurses in this study were in agreement with Beletz and were keenly sensitive to the possibility that trade unions were not only commenting, but interfering in their negotiations.

Many suggest there is little democracy in unions, (Aranowitz, 1974; Beletz, 1988; Hopping, 1976; ) and when nurses in this study perceived that they were being poorly represented and controlled by their union, they revolted by voting against their union’s wishes.

Summary
The results of interviews conducted during job action can be summarized as follows:
1. The majority of nurses experienced moderate to high stress much of which resulted from anticipation of the unknown coupled with inexperienced with striking and union disorganization.
2. Nurses were critical of their union’s lack of organization during job action, particularly in the area of communication and preparation of nurses to carry out job action.
3. Nurses were exhausted from picketing and working on
the same day; many felt their workloads taxed them beyond their limit.

4. The level of essential services in some facilities was too high to have impact and in others, was so low that nurses were unable to provide safe care to their patients.

5. The union was not organized to carry out the strike and the union did not have an effective communication plan or strategy. In addition, it had not prepared nurses psychologically for the conflict of withdrawal of service or for any other potential conflict.

6. Nurses were not given guidelines for picketing nor for picket line "etiquette".

7. Nurses experienced both intrapersonal conflict and conflict with other nurses about what constituted job action particularly, nonnursing duties, picketing, shift sharing, nonessential vs. essential.

8. Some physicians were supportive of striking nurses, others were unsupportive, even to the point of being verbally and physically abusive on the picket line.

9. Nurses experienced abuse from the public in some places as well as from physicians.
10. Nurses found the HEU too inflexible about some aspects of striking; for example, the level of essential services and felt in some cases that other unions interfered with the nursing strike.

11. Anger was directed at nurses from other union members who were unhappy with the inequity nurses working high levels of essential services and thus receiving pay while they were not. Other unions were also upset at the "lack of discipline" shown on the picketline by nurses.

12. Nurses showed profound sensitivity and in some cases, paranoia, when discussing their feelings and beliefs about job action, and their union.

13. Nurses were dissatisfied with their union and in particular, their bargaining committee. Many voted "no" to reject the contract offer because they believed that the offer was unacceptable and wanted to stand their ground on the professional issues. Those who voted "yes" to accept the contract were not pleased with the contract, but wanted to have the conflict over with.
CHAPTER 6

POST JOB ACTION ANALYSIS AND DISCUSSION

This chapter presents the results of the study in tabular form, makes references to other studies and offers a brief analysis and discussion on each issue.

The questionnaire results were compiled and listed through by the computer as outlined in the Chapter 3. The data were analyzed with reference to six main categories of conflicts: Nurses and Striking, Nurses and Unions, Nurses and Physicians, Nurses and their Employers, Nurses and Gender Issues, Nurses and Personal Conflicts, and a section related to stresses associated with striking.

One nurse wrote:

I was looking through some photos with our ward cleaning lady and commented on how everyone was either getting married or having babies, etc. The cleaner said, 'Never mind - it will soon be your turn.' I replied, 'No, I think I will be a career woman.' And she asked me, 'Oh really. What are you going to be?' To me - that was the message of our strike in a nutshell - and I wonder if we really got it through.

Nurses were anxious to discuss their feelings about
the job action. A high return rate and many pages of written comments substantiated this.

I wanted to tell you that I was in the "bush" when I completed this study...I was a bit panicked as to how I'd get it to the mail on time as it meant a day trip out to the local post office and then finding the time between hauling water and cutting wood. I was amazed how quickly I actually organized my time to sit down and do it and how up I felt when finished. Thank you for doing this study and good luck!

Analysis of Post-Job Action - Nurses and Striking

Subproblem 1.0. To what extent did nurses feel they should have the right to strike?

Findings. The majority of nurses (93.4% - Table 1) gave the clear message that they should have the right to strike and they believed strongly in that right (Table 4). Exercising that right to strike was a different matter since 11.3% of the respondents voted against striking. Nurses did not make comments on having the right to strike; however, they commented freely on whether or not they should exercise that right.

Unlike other employees who strike, nurses do not withdraw their services completely. They maintain "essential services" or provision of care for life-threatening situations. The level of essential service is negotiated between nurses and their union for each
The union tries to balance the need for essential nursing services with the right of their members to take job action. Some nurses in this strike believed that their strike action was not a pure strike action since the essential service level was so high. The strike could have been more successful if properly executed - essential services should have been essential. In our hospital, care continued to be of the highest quality with more than 75% of nurses on the inside. If they had struck, the system would have been on its knees within days and nurses would have won; that is, made their true role in the health care system known with less disruption to everyone, nurses and public alike.

Many nurses commented that although they believed in the right to strike, that for nursing, striking may not be the best alternative. Nurses frequently expressed the opinion that striking nurses paid a heavy toll for the eventual outcome. One nurse who believed strongly in the right to strike said:

It is very difficult in nursing to work to rule. I feel the strike was a farce with many wasted efforts for what we accomplished. Nurses will always be underpaid for what they do because attitudes of many nurses are that we are in it for the goodness of our hearts.

Many nurses I spoke to on the picket line were not happy about withdrawing our services but they felt strongly that nurses in our society are undervalued and they felt it was important that we support each other.
Only 4% of nurses who responded felt nurses should not have the right to strike. One nurse pointed out why nurses and the public are concerned when nurses' strike:

I feel really strongly about nurses not going on strike! Last week our local paper carried a letter to the editor mentioning the strike as a possible cause of death of a relative who supposedly had cardiac surgery delayed due to the strike. The writer questioned our right to strike as she felt we are an essential service. These are issues which are difficult to deal with due to emotions of all involved.

Table 2 shows that 14.8% of nurses had been on strike previously. Most nurses did not believe that their family had influence on their strike vote (Table 3).

This is my strike; my nursing career. I make decisions about that sort of thing. My family supported me though.

Only a minority of nurses however, did note that their family had influence on their voting to strike.

I don't think that policemen, nurses or the like should strike. But I voted to strike because my husband talked me into it.

Many participants commented on whether professional people should strike.

I had stress from feeling that this (striking) was not appropriate for professional people. Although I voted to strike because there are issues which must be addressed, I felt very uncomfortable doing so.

Some nurses who voted to strike changed their minds about whether striking was the best way to solve their problems.
It is my first strike and my last. I will not strike again because it is a personal conflict of values. We are supposed to be caring for patients. I think there are for nurses other ways to negotiate salaries than going on the picket line and I think it damns us as a profession to equate us with steelworkers.

Discussion. In some provinces in Canada, nurses must use other methods to achieve their rights and entitlements (Kerr, 1988; Hibberd, 1989). The strength of conviction that nurses feel in this area may have something to do with the general labour milieu in British Columbia in which other working people (professional and nonprofessional) exercise their right to strike on a regular basis.

Strikes, according to Colvin (1987), may not be defined by nurses in the same way as others since they recognize the responsibility to the patient and continue to provide care to those in critical need. That same deep feeling of responsibility Colvin points out, compels nurses to resort to the use of the strike. Kluge (1982, p.6) on weighing the ethics of the right to strike concluded that the right to strike in nurses exists because of the nature of contracts, but that the right is "severely limited" given the public welfare concern.

Analysis of Post Job Action Subproblem 2.0 - The Strike

Issues
Subproblem 2.1. To what extent did nurses feel that this strike was about wages?

Findings. Table 1 and 4 results show that nurses did not believe that this strike was mainly about wages; 59.5% cent of the nurses disagreed with the premise that this nursing strike was about wages. Many nurses commented that the strike was about other nursing issues.

This strike demonstrates to the public and to nurses that we have more basic problems than just money.

We became a cohesive group and carried through actions as a group - we felt we were fighting for the survival of our profession - not wages.

Nevertheless, 39% of nurses agreed that the strike was about money. However, there were qualifications. Some felt that wages were part of the issue but that there were other reasons.

Unfortunately, I feel that our wages may have increased to the highest in Canada but our working conditions have not changed. Morale is so low, frustration so high, that one day soon a fuse will blow.

Although I feel that wages are part of the issue, I felt that not enough emphasis was placed on the working conditions of nurses such as increased staffing so that nurses are not pushed to the limit, increased educational provisions and more flexible work schedules to suit lifestyles and family commitments.

Only 6.7% agreed strongly that the strike was mainly
about wages, pointing out that wages were connected to value:

I feel the strike was mainly about wages although few people will actually say it. The reason I feel that this is the case is because it is the one concrete way that it can be shown that our work is valued. If we are not worth more money, then everything else rings hollow. If we are not paid more (in line with other professions i.e. teachers, lawyers, physicians) then the message is that nurses are not worth any more than we are being paid. PERIOD!

Wages are the most accepted way of showing that a job is valuable and that it is valued.

Another nurse believed that money had to be central to striking because:

I feel that money was a main objective because the union felt that it had the power to change this rather than the increased workload of both nursing and nonnursing duties and therefore would financially compensate for their inability to change the other.

Again, nurses believed that the value of the actual work that nurses do should be considered and related to salary.

Let’s start paying people for what they’re worth related to how important the job is!! The most important commodity (if I might use this word) is people. I would feel much better for receiving an increase in salary for helping someone get well, than for someone else receiving an increase in salary for selling a computer, or picking up garbage!

Some nurses did not like the emphasis placed on wages rather than on other issues:
The union made such a big thing about how we were striking to improve working conditions and levels of patient care, but it seems that all we accomplished was an increase in pay. I see little change in working conditions as a result of the strike. Personally I would gladly have forfeited the pay raise in exchange for a decreased nurse/patient ratio.

The press put the emphasis on wages and did not even mention the importance of things like workload and working conditions to us.

Discussion. Others have found evidence that nurses were more concerned about professional matters than about those traditional industrial bargaining goals such as salary and job security (Ponak, 1975; Stern, 1982; Bloom, Parlette, & O’Reilly, 1988).

Nurses believed in this case, that for professionals, they were not paid well. Seidman (1970) believed that as long as there is a disparity between professionals’ self image and income currently received, there will be widespread labour conflict. Merton (1958) some time ago pointed out that a professional can do his job only if he does not need to be preoccupied with finding a means of keeping alive.

Subproblem 2.2. To what extent did nurses feel the strike was a message to government about recognition of the value of nursing?

Findings. Tables 1 and 4 show that an overwhelming 95.6% of nurses sent a message to the government that it
was time to recognize the value of nursing. Most respondents made comments about the message that they wished to be heard.

This strike was a message to government and the public that we are willing to fight for high standards of patient care and recognition of our values.

It made the public and the government more aware that we are people too and that we are tired of being made to feel that we are worthless.

Nurses strongly believed that the strike gave them a visible, concrete, and public opportunity to demonstrate the strength of their convictions.

I feel nurses had to take the stand they did both for themselves and for the patients. It was long overdue. I would do it again.

Some nurses were concerned about shortages in nursing which they felt were related to both wages and working conditions.

The way the situation is at present in nursing I can not encourage anyone to enter a nursing career.

We did this for nursing, to attract and retain people, not just to get money to buy luxury items, and no one - not employers, not RNABC or BCNU seems to be doing much about that yet.

Nurses compare nursing to other professional groups.

I felt that nursing needed more recognition as a profession - money and other. Teaching has got its act together and we haven't. They have given recognition to the people of their profession. Whatever their union is doing, it is doing it better than we are doing.
Discussion. The message itself was clear - at least as far as nurses were concerned. The results for this question were the response that nurses agreed with most strongly. Nurses wished to be recognized by the government for the value of the work they do; and money was only part of the value equation. Gardner and McCoppin (1986) say that the government image of nurses probably mirrors that of the public image of nurses: that of a dedicated and thus reliably docile occupational group. This group did not want the government to see them as docile.

Analysis Post Job Action Subproblem 3.0 - Striking and Professionalism

Subproblem 3.1. To what extent were nurses concerned about public opinion?

Findings. 74.7% of nurses were concerned about public opinion (Table 5). 6.2% of nurses strongly disagreed and 13.1% somewhat disagreed that they were concerned about public opinion.

A few nurses commented that the public was only aware of the nursing situation and their value when they (or their family) were actually in hospital. Nurses commented that this would mean that the situation would
soon be forgotten and/or would not be meaningful to the public who had not had the experience.

A surprising result here is not the number of nurses who were concerned about public opinion, rather it was the one out of five nurses who were not concerned with public opinion. Table 4 shows there was a fair amount of disagreement between nurses.

**Discussion.** Hetzger, Ferentino and Kruger (1984) in discussing the conflicts surrounding nurses attempting to improve wages and working conditions as an "intricately complex web of agony and irony that ensnares nurses, patients, hospital administrators, unions and the public". These conflicts exist in perceptions of what nurses are and/or should be and how they conduct themselves during times of negotiations and how nurses should act collectively.

For the most part nurses care about public opinion. The reasons that 20% of nurses do not care about public opinion can only be speculated. Perhaps that 20% believed that nurses, who were always concerned with others, felt that if they did not take care of their personal needs they would not be able to care for others. Perhaps they were desperate to get their message out, or so angry with their situation, that public opinion was less of a priority.
Subproblem 3.2. To what extent did nurses feel that the public were supportive during the strike?

Findings. 92.9% of nurses felt that the public was supportive to them during the strike.

People pulled together - families and friends of residents were most helpful and supportive of the nursing staff.

Nurses found that striking gave them a forum for discussion about their roles to the public.

Patients were supportive and gave encouragement for us not to back down. Many people were surprised to find out, at long last what nurses really did and the vast scope of our profession.

There was alot of support by the public - they waved and shouted encouragement to us on the picket line and people on the street stopped to talk and discuss the issues with the nurses.

Some nurses were indignant that they should have to go to such extremes for the public to recognize them:

Imagine having to strike in order to gain public support.

Support was shown in many ways. The gift of food on the picket line was a definite indicator of support.

The restaurants, ambulance drivers, and other companies sent us food, coffee, hot chocolate, on the strike line especially during the wee hours of the a.m.

Support was participative in some cases.

We had an elderly gentleman in our area who picketed with us almost every day. As he was a retired railwayman, he was able to give us a
lot of support and advice on picketing, etc.

Sometimes others would attempt to repay support they received in times of their own personal crises.

One elderly man who had lost his wife to cancer a few months earlier, drove up and parked near two of us who were picketing. He emerged from his old and seen-better-days car, with a bag containing several cans of pop. He came to my coworker and he handed us the bag with tears in his eyes. He said he realized how hard it must be for us to strike, how dedicated nurses are and that his wife had been nursed to her death by caring loving, nurses who always gave their best. He said the least he could do was to offer us a cold drink on such a hot day. He shook our hands, thanked us and left us with tears in our eyes.

Some nurses felt less support from older people.

Most of the patients were outwardly supportive. Still, I have a feeling such support did not cross the private thoughts of some. Generally, the younger (people) seemed more understanding.

Our residents suffered and families became angry and were unsympathetic.

In spite of the majority of nurses feeling support on the picket line, some nurses reported abuse on the picket line and the source was primarily male.

Young people would drive by and throw ice cubes and water on the strikers. There was harrassment from the public - yelling 'go back to work - you earn enough'.

We experienced abuse by individuals in the public for example, an unkempt young man in a pickup truck sped carelessly through the picket line shouting abusive language.
These guys went by in the back of a truck, yelling obscenities which were degrading to women and urinating all over the sidewalk.

**Discussion.** Table 4 substantiates the belief that nurses do feel that they enjoy the respect and support of the public and nurses agree on this subject. The demonstration of this during the strike was done particularly by those who had previous experiences and personal contact with nurses.

**Subproblem 3.3.** To what extent did nurses believe that there were more important matters for nurses to be concerned with than public image?

**Findings.** Only 32% of nurses felt that nurses should be more concerned about other matters over public image (Table 5). 60% of nurses were primarily concerned with nurses’ image. Their concerns reflected their desire to be viewed as professionals:

The most negative part of the strike was that we were unable to emphasize and reinforce enough, the importance of nurses and respect as professionals.

Nurses intensely disliked being compared to nonprofessionals:

Our union was compared to the garbage collectors’ union by a taxi driver I rode with one day. He thought we both should be considered essential!

Some believed that public exposure to nursings’ problems
was not consistent with professionalism.

I felt less professional because all our 'dirty linen' was exposed to the public.

A number of nurses responded that the image of nursing needed renovation:

Maybe it is time to change the image? We need a more business-like image.

Discussion. This result is important for many reasons. It is a powerful statement that nurses' desire to have a professional image to the extent that they believed that there were not other matters that were more important. Nurses wanted to be viewed by the public as professionals. Diers (1987), in her article on nurses professing to be professional, says that "there is nothing wrong with nursing...the world simply has an outdated view of nursing, and our task...is to patiently teach people what nursing is today."

Subproblem 3.4. To what extent did the strike tarnish the professional image of the nurse?

Findings. Only 27.5% of nurses felt that the professional image of nurses was damaged (Table 4 and 5). Some nurses believed that striking itself took away professional status. One nurse worried:

I had fear that we would lose our professional status through union rhetoric.
Many nurses were concerned with the image that the media portrayed of them.

Film crews taped and aired many news reports depicting nurses as militant, cold hearted individuals.

One nurse educator put it this way:

I believe that true professionals can resolve their problems without strike action. How can we expect to rank on an equivalent level with engineers, architects, etc., by picketing and other actions (e.g. the extreme radicals) which was anything but professional.

Another educator was opposed to strike action in the beginning:

because it was 'unprofessional' and out of character for me as a person. But after learning more about the issues with regards to why nurses were striking, it changed my focus to support of the strike.

One middle aged educator spoke her beliefs this way:

I became a nurse for patients (as outdated as it sounds) and as much as we say we did it for them, I think it chipped something off our image which is not easily repaired.

Discussion. Gardner and McCoppin (1986) believe that it is an outdated notion that nurses who take industrial action on their own behalf is unprofessional and it is a fallacy. The majority of nurses believed that their professionalism had not been taken away by striking. Nurses truly believed that their main reasons for striking were professional; they were altruistic and justified and that personal entitlements were secondary.
Nurses were however, rankled by those who described them as "unprofessional". Jacox (1971, 240) said, "to call something unprofessional has been a powerful means of controlling nurses since their desire to be professional is so strong."

Subproblem 3.5. To what extent did nurses dress and act unprofessionally on the picket line?

Findings. Nearly half the nurses (Table 5) felt that nurses dressed and acted unprofessionally on the picket line.

I personally was embarrassed with the news reports showing the loud-mouthed, opinionated nurses that represent a small portion of the union and the nursing profession.

Declaring one’s political stance while delivering patient care was considered unprofessional by some:

I was horrified by the "Vote NO" buttons worn by fellow nurses - I thought that it was extremely unprofessional to be 'advertising' in such a way.

Many comments were made by participants on the appearance, including clothing and physical structure of other nurses as well as how they spoke in public.

Can you imagine how it looks to have nurses on T.V. and in the paper who are fat and poorly dressed representing professionals who are supposed to be teaching the public about healthy lives - how will we ever be credible to the public afterwards?
I was appalled at the image some nurses portrayed while on the picket line. One nurse was interviewed by a television reporter and asked what she thought of the contract offer. She replied, as she chewed her gum, that she thought the offer 'stunk'.

I hated watching our President on the news. She wore these frilly dresses. It looked so unbusiness-like.

The strike made nurses look like money grabbing, somewhat sloppy, aggressive women.

Discussion. These results in Tables 4 and 5, combined with the numerous comments written by nurses in this study, show that public opinion, public support and the image of nursing are of high importance to nurses. Nurses clearly express the desire to be seen as professionals. They do not wish to be portrayed in any manner similar to industrial unions. Many critics of nurses' strikes believe similarly to Hopping (197) that nurses' adoption of union tactics and principles to achieve goals one "cannot help but compare nurses to steel workers, autoworkers and construction workers".

Analysis of Post Job Action Subproblem 4.0 - the Professional Association

Subproblem 4.1. To what extent were unionized nurses involved in their professional association before the job action?

Findings. 18.7% of nurses responded that they had
been involved in their professional association before job action (Table 6). Some of the 80% who were not involved, expressed their opinions about their professional association.

I resent my $200.00 that I pay to the RNABC - we don't get a lot for it. But I am not really union-oriented either.

Discussion. This reported level of activity seems high. Some (Cutshall, 1990 personal communication) state that cohort group activity in other groups is believed to be about 14%. Union involvement was almost equal to that of the RNABC at 19% prior to the strike.

Subproblem 4.2. To what extent did nurses wish to be involved with the RNABC after the strike?

Findings. 20% of participants responded that they wished to be involved with the RNABC after the strike which is nearly equivalent to those who were active before the strike (Table 6).

Discussion. The study did not compare the participants' who were active before and to those who desired activity in the RNABC after the strike. It seems likely, however, that those who were active before the strike would remain active afterward and that job action would not make any difference. The strike appears not to have made any difference to the professi-
onel activity of nurses.

**Subproblem 4.3.** To what extent were nurses satisfied with the support of their professional association during job action?

**Findings.** The majority of nurses - 85% - believed that the RNABC should have demonstrated more active support for nurses during the strike (Table 7).

Respondents' comments were similar to those of nurses interviewed during the strike in that nurses believed that the RNABC had "run for cover". Some nurses were angry at the RNABC.

What does the RNABC do for us anyway. Why would that change now?

Some respondents were disappointed.

I think we were abandoned by the RNABC. They weren't there when we needed them.

Some nurses knew little about the RNABC.

I, like so many nurses know nothing about the RNABC. I couldn't support or malign a group I know nothing about.

The role of a professional association in the labour action of nurses was not clear to most; however, the issue of public interest and the association's role in this matter as well as the representation of the difficulties in the nurse's role was an expectation by many:
I think I was a little disappointed in the RNABC and I know that they have to stay out of the union’s business. But there were a lot of things that were patient concerns that were of public interest. There needed to be a whole separate way to get messages out that would tell the public of nurses’ plights and the RNABC could have done that.

**Discussion.** Kerr (1988, p.231) believes that the professional association cannot be expected to provide “tangible or intangible support” during labour strife since the statutory mandate is to serve the public before professional interest. The results show clearly that nurses strongly believe and agree that there is a supportive role for the RNABC to play. Undoubtedly the support was largely expected because of the reasons cited for striking—professional issues.

**Subproblem 4.4.** To what extent did nurses feel that their union and their professional association should work more closely together?

**Findings.** Tables 7 and 8 show that more than almost any other issue, 89.4% of nurses strongly believe that their union and their professional association should work more closely together. They are critical of the current schism between RNABC and BCNU and suggest that because of that relationship, the interests of nurses themselves are not served as well as they could
Some nurses were critical of their nursing associations (the British Columbia Nurses' Union and the Registered Nurses' Association of British Columbia) not being able to work together.

Participants in the study believed that there must be a "holistic" approach to the resolution of their nursing problems since the issues are not simply related to wages.

A nurse is a nurse is a nurse - that one I can agree with because you choose your area of work, geriatrics, critical care - each one has its stresses and benefits and they all have significance. But if you increase your skills for any area, you should be recognized. RNABC and BCNU can't even get together to discuss that!

RNABC is a licencing body. They have to leave the union to themselves. You almost wonder if the union was even talking to the RNABC because they gave this wage increase to the graduate nurse and the RNABC was saying there aren't going to be any graduate nurses in the future. Why wasn't this communicated?

Nurses commented that the professional association gave them credibility because of the focus on standards and public trust, rather than on personal benefit. They
felt strongly about this aspect:

I don’t think BCNU should polarize itself on the other side of the RNABC. If the two of them don’t do something the rift is going to get wider and I don’t know if they can exist with the two poles. I don’t know what would happen, something would get dropped and I think it would be the union. It would be a most devastating thing if the RNABC would get dropped. That is our credibility. I WOULD get into a fight over that.

The usual complaints of heavy “management/educator” mix at the professional association often leaves front line nurses feeling represented.

There is a lack of respect between the two of them. BCNU is looked on as a militant group, especially now. And RNABC’s more active members are management and educators. I think RNABC must look at their roots and their roots are the staff nurses. A lot of RNABC activists have not been at the bedside since day one. There are a lot of changes happening there and they aren’t aware of them.

Discussion. Gilchrist (1987, p.33) calls on unions and professional associations to “share power and create a virtual interdependence” in order to gather as much mutual assistance as possible because of “nursing’s vulnerability in society, in the health care system, and in educational structures.”
These comments reveal nurses as passive victims who speak about "they", when they refer to either organization. There were no suggestions by nurses as to how this collaboration should happen.

Conroy and Hibberd (1983) postulated that where collective bargaining is controlled by nurses and where professional values dominate, the greater the cooperation between the professional body and the negotiating body and where professional values do not dominate, there is less cooperation.

In this situation there could be disagreement as to how much professional values prevailed throughout the strike since other unions dominated the job action in many instances.

While there could be some value in having a "good cop" (RNABC), and "bad cop" (BCNU) acting on behalf of nurses to the employer and the government, there cannot be value in having those two groups not working together or having dissenting approaches to situations. The losers are the nurses - their members, the very people that they represent.
Analysis of Post Job Action Subproblem 5.0 - Nurses and their Union.

Subproblem 5.1. To what extent did nurses have involvement in their union before the strike?

Findings. Table 6 shows that 19% of nurses who responded said they were involved in the union before the strike. These results mean that over 80% of nurses had no activity in the business of their union, nor in the planning and execution of a strike. A strike committee chairperson commented:

I am a steward and together with the other stewards in our facility and the Essential Services chairperson (a non steward) we organized and directed the strike in our hospital. The nurses were nonactive in union affairs until the contract negotiations started. Until then, we could hardly attract more than 4 - 5 nurses to a meeting. Suddenly, we were getting 60 - 70 nurses all talking strike. As stewards we were preparing for the possibility for strike action but hoping it would not be necessary. In a sense listening to nurses at these pre-strike meeting caused me to think about the great change that had (occurred) or was occurring.

One nurse active in the union expressed the need for nurses to become more involved in their union.
We really need to educate our members about the union. Some of them look on it as 'God' when they stand to gain from it, but forget it if they have to work a bit to make gains.

Lack of union involvement had far-reaching implications for nurses. They found themselves in a labour dispute led by people they were unfamiliar with, unfamiliar with the bargaining process and the issues on the table, and uneducated as to how to carry out job action. One union steward described the results of lack of involvement and education related to union activities before the strike:

Exceptionally high expectations were placed on union officials and they could not be met. Most nurses having not been involved in the union process or even politically educated, expected that the union would be able to solve everything by presenting the problem. Somehow it would all be attended to. They didn't understand the bargaining process, nor I might add, did they want to. They do not understand the ramifications of legislation against nurses nor did they want to.

One participant attributes the lack of involvement to the complex, full lives that women experience.

Since nurses are often mothers and wives, it is difficult for them to find time to give to union business more so than for many men involved in unions but it is still necessary for each to try to become interested at least a little bit more than in the past.

A steward commented on the increased involvement during the time of the strike.
The participation of the members during the strike was overwhelming as they are not known to participate in quiet times. A few years back I decided to quit being a steward because of lack of interest.

Another union steward related how she managed to increase involvement of members during the strike:

In our facility the nurses were as prepared as humanly possible for the strike. An example: a nurse would have a good idea (e.g. rally) and seek out the stewards (who had been without sleep for several days) and chastise them for not planning and organizing a rally. Several times a day, one would be told, 'Why don't you do this or do that?' Only when the stewards said, 'There are four of us and 300 of you - go plan it, you have my permission. Let me know the time and place and date and I will be there', did the nurses start doing things themselves and taking responsibility for the strike, their strike. Most were very proud of themselves. They (and we) discovered many talents hidden in themselves and they will never go back to being ignorant of their own abilities and power. It was absolutely wonderful to enter our strike headquarters and receive a report from nurses who made decisions in confidence and pride. It was a worthwhile experience just for the personal and collective development of the nurses and the union.

Information on family members who were also members of unions were examined: 21.5% of nurses had parents, children or siblings and 31.5% of nurses had live-in partners/spouses that belonged to a union (Table 3).

Discussion. Backman (1970) found that even hard core positive union ideology was not enough to produce union activity, rather that feelings of personal identification and responsibility in the workplace as
well as a high level of interaction promoted union activity. Negative attitudes towards management tended to be crucial for union activity only when management relations are contentious and overtly antagonistic. It is true that many nurses are unhappy with the lack of respect within the system and the state of working conditions within the workplace (Meltz, 1988). It is also true that while nurses do not believe that their management works with them to resolve these problems, many nurses do not have "overtly contentious" relationships with their employers.

For a majority of nurses, activity with a union was alien to their philosophical convictions or how they saw themselves vis a vis class and feminism (Short and Sharman, 1987). For other nurses, a prevailing reason for inactivity was a lack of time and energy to commit to another activity after putting in long hours and enormous energy into their work in addition to managing homes and families.

In terms of family membership in unions and how that might impact nurses’ union activity, Baird (1968) discovered that favourable attitudes toward collective bargaining was associated with nurses whose husbands were members of unions, but not with occupation or union membership of father, spouse or amount of formal
education. In this study about a third of nurses had partners/spouses who were union members; the question of how active they were in their union was not explored.

Subproblem 5.2. To what extent did nurses wish to have involvement in their union after the strike?

Findings. Almost 40% (Table 6) of nurses responded that they wished to have union involvement after the strike; 100 per cent more than were active before the strike.

Discussion. Generally, nurses are nonparticipatory in activities associated with their labor relations framework (Beletz, 1988). Union activity during the strike was novel for most nurses and many saw the importance of being at least informed and part of the decisionmaking process. Most nurses recognized that their complacence with union activity had cost them a great deal during job action. At the time of this writing, it does not appear that there has been a surge of interest in union activity; it will be interesting to watch union involvement if and when another job action takes place.
Subproblem 5.3. To what extent did nurses feel they did not want to be more involved in either the union or the professional association after the strike?

Findings. 49.9% (Table 6) of respondents desired not to be further involved in the union or the professional association after the strike.

Discussion. It is not surprising that half of the nurses have no desire to be involved in affairs of their worklives other than in the workplace. Roberts (1983,p.27) believes that lack of participation in professional organizations may be evidence of "lack of pride in one's group and a desire not to be associated with it" and alignment with other nurses may mean joining with other powerless persons.

Subproblem 5.4. To what extent did nurses feel as though they were trade unionists?

Findings. While some nurses expressed their feelings of association with trade unionism, Table 9 shows that the majority of nurses did not relate to being a trade unionist. Table 9 shows that 12.3% of nurses said they strongly considered themselves as trade unionists, while another 23.8% somewhat agreed. Many nurses (15.6%) remained "on the fence", unable to decide if they were trade unionists or not. Almost a
third of nurses felt strongly that they were not trade unionists. Many nurses commented on their conflicts related to being a professional and a unionist:

Nursing occasionally is 'down and dirty' work but the rewards are significant for those who truly belong. If we relegate nursing as another trade union, yet expect professional behaviour, we set up a cognitive dissonance which adds to our chaotic woes.

Some nurses identified the need for a bargaining unit, but believed that it should be a "professional" one.

Nurses need a bargaining association but it should not be a union. You cannot be a unionist and a professional - nurses need to decide what they want to be.

Many respondents' comments were concerned with the image of unionism and nursing.

I think it damns us as a profession to equate us with steelworkers.

There were those nurses who had a basic philosophical difference with unions saying, "The union was never really my bag."

Some expressed that unionism was "a necessary evil" believing that:

Without the union, nurses would still be suffering for benefits and decent wages.

There were cultural reasons expressed by nurses for their lack of union orientation:

I came from Hong Kong and because of my background, I really don't trust the union.
Discussion. Like Hopping (1976) and others, many nurses felt an inherent conflict between unionism and professionalism. Nurses agreed with the necessity of a union for nurses, but in keeping with their consciousness about the image they wished to portray, nurses had concerns about being considered a trade unionist. Hopping (1976, p. 381) contends that nurses should heed the advice, "If it walks like a duck, quacks like a duck, and looks like a duck, it's a safe bet to say it's a duck".

Short and Sharman (1987) suggest that nurses' discomfort with trade unionism may be related to association with being masculine and working class.

Rosen and Rosen (1955) believed that member beliefs were key to union power as well as to predictors as to the degree of support members are likely to give the bargaining agent. The implications for lack of association with trade unions should be of concern if the union wishes to increase its power base. Nurses may embrace unionism more fully if the union were to become more professionalized. Beletz says that, "Ultimately trade unions are not protectors, but serve as predators of nurses' rights and this, therefore, renders trade unionism incompatible with nursing professionalism (1988, p.147)."
**Subproblem 5.5.** To what extent did nurses feel that the BCNU was justly criticized?

**Findings.** Respondents were fairly agreeable in their critical comments on the union and job action. The main criticisms centered on strike organization, poor communication, poor representation of nurses' image, an inexpert bargaining team, and unhappiness with leadership. Table 9 shows that 65.8%, a majority of nurses, felt that criticism of BCNU was justified. One nurse captured the essence of the discontent with the BCNU.

BCNU did not inform the public properly of the problems that nurses face today. They were not well organized, they did not keep their stewards informed of the day to day events. They DEFINITELY did not go by the wishes of the members. I feel that the majority of nurses felt the BCNU let them down.

Another nurse echoed the most frequently mentioned complaints.

Poor negotiating committee, poor union and poor press.

A common complaint was that union leaders were not in touch with the membership.

BCNU were busy attempting to look after themselves and lost sight of its membership.

And this nurse from a smaller town in B.C.:

I felt let down by the union. The people making decisions seemed to have no idea where the nurses were coming from and made no effort to find out.
A "weak union" was a criticism of many:

BCNU was weak - I didn’t feel very proud of their performance.

I worked very hard at picketing and at strike headquarters, but with no direction from BCNU. They are a weak union.

Union "inexperience" was an unacceptable excuse for some:

Understandably our first strike was bound to be fraught with disorganization, but the skirmishes amongst our union was most distressing (and embarrassing).

Lack of preparation and leadership were other complaints. This nurse echoed many comments:

"They didn’t have a battle plan and they had Pat Savage."

The BCNU’s lack of appreciation of the responsibility that they had towards members was a criticism.

Everyday nurses would face the day with 'My God, what is going to happen today, what will I have to face?' I think that nurses feel abandoned, abused. I think those employed people at the union have to be evaluated to see if we are getting our money’s worth, if not, they should go.

Nurses were distressed in their belief that the union’s dissent had soiled the image of nursing.

I feel the dissent within the union has given the nursing profession in this province a black eye.

Many nurses described family difficulties including how they were going through separations and divorces at
this time. They felt the union was inflexible and insensitive to their needs. One nurse in her twenties said:

It (the strike) came in the midst of a period of crisis in my personal life. The union was inflexible in their lack of consideration of people's differing circumstances.

Many nurses commented that their enthusiasm for their cause was dampened by the union.

The heartbreak of watching inept union leaders fritter away all the enthusiasm and support of front-line nurses and then finally sell them out.

I was interested, but when it got down to this infighting, I was so unhappy with the union, I lost interest. They were making such a mess out of their image - how they were perceived by the public, the government, and the membership themselves - they didn’t handle it properly. They kept doing an about face and they didn’t take a stand on any issue. It was just sloppy.

Nineteen per cent of nurses had a different viewpoint in that they believed that criticism of the union was not justified:

These nurses were (angry) and remain angry. They did not cite money very often except to say 'If I have to put up with all this crap, I’m going to be paid well for it'. They wanted a strike. That’s what was frightening, and they had absolutely no idea how terrible and wonderful a strike could be. They wanted to let everyone - the government, the public, the employer, know how distressed and helpless they felt. They were sick of being the invisible workhorse for the system. They identified the problem, set their goals, carried out their actions, and expected the outcome to be much more than what was able to be obtained. Hence the anger unleashed on their own organization.
They expected the union would solve all the problems in one fell swoop. Some of the problems cannot even be addressed in contract negotiations and are not the concern of, nor can they be addressed in a Master Agreement.

BCNU President Pat Savage pointed to the members and spoke of the need for their responsibility in the circumstances:

I was at one meeting and the members were stamping their feet, they were just been unreasonable, they weren't prepared to listen. I told them that we are in the mess we are in largely because we collectively are not willing to do anything about it, so each nurse needs to take responsibility herself for ensuring that the change happens, to make the commitment, to be willing to do more than bitch over a cup of coffee. To be willing to sign on the dotted line. Each nurse has to be willing to do that.

A BCNU steward felt that angry nurses misplaced their anger on union officials:

Nurses are still angry and have misplaced it on the union officials included those as low on the ladder as the stewards. We are constantly trying to educate them that their anger should be directed to the government and in my personal view themselves as part of the public.

Discussion.

Evaluation and change were needed on the part of the union. It is too simple and too superficial to suggest that organizational and leadership change on the part of the union would be enough to satisfy membership. Nurses were asking for more than an old fashioned union-management showdown, nurses wanted
sophisticated, skilled representation at the bargaining table and professional representation to the public by their union.

On the part of nurses, some soul-searching was required with respect to their responsibilities vis à vis their union and job action.

**Subproblem 5.6.** To what extent did nurses feel that BCNU enlightened the public regarding the role of the nurse in health care?

**Findings.** Table 9 shows that 70.8% of nurses responding believed that BCNU did not interpret the role of the nurse to the public. Nurses believed that the union did not take the opportunity to assist the public to understand their role and its importance in the health care system.

I feel the BCNU did not stress effectively enough what nurses are fighting for - mostly recognition in the medical team and in the community as the caregiver and the only one who knows the patients best. We spend 24 hours with them in 12 hour stints whereas doctors and those who make the big decisions at the most spend 15 - 30 minutes a week with the patient.

One nurse blamed both RNABC and BCNU for not portraying the image to the public and suggested:

They should use the month or two prior to our contract expiration to inform and educate the general public of our invaluable encompassing role. We deserve recognition!
A few nurses appreciated a rare indepth coverage on their role written in a way that the public could relate.

I appreciated some of the lengthy reports in the Vancouver Sun about what a nurse’s day was like. I thought that expressed the nurses’ role better than anything I heard from the BCNU.

Discussion. In keeping with the previous results relating to the reasons for nurses voting to strike in that nurses wished to be recognized for their value and the importance of nursing image, the results are not surprising in that nurses had strong expectations of their union to interpret their role to the public.

These results should be no surprise since one of the greatest sources of unhappiness that nurses speak of is a certain lack of respect for nursing in the health care system itself, even though nurses enjoy the respect of the public, particularly those who have been in hospital (Meltz, 1988).

Nurses were adamant that they wanted their union to provide the public with insight into the role of nursing and its importance in health care. The irony was that even their own union seemed unable to grasp the message let alone interpret it to others. The RNABC remained silent.
Subproblem 5.7. To what extent did nurses feel satisfied with the way nurses were represented and informed by the union during the strike?

Findings. Tables 9 and 10 demonstrate that one of the greatest criticisms of the union during job action was the external and internal communication by the union. Externally, nurses were unhappy about representation of nurses in the press and internally, they were unhappy with the lack of communication that existed at all levels. Table 9 shows that 72.1% of nurses were disgruntled and only 23.7% felt to some degree that their position was represented and communication was good.

Nurses believed that their image and their message was not presented in the way that they believed it should have been.

The disorganization and misrepresentation of nurses by the BCNU was negative. I felt we looked foolish many times in the media. It was difficult for people to take us seriously. It was embarrassing.

I was very disturbed about the media coverage and distortion of the facts. I clearly saw how media prints facts/distortions the way they want. This angered me immensely.

Many nurses felt that the media portrayed nurses inappropriately and that the union did little to alter that portrayal.
The media printed incorrect information and I believe a stronger counteraction should have been taken in this regard.

When HLRA was printing untruths about BCNU and achieving their goal of turning public support away from BCNU, BCNU hardly printed any rebuttals - how was the public to know the points we were trying to make?

Nurses believed that the chief reason the message was not able to be delivered was because the BCNU were out of touch with their members and thus weren't familiar with their message:

I became disillusioned when I found out that the BCNU did not know what they were doing and when I realized they don't have any idea as to what nurses need or want.

The most negative aspect of the strike was a lack of clearly identified issues for nurses (other than money) by the union, the government and the public despite the vote and length we went to, to identify those concerns.

Some nurses heard part of the message from the union, but it surprised some that even the so-called "working nurses" union's understanding of the impact of the problems on the nurse at the bedside was not apparent.

There was too much emphasis being placed on shortage of critical care nurses. I come from a general medical-surgical unit and there is a lot of nursing stress from lack of physio, O.T. (Occupational Therapy), monitors, bathrooms in rooms, and heavy patient assignments. There is lack of recognition for expertise and it is not like critical care where there is 1:1 nurse patient ratio, monitors that practically talk, physio and respiratory on hand, etc., etc.. Is this a frustrated nursing viewpoint?!!
The union kept stating the number of nursing vacancies in the province but seemed to be using that as a bargaining tool without actually realizing what it means to those of us who work extra shifts because there is no one to replace us.

Nurses were disturbed that their original message had been transformed by the media into a simple message: money.

BCNU made it appear that most of the problem was because of money. They didn’t talk much about staffing problems, workload. Not enough of these problems were emphasized. This damaged our image in the public’s eye.

Whenever Pat Savage hit the press, only the monetary thing would come out. When the media started hitting on the bit about these hospitals that were going to the government about nurses’ job action and how it was killing all these patients in hospitals, no one ever responded to that bit about how patient care was unsafe and how nurses won’t do overtime. It never got through to the public that nurses are there for 16 hours, they get 8 hours off, and then we expect them to come back for another 16 hours. Could somebody please sit down and look at the fact that this is how hospitals are surviving now and that nurses are doing more than they could ever manage. The RNABC should have said something about this. This has to do with public trust.

Another nurse with five years experience in a Lower Mainland hospital:

I feel the media did our cause a great injustice by reflecting a one-sided opinion. We were portrayed as money hungry complainers. With the NO vote on contract acceptance, this opinion was reinforced.
A medical nurse commented:

They should have corrected the improper coverage by the press giving the general public the opinion that we did not care if patients were dying - that we just wanted more money.

According to nurses, many reports given to the press by patients, families, and hospitals themselves were not accurate, yet were not defended by the union:

Extended care residents don’t always remember as much as their name and their statements were quoted in the paper: 'I haven’t had a bath in 10 weeks', 'Residents are left naked all day' etc.

Facilities were crying that it was necessary to close Operating Rooms when in fact they were closed prior to the strike for lack of nurses. The public should have been informed repeatedly of the facts.

The most negative thing about the strike was the way the media blew up those personal stories on the news and in the press. I felt our union let us down in that they didn’t inform and educate the media in our best interest.

In terms of internal communications, nurses described the communication between striking hospitals and between the union to their facilities as "abysmal". This nurse’s comments generally reflect the average nurse who felt they were not informed well during the strike (Table 10).

There was a poor information network during the strike.

Lack of information only served the union poorly.
Another nurse spoke of the type of information her hospital had received saying, "We heard wild rumours instead of concrete information from BCNU."

The impact of not having information made nurses feel powerless and lacking control.

Here we had to cope with picket lines, essential services, and heavy workloads and we had no information and we felt totally out of control of the situation. Here we were on strike for reasons of feeling powerless and now the people that were supposed to be helping us gain power were doing it to us as well.

BCNU stewards especially complained.

When calls were placed to BCNU headquarters for direction or answers to the many questions that came up, very little information out and no one seemed to have the answers.

A news blackout made it difficult for nurses to keep focussed on their job action and nurses frequently expressed frustration with not being kept posted. Some nurses obtained more information from their employer than from the union.

The secrecy of not knowing what was on the table was very frustrating - it would be nice to know what one was picketing for - that would create less dissension with local colleagues; there would be a common goal to be united with.

Many complaints focussed on inconsistent information:

There was lack of consistent accurate information as to what was happening during the negotiations.

Many nurses had the sense that everyone else was in the
know before they were.

It was negative - that feeling of being 'out of touch' with what was happening at the office - not being informed of events before the media was.

There was lack of communication between the BCNU and local stewards. It's pretty sad, that you hear what's happening during our dispute over the news first.

A frequent complaint of casual nurses is that they receive little information and are not represented adequately; the strike seemed to crystallize those feelings:

I had no communication from the union whatsoever pre and post strike. I never knew what was going on. This may be because I am a casual worker, however, the union still demands dues from me and I just never seem to get anything back. Sometimes I wish I had a choice whether or not to belong.

**Discussion.** Nurses felt misrepresented by their union to the public and in their management of the press. Nurses believed that their union misrepresented them because the union leaders were not in touch with the way their membership wished to be represented. Striking for economic reasons is less acceptable to nurses than striking for professional issues (Beletz, 1988). As a result, nurses saw their desired "professional" strike message become trivialized and simplified. The message became lost in the media's
representation of the issue as being primarily money.

Internally, much of the abundant criticism directed at the union was related to lack of communication from their union to nurses before, during and after job action. Nurses found it difficult to sustain commitment and support for their union and to act in unity when they were not being informed of union activities in other hospitals, in other regions, and at the central office. Nurses also found it difficult to not be kept abreast of the direction of bargaining.

Subproblem 5.8. To what extent did nurses feel that they understood the decisionmaking process in the union?

Findings. Tables 9 and 10 show that 34.8% of nurses believed that they were familiar with the way that BCNU made decisions.

Pat Savage, President, commented:

We have a policy that when a majority decision is made with our committee, then you support that decision. One of the things that was hard, is that you have to suppress your personal opinion. That is the process that we work under, otherwise we have chaos. That is the forum we have to deal with.

An Essential services chairperson in a community hospital expressed concern about the WAY decisions were made:
I was disappointed with the way the whole strike was orchestrated through the union office. I demanded help during the strike that never materialized. The essential services "Manual" was not very practical in planning job action. It seems as if the BCNU was always behind the eight ball, playing 'catchup', knee-jerking reactions, as if there was no forethought and reasoning that had taken place before decisions were made.

Those who were involved heavily in organizing job action at the local level relate how nurses had difficulty with decisionmaking related to job action. This comment reflects a reciprocal frustration with members’ lack of initiative to take part in the decisionmaking process.

It was difficult during the strike and job action to get nurses to make decisions. Every nurse would do everything and anything the steward directing events would ask of them. Only when the stewards who were at everyone's beck and call 24 hours a day were totally exhausted and refused to do more or make another decision, and ordered the nurses to solve her problem herself would they do so. It took about a week to reach this point.

Half of the respondents (51.4%) had little or no idea of how the union came to their decisions.

The fact that the BCNU made decisions prior to coming to the membership caused a lack of trust in the leadership and I believe it was our downfall.

Discussion. It is difficult to understand how almost 35% of respondents were aware of how the union made decisions when only 19% had been active in the
union and when communication was so poor. Although union policy states that there members will support the majority vote of a committee, that policy presumes that the majority on a committee will reflect the majority of the membership, and that the committee members are knowledgeable when making decisions. Participants of this study suggested that neither was the case. In discussing unions and nurses’ rights, Beletz (1988, p. 145) criticizes unions for "decisions that are made based first on what is good for the union, and second on what the whole membership wanted, and the concepts of professionalism were fantasy and illusion spoken about just to keep the troops in line."

Subproblem 5.9. To what extent did nurses feel satisfied with their union leadership?

Findings. Union leadership was a contentious issue during the strike; 70.1% of nurses were not pleased, and only 22.6% of nurses were pleased with the leadership in their union (Table 9 and 10). Although leadership could be defined as both elected leadership and nonelected management of the BCNU, most of the dissatisfaction with leadership focused on Pat Savage, the President of BCNU.

Displeasure related mainly to the inability being unable to present a strong and consistent point of view
unable to present a strong and consistent point of view that was representative of the majority of the members to the public.

Pat Savage represented B.C. nurses poorly with her frequent change of position on the contract.

I think the main thing I thought about the President was that I wished that she thought a little bit before she opened her mouth. I think that is partly inexperience. I can’t imagine what it is like to come out of a meeting and have 12 microphones shoved in your face. I think I would like to, in the future, vote for someone who is little bit more keen on P.R. Unfortunately you don’t get to see these people in action until they are in office.

Pat Savage commented on becoming the Union’s first fulltime President:

There were new things to adjust to being a politician so to speak. There was the expectation that I would be all things to all people at all times. You will be available and certainly during the strike you are at everybody’s beck and call, the media wants you and they want to do interviews and they will want to deal with members concerns.

Some members felt they had paid dearly for the novice leadership within the union:

Striking was not a very effective method to improve the lives of nurses because of the disorganization and inexperience of our union leadership.

Pat Savage tried to tell us she was not green - she would tell us that when she spoke. But I don’t think a lot of those things would have happened if she had more experience.

Although Savage took office in the Fall of 1988, she
union and took on the full time presidency in January, 1989. She describes her experience:

When I took office last September, until January I was living here in hotels and shuttling back and forth to Victoria. In the first few months I was working about half to three quarter time as President and half time at my job. I was working about six days a week because one full day was in travel/commuting time. I did not get located in Vancouver until May when we had a major move. A week after we got our belongings moved, we went into three weeks of mediations, came out of that, and in less than 48 hours later we went into a strike. So I was still adjusting to the role of being a President, having the new duties to do and being in the learning experience of being at the bargaining table. Having the experience now, I would do it differently. I am wiser for the experience. It has been a period of tremendous growth for me.

Pat Savage, also described her experience at a "stormy" meeting with the 700 Vancouver members the day after a contract of 29.5% increase in wages was proposed. Nurses challenged the President on her support of the agreement. The President said she made a "critical mistake when she reneged on her executive' recommendation that nurses accept a tentative agreement." (Vancouver Sun, June 27, 1989)

I was attacked at the Sheraton. That was difficult because I was attacked personally for having negotiated an agreement. I was accused of having sold them down the river. I didn't even have a vote on the committee. It was difficult. I had nurses come up after the meeting and tell me that they were afraid for my life. I tried to describe it to my husband
meeting and tell me that they were afraid for my life. I tried to describe it to my husband afterwards, and I said ...the only thing I can liken it to is a lynch mob...I was afraid after the fact.

Not all nurses supported the way their colleagues handled the meeting at the Sheraton:

I was not impressed by the apparent crucifixion of Pat Savage by members of the Vancouver Region. This was very damaging for the union.

Nurses were furious with Savage’s handling of the contract. A common theme of nurses’ criticism was the belief that their President took one side in public and another side “off the record”.

I was very disappointed by the performance of Pat Savage. I felt she was disloyal to nurses. In public she stated the contract as a “good deal for the patients, public and nurses. In private, she would say she knew it was a lousy deal. While agreeing with nurses (in private meetings), she essentially left the nurses to deal with the anger of physicians and the public.

Much of the criticism of Savage was focussed on her lack of consistent, confident, and clear message to the members and to the public. One nurse from the interior commented:

I felt we were dealing from a position of weakness following the Pat Savage ‘boo boo’.
Another nurse echoed:

Pat Savage's wishy-washy dealings with the newspaper as a result of not talking to her members before going to the press.

One nurse from the Kootenays accused Savage of causing the dissension that followed:

I was deeply offended at her treatment of the VGH nurses. Their concerns were justified. I understand that she has made a mistake by promising the Vancouver group that she would reject the proposed collective agreement. Nevertheless, I was disgusted to hear her tell nurses elsewhere in the province how she had been pressured by 'rude rebel Vancouver nurses'. It started a whole 'us versus them' attitude which didn't help us at all!

Some nurses would blame Savage for not taking leadership in guiding the bargaining committee to represent nurses point of view to the point of firing them.

The last straw for me vis a vis BCNU was when the bargaining committee refused to resign and Pat Savage stood by and said nothing and did nothing.

Some nurses had "the feeling that the leadership of BCNU had lost touch with the feelings of the members."

Pat Savage would agree with that viewpoint:

I wanted to spend as much time on the picket lines talking to members because that is what I want to be - with the members - not in some office. That is what was difficult about being at the bargaining table all the time...it cut me off from the membership. I wasn't able to be out there with the members finding out how they were feeling...Because we were in
mediation for a 21 day period with two very short breaks I wasn't able to get close to the members so I felt like I had lost touch with them. I was there (at the negotiating table) in response to Council's direction. Council reconsidered it when it recognized the problem that it had created. But it was after the fact so I didn't have that opportunity to be in touch with where the members were at.

Other nurses were more sympathetic to the President:

Pat Savage did her best but was caught off guard once and no one will ever let her forget it.

Pat Savage:

I came here for a period of time and that's where I will go back - to my roots. I had a vested interest: that means MY wages and MY working conditions as well.

Other nurses defined leadership on a broader scope and felt strongly about paid staffs' accountability to membership.

Members of BCNU executive are paid very well - they ran a poor strike and "this was the first experience" is not a good enough excuse is my opinion. They should have researched how other unions conduct strikes. Those on TV should be required to take a course on public speaking. I went to a meeting conducted by union executives. The attitude portrayed was 'we know better'. Power should come from the bottom up and not the top down. I didn't like being told 'we will not answer your question because we have irons in the fire we can't talk about'. These people should be responsible and answerable to those who employ them. Also, Pat Savage should resign.
The union had a major responsibility. I think the paid personnel should have taken more responsibility. An elected president is green.

A nurse described the chaos and conflict surrounding the staff in the central union office during the strike:

Our stewards did go to Vancouver on their days off to try and solve or at least express their concerns on behalf of the membership about what was happening. They first met with the Labour Relations Officers who appeared to be in total emotional disarray. In contacting the CEO, they were met with a flippant attitude; however were allowed to meet with one of the senior managers. Nothing was resolved.

Chief Executive Officer, Glen Smale was criticized by those who were familiar with the union infrastructure:

We never heard anything from the CEO before, during, or after the strike. I was not pleased with senior management of BCNU playing one hospital against another stating that were now performing better (like 'a well-oiled machine') as opposed to the other hospital. They had two different physical layouts. Not called for in times of stress.

Discussion. The issue of leadership in nursing unions has had little discussion in the literature. While leadership became a focal point in the job action, nurses in this study were not clear about the roles, the responsibilities and the relationship of the elected leadership to the paid leadership. Those who were aware, were highly critical of the infrastructure and found the "disarray" to be a significant hindering
factor both to the presidency and to the membership.

Metzger, Ferentino and Kruger (1984) posit that a vote of "no confidence" in union leadership may be more than mere individual rejection, rather that it is the inability of the leadership to translate the concerns of nurses at the bargaining table into acceptable settlements. Moreover, they add, leadership is often unwilling to exercise control. In this case, the membership clearly felt that they had not been effectively represented at the bargaining table and were presented with "wishy-washy" leadership.

President Savage herself, has the sense that she should be with the membership during the strike action, however, acts on union council's decree that she be at the bargaining table - an action that spells her demise and perhaps the demise of a settlement offer. Roberts (1983) in paralleling nurses to other oppressed groups, contends that leadership needs to come from the grass roots and needs to be involved in a continuous dialogue with the grass roots. Roberts argues that in this way, leadership will better represent the goals of the group.

Subproblem 5.10. To what extent did nurses feel satisfied with BCNU stewards' conduct during job action?
**Findings.** Generally, Tables 9 and 10 show that nurses were satisfied with their local organizers and planners of the strike - the stewards. Even if most nurses were unhappy with their union, 69.5% of nurses expressed satisfaction with their stewards.

I thought our union stewards in this hospital worked very hard and long and did an excellent job for us. I was less impressed with the central union office.

Only 26.3% of nurses were unhappy with stewards and those nurses had comments about the way the stewards conducted themselves during job action.

This steward’s response probably hits a note of accuracy about reasons for nurses’ discontent:

The strike headquarters (which included me) were a dumping ground for everyone’s negativity in the strike.

One head nurse complained:

The strike was poorly organized with alot of militant staff. Union reps had few 'people skills'.

Many people who were unhappy with the way that stewards conducted themselves during the strike believed that stewards had a new found power that they were able to exercise:

There were some shop stewards whom I don’t think had the right to do what they were doing. They got carried away. I think that they kind of enjoyed their power position. The weren’t very tactful. There was no control over them.
A head nurse commented on how she believed that union stewards jeopardized care:

Those two individuals were inflexible stewards and I will be civil to those two nurses, but I will never trust them again. You could never be sure of how they would interpret stuff - they would never clarify things. I trusted them to be professional in the way that things were going to be conducted but I got left holding the bag. Of course you can't be working at full capacity during a strike, but let's be safe about this.

If nurses did not feel prepared, they did not feel that some stewards were either:

The union did not prepare the stewards properly. These people went out there and did their own thing. Some of the things that they said and the rules they had, I thought had come from central office, but you would find out later that it was just this group that decided and the whole hospital was affected.

Conflict was a two way street between nurses and stewards:

I didn't like the heavy handedness of the steward in charge of this area's headquarters, but I also felt that one group of nurses were particularly bitchy when they met with her.

One steward expressed her frustration with not receiving information from the central office:

I hated dealing with the union when they constantly failed to provide me with information. It was embarrassing to hear results of negotiations on the radio before I could provide them to nurses.
The union lost some stewards who felt isolated:

It was a frustrating to hear news through the media or through HLRA before our own union. The organizational structure of the union during the strike gave no clear communication for information or whom to call for advice. To phone BCNU was an exercise in futility. The guidance we did receive was next to useless, or contradictory. As a steward, it was a lonely, scary experience to work 14 - 16 hours a day and feel you had very little support from the top. I would NEVER do it again, and I am a person who doesn’t believe in the word ‘never’.

Stewards told of a thankless job:

Being on the strike committee seemed like a thankless job which we never seemed to be doing right to please some of the membership.

Discussion. Stewards generally were appreciated for their work during the strike. As the previous discussion on union leadership pointed out, leadership from within encourages development of goals that represent the group and this type of leadership is more able to develop unity and pride (Roberts, 1983). Stewards were "in the same boat" and had ongoing dialogue with their coworkers and, in this way, were seen mostly in a positive light.

Nurses were unhappy with their steward colleagues in instances when power was used unfairly to punish some and to reward others or when stewards were unfacilitative in communication or inflexible in actions. The union should expand their preparation of
stewards before job action to include such topics as effective communication, team building, and the positive use of power.

Subproblem 5.11. To what extent did nurses feel that nonnursing trade union leaders should have commented on nurses' contract?

Findings. These results were similar to those strong feelings expressed by nurses during the strike. There was little disagreement between nurses on this issue. The majority of nurses do not feel an affiliation to the industrial trade union movement and do not wish to be associated with it.

Table 9 shows 79.4% of nurses did not feel happy with nonnursing trade union leaders commenting on the nurses' contracts. Specifically, they were most critical of Jack Munro, the IWA (International Woodworker's Association) President.

Jack Munro is a jerk. He would have never accepted such a contract for himself. He probably didn't know what the contract was and he did not believe that nurses were of value anyway.

What was the most negative part of the strike? The comments made by Jack Munro and Ken Georgetti who told us that we should accept the contract!

Comparing contracts of nurses to other industrial union
contracts, to some nurses, was like comparing apples and oranges:

I don’t think they know the issues involved. Which is the whole problem with our union. They didn’t tell people what nurses do. And I don’t think any nonnursing person has any right to discuss that. They go strictly on wage packages and they thought that sounded good. If that’s all you are working for - the dollars - as most unions are, then maybe it is. But for most people that spend a good portion of their time here, and if they are not here they are thinking about it at home, there are a lot of other things that are important. Jack Munro doesn’t have a right to comment but he is a vocal person - and I guess the press needed that opinion.

BCNU President Pat Savage commented:

Their opinion was solicited because of their role as leader of a union and the trade union movement. They are entitled to their opinion. They are not nurses so do they have an accurate picture?... Do I think we have a right as a union to stuff a gag in their mouths? Absolutely not.

Nurses generally did not feel a comradeship with other unions; in fact, many felt the opposite.

I resent the Union using other trade union contracts to compare with BCNU’s. Why didn’t they use other professionals’ unions/associations?

Some nurses felt a little pride in the strength of conviction of nurses compared to that of other unions:

I am hoping that we don’t have to affiliate with these trade unions. A lot of people feel we have to have the strength behind us. But I think we surprised a lot of them with our strength.
However, one nurse who had been active in the union, spoke of her desire to be a member of the Federation of Labour Unions:

As a member of the Federation, our leaders will benefit from the fellow unions and will become more well educated. In turn they can educate our members better.

Nurses involved in the union council expressed concern that the B.C. Federation of Labor had been involved in the negotiations and decisions that were being made. One nurse said she was told by Ken Georgetti to take the picket signs down.

On asking Pat Savage, BCNU President, if the BC Federation of Labor had been involved in any way in the strike settlement, she commented:

Some people thought that they were sought out by the government. Who knows? I have heard that before. Speculation.

Discussion. The results were strongly stated and support the data and comments expressed by participants in the study. These results are supported by Beletz (1988, p.144) who also argues that other trade unions cannot speak for nursing; nurses can witness the difficulties that nursing has had with "other health disciplines in gaining acceptance and understanding - can one then imagine that truck drivers, butchers, carpenters or teachers have greater insight?"
Beletz (1988, p.145) also warns nurses that "images are created that the entire trade union, if not the whole labor movement will come to the support and the defense of the demands of nurses. Rarely is mention made of the fact that support cannot be guaranteed, that support is determined by the politics of the moment."

Subproblem 5.12. To what extent did nurses feel other unions were better prepared and informed than the BCNU?

Findings. The perception was that other Unions were better prepared and informed than the BCNU. Table 9 shows that 17.6% of respondents were undecided on the matter, but 68% agreed. Many nurses received their information from other unions and their members.

A BCNU Labor Relations Officer should have established an office in our centre and been there most of the time. We had to use HEU offices for FAX and Xeroking, etc.

Other unions seemed to feel that one of the chief problems of the BCNU was their poor communication with the membership. While the writer waited for a union meeting to begin in the Pulp and Paperworkers Union Hall in a community on Vancouver Island, the paperworker union member opening the hall gave a 20
minute talk to the writer on how BCNU should improve their union communications "like other unions".

**Discussion.** It would not have been difficult for other unions to have seemed better prepared nor to have informed their membership better than the BCNU since lack of communication and organization was the biggest complaint of the BCNU membership. The result of this, as mentioned in the discussion previously on the lack of communication, was a disunited, aggrieved membership.

**Subproblem 5.13.** To what extent did nurses feel that BCNU did not respect the trust of nurses?

**Findings.** Trust, or lack of it, was a significant issue between members and the union. Tables 9 and 10 show that 62.3% of nurses strongly believed that BCNU did not respect the trust that they had placed in them. The prevailing reasons for nurses' feeling mistrustful of their union were perceptions of being inadequately represented at the bargaining table, being deceived by the union, hearing constantly changing positions, feeling unprepared and unsupported. The results in tables 9 and 10 indicate that this member-to-union mistrust was a prevalent feeling and one that may be difficult to reverse.
Trust was low at the start when they pulled us out, but it just went downhill from there. When Pat Savage did an about face, that really did it.

One nurse, an in-contract supervisor, described her experience:

Someone handed me a piece of paper and said, 'Here, you might be interested in this, it will probably affect you.' The notice said that job action would commence as of 1600 hours today. I don’t think I have ever felt so betrayed in my life. The union had said everywhere that as long as there were talks going on, that there would be no job action. 72 hours was up and they were serving us with strike notice. I was furious. The staff was confused and I felt like I was in the middle of an ocean, on this little island, with no way to get off. They had betrayed my trust.

Nurses had harsh words for the union in this respect.

Our leaders (and I use that term loosely) didn’t believe we had given them a mandate and they stabbed us in the back with their on-again; off-again choices.

A staff nurse commented on her feelings about who "paid" for the cost of the strike:

I think we put a phenomenal amount of trust in people. I get this stuff from the BCNU, I read the information so I can vote based on the information. I never really see them to know how well they will come across. I put trust in the bargaining people and they power built themselves and when things didn’t go well, come hell or high water, someone was going to pay for this and if it were going to inconvenience everybody, so be it. I guess it was going to be us.

There were recurrent themes in nurses' comments. Some related to bargaining, to voting, to misrepresentation.
I had faith in the President and the Bargaining Committee - then they turned on nurses and did not bargain in good faith. It was very disheartening.

At this point, I don’t have much respect for or trust in the union. I was misled when I voted.

I found out that this union isn’t working for us - they do their own thing regardless of membership feelings.

Nurses were looking to their union for support during troubled times and didn’t find it:

The support from the union did not seem to be there when and where you needed it - we felt like we were on our own - sink or swim.

Lack of input into decision making was another source of mistrust:

I felt that I had no input into decisions being made for me by union management.

There would be long term effects as a result of this lack of trust, some members believed.

Many union members lost faith in their union - if a strike is called in the future, less people will be for it.

Discussion. After a strike, one would normally attribute feelings such as "loss of faith", "no input into decisions", "turning on us" to employees about their employers and not to union membership about their union. Beletz (1988, p.147) says that the individual nurse as well as the collective profession, pays an "exorbitant and untenable" cost for union
representation:

Forfeited are nurses’ rights to determine their own destiny; to control their practice, working conditions, and professional affairs; to advance their particular needs; to speak for and represent themselves; to be perceived as an untainted profession by the many publics nurses interact with. Trade union representation destroys nurses’ unique professional identity and renders them pawns."

Nurses who took strike action, desired far more than to increase their economic entitlements, they were looking for an increase in professional rights. They believed that the union would represent them and protect them as they advanced their cause. When nurses recognized the reality of the situation, that they were unrepresented and vulnerable, they became fragmented, mistrustful, and divisive.

Analysis of Post Job Action Subproblem 6.0 - Job Action and Conflict.

Subproblem 6.1. To what extent did nurses feel there was equitable shift sharing during the strike?

Findings. Tables 11 and 12 show that 68.4% of nurses felt that there had been equitable shift sharing. 28.3% of nurses were unhappy with the way that shifts had been allocated.

There seemed to be no defined criteria for how
shift work would be allocated to meet essential service requirements. Since some nurses were designated as "essential", they would be permitted to work some shifts and would be paid for those shifts.

Some nurses worked all shifts throughout the strike because they were "essential". Unlike other units, their nurse-patient ratio remained the same:

I work in CCU therefore none of my shifts during the strike were cancelled and I found it difficult to know how overworked nurses in other areas were.

Those who were deemed "nonessential" would work few, if any shifts and would, in turn, not be paid.

Being declared "non-essential" was in the eye of the beholder according to this diabetic educator and counsellor:

I resented being seen as nonessential when most of the nurses have no concept of what effect this action had on my patient load.

An educator commented on her experience:

I felt angry that although I was available around the clock for any shift, weekday or weekend, I was only able to work less than part time. I was willing to work in Extended Care and Family Practice as I was an obstetrical nurse before teaching. I felt limited in my expertise but I was willing to work....

A few nurses offered to share shifts and got a variety of responses:
I strongly resent the threats of 'laid off' - non essential RN's who said, 'You owe me a day's work - we are all in this together'. Some of these people when offered a shift, turned it down because it was an evening, night, or weekend!

A "nonessential" nurse commented:

I saw demonstration of greedy behaviour, hogging of shifts and that I call that unsupportive of job action.

"Non-essential" nurses learned what it was like to be on strike as in other, more "normal" strikes in which workers lost money:

Being non-essential, there was no opportunity to make even a little money. The feeling that nurses in areas such as ICU, Emergency did not worry how long the strike extended due to monetary loss.

Obtaining shifts to provide essential services seemed to be equated to the amount of picketing nurses did in most hospitals. It seemed in many facilities, that if nurses were opposed to striking and picketing, they were unlucky in obtaining shifts. These nurses related the experiences of many nurses:

I was against striking and picketing and the union reps. did the utmost to force me to do any type of picket duty. They were even going to replace my shifts with staff that had not picketed either. I would have respected the line if picketing staff didn't get enough shifts, but I did not respect the line to let non picketing staff work my shifts.
I was absolutely furious when I did the locally required number of hours on job action duties and only received 18 hours of work as essential services. Many other staff members lost less than 1-2 shifts. This was very inequitable—especially when I didn’t agree with job action in the first place.

Nurses who felt picketing was against their principles were banned from working any shifts. This was unfair.

Discussion. Compared to other unions, nurses have an unusual problem they must work as they strike in order to supply essential services. In this strike, a high level of essential service was maintained in some areas in hospitals. The union had not organized for nor anticipated the chaos and conflict that would arise from the resulting inequity from maintaining essential services.

Subproblem 6.2. To what extent did nurses feel that they pushed themselves to the limit during job action?

Findings. Table 12 shows that nurses strongly believed that they had pushed themselves to the limit during job action. Stories of exhaustion from picketing and working on the same day were most common.

I could not believe that my days were longer than ever—picketing and working, working and picketing—and working harder than ever to do so little.

A few nurses commented on their exhaustion in giving
patient care.

Workload increased over an already unbearable workload - in addition to working more than full time.

Essential nurses felt as though they were carrying the strike on the "inside":

The staff that were essential, worked their buns off trying to deliver only the bare essentials.

Nurses who already in times of no strike were feeling maximized in their ability to care, reached new levels of exhaustion:

My already over-taxing job became totally exhausting trying to meet the needs of the patient. I became angry at staff for seeming so unfeeling about patient needs and mine trying to get the job done.

More nurses commented on their feeling of exhaustion from the overall situation of striking, working and union conflict:

The singular negative effect of this strike was the exhaustion and exhaustion-related feelings. The energy drain was a result of being involved in negative activities of confrontation, suboptimal performance, and substandard personal care for patients.

Discussion. Once again, unlike other unions on strike, nurses worked harder than ever by picketing and by carrying workloads that exceeded their normally heavy burden. Muyskens (1982) points out that striking for nurses, is a paradox, an awkward and tortuous means
of settling nursing disputes. He notes that the best way for nurses to accomplish patient advocacy is to execute an effective strike, yet it causes the public to suffer hardships and inconveniences. Huyskens and others fail to see the hardships that the delicate balance of withdrawal of service yet maintenance of lifesupporting care is a hardship on nurses as well.

Ironically, the union that championed workload issues for nurses, did not organize their members in a manner that would avoid this. Nurses found they had to make a Herculean effort to be an informed unionist, a regular picketer and a supernurse all on the same day, and day after day at times.

**Subproblem 6.3.** To what extent did nurses agree that they had adhered to job action?

**Findings.** Tables 11 and 12 reveal that most nurses felt they had adhered to job action. 27.3 per cent said they did not adhere.

Job action consisted of withdrawal of all but essential services, not crossing the picket line, not performing nonnursing duties and later, not working overtime. Some nurses had difficulty adhering to job action, while others had less difficulty. Besides striking, the major job action was that of refusal to
do nonnursing duties. At the outset of strike action, clear direction was not given as to what appropriate decisionmaking with respect to nonnursing duties was and how to make those nursing judgements so that there would not be a detrimental effect on the patient if the job were not carried out.

There was much argument about what constituted a nonnursing duty:

One of the main conflicts between peers that prevailed during the strike and continues afterward is a consciousness of nonnursing duties and whether or not to refuse to perform them regardless of hospital fiscal policies and limited resources.

Nurses had trouble adhering to refusal of nonnursing duties mainly because the system was not set up with a safety net for the jobs to get done. Some nurses were able to work through that problem:

I found other jobs to do that were patient related and just left all the laundry and requisitions etc. I ignored them and they piled up and I guess someone did them. If it were dangerous for the patient, or if it were making life difficult for other nurses, I would grab an HEU person and "help" them. I used my judgement.

Some nurses couldn’t let go of "nonnursing" duties:

The union steward handed out the sheet of paper with nonnursing duties on it. I didn’t particularly agree with it and I don’t think I was alone in my thinking. She wouldn’t let us serve coffee and tea to the old residents in the daytime. But I personally didn’t stop serving coffee and tea at seven in the morning.
- I enjoy it. I get to sit and talk to the patients - it is sort of a fun time. Besides, pushing fluids is a nursing duty after all, and that is how we got around it.

Discussion. This lack of clear direction about the whole aspect of nonnursing duties caused battles between nurses at the local level, and at the broader level between the union or the professional association. In addition, there was conflict because employers had few mechanisms in place to carry out the tremendous number of nonnursing duties. Longstanding habit, and nurses' obsession with "getting the job done" contributed to nonadherence in some places. Much later, after the strike, the professional association communicated to their members guidelines on making decisions about what constituted a nonnursing duty.

Subproblem 6.4. To what extent did nurses feel upset that other nurses continued to carry out nonnursing duties?

Findings. Table 11 shows that 52% of nurses were upset with other nurses who continued to carry out duties which would be considered to be nonnursing in nature. If nurses were not adherent to job action, they were considered to be unsupportive of the cause by some; strong adherence to job action was labelled as "militance" by others.
One nurse described her experience with nonnursing duties:

One of the things that the union was saying to us was that we were not to porter patients, that we were not to clean up after a case: instruments, sheets, etc. We were not to do it but there was no one designated to do it. So you were to leave it; it was administration's problem. The staff had mixed feelings as to what to do. Literally, we snuck around and did it anyway.

One head nurse hoped that her staff would continue business as usual in which nurses would continue to prepare sets for physicians, a duty which was considered to be nonnursing. Her concern was that it would have a negative effect on physician-nurse relationships after the strike:

They said they wouldn't set up for physicians. Well, you spend all this time trying to get a rapport with them and then in one fell swoop they destroyed the whole thing.

Discussion. Refusal to carry out nonnursing duties seemed to be the most militant action of striking nurses. Alutto and Belasco (1974) found that not only was militancy pervasive throughout the professional population of nurses and teachers, it was likely to amplify since societal values legitimize confrontation by groups. Militance, according to Beletz in a 1979 study, was more likely to be endorsed by nurses who were oriented toward the union model of collective
bargaining rather than a professional model.
This study did not measure the level of militancy and the correlation to characteristics of nurses.

**Subproblem 6.5.** To what extent did nurses feel that it was easier to do nonnursing duties than to ask others?

**Findings.** Employers and nonnurses quickly learned of the staggering amount of work performed by nurses which was unrelated to direct patient care. Withdrawal of this service alone could bring hospitals to a near standstill. Over half the nurses (52.9 per cent) felt that it was easier to carry out nonnursing duties than to ask, or find someone to do them (Table 11). Some nurses believed that their life would be easier if nurses would just DO the nonnursing duties.

The laundry and the garbage just piled up and piled up. I couldn’t stand it anymore so I just emptied the damn stuff myself.

Clearly, nurses were uncomfortable with leaving tasks undone and in some situations had to carry out what, on the surface, appeared to be a nonnursing duty, but that had implications for safe patient care: so nurses carried out the job, if they had to. You can’t leave things such as not putting the results of tests on charts because the doctor may not see the results.

The impact of not carrying out what seemed to be a
benign, unimportant job such as bed moving, was enormous at times and nurses worried about that:

...even things like moving beds. I had a patient that kept running away so I wanted him close to the nursing station. I had to move his bed. I couldn't get anyone from management or housekeeping. In the meantime the patient strayed outside.

Many nurses were worried about the consequences of their action - or for that matter - their nonaction:

I think that younger nurses saw things differently. At the end they tried to step up job action when they refused to do jobs that were part of nursing work, like ordering pharmacy stocks on nights. They said it was Pharmacy's job. I said if you need a drug, it is YOUR problem. They were, I think, scared of the union taking disciplinary action.

**Discussion.** Regardless of how organized facilities were with respect to carrying out nonnursing duties, it was clear to striking nurses and management that there were not enough systems or people in place to carry them all out. In such situations, nurses feel that performing these tasks are the only option available to them since other action would jeopardize patients' care. Corley and Mauksch (1987).

**Subproblem 6.6.** To what extent did nurses feel that other nurses watched to see if they broke union rules?

**Findings.** Forty-two per cent of nurses felt that other nurses were monitoring their adherence to union
rules (Table 11). The results substantiate that there were at times strong feelings that nurses' adherence to union rules were being monitored by other striking nurses. A few union stewards monitored and there was some minor discipline associated with noncompliance.

One nurse described her experience in an Emergency Department this way:

A steward came down and said, 'I was down here at 6 a.m. and all these beds were not made, how come they are made now at 8 a.m.?' One of the staff had made them but I was so angry, I told her that I had made them. She said, 'Well, you are going to go out to the picket line.' I told her I wouldn't. She said, 'Oh yes you will.' I said I am sorry but you agreed to a level of staffing for our department and I am not going out because we will be short. She told me to call her after work and there could be actions taken then. That really got me riled.

Nurses, who are socialized into teamwork, had some difficulty with the "not my job" concept:

I heard this guy, this coworker, say to me, 'Don't you move that bed because I'll be watching.' I said, 'Oh, phoo on you.' A waste of time. Whatever happened to teamwork? Nowadays, it's 'not my job Charlie'.

Discussion. Compliance to job action by nurses has not been explored. Attitudinal militancy (towards an employer) has been examined to a small extent, but behavioural militancy during job action has not been. It would be worthwhile to determine what the factors increase militancy in the workplace during job action.
One aspect of militancy may result from another point of view: that of the nurse refusing to carry out union orders.

Analysis of Post Job Action Subproblem 7.0 - Post Job Action and the Negotiated Offer

Subproblem 7.1 What caused participants who voted "no" to reject the negotiated contract?

Findings. Nurses had a variety reasons for not accepting the contract offer. It is not clear what would have been an acceptable contract. However, the bottom line was that nurses had voted to strike to be recognized for their value. When nurses saw the contract offer and saw that the only evidence of their "value message" was that it had been reduced to monetary terms alone, their fury was boundless. Nurses felt insulted, ignored, and deceived. Other than on monetary items, there seemed be no acknowledgement and no change in their working conditions. It seemed that their union had not heard their message, and so had not taken it to the bargaining table. The money then, was clearly not enough.

Nurses found it incredulous that their union had not heard their message, since they believed it had been loud and clear. If the union had heard the
message, it was not obvious to them that their bargaining committee would have the expertise to translate their wishes at the table.

Table 16 shows that 57.3% of study participants voted to reject the proposed contract, 36 per cent voted to accept the contract and 6 per cent did not vote. In the actual vote on July 12, 1989, 68 per cent of nurses who cast a ballot rejected the contract.

Pat Savage, BCNU President, postulated why nurses voted "NO", to reject the contract:

Nurses were looking for a quick fix to everything that ails a very sick system and there was desperation because working conditions have deteriorated so much over the last few years during the shortage and all the implications that has on their work and the resultant effect on patient care. Nurses were desperate to have something done and when we went to the bargaining table we had probably the largest number of proposals we have ever had. It was the most difficult round of bargaining we have ever had.

Nurses stated their reasons for rejecting the contract. 47.3% of nurses rejected the contract because they believed that the contract was unfair considering nurses' experience and education.

Only 42% said there was not enough money in the contract:

I was very upset that graduate nurses were being given a salary so close to RN's. I feel they deserved to get a scale but it should have been much lower. I feel this belittles our
attempts to be taken seriously as a profession. After all, if a doctor or lawyer did not pass their finals, would we let them practice for 50 cents less an hour than successful candidates?

Another nurse commented that, "There were too many benefits altered."

Almost 40% of participants believed that the leadership of BCNU were unaware of what the "bottom line" for nurses was:

I voted NO because the union "Yes" representatives could not or would not explain the contract to my satisfaction. I felt they were ill informed and therefore their opinion was not valid. The incompetence of the group was not to our advantage.

BCNU did not RECOGNIZE, RESPOND, OR REPRESENT the members' concerns. They were too busy attempting to look after themselves and lost sight of the membership.

Twenty-two per cent of nurses believed that "no" campaign nurses continued momentum that nurses already developed.

When asked at a meeting what they planned to do if nurses voted NO to accepting the contract, the Union staff said 'they were not at liberty to say' - I decided to vote no.

Many nurses believed that the contract was too long:

The contract duration was too long initially. I felt it was important to shorten the duration so that our battle to upgrade nursing wages to an acceptable level continue at as early a time as possible.

The contract did not address nurses’ working conditions adequately, one of the reasons for which nurses voted
to strike:

There was nothing in that contract to assure me
that my working conditions would change - the
professional responsibility clause did not
provide for a conclusion to a problem - there
would be no final decision as in, for example,
arbitration.

Nurses were not only concerned for themselves
personally, they could not see changes in the contract
that would keep their profession alive:

There wasn't enough there to attract into the
profession. Nurses are becoming fewer with no
incentives to keep them there i.e. shift and
weekend differential, more weekends off,
shorter work week so a nurse can still have a
home life other than more work and exhaustion
with no time for spouse and kids.

Nurses complained of a Dickensian working environment:

I am tired of working short-staffed. Too many
friends are going to the U.S. for more money or
out of the profession due to stress, and I have
poor working conditions i.e. non-renovated
nursing ward, outdated equipment, or
nonexistent equipment.

Nurses who rejected the contract believed that the
contract that was voted on was inferior to the original
contract for which nurses went on strike:

I felt the contract was no better that the
first one and in some ways it was worse (e.g.
Casual package was not addressed and
settled).

We lost our early pension without penalty - we
need options like any other union.

I felt the contract we were asked to ratify was
inferior to the original offer and there was
I felt the contract we were asked to ratify was inferior to the original offer and there was little to lost by voting NO.

Nurses believed that if they took the second offer which, to them, seemed less attractive than the first offer for which they voted to strike, they would be viewed as foolish in the eyes of the negotiators and the public:

I felt we stood to lose our credibility if we accepted an offer not much different and possibly of lesser value than one rejected by the membership in the may vote and thereby diminish our chances of negotiating a reasonable contract in the future.

Nurses listed a myriad of other reasons for voting NO; the most commonly expressed other reason stated was for the same reason that nurses voted to strike: they wanted to send a message to government that nurses wanted to be valued and they did not see evidence of it in the contract.

I felt there were so many non-monetary issues that were not addressed e.g. nursing profile in society, professionalism, responsibility, etc.

I felt that the contract did not address all aspects of nursing that needed changing. I felt that too much emphasis was put on wages and not enough on professionalism, workload, job stress, responsibility and time off.

The future of nurses in the field and our numbers was at stake - I may need a nurse one day!
Nurses need to be involved in decision making and to be recognized as an important member of the team. We do not follow orders blindly—we assess, make informed decisions, and plan for our patients' needs.

Nurses believed that their message had not been heard and that the government had their heels "dug in". Some believed that voting "no" would be another way to continue to drive the message home:

Actually, I felt the contract was the best that could be negotiated. But, I wanted to make a political statement to the government. I wanted to let the public know what is happening in health care in this province and hopefully encourage them to make some changes.

Nurses who felt that they were being manipulated or patronized, decided it was time to take a stand:

To vote 'yes' would have been like any other time nurses have tried to get a better deal and buckled under the pressure. I didn't and don't believe the nursing situation can be changed in one contract, however changes have to start somewhere.

I voted no because of the continuing attitude by HLRA that nurses can be manipulated into taking a generally poor contract offer.

HLRA ultimatum was a power push that signalled that nurses' needs were not being taken seriously.

Discussion. Are the chances great for rejection of other settlements, or is this a one-time situation? Hetzger, Ferentino and Kruger (1984, p.100) believe that rejection is common among nurses who have other concerns than those identified by management and their
proliferate because of "the inability of nurse union leadership to translate the real concerns of nurses into acceptable settlements..."

**Subproblem 7.2.** What caused participants who voted "yes" to accept the negotiated contract?

**Findings.** Voting "yes" did not necessarily mean that nurses were pleased with the bargaining committee or trusting of their union's expert knowledge. Most of the participants who voted "yes", to accept the contract offer did so because they could not stand the conflict any longer. They were tired, discouraged and considered that continuing the exercise would be futile. Some were experiencing financial difficulty. Many were concerned about their image and how long public support would last with health care and the nursing union in disarray.

For the viewpoint of those who were looking at the contract from a strictly monetary sense, many believed that there it was not a bad increase and that there was no more money or benefits to be had regardless of the expertise of the bargaining committee. Some recognized that the nonmonetary "value" items had been lost in the shuffle and the confusion and chaos would have to be sorted out "next time" after order had been restored.
sorted out "next time" after order had been restored.

Thirty-six per cent of respondents voted to accept the contract (Table 16). Nurses listed their reasons below: 11.5% percent were satisfied with the contract and a variety of them expressed their satisfaction stating that it was a good start:

I felt we had achieved all we could at that time and should apply our new strike knowledge and skills (everything from negotiating to picketing and to giving care on wards during the strike) to the next contract.

The casual package was an improvement and the wages were an increase. You don’t get everything you want in one contract.

I think the original high percentage increase of salary demanded was unrealistic and way out of line of recent settled agreements by other unions.

The contract offer had many clauses that could be expanded on in future negotiations - they were 'foot in door' items.

Sixteen per cent of nurses wanted the conflict over with; a few were worried about losing public support:

I don’t think we would have maintained public support if the strike had continued any longer.

Some nurses gave up because of exhaustion:

I was tired. As I contemplate nursing after 39 years, I would hope that nurses’ patience will not be pressed to the flash point in the future and their opinions will be given more credence.
ionals again and regroup until next time and really go after something in the next 2 or 3 years. I never wanted to go on strike again.

Eleven and one half per cent lost faith in the bargaining committee’s ability to achieve a better settlement; they believed that the bargaining committee had difficulty facing the membership:

The way in which I found out about the offer (via the media) made me question the ability and confidence of the bargaining team.

Some nurses believed that the responsibility had to be taken by the members who had, after all, either voted for this bargaining team, or who had not exercised their vote:

I was mad and amazed at the way nurses had thrown out their ballots for the bargaining committee and now were complaining about them. I thought here you stand, angry, yelling and screaming to get them out and you didn’t exercise your rights. If you thought about it, when you haven’t done anything, you get what you deserve.

Of nurses who voted yes, 10.8% wanted to vote with their union’s recommendation, believing the union had better insight into the situation:

I felt that the union had achieved the best they could given the current economic state. I felt that the government threat of legislation was not a veiled threat.

No better offer seemed possible, regardless of who was bargaining.

Participants listed other reasons why they voted "yes".
Participants listed other reasons why they voted "yes".
Some qualified their "yes" vote with a:

But, if I were a younger grad. in a very high-tech, high stress job, I'd have voted 'no'.

Tables 17 and 18 reveal as might be expected, that nurses who voted "no" believed that their bargaining committee should have done better, that BCNU should have more expert negotiators and that the "no" campaign gave them confidence to stand up for their rights. Other correlations that are more surprising are that nurses who voted "no" also found physicians actions were not supportive, and found that striking was a difficult moral decision.

Discussion. Beletz (1980) argues that contemporary nurses may be "radicalized" when contrasted to nurses of bygone years and who are no longer uncomfortable with techniques of confrontation and militancy. In this case, that would seem to be true; only a minority of nurses wanted to have the conflict over with.

Subproblem 7.3. To what extent did nurses feel that BCNU should not have publicly recommended an offer without a vote?

Findings. Tables 20 and 21 show the strength of the belief of nurses that the offer should have gone to the membership before BCNU recommended that the offer be
accepted. Seventy-seven per cent of nurses agreed with this.

I think that what upset me most was reading about the contract offer in the paper and reading that the union was recommending that we take it. They did not have the right to do that.

They didn't even ask us if we wanted it. They just turned around and said it was as good offer. They were asking people to vote yes. What were they DOING?

Discussion. One of the main dissatisfiers that nurses complain of in their worklife, is that they are consulted on very few things that have direct impact on them. The usual way nurses are told about changes is by "being told" from their supervisor or a change will "just happen". The almost violent reaction that nurses had to their union's recommendation that they accept the contract was that nurses undoubtedly viewed this as another example of something else that they would be "told" to do without any choice.

Subproblem 7.4. To what extent did the nurses feel that the Bargaining Committee should have done Better with HLRA?

Findings. Table 20 shows that 64.9 per cent of nurses believed that the Bargaining Committee could have negotiated a better offer. There was little
disagreement on this issue (Table 21, S.D. = 941).

Seventeen per cent of nurses were undecided if their bargaining team could have done better, but 17.9% of nurses believed that the bargaining committee had gone as far as possible with HLRA.

I felt that getting a new bargaining committee was not going to help. They would have to learn what they were supposed to do plus what had gone down before. I wasn’t impressed with the bargaining committee, but I vowed that I would take more of an interest when this was all over.

I feel that the bargaining committee was correct when they said there was no more money and they were vindicated in that by Vince Ready and the final settlement.

Pat Savage, BCNU President, commented:

There was a lot of stonewalling. The government were not willing to address the issues. Their perception was that we weren’t representing the wishes and wants of the nurses, that the picture we were painting was not realistic. It is difficult bargaining in that arena because in reality the government controls the purse strings and HLRA is really the middle man. You always knew they (the government) were there.

Savage continued:

I had and still have concerns with the monetary aspect of the agreement that was negotiated - it will not address the shortage and I know what that means for nurses in the workplace. I guess that I was surprised at the outpouring of emotions that members simply weren’t prepared to accept the fact that the committee had gone as far as it could do with the government. There was, from the committee’s point of view, no more to get.
Discussion. The "outpouring of emotions" was hardly surprising for a number of reasons. Nurses found it difficult to accept that their bargaining committee had not met their expectations. What was astonishing, was that the union President was unaware of the depth of conviction and trust that her membership had in the bargaining committee to negotiate a contract they felt had been promised to them.

Savage had told the union's Provincial Wage and Policy conference in a December, 1988 address:

The voices of our members have been heard...and out of this provincial conference will come your clear direction to the bargaining committee. Armed with this mandate, the bargaining committee can move forward to negotiate on your behalf...we can't influence their (government) decisions by allowing them to control us. We will influence their decisions by standing up for ourselves and by showing all parties involved that we are willing and able to stand up for our rights.... It surely is a battle worth fighting... I am convinced that we have the strength of our commitment to achieve our goals.

Nurses certainly responded to her call for "standing up for their rights". Nurses had high expectations and, they believed, had been promised that if the members had strong commitment, they would be rewarded. Nurses were convinced that their strength and perseverance would force the bargaining committee back to the table and that the HLRA would have to take
them more seriously.

Subproblem 7.5. To what extent did nurses feel that BCNU needs Expert Negotiators to Bargain for them?

Findings. Nurses clearly felt outmaneuvered at the bargaining table. Under the BCNU constitution the responsibility of the negotiator is assigned by the Chief Executive Officer of the BCNU and the members of the Committee are voted by the members.

Nurses became aware of the limitations of their negotiators when the committee met with them and attempted to explain and defend the proposed offer. They were definite in their message that they didn’t want this to happen again.

Table 20 shows that an overwhelming 88.8% of nurses wanted more expert negotiators to do their bargaining for them. Some nurses believed that the bargaining committee needed preparation - in bargaining expertise and on the issues:

I think people should be put on bargaining committees that should know what they are going to be faced with when they get to the table. Then they had better know what the membership wants.

Other nurses, and many of them, commented that labour lawyers with expertise in bargaining should be hired:
A labor lawyer should have been hired to assist the negotiating committee in the bargaining process from the beginning.

They need advisors who have experience. They (the union) should have paid for that.

Pat Savage described her experience as president and as an ex-officio member of the negotiating team:

I think I have changed through all of this. I am more knowledgeable about the process. I had sat as a member of the bargaining committee for part of the last round of bargaining negotiations and unfortunately had to leave before that round of negotiations was completed. So this was the first complete round of negotiations that I was part of...we have never had a President involved in the negotiating process, so it was a learning experience and many many people have an expectation that you do it perfectly regardless of the depth of experience that you have. They are not prepared to let you make any mistakes of any kind. I am human.

Discussion. Metzger, Ferentino and Kruger (1984) point out that these rejections are not uncommon in units represented by traditional trade unions and settlement rejections can happen even with the most skilled labor negotiators and the best of intentions on both sides.

Subproblem 7.6. To what extent did nurses feel that the "dissident nurses" gave them confidence in their rights?

Findings. Generally, nurses were in agreement that
the momentum of the "no" campaign made nurses more confident in standing up for their rights (Tables 20 and 21). Although 65.1% of nurses agreed that the NO campaign made them feel more confident about standing up for their rights, 22.8% of respondents disagreed.

The results show that while most nurses did not feel that the dissident nurses themselves gave nurses the confidence they needed to vote against the contract offer, the momentum of the campaign certainly did. Nurses were hungry for leadership, information and empowerment; all of which they found lacking in their formal union structure, and they found in the dissident nurses. Nurses' opinion of the contract offer was reflected in the "no" campaign. Nurses who were unhappy with the "no" campaign focused their unhappiness on the two dissident nurses, Stringer and McPherson whom they called "militant", "radical" and "politically motivated".

Some nurses were pleased that the NO campaign represented their views and that the so-called 'dissidents' had courage to carry the message.

The 'NO' campaign vocalized what I already felt. I would have voted NO even without them but would not have started the campaign myself.

Many nurses believed that saying "no" was the only way
government pushed one way, their employer another, and
the union, another, still:

By the middle of the strike I was a strong
supporter of the "NO" campaign as it was the
only option to have input and some sense of
control.

Nurses saw their union as being reluctant or unable to
provide them with information; many nurses felt
intimidated by their own union.

When the NO vote was being considered, we were
not given the whole picture. We were harassed
by our own union stewards.

Since the union was unable to keep their membership
informed, nurses sided with those who would be
responsive to their questions and to provide them with
information:

I appreciated what the VGH group had to say.
At least they told me information. They came
across as radical, I suppose to a certain
extent. I didn't care if other people thought
they were like teamsters. The information they
gave me was good. I don't think it mattered
what they looked like. I think they were really
genuine. I wonder how many hours they put in.
They were really very good as far as coming
around and asking how we were doing - just that
little bit of support...I think they were
really tired. I think they were good at
communicating things.

Some nurses felt that BCNU leader Pat Savage should
have been supportive when the vote clearly indicated
that the majority of nurses were not in favour of the
offer:
The NO campaign was right on. Thank God they took it as far as they did. Why didn't Pat Savage carry on with her conviction that the NO nurses were the voice of the majority?

Savage talks about her changing her position regarding the comments she made on the negotiated settlement:

I could not make that decision. I clearly said the next day that I had made a human error and I said it was a statement that came from the heart because I believed that offer negotiated wasn’t going to do it for nurses and the government has to be accountable for that. I am a nurse and not that far removed from being at the bedside myself but I had clearly overstepped my bounds. When I recognized that, I had to admit my mistakes. I think I have to take responsibility for what came out of my mouth. That was guts honest and I don’t think it is fair to place blame for that on anybody else. I had never been in a setting like that before.

One nurse explained what others saw as "militancy" of the No group:

The militancy that people saw in the VOTE NO group was the fact that the union group that came out here was almost apologetic: 'I'm sorry group, this is all that we are going to get and we had better succumb because if we don't we will be punished.' Any thing that we brought up from the floor - it was apology, apology, apology. But then the NO group said, 'Look, you don’t have to accept this and did tell us that the contract language says this, this and this. We weren’t aware. They were a strong, informed voice instead of an apologetic voice. I didn’t consider it militant. I thought it was informative. Militant was like doing it without others' interests at heart, it was dogma.

In keeping with nurses' previous beliefs that their union did not respect the trust placed in them, nurses
were suspicious that their union was not acting on their behalf, nurses commented on the "dissident nurses":

If it weren't for Bernadette Stringer and Debra McPherson, we would be unaware of what was going on and we certainly found out - nepotism, money issues, a bargaining committee that wasn't backing our own interests.

Not all nurses were happy with the dissidents for a variety of reasons from disliking one or the other, from feelings that they were too "radical", and from the belief that their actions were politically motivated:

I felt that Debra McPherson represented my feelings to the media in a very powerful, positive way.

I support the attitude and approach of Deb McPherson, but not Bernadette Stringer.

They are too radical.

I was not against the 'no' campaign. I was against the two members who did the 'no' campaign. As members of Council they should have supported the bargaining committee, ethically speaking. Other members could have done (promoted) the 'no' vote. Secondly, they did not do it just for the 'no vote', they did it so they would be recognized in upcoming executive elections.

I did not like the political motivation of the leaders of the 'no' campaign in Vancouver.

I am very concerned about what the two very vocal Vancouver members can do to destroy BCNU.
I am very concerned about what the two very vocal Vancouver members can do to destroy BCNU. I don't know the two ladies, but I am distressed that they are very militant.

Other nurses associated the NO group with Vancouver nurses rather than with others in the province:

It was awful seeing the "No" group in Vancouver on CBC news screaming their heads off.

Some nurses were concerned about the far-reaching effects they felt the NO campaign had.

I felt that the Vancouver General Hospital BCNU reps bespoiled our professionalism. I felt that BCNU had no right to include their representative in the bargaining committee. I believe the NO action concreted the HLRA against nurses.

The dissidence arose from Vancouver General Hospital (VGH) and one nurse from that hospital was not unhappy:

I was proud of VGH's stand and unity of nurses and our strike leaders at VGH.

Other unsupportive nurses commented about perceived militance of the two members who led the NO campaign:

The 'dissident' group from Vancouver caused public disapproval and made us (the union) look like we couldn't decide among ourselves what we wanted.

The nurses from Vancouver General and other hospitals had a right to their opinions but they could have very seriously hurt if not destroyed the job action.

There was mistrust to the point of paranoia in some cases between the BCNU and nurses who were opposed to ratification of the contract.
BCNU told membership on many occasions that they membership had to increase their involvement within the union. I personally know of two instances where people involved in the 'no' campaign offered their services as stewards prior to the ratification vote. In both instances, their people were rejected by the two different Region's executive. In ______, there was not a set procedure in place to become a steward. In the past, people simply offered their services as stewards and were accepted with open arms. Suddenly because you did not agree with the union line you were left out in the cold. This reinforced my feeling that the BCNU is being run by bureaucrats who are out of touch with their members and are more concerned with getting a job done that they are with getting a job done right.

Some nurses felt the No vote caused disunity in nurses:

The NO vote vs. the YES vote caused division among fellow nurses.

Nurses who voted "yes" to accept the contract but who worked in hospitals in which the majority of nurses voted "no", felt similar to this:

I had the feeling that you couldn't be truthful about how you really felt because your colleagues would get angry. My hospital voted strongly "no". I had a secret ballot, so I said everyone has to make up their own minds, and I voted to accept the offer. I never told anyone. I found it hard. I didn't want anyone to know.

One nurse considered herself militant because she was unsupportive of the growing majority of "no" voters.

Militancy is an individual thing. It is how you perceive it. If something goes against my norm or mainstream then it is militant. If you look at the other side of the coin, then those who were the NO vote would consider ME militant because I wasn't going with the mainstream.
Pat Savage, BCNU President expressed "surprise" at the NO movement saying:

People were not prepared to honour the process. I believe it caused the members of our union a lot of confusion. And I think members voted no for a lot of reasons. I don't know that we will ever know how much effect the so-called "no campaign" had on the decisions that the members made.

This nurse voted YES to accept the negotiated offer because she felt that the union had done the best it could in the current economic state and that threat of legislation by the government was not a veiled one:

I was greatly angered and dismayed by many of the nurses who were extremely vocal and irrational in their 'Say No' campaign. I felt they let their emotions run roughshod over any rational thinking and behaviour.

Discussion. The "no" campaign should not have been a surprise given the history of the labor climate in British Columbia generally. Traditionally, collective bargaining settlement commitments made on behalf of nurses have been "frittered" away by the rank and file (Metzger, Ferentino and Kruger, 1984, p.100). There is "knee-jerk" management condemnation of the leadership of nurses' associations and the accusation that units represented are uncontrollable. As mentioned previously, these rejections, chaos and ill will are not more common among nurses than among other traditional trade unions.
traditional trade unions.

Subproblem 7.7 To what extent did nurses feel that dissension within the union was a negative aspect of the strike?

Findings. There was no doubt that nurses felt that dissension between them did not help their cause. The most common sources of dissension had to do with inequality of shifts, picketing, nonnursing duties, and beliefs about striking and whether or not the proposed offer should be rejected or accepted. Table 20 shows that 69.9% of nurses felt that the dissension between nurses was negative. Most agreed that the focus of dissension was mainly on settlement of the contract offer.

There is disunity in the profession regarding reasons for the strike and what would be an acceptable offer.

Our public image was damaged when we were split in our loyalties and in disagreement about our settlement.

There was however conflict related to other aspects of the strike:

The most negative part of the strike was the conflict among nurses; i.e. some nurses would not picket, but they didn’t lose any pay.

Twenty six per cent of nurses disagreed that dissension was a negative aspect of the strike.
Discussion. Positive or negative, there would be agreement that there was dissension and not solidarity between nurses, whatever the cause. Beletz (1988, p.147) says that trade union representation "fragments and is divisive, and creates discourse for the profession and confusion to the public". Nurses according to Roberts show the consequences of being an oppressed group: among them being self-hatred and divisiveness among nurses.

Analysis of Post Job Action Subproblem 8.0 - Nurses and Gender

Subproblem 8.1. To what extent did nurses feel that trade unions generally are not attentive to women?

Findings. Table 22 reveals that some nurses (20%) were undecided about how attentive trade unions were towards women's needs generally, and nurses' needs specifically. 55.6% of nurses felt that trade unions were not attentive to nurses' needs.

I voted no because of pressure from other unions in BC to accept an unfair contract. Again, nurses were being made to feel they had to make do with something that was clearly unacceptable because we are (a profession) largely made up of women.

One nurse commented that a positive part of the strike was that nurses could finally show the public what
not just holding the patients' hands and acting as if 'the Dr. is GOD'. The general public generally accept that nurses get paid enough and the contract gave a huge wage settlement. Most people with that feeling were in trade unions and for the most part were MEN.

Nurses railed at their union for what they believed to be a deference to the trade union movement in the negotiation of the nurses' contract. One nurse strongly expressed her views:

There was reinforcement by the union and the bargaining committee of public opinion that women are second class, unable to make up their minds, incompetent and that they needed men to make their decisions for them.

Discussion. Nurses were conscious of the male dominated leadership of industrial trade unions. Beletz (1988) agrees, calling trade unions "chauvinistic". BCNU must walk a fine line; they need to have the support of the trade union movement, but must heed their memberships' sensitivity in being aligned with the male dominated trade union movement.

**Subproblem 8.2.** To what extent do nurses consider themselves to be feminists?

**Findings.** Since 97% of nurses are women, it was surprising that more nurses did not consider themselves to be feminists. Table 22 shows that only 52.1% of the nurses considered themselves feminists and
34.9% did not; 13% were undecided. This was one of the most sensitive questions and it evoked strong responses from nurses who did not view themselves as feminists.

One head nurse in a small hospital put it this way:

I don’t feel like a feminist. I think of the feminist movement back in the 70’s - they were very assertive. I don’t feel good about the feminist movement and I don’t want to be part of it. I don’t want to be aggressive. There are other ways of doing things. I am no feminist.

One of the male participants commented on his disinterest in women’s rights stating that:

I am a male, an advocate of nurses’ rights and am generally unconcerned with women’s rights. I very often became a father figure or an "earth mother" to my fellow RN’s on the picket line as did other males I spoke to. Also males were not prone to "hysteria" either on the line or in the presence of the media. I am speaking in general terms only as I feel our union executive and stewards acted most professionally.

One nurse believed that feminism and humanitarianism were incompatible:

Women are supposed to be the humanitarians. It is not accepted that feminism is here in nursing yet - it is coming - but it is not here yet.

Whether they considered themselves to be feminists or not, nurses had lots to say about how other people view or treat them because they are women. Nightingalism was a frequently used term when nurses pointed out how others viewed them. Even though nurses were
uncomfortable with the "feminist" hat, they were anxious to remove their Florence Nightingale cap.

It (the strike) showed the government and the general public that the work we do must be valued and that we are not longer in nursing to be a maid servant to Docs and we are not Flo in a cape and white hat.

Nurses were pleased that they had been strong and cohesive during the strike in spite of the Nightingalism issue.

I was happy to see a demonstration that nurses as a group can commit and pull together for a common cause despite their nature to please and serve.

Discussion. Perhaps, since the majority of nurses who responded to this survey were between the ages of thirty and fifty, the word "feminist" itself summoned up images of the stereotypical, militant woman from the 70s era and nurses were uncomfortable being aligned with that image. Perhaps nurses were worried that if they considered themselves feminists, their NURSING issues and concerns would be discounted and disregarded by the public. Perhaps nurses have not been educated and socialized into being comfortable with feminism.

Baumgart (1989) argues that nurses have much to learn from the women's movement which offers an alternative view of nursing and health care issues. Nurses must overcome gender bias, Baumgart says, by
creating a new nursing culture by developing some of the principles of feminism such as developing supportive networks and coalitions of like-minded individuals as well as a system of caring.

**Subproblem 8.3.** To what extent did nurses feel that the occupational problems of nurses are related to those of women generally?

**Findings.** Consistent with the previous results in which over half of nurses did not consider themselves to be feminists, 24 per cent of nurses disagreed that their occupational problems were similar to those of women generally (Table 22). Table 23 shows there was as much agreement on this by nurses as there was disagreement between nurses (S.D. = 1.350).

Table 22 shows that 69.2% of nurses attributed the problems that they experience in nursing to be related to problems of women generally. Many nurses believed that nursing is "behind" in social development:

Nursing lags behind about 20 years behind the times, largely because it is female - it is only recently that more modern women are in the profession and the prospective nurses chose other careers.

Nurses recognized that they had been passive in relation to needed changes:

Nurses haven’t been aggressive and we have sat
Nurses haven’t been aggressive and we have sat back and allowed people outside our profession to give us this amount of money and pat us on the head and say away we go.

Finally, nurses (mostly female) realize that they have a responsibility and right to speak up for their livelihood. No one else will pay their bills.

A male nurse was in agreement and wrote:

I think the government has a very low opinion of the job worth of nurses. I feel nurses are discriminated against according to sex.

Throughout the strike, nurses still had responsibilities in their family life. There was no day care available at the strike headquarters and nurses who were strapped financially had a difficult time paying for day care:

My husband was out of town from April until September and we have a 2 year old. I was very stressed with home as well as in the job situation and there was very little support from the work front.

One nurse did not that this labour dispute had anything to do with gender. Yet she went on to say:

I don’t think that this is a feminist issue. It is a fact of life that the public doesn’t want to pay us a whole lot more salary. The fact that the medical profession has made so much money and nursing profession had made not much money has something to do with the fact that we have been Nightingales.
This nurse continued on a different vein:

Jack Munro has the gall to come out and say 'You girls should accept the offer.' Well in the first place we are not 'you girls' and secondly, his IWA workers have received premium wages on the weekends for years, unlike us.

Discussion. Overall, the issue of the nurse in the health care system and the function of power, structure and gender is inadequately explored (Corley and Mauksch, 1987). Even acknowledged scholars such as Simpson and Simpson (1969) speak of the depth with which the relationship between gender and status is viewed.

Baumgart agrees that there is a "cultural lag" (p.72) in nursing between the changing society and the old social processes in nursing. Baumgart (1989, p.9) argues that nursing "exemplifies many of the limitations of so-called 'women's occupations' or 'women's ghettos'". Baumgart points out that while unions have achieved some gains, they have not addressed structural problems related to inequities in their status or in their working conditions. Baumgart could have extended that into the non-addressal of the way that nurses hold job action.

The BCNU often comments on the problems of nurses as women and frequently criticizes the employer for being insensitive to the needs of their employees who
are primarily women. However, the union itself was not sensitive to the needs of their members in many respects during job action. Strike headquarters did not have day care facilities and there was no money available for mothers who were going without salary but who had child care responsibilities yet were expected to picket.

The issue of abuse on the picket line was not addressed by BCNU on a province wide basis. The mostly-female picket lines were was unusual compared to other industrial male-dominated picket lines. Safety was an issue for many nurses who picketed at night, who were expected to block entrances to hospitals and who sustained abuse from primarily from a male public and male physicians in some cases.

**Analysis of Post Job Action Subproblem 9.0 - Nurses and Physicians.**

**Subproblem 9.1.** To what extent did nurses feel that physicians respected and understood nurses' issues and concerns?

**Findings.** The majority of nurses felt certain that physicians did or should understand their reasons for striking since physicians probably even more contact with them than their employers and since physicians
share their clinical culture. Table 24 shows that 61.8 per cent of nurses agreed that physicians respected and understood reasons for which nurses took job action.

However, only a few of the respondents commented.

We got a port-a-potty from one of the physicians for the picket line. That was very considerate. And lots of doughnuts from them.

Thirty-three per cent of nurses disagreed that physicians showed respect and understanding.

The utter boorishness and lack of respect nurses met from the medical profession. We should never count on them ever for support in bringing about needed changes in health care. I am convinced it would be a one way street based on greed and narrow mindedness!

The physicians displayed a real lack of interest in our situation.

Some physicians were quite vocal about their disrespect for their colleagues.

I felt furious at a Dr.'s statement heard on the news, 'After all, nurses are not professionals.' He was the Director of Medicine at ______ Hospital!

Some nurses believed that there had to be active lobbying of the physician group.

We have to change doctors' views of nurses - without us they won't be able to do their jobs. Some treat nurses as handmaidens instead of professionals that have a great deal of the knowledge that they (physicians) do. If the doctors' views change, so may government and government bargainers and we won't have to go through this again.

One nurse tried to explain the issues to a physician
whose wife was a nurse.

I told him that there are no nurses. I reminded him that the situation was a result of many just like his wife's, who is not working any more. I told him this is what happens to nurses - they leave nursing. According to him, his wife could stay at home, but we should be able to find nurses anywhere.

A head nurse in a community hospital commented on the privileged place that physicians enjoyed compared to nurses.

This hospital is physician run. If the doctors wanted to start a heart transplant unit and they nagged long enough, they would get it. Nurses will be punished for what they got (during the strike) and will be expected to cut back. But the medical staff won't be expected to cut back. They get what they want. During the strike they were still ordering to ICU when there were no beds, but it was 'our problem'. They carry a phenomenal amount of weight and privileges that no one else can have. It is incredible and I don't think there is an Administration or a Board that isn't run by them.

**Discussion.** The relationship of physicians and nurses has come under increasing scrutiny in the last few years, albeit not so much labor-related as it is gender and status related. The combination of male dominance, female compliance, economic disparity, clash of work roles, and an educational gap are the most common reasons cited for differing values and physician-nurse conflict (Morgan and McCann, 1983). Baumgart (1989, p.71) says "the discourse of altruism
clearly did not permit complaints, confessions of unhappiness, recognition of economic value and adequate remuneration, or any questioning of physicians' actions. The dominant culture gave very few ways for nurses to express their experiences within the system. There has been little discussion about the complaints of nursing or the value of nursing in the medical literature and certainly no discussion on how physicians should behave in the event of labor action.

Some literature on nurses and physicians postulate that closing the economic and education gap will not only facilitate communication between nurses and physicians, it will lessen status and value differences (Darbyshire, 1987; Morgan and McCann, 1983).

Darbyshire notes that a century of paternalistic domination will not end quickly, but it should be clear that the "Stepford Nurse/Wife of yesteryear is gone and she will not return...and there is no point pining for her in the pages of the British Medical Journal". For nurses, Darbyshire says, they often unrealistically assume they will be accorded respect simply by asking for it.

**Subproblem 9.2.** To what extent did nurses feel that physicians were verbally supportive, but were not
supportive in their actions during the strike?

Findings. Although there were some pockets of physician support, nurses were disappointed that their medical colleagues were not as supportive as they expected them to be. Nurses believed that physicians were aware of their plight. They also expected physicians to be more supportive because they themselves were due to settle their contract. In the media, the medical association verbally supported nurses, but at the personal level nurses found less support than they hoped for.

Unfortunately, the aspects of hospital care that nurses could use to control their working conditions and practice are directly related to the same aspects (admissions, discharges, surgeries) that will have the greatest effect on physicians' hospital income. Even though physicians are "borrowers" of the hospital system, they wield excessive power in that system.

Nurses were surprised and offended, but accepting of the verbal and physical abuse delivered to them by the physicians. The lack of outrage by nurses to this abuse may be due to nurses' desensitization to common abusive physician behaviour by some physicians to nurses in their regular work environment.

Table 24 shows that the majority of nurses (70.1%)
believed that physicians were verbally supportive but in their actions were not supportive. Most of the nonsupport seemed to be related to not making allowances in relation to admission of patients and the ordering of diagnostics and treatments, and doing nonurgent surgeries.

There were problems with admitting many, many patients with very little physician support, especially surgeons. The work level was heavy the whole time.

Our medical staff supported us verbally and then admitted non-emergent patients — that really made us mad!

We had an overdose and the doctor was requesting blood work. With HEU being on strike and without blood being obtained from the original IV, the physicians were to draw bloods. After we informed a particular doctor of this, he wrote an order for an IV we were unable to start the IV and therefore unable to get the blood samples so the doctor refused to draw blood. The patient was discharged without the bloodwork ever being done.

Physicians were frequently reported to be abusive on the picket line.

I can’t believe how angry the doctors were when they tried to get into the parking lot on the hospital grounds, even though there was ample parking elsewhere. It was like it was their God given right. They actually swore at us, some of us were nearly hit because they put their foot on the gas and tried to gun their car through (and some nurses would have actually been more than brushed by the car if they hadn’t moved really quickly!) These are the guys we bust our buns for day in and day out.
One of the doctors, who happens to be my family doctor as well told me on the picket line, he was going to get a cattle prod from his farm and just barrel through this line. I thought he was kidding, but I could see he wasn’t.

Nurses expressed disappointment in physicians who were confrontive:

A surgeon and former president of the BCMA (B.C. Medical Association) called the floor asking, 'Who will take care of my patients?' Upon learning that our floor continued to be fully staffed, he restated his question, 'But who will take care of my patients?' I wonder who he thinks take care of them? The lack of support from the people who totally depend on us, was very disturbing.

Some of them (physicians) were supportive. They stated their comments. Some were nasty. No one would clean the plaster room and you know what that can get like. I left a note saying, 'PLEASE PICK UP AFTER YOURSELF', and 'someone' wrote on the bottom, 'DO IT YOURSELF, IDIOT'. I thought, Gee, I don’t need this.

Discussion. It would seem that the job action caused the Doctor-Nurse game first described by Stein (1967) to fall apart. The game which has a cardinal rule that open disagreement between the players must be avoided at all costs, showed bad gamesmanship on both parts: the nurse being somewhat less than subtle about her entitlements and expectations and the physician losing his omnipotence.

The players in the game, were not sensitive to the impact that loss of face would have particularly on physicians and carried on with the game rules.
pretending that conflict did not happen. BCNU, critical of nurse abuse, did not deal with the issue of physicians in their strike plans, in the press nor with individual nurses who were abused.

Employers did not familiarize physicians with the necessary "etiquette" to deal with picket lines, or assist physicians in their understanding of essential services or in forecasting the impact of unsupportive actions. Employers themselves were struggling with their strike skills and most barely included physicians in their strike plans and physicians, for the most part, were not interested anyway.

**Subproblem 9.3.** To what extent did nurses feel that physicians who were financially affected by the strike, the least supportive to nurses?

**Findings.** Strikes have an adverse effect on physicians' ability to treat and admit patients in hospitals and thus, their income since it is inextricably connected. Table 24 shows that 66.9% of nurses strongly believed that physicians who were affected financially were the least supportive during the strike. Table 25 shows that there was little disagreement on the part of nurses in this area (S.D.=1.1555). Operating room nurses were the most frequent
commenters on surgeons:

One surgeon wanted a case put on merely because he was going away. He was extremely belligerent because I was doing nothing to help expedite getting this woman on the slate whom he said was in great pain. I said you could transfer this woman to another surgeon on call and we would have a spot to do her the next day. Rather than do that, rather than have a loss of income, he discharged the patient home on pain medication. So how life-threatening was this woman’s gall bladder? That showed his support for us!

We really didn’t get support from physicians – I am still hearing comments that the long surgical waiting lists are caused by the strike.

and:

The surgeons said they supported the strike, but when it came down to cancelling their surgeries – we saw how supportive they really were!

Nurses believed that the nonsupport would cause a rift in the physician-nurse relationship.

It was their pocketbooks that were affected and there were a lot of angry comments passed on to the nurses. The comments generally said that nurses didn’t work hard enough or weren’t worth what they got now let alone more in the future. Those kind of remarks probably hurt more than those of administration’s. It probably severed many relationships and I feel I can never do as much for the physician as I did before. They were usually the older physicians, the younger ones just stopped saying anything. We knew they weren’t supportive.

Debra McPherson on hearing the comment that the health care costs were like a cancer growing:

The only cancer that is growing in B.C. is the
one that's growing in physician's hip pockets.
A group of nurses at a meeting described physicians as
acting as "assholes" during the job action, McPherson
further retorted:

Perhaps they are assholes, but they are successful
assholes.

Discussion. Fennell (1987) argues that the
"unprecedented rates" at which physicians have been
organizing includes economic and professional issues
especially a "protest movement against the reduction of
physician control in medicine today". Nursing's desire
to close the economic gap (Morgan and McCann, 1987) can
be seen as a direct threat to the income of medicine.

Analysis of Post Job Action Subproblem 10.0 Nurses and
their Employers

Subproblem 10.1 To what extent did nurses feel
their administration worked with nurses to improve
conditions?

Findings. Only 40.9% of nurses agreed that adminis-
tration works with them to improve conditions (Table
26). These participants did not believe that their
employers worked with them to change their working
conditions. Since working conditions were a major
reason for voting to strike, employers must assume a
good portion of responsibility for nurses’ dissatisfaction with their worklife.

The central issue for nurses was that their employers were not acting on their identified concerns or in some cases not identifying the concerns and management, to nurses, were not visible enough.

Nurses described themselves as their employer’s pawns:

Until our management wakes up or changes and quits using us as pawns on a chess board and increases the numbers on staff, little has been gained. I, for one, am ready to leave the establishment. I am a human being with needs. I do not eat, sleep and breathe nursing. I have a family and my health, both mental and physical to consider and that takes priority over being pushed around or ignored...

There were many nurses who described situations similar to this nurse’s description of an unsafe situation which had repeatedly been reported but had not been responded to or acted upon:

When there was job action, I felt that in our case, things were no worse off than they were normally. Here is this Director complaining bitterly about the level of care. Listen, we had been writing her letters about unsafe conditions in the Labour and Delivery area for months - asking for a reply - and never got one - never got a bit of action. We were left to sweat it out. The strike comes along and we are villains.

A common theme was the lack of action on the part of administration:
Our administration - all talk and no action. Talk is cheap.

Nurses were disconcerted that administrators could or would not hear their message:

The administration's response was to take the strike action as a personal affront rather than as a statement about health care and the importance of nurses to that system.

Most nurses commented that management had not been visible to nurses and that they were unaware of who the administrators were. A Head Nurse in a community hospital:

I personally don't feel a gap between the administration and staff nurse. But then I have a relationship where I can walk down the hall and open the administrator's door. The staff nurse doesn't know the administrator's name. They are not visible. I don't think that 50% of the nursing staff in this hospital would know the Executive Director if they saw him. I don't think they know his name. You don't see them anymore.

Some nurses found management more visible than ever before:

Management was around everyday during the strike, but normally staff do not see these people.

I met several people from hospital administration - what a treat!

Discussion. Much of the contemporary nursing literature is devoted to management/staff partnership or shared governance. Chernecki (1988) points out
that the autocratic style of management still exists and calls for a style of participation in decisionmaking in which nurses can become part of the solution. Colvin (1987) contends that the nursing Director, a simultaneous nurse-professional and an administrative bureaucrat, should be in the same bargaining unit to promote standardization and control. Cleland (1987), Colvin (1987) and others subscribe to models of shared governance to promote equity in decisionmaking and to establish an acceptable means of employee-employer conflict resolution.

Subproblem 10.2. To what extent do nurses feel that administration exploits nurses' commitment?

Findings. Nurses clearly and vividly expressed their intense feelings of exploitation by their employers. Nurses feel that they give their employers extensive value in terms of their "innate caring and commitment" for their money and in return, are used as "pawns" and are considered to be "dispensable" by management. 60.4% of nurses believe that during the strike, commitment by nurses was exploited (Tables 26). One nurse expressed it simply:

They strip-mine our physical and emotional resources.
Another nurse with 18 years of experience pointed out that nurses were exceptional in terms of commitment:

Nurses give their employers +++ value for their money because of our innate caring and commitment. I have reached this conclusion after years of observing family and friends who are employed and many other people with whom I have some type of contact or business dealings with.

Nurses frequently pointed out that nursing was indeed essential:

Administration does not have the ability to see us as what we are: the backbone of the hospital.

Nurses commented on management’s lack of appreciation for nurses’ commitment:

Patients say thank you. Their families say thank you - but I don’t believe I have ever heard my employer say thank you. Nor act like there was an implied thank you.

A middle aged nurse commented:

Nurses wanted everyone to know how distressed they were and how helpless they felt for themselves and for their patients. They were sick of being the invisible workhorse for the system.

Nurses consistently commented on the where they believed nurses, and even patients, were in the hierarchy of management’s priorities:

People need to be aware of the priorities of administration. They are - in order - economics first and patients second.

Many nurses commented that if they had poor relations
and conditions in their work environment, they should at least be compensated for it.

Nurses did not cite money very often as a reason for striking except to say 'If I have to put up with all this crap, I’m going to be paid well for it.'

A nurse with a BSN and 15 years experience expressed her frustration eloquently:

After we settled, I quit. A position came up elsewhere, (non BCNU and nonhospital) so I left without so much as a day’s notice. The message that the government, and the employer sent to nurses was 'you are entirely dispensable'- so why would they need notice of my departure? My services are not valued in the hospital setting. The new collective agreement won’t help address the crisis in health care. Nothing will change until the government, the employers and the public recognizes their most valuable resources in the health care industry are the employees. Educated, dedicated, motivated and remunerated nurses are essential to preserve our well-being.

Discussion. Corley and Mauksch (1987, p.141) found that commitment among nurses “served as a basis and justification for neglect and reduced responsibility on the part of other hospital workers regardless of occupation” and that “knowledge of commitment among nurses absolves others, particularly those in power, from a sense of guilt or failure”. Unlike the nurses studied in this strike, the researchers found that nurses were unaware that their own commitment was being exploited. Similar to the striking nurses in this study, the nurses of Corley and Mauksch’s study saw
others doing less that their own position or responsibility required.

Subproblem 10.3. To what extent did nurses feel that administration was justified in concern for patient safety?

Findings. Nurses were split in their concern (or lack of it) for patient safety. The lack of concern for patient safety would be less likely attributed to nurses who were uncaring, rather more likely due to a high level of essential services in some units and hospitals. Also, nurses believed that they expended more energy and commitment to ensure safety of their patients during the job action. In spite of that, there were situations which nurses described in which there was a reduced quality of care.

Nurses were resentful that employers had a sudden interest in patient safety. They believed that employers were not as concerned at other nonstriking times when nurses identified unsafe situations to their employers in which they felt compromised. Nurses also believed that they were the only ones who could accurately determine what was safe and what was not.

An almost equal number of nurses (47.2%) believed, as there were those who did not believe (47.6%) that
there was reason for concern about patient safety
during job action by hospital administration (Table
26). Table 27 also shows that patient safety did not
seem to be a concern for most. Some nurses felt that
they had enough staff and resources especially when
they worked as a team:

Everyone on our floor really worked together
and put in alot of overtime with no pay and
they were still cheerful about it. Patient
care did not deteriorate nor was it unsafe.

When nurses expressed what was negative to them during
the strike one of the most frequent responses related
to heavy, unsafe patient assignments.

I personally felt on our floor that we were
working under 'unsafe' conditions. Our patient
load was very heavy, our staffing was very
minimal. Everyone dreaded having to work on
the floor, most felt the patients' needs
weren't being met.

We were still expected to care for the same
critical patients, but we were running out of
the most basic supplies such as I.V. fluids,
dressings etc. It took hours to get the right
person to ask and then it was often without
success.

We never see our administration for months at a
time. During the strike we saw them, hovering
over us, looking to see what we were doing,
terrified we would kill someone. What do they
think happens the rest of the time?

In this case, a nurse says the patient, a 17 year old,
would likely bear the "scars" of the strike forever.
There was one episode where a patient needed emergency facial surgery stat. He was turned away from .... (a larger hospital) and sent to our hospital for surgery. Once the surgeon and anaesthetist assessed the patient they refused to perform the necessary reconstructive surgery since we do not have an ICU and ventilators if the patient were to require it.

Discussion. There is little evidence in the literature that there have been studies on the impact of strikes on patient safety. Generally, there is discussion on the moral aspects of withdrawal of service (Miller, 1975; Muyskens, 1982) and reference to what would seem to be black and white circumstances of provision of essential services: emergency, and lifesaving care. Unfortunately, that which is known as "essential" is anything but black and white, as is the degree of care needed to ensure that essential services have been met.

This judgement of what is essential and what constitutes "safety" is left to the eye of the beholder. Metzger, Ferentino and Kruger (1984) believe that no less important is the matter of patient perception. Patients see nurses as being more important to their recuperation than their own attending physicians and do not recognize the contribution of other employees such as porters, engineers, aides, food service workers, clerks.
The issue of safe and essential care during a strike by nurses (and other health professionals as well) deserves further study.

Subproblem 10.4. To what extent did nurses feel it unfair that administrators received privileges for strike work?

Findings. Nurses were adamant that their administration should not receive more than overtime pay for their work during the strike. Some part of that lack of charity would be linked to their belief that nurses themselves are not recipients of benefits or recognition for their work.

Table 26 shows that 66.5% of nurses agreed that it would be unfair for administrators to receive financial or other privileges for their strike work.

I found the antics of management amusing as they set out on the great adventure of cooking, cleaning, doing laundry, etc. They had planned to reward themselves with a party but prudence won out in the end!

Many nurses were not convinced the job their administration did during the strike was impressive enough to warrant bonuses.
Administration was a farce! They could never be reached to perform the 'nonnursing duties' created by job action. The jobs were eventually performed by HEU who rightfully became resentful towards BCNU members. The food was appalling, insufficient for patient needs, administration dined out on take-out foods - at whose expense, we will never be told. On top of this, they received a bonus!

A few nurses were not impressed with the work of management during the strike and what they believed that management considered "essential":

There were a couple of administrators who were seen to feather dust desks. That was important to them and they also received full compensation for their work for the hours that they put in. I think they probably had a different idea of what was 'essential' to be done than we did. They did porter patients but some said that they were so tired because they had worked for 14 hours - maybe feather dusting a desk is hard work - I don't know.

Other nurses were positive about their management's attitude during the strike but spoke of disrespect by nurses to management.

Administration was great...I have to commend them, they really put up with a lot of guff and they put in a lot of hours and they bit their tongue a lot. I hear after the fact of how some of them were treated by nurses. They were really inconsiderate. They were rude. Paging them as a porter and telling them to get down there and make a bed. There is a nice way of saying it. It is an ongoing problem for some anyway. If they were rude usually, they got ruder.

Some nurses wanted first hand information as to whether their management received bonuses.
I think the fact that nurses went directly to management and asked, 'Did you get those kind of gifts and bonuses?' and assessed their body language to see if they believed them tells you something about the management-employee relationship in our hospital. (By the way, they said no, they only had overtime).

Other nurses felt that their administration had worked as hard as the striking nurses.

The administration at my facility worked very long, hard hours during the strike as well, and for the most part did not retaliate with individual members of BCNU even though everyone was fatigued and stressed. We came through without a lot of hard feelings employer to employee and recovered and I am glad for that.

The administration showed willingness and good nature in doing garbage, housekeeping, etc. It was a real learning experience for them and I feel they are more aware of the patients and the workings of a hospital.

Long hours and hard work took its toll on administration.

The animosity that grew among hospital administration that were having to work extended hours and weeks without days off. They couldn't seem to realize that nursing had been doing it for years and here they were complaining of it after only a few weeks.

During the strike, a number of nurses expressed a perceived injustice with respect to the "plush" environment of administrative headquarters vis a vis the budget cuts in nursing resources.
I think when you see the carpeted corridor, and the furniture, you don't think it makes sense to cut your supplies in the nursing area. We asked for a lounge in the nursing area for years and we couldn't get one, but their needs seem to have come first. That is upsetting.

If management received bonuses and gifts in some hospitals, they weren't always gracious when nurses received gifts.

One night one of the doctors brought a hibachi and had the daughter of another HEU staff person prepared to set up to sell hot dogs to the nurses. The management stopped that. They said they didn't want hot dog sales in their parking lot. That made nurses mad.

Soon after the job action was finished, some nurses pointed out that changes had been immediate in their workplace; most however made comments similar to this one:

Administration, as they tried to cope during the strike, admitted where problems were and that we had some good ideas and solutions some were even put into effect during the strike. Once the strike was over, the solutions were stopped, promises were made - and now - no improvement.

Discussion. The literature does not discuss the merits of rewards for administrators during job action. The issue of compensation for management needs to be more fully explored. It would seem unfair that there would be no incentive for the long hours and stressful work of management during a strike, although it would not need to be necessarily financial reward.
**Subproblem 10.5** To what extent did staff nurses feel that nurse administrators valued and respected nurses during the strike?

**Findings.** Only 42.2% of nurses felt that nursing administrators demonstrated that they valued and respected nurses during the strike (Table 26). Nurses expected that a manager who was also a nurse would have some insight into a nurses' needs in the workplace and would have some ability to demonstrate value and recognition to nurses. Nurses, however, weren't getting it in the workplace and it evident that was missing in the contract. Surely this confirmed nurses' reasons for striking itself and strengthened nurses' convictions to go the distance for a better contract.

Pat Savage, President of BCNU:

> There is no nurse in the top position of management. They report to someone. They have input, but they aren't the big decisionmakers. In management, they are so far removed from what is going on at the bedside, even nurses who are in management positions, the bedside nurse they have no idea what is going on. They are ...not there at 4 a.m. and they don't know what it is like to do six things at once with one pair of hands. They have not worked enough hours in those kinds of positions or they simply have lost touch with reality.

One nurse expressed concern that nurse administrators as well as other in positions of authority may be threatened by increasing awareness of power.
I had ongoing feeling of betrayal and anger towards administrative nurses and other administrators who were not understanding or supportive. I feel there is real resentment of authority - government and hospital administrators of nurses who have become aware of their collective power.

One nurse, who was a supervisor, described her feelings:

My feeling of discomfort with the management came from within. I couldn’t go near the office. It seemed like it was enemy turf... I usually feel more like management because we are sort of the management representative when they are not there.

Nurses commonly described nurse administrators as if they were "Queen Bees":

One of the problems with nursing is, as nurses obtain a title (head nurse, etc.) they generally are out to look after themselves and then work against the staff nurse and it becomes more evident during any job action such as a strike.

This nurse voted NO to striking and valued and respected her nurse administrator.

I felt there was too much pressure put on the administration e.g. the DON was working 12 hours shifts and (had) no days off. I felt helpless not to do more for patients and for administrators.

A Lower Mainland small hospital nurse believed that nursing administration was understanding of the issues, however, they were not translating the issues to their colleagues who were nonnursing administrators.
I think non nursing administration thought we were being downright miserable and that we were refusing that contract to make them work harder and their life more miserable. I don’t think they really saw the issues that nurses were struggling with - there was good reason to believe that this wasn’t a good deal - after all wages weren’t what the whole battle was about.

Some nurses had more basic problems when their employers were less generous.

The Biltmore hotel was our bathroom during the strike. So no one drank coffee. One day they were under the eave in the pouring rain and management moved them out into the rain. The anger was with those people at the time and didn’t spread through the ranks.

This nurse’s administrator was more generous:

They gave us some rooms in the gymnasium to set up our headquarters. She said this is your hospital, your workplace and you need a place to be during your strike.

At only one hospital were comments similar to these.

All respondents in this particular hospital felt positive about their nurse administrator:

I saw how important and caring our administration is in THIS hospital - I had never experienced it before elsewhere.

Hospital is under a larger Hospital Society which includes a larger hospital. The larger hospital went out on strike first and due to the pressure and complaints from union stewards at that hospital, our hospital was forced to go out earlier than scheduled. Because we were smaller, we were not going to go out right away. Also our administrator was very supportive of use and even showed her support by giving us drinks (coffee) etc. while
picketing. Again the larger hospital's stewards heard of this and subsequently word was out that action must be taken against our administrator. I was ashamed of admitting I was a nurse because of the 'back stabbing' happening with our own peers.

Our administration and head nurses were supportive. I felt comfortable in holding my own opinions and acting on them.

Our administrator decided to change some of the non-nursing duties on a permanent basis because she agreed that other services were more appropriate for handling them. We now have our trays collected by dietary (not practical for them to hand them out due to error with NPO etc.) and housekeeping empties our laundry.

The nursing administrator in MY hospital was committed to nurses, and showed she valued and respected nurses. Our administration is progressive. Our Director of Nursing is very supportive of nurses and has done many things to help make our working conditions very good. Our hospital went on strike in support of our co-nurses all over the rest of B.C.

Discussion. It is lamentable that a minority of nurses in the 28 hospitals surveyed had confidence that their nurse administrators valued and respected them during strike action. Almost no literature exists on the etiquette of strike behaviour for administrators, but it is easy to extrapolate how behaviour in non-strike times would amplify during stressful strike periods. Metzger, Ferentino and Kruger (1984) list the concerns that nurses have: lack of support from nursing administration, the authoritarian behaviour on the part of management and the inability to communicate concerns
to management as having important implications in their impact on predicting strike behaviour.

Part of the nurse administrator's role is to create an organizational culture in which respect and value is inherent. Leadership, Baumgart (1989) says, is more complex and broader than administration and incorporates "less tangible and more individualistic activities required to create an organizational culture by communicating a set of common values and by developing an organizational climate in which nurse are motivated to achieve these values in the workplace".

Subproblem 10.6. To what extent did nurses feel that nurse administrators were more committed to the organization than to nurses?

Findings. These results are consistent with the results of the previous questions about how valued nurses feel in the hospital organization in times of no strike. Only 28% of nurses felt that nursing managers were more committed to nurses than to their organization during the strike (Tables 26); 57.6 percent of them felt somewhat like this nurse:

One thing that did strike me, from my hospital, was the large chasm between administration and staff nurses. I used to believe that they had an honest caring and concern for their staff (a caring beyond budgets and policies)...this job
action dispelled that notion as I saw and heard some very nasty and insensitive actions and true colors came to light.

Nurses from hospitals in which their Vice President of Nursing sat on the HLRA negotiating team expressed betrayal:

How was it conceivable, let alone possible, for the so called Director of Nursing at our hospital to have the interests of nursing made known to the public, HLRA and the Health Ministry when she is sitting at the HLRA negotiating table. To start with, she was at the wrong table and should have at least pretended to be on our side.

Discussion. Most staff nurses have little contact with their nursing administrators and are unclear about how their interests are served in the organization. Colvin (1987, p.48) says that "Directors of nursing must engage their resources for the benefit of the profession as well as for the hospitals that employ them".

Subproblem 10.7. To what extent did nurses feel commitment to their hospital of employment?

Findings. Sixty-two per cent of nurses said they were committed to the hospital employing them (Table 26).

Discussion. These results should not be surprising since they are consistent with that
described by Gouldner (1972) in which she pointed out that commitment to the values of an organization was distinct from the commitment to the organization as a whole. Corley and Mauksch (1987) found that nurses' commitment to the organization was contingent on the perceived commitment of the organization to the patient.

Analysis of Post Job Action Subproblem 11.0 - Personal Conflict

Subproblem 11.1 To what extent did nurses feel powerless and lacking control during the strike?

Findings. The source of this sense of powerlessness and vulnerability seemed to be related to nurses' inability to control their destiny. The strike seemed to take on a "life of its own" as nurses found their message, their image, their income, their worklife and their homelife in the hands of an unresponsive, disorganized union. Table 28 shows that more than half (54.3 per cent) of responding nurses described themselves as feeling powerless and lacking control of their life during job action. Table 29 shows that although many nurses (x = 3.141) felt powerless, there was great disagreement among them in this regard. Many nurses commented:
The union played power games and used threats.
I felt vulnerable.
I felt helpless.
I had the feeling that the union had power over me.

For those nurses who felt powerless and lacking control, there were a variety of reasons given for their feelings. Some nurses felt they could not control their workload:

I felt unable to control things and I let my patient load down.

Many nurses did not feel part of the strike process and they felt their concerns went unheeded:

I felt afterwards and during the whole strike that I was banging my head against the wall because no one was listening to my concerns and I was very disillusioned by the whole strike/bargaining process. After a while your head gets a little sore - one quits banging away.

Others felt that their fate belonged to the union:

Basically, putting your whole life in these peoples' hands: deciding what you are going to get paid, what hours you are going to work, overtime, how many shifts you will work in a row. They (the union) make all of the decisions. They affect the way the public will think about you, the physicians, management. I put my trust in them. It went downhill from the beginning.

Discussion. The strike presented an interesting paradox for nurses. One of the chief reasons for
striking was that nurses lacked control and autonomy in the workplace, their input into decisionmaking was not sought nor valued by management. During the strike over half of the nurses complained that they felt powerless and lacking control with respect to their union representation. Beletz (1988, p. 147) claims that trade union representation does not provide power: "If anything, it dilutes, diminishes, and may destroy the nurse power".

Subproblem 11.2. To what extent did nurses feel that striking was a difficult moral decision?

Findings. While many nurses felt that striking was one of the most difficult moral decisions that they had ever made and many believed they were driven to the point of desperation, others were less troubled by their decision. For both, striking seemed the only option to change matters. There was great discrepancy among the group.

Sixty per cent of nurses found that taking strike action was one of the most difficult moral decisions that they had ever made (Table 28).

This was the biggest decision of my life. I knew before I made it, that it would change my life, and it has. I feel like I have lost my innocence, and I am somewhat soiled.
I had high stress during the strike since I had great inner conflicts about striking in the first place. I don’t think I would ever vote for another strike.

There was stress from feeling that this (striking) was not appropriate for professional people. Although I voted to strike because there are issues which must be addressed, I felt very uncomfortable doing so.

I voted to strike only under a great deal of duress and it was my own feeling that professional people should not picket. It came time to make a stand and if this was the only way and it was needed then I would go for it, but I didn’t like it - not for one minute.

Table 29 also substantiates the findings that over half the nurses ($x = 3.395$) found the strike to be less difficult morally, but it also demonstrates that nurses greatly differed in their opinions on this matter (S.D. = 1.607).

Nurses have finally asserted themselves enough to be heard. Before they were just a bunch of spineless women, too moral to stand up for their needs.

**Discussion.** Miller (1975) claims that nurses take aggressive action to attain bargaining goals only after substantial soul-searching and evaluation of nursing ethics. Nurses in this strike reasoned that while it might be considered unprofessional to walk out on patients, doing so might be the only effective means to be heard, and that this would ultimately benefit patient care.
Muyskens (1982) in exploring the circumstances under which it would be morally right for nurses to strike states that the potential for conflicts of duty is what makes the question of the nurses' right to strike difficult and complex. Muyskens notes that the issue is compelling because nurses often find themselves in situations where they cannot meet their responsibilities and lack power to change circumstances. Nurses then may have a collective responsibility with regard to nursing practice and standards to engage in some time of job action including striking. If, however, nurses went on strike solely for higher wages and not with an aim of advancing patient care, the case would be quite different in that patients would be held hostage in advancing nurses' interests.

**Subproblem 11.3.** To what extent do nurses feel that they have become a more powerful group since the strike?

**Findings.** In spite of feelings of powerlessness and helplessness of some in some situations, the majority of nurses believed that the strike experience had empowered them in some way. Nurses described their power as collective as well as personal. Nurses also
came to the realization that in order to provide better care to their patients they must meet their own needs first. Nurses had increased feelings of self esteem by being placed and by placing themselves in roles that they had never before experienced and finding themselves successful in these roles. Taking a strong, solid stand helped nurses to boost their pride and confidence: the result was empowerment.

Tables 28 and 29 both indicate that nurses believed they were a more powerful group following the strike. The power and strength that 71.8% of responding nurses felt was like an "awakening giant" as it was described by many nurses. One nurse with nearly 20 years of experience wrote:

Nurses finally after all these years have stood up and have been counted - and stood their ground. Even if we had been legislated back to work, we were making a point to the government and the public as a whole - we were going to be reckoned with!

Most nurses commented on how powerful nurses could be when they were cohesive. There was definite raised consciousness about strength in numbers:

We are beginning to think as a politically powerful body.

Nurses spoke of the collective power through cohesiveness.
Nurses learned that they had power when they stood together.

A nurse from a community hospital was pleased with their cohesiveness:

We nurses all 'hung together'. Many who were anti-union or anti-strike actually helped, picketed and all refused to work unless the essential services committee asked them to.

This cohesiveness, some believed, even changed nurses' self-image.

There was increased strength and unity of nurses as a body and in affecting nurses' attitudes about nurses.

A steward described her pride in her colleagues.

The most positive aspect of the strike was seeing the growth of my colleagues as they took a direct stand and used their individual power... Watching these men and women become personally committed and resolved to defend/promote themselves, each other and their profession was an experience to be treasured and I was glad I was there and part of it.

Others developed leadership skills as well, only to be lost after the strike.

I did learn a great deal about myself and several other nurses who came out of the woodwork and provided strong consistent leadership and now again have faded to black.

Nurses were surprised themselves about their newly found empowerment.

I think nurses realize they are not wimps. If we do keep ourselves together we have a lot we can do and we have a lot to say, and we can make changes.
Personal empowerment was not uncommon for nurses to describe.

The freedom of the subjective experience... it laid to rest all my former skepticism and lack of courage to stand up for what I believe and left me better prepared for the whole psychological experience. It laid bare all the truths that we nurses are having conflict with.

Meeting and speaking with members of the public enabled me to develop more confidence and self assurance. I discovered that I could lead rallies, talk on the radio, be interviewed by the media, explain our position to the public and administration better than I thought I was capable of.

An additional lesson nurses learned for some was that in meeting one's own needs, one could then meet the needs of others.

The dawning realization that to give better care to our patients means that we have to meet our own needs first.

Some nurses believed that unionism is the route for release from conditions of oppression and poor quality patient care.

Increasing education of nurses that is as union members can do much to change unsafe and oppressive situations so that nursing can be a wonderful and rewarding career.

Raised consciousness and politicization was the theme of many comments related to nurses becoming more powerful.

We are beginning to think as a politically powerful body.
The strike was a first step in an ongoing struggle. We are only waking up to the possibilities and the exercise of power. We may take a step forward and a half a step back but I really believe now that we have a chance to make a difference.

**Discussion.** Labor struggles in parts of Canada have established nurses as formidable adversaries (Hibberd, 1989) who have had the ability to wield formidable power. Hibberd attributes this power to strong union leadership, and nurse members who possessed a range of skills that they used in everyday work: interpersonal relations, communication, organization and teamwork—all of which contributed to smooth orchestration of a strike. Other sources of power, Hibberd notes, are nurses' commitment to their bargaining objectives, and a realization that there is no substitute for skills of a nurse.

The nurses of this strike learned to network, they experienced the "power and joy" that Baumgart (1989, p.71) refers to of helping each other and in sharing a mutual success.

**Subproblem 11.3.** To what extent did nurses feel that meeting and talking with other nurses was a positive experience?

**Findings.** These are important and significant
results. They are important in that the experience of getting together and discussing issues, concerns was an exciting experience for a large majority of nurses. It is significant in that it was a new experience for nurses and that it happened on a picket line. Nurses seemed “starved” for contact and discussion with other nurses.

Tables 28 and 29 both show the strength of nurses’ feelings with respect to the issue of socializing with other nurses; 88.8% cent of nurses who walked picket lines in the strike enjoyed the company of other nurses. The most common reason cited for this was that in their daily worklives, they rarely have time for networking, for discussing common problems and to learn about the work and lives of other nurses.

The whole experience of meeting and talking with other nurses during the strike was positive, possibly because we were out of our rigid routines and familiar patterns. The more we met, the more we kept adding things we like an accepted from each other and most important, we were able to vent all those pent up feeling - anger, unhappiness and to share in those complicated feelings with each other - no fear of being labelled 'trouble’ - or of reprisal, etc. We could explore the ways we could hope to make nursing and health care 'healthier' for all. We are strong as a group and we have a big edge as a group as a voice for women and we much not let other things cloud the issues. The strike was a clearing away - a clarification of what, where, why and how we will have to continue to grow.
Some nurses found the experience enlightening.

I enjoyed picketing with nurses working in other areas of my hospital and found this was a learning experience about conditions in areas other than my own. It was also an excellent opportunity to learn of different types of nurse training programs across Canada and from other countries as well.

The experience was a bonding one for most nurses.

It brought nurses together. We found we all had similar feelings, desires, and goals re: nursing practice.

A lot of us finally got together and talked.

Nurses commented on some of the effects of decentralization in hospitals in relation to communication:

The camaraderie on the picket line was great. Hospitals have eliminated many 'go betweens' (supervisors, students etc.). The communication among the wards is terrible - no one talks to anyone anymore and we have lost touch with each other as human beings. Spending 4 hours with someone I didn't know was stimulating and informative and there was a noticeable improvement in communication throughout the hospital after the strike.

Some nurses found food for thought in conversations.

I was made more aware of RN's responsibility with helping newly graduated nurses. In my job we do not hire nurses without experience so I was unaware of the stress involved for RN's teaching new staff members. I was made aware of their concerns regarding lack of preparation of these new nurses when they are expected to take a full patient load...It has made me question the educational preparation of nurses at both the diploma and degree level of nurses expected to function in the hospital setting...are we expecting too much from these people?
Should we re-examine our nursing education programs? We are experiencing a country wide shortage - is there a connection?

Interestingly, one nurse commented that the bonding that happened during the strike dissolved soon afterward when all meeting and communication stopped and it was business as usual:

The togetherness disappeared after the strike had ended and so did the so-called friendship.

Discussion. It is tragic that front line nurses do not have opportunities in their daily worklife to share common experiences and to network and problem solve as do others who work within hospitals. This finding should be food for thought for nurses and for nursing managers in particular.

Baumgart (1989, p.71) points out that "feminist literature argues that women have not learned collective strategies associated with teamwork and with trusting allies and teammates. Women...have been taught to disaffiliate from each other, to see each other as competitors, and to devalue female friendship". Supportive networks and coalitions for nurses have helped nurses to achieve considerable power, Baumgart says and leaders need to foster these new sets of behaviour among nurses.
Subproblem 11.5. To what extent did nurses feel uncomfortable being a source of conflict rather than one who resolves conflict?

Findings. Since most nurses get satisfaction from resolving differences and work hard at achieving harmony and homeostasis, the situation of ongoing conflict could be a negative one particularly for nurses. Again, some nurses were less troubled than others about their being at the centre of conflict. Table 28 shows that the majority of nurses responding (61%) were uncomfortable being a source of conflict rather than the one who resolves conflict. However, there was great discrepancy in how nurses felt about this issue (S.D. = 1.488).

...the energy drain of being involved in 'negative' activities of confrontation, suboptimal performance, and substandard personal care for patients...

Discussion. Beletz (1988, p. 252) questions whether contemporary nurses have become "radicalized", when contrasted to nurses who have formerly been characterized as "uncomfortable with adversarial relationship and techniques of confrontation and militancy". It would appear that this is not so in this job action, that nurses still do not like to be the focus of conflict.
Not only were nurses uncomfortable with the conflict, so was the public. Denny Boyd in the Vancouver Sun (June 15, 1989) describes the "disturbingly inappropriate" scene of a picket line around a hospital is like "seeing armed soldiers around an embassy, policemen in a school yard. The juxtaposition is jarringly wrong, telling you that trusted systems have jammed up."

Analysis of Post Job Action Subproblem 12.0 - Stress Experienced by Nurses.

The literature on nursing strikes is paltry in itself, and in particular, there is no evidence of studies or literature on stresses experienced by nurses during job action.

Subproblem 12.1. To what extent did nurses feel stress with respect to cutting back on service to the public?

Findings. For nurses, the degree of stress experienced by nurses about reduction of public service seemed directly related to their perception of whether or not the essential service level was too high or too low. Images in all types of media of decreased public service increased the stress of some nurses. However,
since more than three quarters of nurses experienced only low to moderate stress, they may have believed that services had not been cut drastically enough to have severe impact or inconvenience to most members of the public. Table 30 shows that nurses felt low (30.9%) to moderate (41.7%) stress in relation to reducing their services to what was deemed to be "Essential".

I was stressed from hearing of delays in performing surgeries - it added stress and anxiety to patients needing surgery.

It was getting particularly stressful watching the news and listening to what was going on. They were blocking people going into hospitals, I don't mind them being outside showing placards and walking outside showing they are on strike, but I don't think you should stop things from going into hospitals - food, visitors and supplies. Some were going into hospitals to look after their relatives since there weren't enough nurses there. The patient is the last focus. I was worried the whole time that our hospital would be pulled out.

People who had families inside made you feel guilty.

One nurse had reason to focus her stress into a fear state:

I had actual fear when cited for contempt of court (over essential services).

Nurses who experienced low or no stress over the issue of public service, probably had high essential service levels:
Forget the essential service plan of 69 - 80 per cent. This prolongs the strike and makes nurses look pitiful.

I wasn’t worried about cutting back on service - I thought we provided too much service during the strike!

Discussion. Over the years, it became evident to nurses, that if they refrained from exerting overt pressure on labor negotiations, their grievances would be met with benign neglect (Miller, 1975). According to Miller, nurses quickly learned that emergency circumstances created by withholding services resulted in meaningful collective bargaining, whereas when nurses have used other alternatives to withholding of service, nurses’ negotiations have been totally fruitless. The problem in this strike seemed to be that all nurses were not clear what they would agree to in terms of essential services and nurses in some cases negotiated for and agreed to accept a higher level of essential service than that which would have caused intolerable conditions for the employer, but would have met the moral obligations of the nurse.

Subproblem 12.2. To what extent did nurses find heavy workloads stressful?

Findings. Although the level of essential service was quite high, nurses experienced fatigue, stress to the point of exhaustion and illness for some. Sources
of stress were related to significant cuts in staffing, high patient acuity, and/or high patient volumes because hospital administration and physicians had not discharged or reallocated patients. These nurses carried the burden of the strike on their shoulders.

Of all the potential stressors of the strike, heavy workload caused the highest stress next to the uncertainty of strike time. Table 30 shows that the majority of nurses felt moderate (29.4%) to high (49.2%) stress in relation to heavier workloads, increased responsibility and minimal staff. Ten percent of nurses responding said the question did not apply to them, presumably they did not have to be concerned with workloads since they were considered to be "nonessential".

Most nurses who provided care commented on the stress they experienced while trying to provide minimal care:

I personally felt unable to give adequate care during work days and this was very stressful to me.

I had extreme emotional and physical stress struggling to give just minimal care with decreased RN staff and support staff. On a pediatric ward, unless you have a relative or friend with a patient, you cannot restrict yourself to minimal care. I am sure this applies more or less on adult wards. We had to be staffed accordingly and often we weren’t.
Besides providing direct care, nurses were responsible for organizing essential services which was stressful in itself:

The pressure of running the hospital i.e. providing the staff to meet essential service levels was unbelievable - what is even more unbelievable is that several of us "staff nurses" managed to do just that!

Nurses frequently commented on how taxing the work was, even to the point where nurses became ill.

I never worked so hard in my whole life.

The problems encountered while maintaining essential services were at times overwhelming.

People worked short staffed causing stress and tiredness and that led to sickness. That left a bad taste in everyone's mouth.

Discussion. There is little, if any literature on the stresses of nurses that are experienced during a nurses' strike. Since nurses have the moral obligation to ensure that patients are cared for safely when withdrawing service (Miller, 1975; Muyskens, 1982; Hibberd, 1989) the constant pressure to maintain a balance between their moral obligations to the patient and their collective responsibility to their colleagues of decreasing their level of service is obviously a source of trouble for nurses. This source of stress should be explored more fully in future in the light of the whole question of striking.
Subproblem 12.3. To what extent did nurses feel increased stress from not carrying out of nonnursing duties?

Findings. The source of nurses' stress was first of all to try to determine which duties would be considered to be "nonnursing" in nature and then to find someone to carry these out. This had to occur after nurses made a judgement on whether or not their leaving a particular job to someone else would have impact on safe patient care. There was considerable conflict between nurses who disagreed with each other about whether a task would be considered in that category and whether or not one would carry it out in view of their peer's opinions.

Table 30 reflects the moderate (40.9%) to high (32.3%) stress related to what was known as "nonnursing" duties. These stressors were described previously when nonnursing duties were discussed with respect to job action.

Subproblem 12.4. To what extent did nurses find it stressful to picket during the strike?

Findings. Many issues surfaced in the discussion of picketing. To some nurses, picketing meant socializing with other nurses, a profoundly positive
experience, separate and different from the often profoundly negative experiences they were having inside the hospital.

Some nurses were deeply uncomfortable and avoided picketing or simply had to learn to live with their discomfort. Initially, nurses lacked the social graces of picketing and were not given direction as to the "dos and don’ts" of picketing. Overall, most nurses who picketed became desensitized to picketing.

As previously described, negative experiences happened when the public, physicians or their employers were abusive to them on the picket line or if nurses had to block entrances to their hospital.

In terms of union management of picketing, nurses were unhappy that the organization and monitoring of essential shifts and picketing was poor. There seemed to be no universal criteria for either.

Only 24.5% of respondents found picketing to be highly stressful (Table 30). A good portion of nurses (44.7%) found picketing to be low stress and described their experiences similarly to these nurses:

I loved picketing - it was a nice experience and much easier than working essential service.

Picketing quickly became a major support source and the 'bright spot' of the campaign.

Another nurse described her picketing experience this
It was strange (picketing). It was like you were outside a foreign place. That door was like brick wall. It was a strange feeling and yet anyone you spoke to was always pleasant. I think I had more fear because it was new more than for any other reason. I couldn’t understand why, but I didn’t sleep properly and it was always on my mind. I had to be a part of it, but did I really WANT to be a part of it?

There were, however, nurses who found picketing moderately stressful (27.8%) and even highly stressful (24.8%).

I found it excessively difficult to picket, it was probably the most stressful aspect of the entire job action for me.

A supervisor described her stress this way:

I was on holidays when I heard the strike vote results. I was sitting on an island and felt sick to my stomach. I came back to work and had to go out on the picket line. I was scared to go which might seem strange. I was terrified. I had to let other staff know I supported them, but I didn’t want anyone from management to see me.

Safety was on many nurses’ minds:

I hated picketing at night. The police were good to us though.

Picketing was not popular with some:

I was not thrilled about being on the picket line and did the least that I could get away with.

Trying to find a soulmate to picket with could be difficult at times:
One night I went to picket and I didn’t see anyone I knew. I asked a group of girls if I could walk with them and they didn’t say a word to me. So I thought they obviously didn’t want me so I sat at an entrance with somebody and that was just fine but I thought well, we are all in this together.

The art of picketing did not come easily to nurses,

People didn’t know how to picket. They sat in front of doorways and driveways. They didn’t know that was a militant action and you only did that if you were going to jump up on cars and stuff. How do you educate people about where you go with picket signs - I found out - NOT restaurants!

Nurses expressed these sentiments about their concern for the unprofessional image of picketing particularly at the outset of the strike:

When I started picketing, I was humiliated that as a professional, I had to stoop to this level to be heard.

The least comfortable spot for nurses to picket was at entrances into hospitals. Nurses’ inexperience and discomfort in this area caused inner conflict and conflict with other unions in addition to conflict with the public:

I did not like stopping people on the picket line and demanding I.D.

Visitors and relatives were constantly stopped at the picket line in spite of knowing that these people visited daily.

Patients let their opinions be known to nurses in many cases, even about picketing:
Some of our residents were angry at the staff for picketing.

One of the issues frequently brought up was that of the nurse having to picket as a condition in order to be given the "privilege" of obtaining essential shifts.

I picketed 39 hours and those were hours which were assigned to me - if I had picketed fewer hours than asked, my shifts would have been less.

Table 13 shows that exactly half of the responding nurses picketed as they were directed to do, with 67.1% picketing over 4 hours in the 17 day strike period. Only 4% picketed less than 4 hours; nearly the same number (3.7%) did not believe in picketing.

Many nurses were angry with other nurses who would not show up to picket or who would sign on to picket and then leave:

I felt there should have been stronger action taken, or some action taken, for those who did not picket at all.

There wasn’t enough policing of the people who were picketing. They would sign on and go home. The picketing should have been assigned. A lot of nurses that were doing the grumbling for the shifts weren’t doing their share of picketing.

Crossing the picket line was stressful too:

As an 'essential services nurse', I found it stressful to cross the picketline.

There was some frustration experienced by nurses that put in a lot of picketing towards those nurses that were designated 'essential
service’. The essential services nurses were often working full time hours and did not feel they had time or chose not to make time to do much picketing.

Nurses who were uncomfortable with picketing found various ways of dealing with their discomfort.

I felt very uncomfortable picketing so I chose my job action to be: no working and no picketing.

There were many tasks to be done besides walking the line; some were related to scheduling, organizing. Food was an undeniable necessity to keep spirits up and many nurses found that role acceptable.

I needed to hire a sitter to picket which was crazy in my opinion. Instead, I made sandwiches, cakes, muffins, etc. at home and delivered this to strike headquarters.

For nurses, unlike other professionals or trade unionist who take job action, many put in a full shift and then was expected to follow up or precede the shift with picket duty. This was particularly true in small hospitals where there were not enough nurses to do it all.

It was emotionally and physically exhausting to picket and to work all in the same day.

I am very apprehensive in being involved in another strike. I found the long hours and picketing plus working too much.

Nurses were easily accessible when picketing to be brought in for essential service work.
I picketed every time I was asked, but
everytime I came to picket, I was called inside
to work on the ward.

For the nurses who were organizing the strike
headquarters, there was often not a choice about the
amount of time on the picket line. These were not
uncommon comments:

I was the strike committee chairperson and
spent 20 hours per day for most of the length
of the strike.

I had no choice because I am a steward and I
had to set an example.

Discussion. There is little or no evidence of
literature on nurses and picketing itself. From this
study's view, nurses found that the positive aspects of
picketing which included networking and socializing
outweighed the feelings of "unprofessionalism" abuse
and the abuse experienced by some.

Subproblem 12.5. To what extent did nurses find
union disorganization stressful?

Findings. Almost equal numbers of nurses experienc-
ed all levels of stress related to organization by the
union (Table 30).
One nurse who had been involved in a Saskatchewan
strike previously put it bluntly, "This strike was a
circus!"
Discussion. At the local level, nurses made up for the lack of organization by the "main office" union by using organizational skills that they employed in their work to organize their job action. This organization at the rank and file level was also described by Hibberd (1989).

Subproblem 12.6. To what extent was uncertainty with respect to the length of strike time stressful?

Findings. Length of strike time was a major source of stress for nurses. Length of strike time was not only stressful to nurses because of loss of income, but nurses were exhausted from picketing and carrying heavy workloads at the same time. The prolonged union disarray and the dissent between nurses and everyone else including their colleagues took a heavy toll on nurses.

The concern for strike length produced high stress for the most nurses (49.4%), and moderate stress for 36.2% (Table 30).

When I found out what the NO vote result was, I felt totally deflated and I felt scared. I though they would force us to keep a picket line. I prayed HEU would stay out a longer time as a safety net for us.

For nurses who were not essential, length of strike time would be more stressful:
I voted to accept the contract - I didn’t want the strike to go on because of lack of income. I was not essential.

A critical care supervisor commented on the impact of decreased income on relationships:

I think the increased stress of decreased income and the uncertainty of when work would resume, plus worry of home problems due to lack of funds definitely put added stress on previously close friendships.

**Discussion.** With respect to nursing, the longest strike up to that time in Canada had been one held in Alberta in which nurses were "out" for 23 days (Hibberd, 1989).

**Subproblem 12.7.** To what extent was decreased income stressful to nurses?

**Findings.** Equal numbers of nurses experienced all levels of stress in relation to decreased income during the strike (Table 30). Most nurses needed their income; however some worked as much as full time (or more) because of their being designated as essential. Those who did not work essential shifts or who had less than their usual income found going without income stressful.

I was stressed by decreased financial income. There was great uncertainty about the duration of the strike. But I was also stressed that the public did not understand our concerns and why we voted to strike.
Nurses who worked in hospitals that went on strike earlier than others and those who were designated nonessential were worse off, generally.

Because our hospital was on of the first to go out, I had 13 shifts affected because I am an instructor and am considered nonessential. Nurses in my area did not want to give up shifts. I lost a lot of money. I am a single parent and a part time student so this loss of income was very distressing.

There were nurses who were fearful that others would become aware of their personal situation.

The biggest fear that I had was that I would not be able to work and I would have to put out my own money. I couldn’t do it. Neither did I want anyone to know that I couldn’t do it. I have pride and no one knows what goes on away from my work life and I don’t want anyone to know what goes on in my home. My husband hasn’t worked in years. I was continuously stressed and worried about being pulled out. Funnily enough, even though money was a problem, I was even more upset about the thought of striking. I have a lot on my plate at home.

Some nurses complained that there should have been wage sharing.

I personally feel that very nurse should have given a percentage of their wages during the strike to BCNU so that those on the picket line were paid equally. The hospitals that were not picketed had nurses working full time and they benefited from our hospital’s strong stand.

Discussion. Again, this is another aspect of nurses’ strikes that has not been studied. What is the impact of a strike on all of the various levels of health care workers when some are considered essential
and are thus paid for maintaining care while others are considered to be nonessential, thus receiving no salary at all.

**Subproblem 12.8.** To what extent did nurses feel stress related to feeling torn between expectations of their employer and their union?

**Findings.** At the time of the strike, the nurse was serving two masters: their union and the patient for whom she said she would provide essential care. Care for the patient means an indirect responsibility to the employer. Staff nurses in nonstrike times have little contact with their management as reported earlier in the study so they feel much less loyalty to management than do head nurses who have a great deal more contact with management. The same would apply to the union and staff nurses since only 19% of staff nurses had been active in their union prior to the strike. However, since 60% of nurses felt committed to their employing hospital, that commitment may have been a source of stress during the strike.

Forty-three per cent of nurses felt low stress related to conflict about expectations between their employer and their union (Table 30). Almost one quarter of respondents who did feel high stress as they felt
sandwiched in the middle of union and management.

Discussion. Strike stress related to loyalty to the employer and the nurses' union has not been studied and should be further explored, particularly with respect to educators and head nurses.

Subproblem 12.9. To what extent did nurses feel stress related to the stress that their colleagues were feeling?

Findings. Besides concern regarding length of strike time and heavy workloads, the stress experienced by colleagues was a source of moderate (49.2 per cent) to high stress (33.7 per cent) by nurses (Table 30).

Even though a common bond was established with my coworkers I found that it also brought out the 'worst' which caused strife and stress on the ward.

Watching the fear, pain and confusion of my colleagues during the job action (I did my reaction before and after) was assuredly a source of distress...

Discussion. In spite of the dissension created by prostrike and anti-strike groups, by "yes" and "no" factions, by nursing and nonnursing duty arguments, or by haggling over essential service shifts - nurses were deeply touched by their colleagues' emotional pain.

Subproblem 12.10. To what extent did nurses feel
stress related to their family during the strike?

**Findings.** The table shows that 68.5 per cent of nurses described their stress as being low in this area. There were those who did experience significant stress within their family related to their striking. One nurse who was interviewed in her home who believed her husband to be away, discovered after the interview that her husband had come home during the interview and became panicky; fearful that he may have heard some of her thoughts and feelings pertaining to the strike. Some nurses realized then how little their families understood their work.

I have been married for 18 years. I realized during the strike that my own husband does not understand the role of nursing or the stress involved in the role. I found myself defending nursing even to him.

A nurse who did not vote on May 17, but who did vote "Yes" to accept the negotiated offer because she wanted the conflict over with felt moderate stress with her family members:

My immediate family was not at all supportive of the nurses' strike; some of my family felt we did not have the right to strike.

Other families were supportive:

Because of planning staffing, and doing picket duty and serving on essential services committee, my family really suffered because of the strike and yet they did remain very understanding.
My family was supportive - proud of me and my fellow nurses for standing up for what we believed. My children surprised me by their willingness to make financial sacrifices because of 'mom's principles'.

My family members are all very supportive and believe that nurses are underpaid, undervalued and have a tremendous commitment to their profession.

A family member told me that nurses are professionals and shouldn't even belong to a union. In some respects I agree.

Discussion. Generally, nurses had solid family support and understanding of the issues for which they were striking. When there was dissension, it related to a family member who had opposite views on striking, or who had a poor understanding nursing issues. Again, this areas has not been explored in previous strike research.

Subproblem 12.11. To what extent did nurses feel stress related to friends and social attitudes during the strike?

Findings. Only 10 per cent of nurses felt high stress with regard to their social life outside work. Table 30 reveals that more nurses felt moderate stress (26.2 per cent) from their social contacts than they did from their family (14 per cent).

Discussion. Again, nurses had strong social support systems. Using both their family and social
support systems were probably not new to nurses. Nurses, by nature, are relatively comfortable in seeking as well as giving support and nurses would have previously needed support to deal with their job stress experienced in nonstrike times.

Subproblem 12.12. To what extent did nurses feel stress related to physicians' attitudes during the strike?

Findings. Overall, physicians caused nurses less direct stress than other aspects of the strike as shown in Table 30. 48.4 per cent of nurses experienced low stress, only 15.2 per cent experienced high stress related to physicians. Operating Room nurses complained the most frequently of all:

There was increased stress in the workplace, increased stress and dissension among coworkers and other hospital staff - especially the physicians.

Discussion. Less stress associated with physicians would probably relate to the fact that there were "pockets" of problem areas with physicians such as high contact areas: operating rooms, Emergency Departments and picket line entrances.
Subproblem 12.13. To what extent did nurses feel stress related to attitudes of administration?

Findings. Table 30 shows that 40 per cent of nurses experienced low stress over the attitudes of administration during the strike. 26 per cent experienced high stress.

We found out at our hospital exactly what administration thought of nurses. They used intimidation methods in the hospital to make nurses do non-nursing duties. They were very slow to respond to nurses for non-nursing duties or were not around to do them. They would also walk around in pairs and isolate a nurse and begin to verbally intimidate them. It is very difficult working in a hospital where administration is constantly undermining attempts to make the job easier.

From a small interior hospital:

The employer felt nurses were her enemy and expressed concern. Nurses said, 'She's right'. It was a local battle.

We were definitely harassed by administration and we harassed administration. I feel no loyalty to our administration at this point and do harbour some bitterness toward Directors of Nursing.

Discussion. The administration-related stress that nurses experienced during the strike varied from facility to facility. Situations that nurses found stressful were those in which administration did not take leadership in setting the tone for a respectful relationship during strike time. The staff - administrative relationship during strike times were
probably no different than other times; there was simply more strain placed on the relationship.

**Subproblem 12.14.** To what extent did nurses feel stress related to other unions i.e. HEU and HSA during the strike?

**Findings.** Attitudes of other unions were mostly low (41.5 per cent) to moderately (30.9 per cent) stressful to striking nurses as shown in Table 30. Despite the low stress for 25.6 per cent of respondents, there were many comments about the members of other unions. Nurses found other unions to be more inflexible and powerful. Comments ranged from how inflexible they were ("The HEU - there was no give to them.") to resentment because many felt they took advantage of a nursing strike for their own gain.

I think both HEU and HSA were riding on our coattails. They have superior benefits to BCNU in salaries and classifications.

Negative comments expressed by nurses regarding HEU (the union for practical nurses, aides, orderlies, clerks, laundry dietary personnel) was that they lacked professionalism in terms of public safety and in terms of their attitude. There were objections to interference by other unions in the BCNU organization on the picket lines.
We were all dismayed by HEU's power during our strike. Their staffing levels did not reflect essential services and they didn't seem to care about the patient caught in the middle.

Another nurse from Vancouver Island reiterated her feelings:

The antagonism between BCNU and members of HEU and HSA was stressful. HEU's assessment policies caused a lot of hard feelings. HSA members were often very critical and nonsupportive. They also manned the picket lines in a very unprofessional manner.

An extended care nurse felt that residents had received improper care because of interference by HEU when a practical nurse was required, they would (maybe) send an aide, maybe decide not to replace at all. I feel HEU tried to run the show from day one. This caused dissention as their decision were rather arbitrary, while on the other hand mismanaging their own vote by not being overseen by I.R.C. (Industrial Relations' Council). This protracted their time on the line. Incidentally, my own son is an HEU member.

Another nurse from a long term care unit agreed:

The majority of my co-workers are HEU members, and I was really disgusted with the way the HEU stewards reduced their essential services staffing to below essential service levels...supposedly ...to cause management problems. They hurt their own staff instead (as well as nurses and patients). Those who were allowed to work had to bust their asses to maintain what they considered minimal care. Moreover, they had the nerve to take money away from those individuals who worked. It was very demoralizing for these individuals and this helped to lower my morale as well.

Many nurses commented on the "manners" (or lack of
them) of HEU's leaders:

HEU union leaders should be given a course in politeness! They not only tried to tell BCNU members what to do when it was our strike for patient care, they even ran the picket lines.

The attitude of HEU stewards was unsupportive. They did not adhere to their stated 70% shift staffing. 'Favorites' got work over other staff. They should not have been allowed to put 'We support BCNU' on their picket signs. They were doing their own thing. They harassed their own members.

HEU were particularly nasty and caused much alarm to their own members on the picket line.

Nevertheless, many HEU employees did not have any essential shifts and therefore were not paid.

I felt badly that we as RN's personally, and BCNU officially, did so little to recognize the hardships faced by HEU members who supported our strike.

The high essential service levels prolonged the strike and makes nurses look pitiful. Other union members went totally without work while most of our members kept working. That is disgraceful and an embarrassment as these other workers were not on strike, they were only in support of BCNU.

The conflict between existed primarily between BCNU and HEU. Said one nurse:

Conflicts with other unions were terribly stressful to me.

One head nurse said,

My unit clerk and one other were so angry at me because they were nonessential and because I had to do some staffing. There were very hard feelings which culminated with their leaving their positions. Neither of these people
picketed for their own union.

There was breakdown in good communication with relationships with other unions who resented the numbers of RN's working.

There was much dissension between certain HEU members and our union members. Certain HEU members at our hospital voiced feelings saying that we were already overpaid and who did we think we were picketing and refusing to do nonnursing duties when all we did was sit around anyway? It has left some hard feelings that are still present now.

Discussion. There were two major conflicts that caused stress between members of the BCNU and other unions. The first conflict stemmed from a discrepancy between large numbers of nurses working essential shifts and the HEU and HSA members who could not cross the BCNU picket line and were thus going without income. The second major source of stress related to the conflict over the management of picket lines; the HEU being much more "disciplined" than the BCNU members. A third source of friction was the BCNU members' perception that HEU was "inflexible" and "militant" about what was required by nurses to carry out essential services safely.

Subproblem 12.15. To what extent were nurses stressed with respect to concern about being legislated back to work?
Findings. Nurses had felt the threat of legislation over their heads throughout the entire strike. Nurses were being warned by their own union, newspaper editorials, and rumours persisted that the HLRA was polling nurses to see if they would return to work if they were legislated to do so. Although union management were concerned with legislation being prepared by government, nurses experienced stress at all levels in this regard. Twenty-six per cent said they had been highly stressed, 39.4% moderately stressed, while 33.9% had low stress (Table 30). A nurse who experienced high stress writes:

> There was so much uncertainty about what would happen next - would we all lose our jobs or would we be given some poor contract by the government.

The opposite was expressed defiantly by this nurse:

> I would have gone to jail if they had legislated us back to work!

Discussion. Ontario long ago removed the right to strike in 1965. Alberta nurses were legislated back to work in 1982 while staging their third strike. An Act was passed which would pose harsh penalties on those who disobeyed, including decertification of the union. In 1988, Alberta nurses staged an illegal strike and the penalties were heavy; fines to the union and individual nurses as well as notices of dismissal to
striking nurses for "abandoning their jobs". The situation resulted in the government not listening to nurses and neither legal strikes or civil disobedience has produced a settlement with honor (Hibberd, 1989).

It may well be that Alberta had convinced its neighbour, British Columbia, that legislation might be necessary.

Ontario, in spite of its nonstrike legislation, does not have large wage/working condition gaps between its nurses and nurses of other provinces who can exert their right to strike (Kerr, 1988).

Analysis Post Job Action Subproblem 13.0 - Stress experienced by Head Nurses

Subproblem 13.1 To what extent did head nurses feel stressed by being declared nonessential during the strike?

Findings. Table 31 shows that 12% or half of the responding head nurses found being declared nonessential highly stressful. Less than a quarter of the responding head nurses experienced low stress in this area.

I certainly found out how the union really feels about its head nurses!

Head nurses being considered nonessential was a poor move. They are needed for their leadership skills, staff and physician rapport and standards of patient care.
One head nurse was relieved to have some time away from work so she could do her paperwork:

I finally had some time to catch up on work from the hospital!

Discussion. BCNU made the decision to designate head nurses who are primarily department managers as nonessential. This was a contentious move on the part of the union since head nurses believed that the union had labelled their work as worthless and dispensable and had not acted on their behalf. Since then, a few bargaining units have applied to the Industrial Relations Council to have head nurses removed from the contract and reinstated as nurse managers.

Subproblem 13.2 To what extent did head nurses feel torn between their administration, their union, and their staff?

Findings. Table 31 shows that 83% of head nurses responding found that they were feeling torn between loyalties to administration, their staff and their union. This was the aspect that caused head nurses the highest degree of stress. Most head nurses felt they were in an untenable, lose-lose situation. Their union, their management and sometimes even their staff did not assist in easing the discomfort to head nurses in this area.
There was great stress being between Administration and Staff. You suddenly found your efforts and skills are needed by no one - you were not essential, yet (you were) being called at home for support and assistance. There was no support from BCNU for my position as head nurse (after all we were only a minority).

Multidisciplinary staff did not like the way some head nurses were treated by management.

Management has given head nurses the opportunity to be responsible for budget, hiring, the whole gambit that is managerial, except discipline. As a result when we came to the strike, I couldn’t be responsible for this unit and the nurses and comply with what the union was requesting of its membership. The union kept saying that was administration’s problem. My comment to them was that I am administration, and this is my department, and I have responsibility to make this department work. They couldn’t see that point of view.

Discussion. The literature has not discussed the “sandwiching” role of the head nurse in relation to the union, the staff and the management at time of striking or at nonstrike times. This is an issue that needs further study since the majority of head nurses were in conflict on this issue.

Subproblem 13.3 To what extent did head nurses feel that they were ignored, disrespected by their union?

Findings. The relationship between union and head nurse was not all bad. Many head nurses contributed greatly and worked well alongside staff nurses in strikework, both in organization and leadership
throughout. The criticism came from staff members when
head nurses would not take part in union activities
even though they were in contract, yet would criticize
strike efforts. The head nurses experienced stress
when nurses would treat them as management in an
adversarial fashion and exclude them from activities.
Table 31 shows that 66.5% of head nurses responding
felt a moderate to high degree of stress related to
feeling that the union was disrespectful to head
nurses. Complaints about unfair and insulting
treatment by fellow union members were frequent:

I could not believe how the union stewards used
and abused their short term power, especially
in their treatment of head nurses. To have a
union rep. check up on your general duty,
union-ordered duties to see if you were doing
head nurse duties is disrespectful to me as a
head nurse in the same union.

The prejudice against me expressed by our
Chairman of Essential Services felt like abuse.
It upset me greatly until I figured out that it
was at least partly directed against my role as
a Head Nurse. The Chairman refused to speak to
me despite my asking several times to talk with
her. She refused to look at my suggestion for
an equitable rotation to divide the work.

Some nurses did not like the lack of activity of Head
nurses in a union. From an Essential services
chairperson in small hospital:

The reaction of middle management people - they
failed to participate in their union but they
later had lots to say when they didn't attend
the preparation meetings.
More frustration voiced with head nurses that did not work at the staff level during the strike.

Other nurses were happy with the organization skills and efforts by head nurses during the job action.

It was a revelation to me to see the wonderful response of the head nurses. They were the backbone of our strike effort and have continued to be very supportive.

Discussion. Although nursing unions enjoy the membership numbers that head nurses provide them, unions tend to treat head nurses as management. They are often ignored in the collective bargaining process, and were discounted completely during the strike. Little wonder head nurses were angry enough to want out of contract.

Subproblem 13.3 To what extent did head nurses feel stress related to returning to direct patient care during the strike?

Findings. Table 31 shows that head nurses were not particularly stressed about going back to the bedside (17.3% of 24.4% of nurses responding). Most head nurses did not have the opportunity to return to direct care throughout the strike. The clinical activity of head nurses varies, although many are becoming distanced from clinical work. That, in turn, probably distances head nurses from their staff as well as
decreasing their credibility. For head nurses who were uncomfortable with clinical work, there would be little sympathy.

I was acting as a staff member and my staff were happy to have me on the ward as were the residents.

One head nurse who had been more management than clinical before the strike was upset with staff who would not assist her with direct patient care:

In fact, they would give me tasks that I had either not done before or had not done for years. They gave me equipment such as IVACs to manage without any instruction; this was a big joke to them.

Subproblem 13.5 To what extent did head nurses wish to be out of contract after the strike?

Findings. Most head nurses wished to be taken out of contract since they did not feel represented by the union. There were many reasons for this but there were two that were of primary importance: head nurses felt that their role was a management one and they believed that they were a minority group within the union therefore union efforts would focus on the majority.

Table 31 shows that the majority of responding head nurses (80 per cent) wished to be taken out of the union contract after the strike.

HLRA offered an attractive contract to senior nurses and Head Nurses. This was not sent to
members to vote on, but BCNU sent us out on strike. At that moment BCNU lost me.

I feel strongly that management (head nurses) should not be in the union. When general duty RN’s work in charge, have shift differential, and stats can make more than a head nurse with the role we have today - something is wrong with the union!

This head nurse did not want out of the union.

At the moment, despite my complete disappointment in my union’s interest in or ability to represent me, I am not ready to get out of the union. My interest in remaining in the union is to preserve the unity in nursing and in health care and to prevent further I/you situations.

Discussion. Rowsell (1982) argues that for some time employers have been trying to exclude head nurses on the basis that they were managerial in function and states that the majority of these nurses are fighting to remain in the bargaining unit. If these nurses were to be excluded, they would lose the legal protection of the collective agreement and job security. They would then depend solely on a good employer to provide fair, and equitable benefits.

Summary

Nurses were in strong agreement on a variety of issues (Table 32 and 33) by highest means and lowest means. Table 34 shows issues which had the least difference of opinion on six issues; the greatest consensus being the message of the strike was about
value of nurses. Table 35 shows issues in which nurses agreed most strongly and had the least difference in opinion.

Table 36 shows twelve of nurses' greatest differences in opinion with nurses' concern for public opinion being the greatest. Table 37 indicates the five issues in which nurses felt most strongly yet disagreed with each other the most: the first being administrations' justification for concern about patient safety. Close to that issue was that nurse administrators valued and respected nurses during the strike, and next was the issue of nurses considering themselves to be feminists.

With respect to stress, all nurses responded that they had experienced moderate to high stress in some areas. One nurse put it this way:

The strike was a very emotional time for nurses. It was rather exciting while the preparation was being done to organize the strike, but when the stark reality of the picket lines were put in place I felt few nurses were prepared for the stress they felt. I kept hearing: 'I will never vote to strike again'; 'I didn't know what a strike entailed'; I don't ever want to go through this again'. There should have been better information available to members re: THE STRIKE.

**Analysis of Subproblem 14.0 - Differences between regions, hospital sizes and types of hospitals**

**Subproblem 14.1** What differences were significant
between regions in the province?

**Findings.** Generally, the region that most frequently differed in their responses from all other regions was the South Island region. (Table 38) South Island and Vancouver differed most frequently. Specifically, South Island differed from Vancouver was less in agreement in their responses that the public was supportive, and that physicians understood and respected nurses reasons for striking, and more in agreement in their belief that BCNU did not enlighten the public on the nurses' role.

The Kootenays most often agreed with South Island however, it differed to a lesser extent from the other regions in its responses.

With respect to stress related to administrations' attitudes, nurses in the South Island region experienced higher stress and nurses in North Island, Fraser Valley, Kootenays and Okanagon - Similkameen experienced lower stress.

Stress related to other unions caused nurses in North Vancouver Island higher stress, and nurses in Fraser Valley and Central regions less stress.

Head Nurses experienced higher stress by being declared nonessential in the regions of South Vancouver Island, Vancouver, and Okanagon - Similkameen.
Of the nurses who responded to the questionnaire, there were significant differences from those who voted "no" to reject the offer in the Vancouver, Fraser Valley and the Central areas and those who voted "yes" in the South Island, Northwest, and Kootenay regions. These findings would reflect the actual voting pattern.

Lower mainland nurses having the control to indicate what nurses want, even though they have the numbers there, I didn’t feel they indicated what smaller centers want or need.

Problems, or lack of them, are bound to differ from area to area in the province. The serious concerns big city facilities face should be made known to all nursing units throughout the province. Also the problems of small or isolated units should be brought to the attention of the larger hospitals’ staff. We would then be voting more knowledgeably for nursing as a whole than as one nurse reacting to our own personal situation.

There was lack of professionalism displayed by nurses at the coast hospitals.

I support nurses in Vancouver where the shortage is greater than where I live. There were hostile feelings between larger facilities and ourselves.

I feel very strongly that the voices of the nurses in the larger facilities in Vancouver (ie. VGH, St. Paul’s) were attempting to be the voices of all the nurses in BC. I think this is a misrepresentation, as alot of the feelings and concerns of
the larger facilities were not the feelings and concerns of the smaller facilities.

I feel strongly that Vancouver and Victoria carried the brunt of the strike. I feel nursing staff in small hospitals up-country who could not strike and worked full time should have been assessed to support those in Vancouver and Victoria who were not considered essential.

The vote to strike made nurses know that things are the same all over B.C. not in just one area and that if we stick together maybe some things will improve.

In a small hospital it is just too difficult. You have to picket so often and you know so many people in the community when you are on picket duty.

**Subproblem 14.2.** What were the significant differences between the types of hospitals?

**Findings.** There were 28 hospitals that took part in the study. Three of these hospitals were tertiary care facilities or large facilities in which the level of care is specialized and is affiliated with a medical school. Medium sized community general hospitals were those over 100 beds, yet because of the type of specialty care they provided were not considered to be tertiary; small community general hospitals were those under 100 beds. All of the previously mentioned hospitals were acute care in nature; that is, they mostly provide care for individuals with an acute
illness. One other type of hospital included in the study was a long term care facility, one in which care is provided for "functionally-impaired individuals of all ages on an ongoing basis for a prolonged period of time" (Mantle, 1989, p.107).

With respect to stress, nurses in tertiary care and medium sized hospitals experienced greater stress than small hospitals and long term care facilities in the areas of union organization, feeling conflict between their employer and their union. In the area of decreased income, tertiary care hospitals experienced more stress than all other facilities in the area of decreased income.

Smaller and medium facilities experienced significantly lower stress in the area of administrative attitudes.

Tertiary and small facilities experienced lower stress in the areas of attitudes of other unions. Head nurses in tertiary and medium sized facilities experienced higher stress in feeling that the union was disrespectful to them.

One long term care nurse said:

Patient care in a LTC facility remains at the same level and no one can be discharged. We worked with fewer staff in a very heavy setting. There were residents who were angry at us. Those
staff that were essential worked their
buns off trying to deliver only the bare
essentials. LTC facilities should not
have strike action taken.

Conclusions

Nurses experienced conflict that was quantified and
described in the questionnaire. Some of the numerous
conclusions drawn were:

**Nurses and Striking.**

1. Nurses believed strongly that they should have the
right to strike.

2. The majority of striking nurses felt that making
the decision to strike was one of the most
difficult moral decisions they had ever made.

3. Nurses feel passionately that the work they do is
valuable and wish to be recognized for that work
not only in a monetary way, but by other concrete
means.

4. The majority of nurses believed that the strike was
not primarily about wages.

5. Nurses want changes in their contract which will
not only make a difference to their working
conditions but will make a difference to patient
care. Nurses are troubled about the current and
future impact of poor working conditions and how
they relate to job dissatisfaction, burnout and
6. The majority of nurses are concerned about public opinion during job action. Many of those who are not as concerned believe that the public are not aware enough or informed of the issues. Overall, nurses enjoyed public support during the strike.

7. Nurses believed that little else was more important than nursing image. Nurses believed they maintained a professional image throughout the strike. They were critical of those nurses who did not dress, act or speak professionally during the strike.

8. Nurses were concerned about media representation of them during the strike. They saw the media "distort" their image into portraying nurses as being "militant", "uncaring" and "money-hungry".

**Nurses and their Union.**

1. The majority of nurses felt that the BCNU was justly criticized during the strike.

2. Many nurses believed that the union used nurses and abused their power through their lack of preparation and expertise throughout the whole experience. That plus the lack of communication from the union caused nurses to believe that the union did not respect their trust.

3. Nurses themselves felt unprepared and disorganized
as a result of the union’s inexperience and disorganization. Nurses bitterly complained about the lack of communication from the union and perceived that other unions were much better informed. Union stewards were generally helpful, but nurses found some to be lacking in interpersonal skills and inflexible.

3. The majority of nurses did not consider themselves to be trade unionists. Many nurses expressed conflict in their attempt to reconcile aspects of their professionalism with their unionism, particularly during job action.

4. A majority of nurses had not been involved in union activities before the strike; less than half were interested in becoming involved after the strike. It was not surprising that half of the nurses responding, then were unfamiliar with union decisionmaking and were not familiar with the union leadership, philosophy, or the bargaining process.

5. Nurses were angry with their professional association for being invisible and unsupportive during the strike. Nurses believed the RNABC and the BCNU should work more closely together.

6. Nurses wished to be seen as professionals, in a professionalized union. Nurses were dismayed when
the public compared them to industrial trade unions. While nurses appreciated the value of the trade union movement in the support of the nurses' union, they did not wish to be closely aligned with industrial trade unions. Many nurses believed that trade unions were unattentive to the needs of women. Nurses were strongly opposed to the leaders of other trade unions expressing opinions about nursing contract settlements since they believed that those leaders could not be aware of the professional issues. Many nurses were suspicious of the role that the B.C. Federation of Labour played in the negotiations saying they believed that they were "manhandled" by them.

8. The union leader was the focus of nurses' malcontent with their union and the results of the strike. Members' dissatisfaction focused on the leader's lack of experience, inability to represent and articulate nurses' issues effectively, particularly to the media, inability to take a solid position and adhere to it, and a perceived lack of professionalism.

Nurses and the Proposed Contract.

1. The majority of nurses believed that the contract recommended by their union was one which did not
reflect the recognition desired by nurses in both a monetary and nonmonetary sense. Many believed that the offer was of lesser value than the original contract for which they went to strike. Many nurses believed that the money was enough, but that they felt they had been manipulated by everyone and simply wanted to say "enough".

2. Nurses did not support their union’s recommendation to accept the offer; they believed that their bargaining committee were not cognizant of nurses’ contract desires, and lacked the expertise to translate their issues and represent them at the bargaining table. Nurses wanted professional, expert negotiators to do the job.

3. Nurses were disgruntled with the process used by the bargaining committee and the union to sell the contract. Many found the process to be threatening and intimidating. Members felt the union’s explanation of the proposed contract was inaccurate at best and the union’s rationale to accept the contract was weak and not in members’ best interest.

3. Nurses believed that while the dissident "no" group were catalysts in articulating nurses’ unhappiness with the proposed contract, they were
not significant in building nurses' confidence in voting "no".

4. Many nurses voted to accept the contract simply because they wanted the conflict to be over with. They felt that the union had achieved all they could given the lack of expertise of the bargaining committee. They felt embarrassed and uncomfortable with the image of ineptness and conflict in the public eye.

**Nurses and Physicians.**

1. While nurses believed that physicians understood their reasons for striking and were verbally supportive, they were disappointed that physicians were not actively supportive of their cause. Nurses expected physicians to make allowances by discharging and by not admitting patients who did not have lifethreatening problems, by refraining from ordering nonessential diagnostic tests and by abstaining from performing surgery which was not essential.

2. Nurses believed that those who were most affected financially were the least supportive. In some cases, there was verbal and physical abuse from physicians to nurses.

**Nurses and Employers.**
1. It is significant that nurses feel that their employers do not work with them to improve their working conditions, and feel exploited by them since nurses believe that they give their employers extensive value for their money through their "innate caring and commitment". Nurse believe that their employers' priorities are economics first, then patients.

2. Although they are nurses, themselves, nurse administrators did not show they valued and respected nurses during the strike. Nurses believed that nurse administrators were more committed to the administrative aspects of the organization than they were sympathetic to the struggles and issues that concerned nurses attempting to provide front line care. Many nurses believed that nurse administrators were wary of nurses "newly rising consciousness".

3. Only half the nurses felt that their administration had reason to be concerned for patient safety during the strike. Many nurses commented that their administrators should have more concern for patient safety at times of normal operations.

4. The majority of nurses were disapproving of administration's receiving financial or other
privileges because of their strike work. This, they believed, reflected a "look after yourself" management philosophy.

5. At only one hospital did all nurses feel positive about their administration. Coincidentally, at this hospital, the top administrator was a nurse. Nurses at this hospital felt "respected", "autonomous", "valued" and "supported", "in charge of their practice" and "part of the decisionmaking process". They described their leader as "caring".

Nurses and Gender Issues.

1. Nurses were uncomfortable referring to themselves as "feminists" although they were conscious that many of their occupational problems derived from their being primarily women. Nurses feel discriminated against in terms of their bargaining power; they believe that because caring is central to their work, it is devalued. Nurses believe that society, the government, and their employer is more concerned with the monetary bottom line than it is with people. Nurses also believed that they were being asked to "make do" with a bad contract because they were a profession made up of women.

2. In their workplace, nurses pointed out that nurse administrators were not in positions of power to
make the major decisions, that they reported to top managers who were, in the majority of cases, male and who did not understand patient care.

3. Many nurses had to take action for their personal safety on picket lines because of threats and abuse by men.

4. Nurses believed that during the strike they had come a long way as nurses and as women because they acted collectively for a common cause despite their differences. They also felt they had changed their image from a "Florence Nightingale image of pleasing and serving" to a more healthy blend of altruism with individual rights and entitlements.

**Personal Issues.**

1. Nurses overwhelmingly expressed that the meeting and talking with other nurses during the strike was a profoundly exhilarating experience. Nurses not only discussed issues of concern in their professional lives, they explored their vision and beliefs about nursing and health care. Nurses felt bonded by this experience and lamented the return to normal operations in which there would be no opportunity to network and to explore the possibilities of their practice.
Stress and Job Action.

1. The greatest stress was that nurses experienced was that shared with their colleagues who were stressed themselves and in many cases, exhausted.

2. Other stress was derived from concern about the length of strike time, but only a third of nurses were highly stressed about being legislated back to work.

Differences between Nurses.

1. Nurses in all regions and in all sizes of hospitals agreed on multiple issues related to what the strike was about, on the importance of public opinion, and on support as a result of physicians' finances; as well as professional issues.

2. There were some significant differences between nurses from various regions throughout the province and between nurses in different sized hospitals. Nurses varied here in their opinions about BCNU and its actions during the strike, and the collective bargaining process. South Island was most similar to the Kootenays and disagreed with Vancouver most frequently about support of the BCNU leadership and activities during the strike as well as on gender issues. North Island and the Fraser Valley agreed most frequently with Vancouver on those issues.
CHAPTER 7

RESULTS, ANALYSIS AND DISCUSSION OF NURSE ADMINISTRATORS' STUDY IN POST-JOB ACTION PHASE

Introduction

30 Nurse Administrators were interviewed from ten Lower Mainland Hospitals in September, 1989 following the strike. A covering letter was sent by the researcher to the Vice President of Nursing in each agency requesting interviews with nurses who were out of contract on the management level. The purpose was to explore the issues and conflicts which they had experienced during job action and strike time. It was hoped that some insight would be gained into what types of conflict nurse administrators feel during strike/job action; whether or not they had conflicts which were similar or different during job action. Also, the purpose was to explore if nurse administrators had a similar perspective of the issues and were empathetic to the concerns that nurses had in the workplace.

Nurse administrators in all hospitals in which interviews were requested responded favourably to the opportunity of an interview. Each administrator personally, or through their offices scheduled a one
hour interview; however many continued the interviews for up to two hours. Most nurse administrators were as anxious to discuss their feelings about the strike as the staff nurses were.

The interviews were tape-recorded following which the interviews were transcribed.

Results and Analysis

Post Job Action Administrators Subproblem 1.0 How did Nurse Administrators feel about unionized nurses taking job action which included striking?

Findings. The chief reason many nurse administrators stated that they disagreed with nursing strikes was the concern for public safety. Whether or not they agreed with nurses about the reasons that nurses voted to strike, with few exceptions, nurse administrators acknowledged some action had to be taken by nurses to change their wages and working conditions.

Many of the nurse administrators did not believe in striking and/or unions.

"Personally, I don't believe in job action or strikes. I particularly don't believe in it when it involves professionals: nurses, lawyers, physicians. I was angry that they were out there. I thought (that) when they voted to strike, they didn't think in a million years that it meant being without money and wearing a
picket sign. And that made me angry. I felt if they had explored the issues back there and it was an educated decision, they would have voted to give their (bargaining) committee support."

"I think the whole process is archaic. Solving problems this way has to stop."

Only one nurse administrator spoke of striking in a positive way:

"We wanted a strike to enrich what we had, not take away from what we already had."

Discussion. Much of the literature on striking and collective bargaining explores ways for nurses to bargain without having to withdraw services (Muyskens, 1982; Miller, 1975; Hibberd, 1989). The issue of professional collectivism explored by many (Cleland, 1988; Eldridge and Levi, 1982; Zimmerman, 1981) was more palatable to most nurse administrators than that of striking.

Post Job Action Administrators Subproblem 2.0 What were the issues for which nurse administrators believed that unionized nurses took job action?

Findings. Less than half of the nurse administrators believed that the reason nurses voted to strike was mainly for financial gain. The rest were in agreement with contract nurses in that the issues were
related mainly to the desire for recognition and for change in working conditions. Only a few nurse administrators related the significance of their role in bringing about changes particularly in working conditions and many did not feel that they had the power to change those conditions.

"I believe that it was talk only about other issues but I truly believe that it was about money after all was said and done. Money may not be the main satisfier. Shortage is tied in with the money. I don’t think they can make up for all the injustices of nursing in a contract."

Some nurse administrators had a similar perspective to the majority of contract nurses who felt that the most important issue was recognition of their value. They doubted that striking could bring about recognition.

"I think the biggest issue alone was the issue of recognition as a health care professional. But you can’t legislate recognition."

Some nurse administrators believed, as contract nurses believed, that the media focused on money.

"I think that it looked like money, that’s the way the strike went. But it was about working conditions. Nurses get a double message. On the one hand, they are told to act as professionals, but they aren’t treated like professionals at all, they are treated like babies. That is nursing’s problem - and my colleagues’ problem."

A variety of responses were given in relation to what the nurse administrators believed the issues to be.
"I think one of the main issues was money and assignment of nonnursing tasks and not as much professionalism as I thought."

Some felt that recognition for nurses meant that nurses would receive more pay.

"The issues are much larger than the dollars per se. Nurses were really concerned about nursing in terms of their profession and the value that people put on their work and therein the dollars equal the value of the work that you do."

A few nurse administrators believed that the strike was a vehicle for change that nurses could not make in any other way.

"I think they voted to strike in my hospital because they were tired of doing the garbage - they were so angry. They used it as a way to change the way they were. It had something to do with working conditions, and not much to do with professionalism."

A common theme among nurse administrators was that there was not a nursing shortage, but rather a shortage of nurses willing to work in intolerable conditions for inadequate compensation.

"I think that one of the issues was the control factor. Nurses wanted more say in their working life - an issue that probably couldn’t be resolved at a bargaining table. The other issue was money. Most felt they deserved more for how they worked and in the conditions they worked."

One administrator had insight into the strong need that nurses had to communicate with each other. She said,
"I really believe that nurses wanted to talk."

One nurse administrator believed that the issue was beyond nursing itself and that there was good reason for everyone to be concerned.

"I found it very difficult to cross that line. That professional side - it wasn't just the union that had those concerns, it is a much bigger picture than that - much larger than really all the groups combined. Aside from the money concern, the fact that it is so big is a concern in itself."

One administrator believed that the issue of socialization of nurses played a heavy role in the strike issues and that nurse administrators have a heavy responsibility to resocialize nurses.

"I saw a difference between nurses at the hospital where I was before this one. They were more sophisticated and assertive there. We (management) had given them more responsibility, accountability, and the more you developed them, the more sophisticated nurses were during the strike. It was different here where nurses were socialized to be second class citizens. A lot of nurses are older here, and the organization is less than static. Nurses were totally unassertive here and are subservient to medical staff. All of a sudden they were waking up. It is amazing what they have put up with. They are starting to look at what other nurses are asking for and thinking that it is all right to ask. I think the strike wasn't bad from our standpoint. I am only sorry that nursing management didn't do that for them."

Striking was an expression of militance according to one nurse administrator and militance was a symptom of anger.
"The fact that nurses went on strike was so contrary that it was a demonstration of militance. Maybe more correctly it was a demonstration of a deepseated anger, hostility that came to a head."

One nurse administrator spoke of naivete as being the source of caring and of nurses as being naive.

"I think that nurses are naive. Caring comes from naivete. You wouldn't want people who are shrewd out there taking care of you who would sell their grandmothers. They are naive about what the real world is like and that society should recognize humanitarian kinds of work. Sometimes I think nurses don't really believe down there in their gut that what they do really makes a difference."

A few nurse administrators understood the issues were but seemed frustrated about dealing with those issues.

"There was anger about working conditions, there was anger about rotations (I have 1000 nurses, I can't have 1000 rotations), this thing about the medical profession not giving us what we want and not being able to say what they do want...they are so mixed up...that's why they were unable to bring their goals to the bargaining table. After a while you just live with this big black cloud and can't differentiate it."

The hope that nurses would be able to effect change through job action was expressed by one administrator.

"I think that nurses are not going to let go of this thing and quite frankly, I hope that they continue to press. If they get this organized in the right way, then they have more of an opportunity to effect change than I do as a single voice."

This administrator believed that nursing administrators
themselves contributed to nurses’ feelings of powerlessness and lack of value. For nurse administrators, it is not in their best interest to "flatten" the administrative level and bring about more decisionmaking power and input at the front line provider level since that would jeopardize the job of the administrator herself.

"I can understand why the nurses did what they did because I have listened to some of the nurse administrators at the Administrators' Group. They don’t value what nurses do on the front line. When you empower people you don’t need nursing administrators... However, I am talking to people who believe that you do. The more you layer, the less professional those people have to be. The nurses feel powerless and valueless. I think that is a mistake that nurse administrators make. I don’t know if they have learned from it. What I usually hear is, it might work where you are but it won’t work where I am. My answer is: as long as you are there it won’t work."

The support for bringing about change was echoed by another administrator who felt that time for effecting changes was dwindling.

"There is a clock ticking at this hospital. I feel that we have to make some progress. I will be very disappointed if we have not resolved these issues by next year this time. I won’t blame the union if they go ahead and grieve. They are giving management an opportunity to get it together and if we don’t they should go ahead."

Discussion. Bloom, Parlette and O’Reilly (1980) found in their study on comparative analysis of
perceptions by management and employees on collective bargaining issues that nurses’ reasons for striking often differ significantly from management’s view of the situation. Management tended to believe that the foremost issues with nurses were economic ones, whereas nurses believed that the issues were professional. While autonomy and control of their practice was an issue, there was no "threat of loss of influence or power such as that implied by those demands" (p.31).

**Post Job Action Administrators Subproblem 3.0** How did nurse administrators feel about unionized nurses’ image during job action?

**Findings.** Many nurse administrators were disturbed by the appearance of nurses on a picket line. It was not uncommon for nurse administrators to be uncomfortable with any image of nurses on strike and particularly with the image of those on picket lines. Nurse administrators feel as strongly about the image of nursing as does the in contract nurse. Nurse administrators seemed to feel that their leadership was reflected in the actions of their staff nurses.

The theme of many comments was similar to this:

"Some of the women did not portray a professional nursing image. They looked to me like blue collar workers - I think nursing has
always been blue collar."

The most frequently mentioned issue with respect to nurses' image during the strike was the physical image of nurses and in particular, that of weight. The concern that nurses were not represented by healthy, articulate role models was not different from the concerns expressed by nurses who were striking.

"I was embarrassed to be a nurse. The militancy from VGH was embarrassing. They interviewed nurses on the picket line that were overweight, weren't particularly articulate, they weren't well dressed, and they were yelling and screaming. They never seemed to interview nurses that I work with everyday which were people who were kind of confused."

Some administrators saw the image of nurses as something other than physical presentation. They saw nurses blindly and unquestioningly following the union.

"It was like the herd instinct. The union said to do something, so they all went along with it."

Some nurse administrators were conscious of their own image during the strike.

"On one hand it was quite a laugh for nurses that we were all cleaning toilets and making beds. On the other hand, alot were terribly sympathetic that someone who typically trots around in high heels and jewellery was scrubbing around in nursing shoes, grotty outfits and getting right in there."

Discussion. Short and Sharman (1987) refer to the influence of the "lady-nurse-types" (p.200) in the
hospital hierarchy that inhibit nursing from utilizing full trade union power. Some of these "types" Abel-Smith, 1960) claims, find identification with the working class within trade unions incompatible with their social aspirations.

Post Job Action Administrators Subproblem 4.0. Were nurse administrators concerned for public safety during job action?

Findings. During the strike, both the decrease of human resources and increase in the stress level of all health care personnel, both striking and management could have exacerbated the strain on the already poorly functioning hospital/health care system. Normally, the "warts" are not as visible or they can be denied by all except those who provide direct care. During the strike, they became reality and unavoidable to all, at least all "inside" the hospital system.

Concerns expressed by nurse administrators were more frequently based on lowered standards of care rather than on safety issues. Emergency Departments were the area of least control. Occasionally, nurses administrators felt that the public was at risk.

"Where my concern was, was the Emergency Department and that's where you just wanted to stand and cry. We knew there were people going
home from there who shouldn’t have been. And the discharges were so sped up that people were sent home way too early. I would be down in Emerg. 48 hours later and they would come in again. By then, they would be septic or whatever. They would come back alive but they weren’t doing well. If somebody did a study on readmission rates during the strike it would have been phenomenal."

"It was like a MASH unit. The nurses didn’t know where to turn first. As long as they (patients) were breathing - that was the main criteria. One of the other Directors and I went to move a patient in Emergency and she had died. She probably would have died anyway, but in Emergency that should never happen. We felt terrible. We, of course, clinically had to decide whether or not she had died! It was about 49 years since I had done clinical!"

"I saw a man die in the Emergency Department without the kind of support he should have had."

Some related stories of the public who were extremely worried about how to access a system.

"Families would sometimes call in at all times of the day or night. We were discharging all times of the day or night. The families would call and say, ‘I don’t know what to do, I have Mother at home but I don’t know what to do with these heart pills.’ The teaching was down - everything - it was quite scary. The community support systems could not respond quickly enough. I heard a lot of horror stories from other places - they probably heard a lot of horror stories about us too."

Many nurse administrators described situations in which the nurses providing essential services had some discomfort in admitting to their administrators that they were in an unsafe situation. Administrators also believed that nurses had difficulty asserting
themselves in the strike situation when they were in an unsafe situation and required more help.

Nurse administrators told many stories of situations in which nurses turned to them for advice about what to do with respect to care and acting on union directives.

"You had to really push people in terms of what was safe and what was not safe. They were waiting for you to come along and tell THEM what was safe from your point of view."

Since staff would say they could manage on less staff during the strike, this administrator would likely use this information after the strike.

"Most of the time before the strike they would scream for more nurses to carry out the patient load. Now they were screaming that they could manage with less. Interesting..."

A few nurse administrators were concerned about the amount of time spent on staff changeover which happened frequently because of an attempt to provide equality with shifts for essential services and shifts for picketing. This coming and going resulted in a concern for lack of continuity in some facilities.

"I was not concerned about safety. The biggest concern was how they initially set up their shifts. They had four hour shifts and they were coming and going with fours...they would get report and they would barely get out with their patients and then it would be time to leave. They really never knew their patients, they couldn’t see any change in their patient's
condition and they spent alot of time reporting on and off - that really concerned me."

Discussion. For nursing, striking is a powerful weapon. Whether it is moral or not is a strongly contested point and has been discussed earlier in Chapter 6. Public safety was undoubtedly an issue in some facilities at some times. Public risk in this case did exist even with relatively high levels of essential services (70 per cent staffing levels). What can never be accurately estimated, is the extent to which public safety was at risk during a strike compared to times of normal operations. During times of normal operations there are long surgical waiting lists, lack of medical beds, overcapacitated Emergency Departments, shortages of nursing staff and lack of resources (both human and equipment) to meet the demands of patient care.

Post Job Action Administrators Subproblem 5.0. How did nurse administrators view their relationships with unionized nurses during job action?

Findings. A common bond existed between some nurse administrators who were empathetic to striking nurses. There is no doubt that some nurse administrators spend an extraordinary amount of time and energy attempting
to understand the issues and finding solutions to problems of front line providers. The message is clear here. The credibility gap is directly proportional to two things: the amount of layers between the front line provider and the administrators and the administrators' ability to "be there" when needed, to provide the needed amount of support, helpful observations and assistance to the front line nurse.

"We knew we had to be here, but we wanted to be on the picket line too. We felt that something needed to be done. I found it hard to cross the picket line - not because of the union stand, but because of the underlying issues. Not agreeing with the way the issues were presented, but knowing that things have to change and they have to change for the better. We were of two hearts. Although we had our job to do when we were here as management, it was hard to cross that line. I thought that the staff might think I left those issues at the picket line or if I crossed that meant that I really cared about them - I did and I really do. I think that they know that - I hope so anyway."

Some nurse administrators used the strike as a way to decrease the gap between themselves and the staff nurses by cleaning and providing direct patient care.

"For me I got a lot of positive out of the strike. I became more visible. I got to know my staff better. I got to meet patients and families which really turned my crank. I wanted access to staff and to be there and I think I certainly went up a few rungs with staff who never really knew me before. The strike has basically broken the buttle for me. I had a funny blue outfit on and I made a point of buying a pile of pink socks because I wanted
to do something different. They see me as being a person who listened to them and who worked and who wasn’t afraid of work”.

Another administrator was able to use the strike action to her advantage.

"I did kind of roll with things as they came. I have a sense that I dealt with it differently than other administrators here - all I can say is I really felt what nurses were going through and I kept putting myself in their position. I was less worried about me and how it was affecting me and I tried to project into what was happening to them and how could I help them."

Nurses who believed they were demonstrating support to their nurse administrators had an odd way of demonstrating it according to this administrator.

“They were sitting out there on the picket line and singing songs about management. It was late at night and I was going home. One of the nurses thought she was really being helpful when I went by as said ‘Oh this will make your day, here’s a song and we wrote it about you’ and they sang it. I laughed and joked and went through the picket line and then I just started to cry all the way home, mainly because I was tired. It was meant in good humor, and compared to all the other ones they wrote, it was kind, but I really took personal offence to it. It really hurt. It was hard. I felt like I tried to support them and my resources were so low. But I kept saying, be positive because if they didn’t like you they wouldn’t run it over to your car - no one else in management heard ‘their’ song”.

Occasionally nurse administrators felt that the empathy and understanding was a one-way street: administrator to staff nurse.
"Directors always feel responsibility to know what her staff does but staff never feel it their responsibility to know what their Director does."

The conflict often boiled down to petty issues.

"I was reduced to being a little bit petty throughout this whole thing. Some nurses took out I.V. bags to keep their hands warm and I felt 'Well, they have stolen hospital property'. They had moved all sorts of chairs and so on outside."

A nurse administrator expressed her management values this way:

"There are three values here. One is that the most important are our front line staff. The second value is that we are stewards of our resources. That means two things: first, we look after one another and if something good happens, we honour one that person, if something untoward happens, the last person that gets examined is the front line worker. Second is that we must be mindful of public finds. The third value is that we are committed to the extraordinary - we want to go above and beyond the traditional hospital. We believe that the strike enriched us - we believe that we had something that no one else had."

It is significant that all staff nurse participants in the study from the facility of this administrator described this administrator as "caring, understanding, supportive". Her attitude about the strike was related as following:

"We looked at it as an experience similar to childbirth, it is the 18 years afterward that we are interested in, not the period of time during the strike. We would get through the
days. Don’t put all your eggs in the childbirth part."

This administrator shared her secret for success for having a "magnet" hospital: one in which nurses were attracted and happy with working conditions.

"Each hospital has its own unique culture. I had a dream about what I wanted to do. If you have a management who is eager and willing to step out and try something in faith and do something different, and if you have eager receptive staff, the power is when you come together."

She continued:

"I think that the grass roots has to feel that they are a valued, contributing member of the health care team but they have to know what it is clearly that they do."

This administrator believes that a low vacancy rate for jobs is concrete evidence that nurses feel valued in an organization.

"The vacancy rates for nurses should be examined by corporations. I would ask if I was an administrative person, why my vacancy rate was the worst and what the corporations that have lower vacancy rates do that is different."

Discussion. In times of no-strike, Baumgart (1989), Bloom, Parlette, and O'Reilly (1980); Chernecki, (1988); Cleland, (1997); Colvin (1987) and many others recommend shared governance, or participatory management in order to obtain input by nurses and thus prevent and resolve conflict issues. Baumgart (1989) believes that fostering caring among
nurses is important and that nursing leaders need to create and transmit that culture in nursing. The problem seems to be that if the groundwork for "caring" and "participative" management style were not firmly entrenched before job action, its absence is amplified during the strike.

**Post Job Action Administrators Subproblem 6.0.** What were sources of stress experienced by nurse administrators during job action?

**Findings.** All nurse administrators described high levels of stress and the sources were diverse. Unlike contract nurses, common sources of stress were homerelated. The ability to deal with stress was hampered by mental and physical exhaustion. Management had no plans to assist with the management of stress in the facility for any administrators. Afterwards, some facilities had psychologists visit the facility to resolve the conflict, but it was more like a perfunctory item on a strike plan rather than a meaningful process which related to the organization and its culture.

No resource existed for short term management of stress at the time of the strike. The problem still exists - management dreads strike action because of the
management dreads strike action because of the overwhelming stress experienced during the last strike action and the lack of conflict resolution afterward.

The most common source of stress was exhaustion. Physical exhaustion played as much a part in the stress levels as did mental/emotional exhaustion.

"I was not as much physically pushed as mentally pushed to the limit...I was ward clerking and not only doing the day to day work but there were tensions every day and every day they would get higher and higher so that by the end of 2 weeks the fun and the laughter had gone. The tensions were from the medical staff because they couldn't admit and they couldn't discharge so there was a kind of stalemate in terms of patient care and there was tension in terms of the nurses themselves because they were trying to provide the care without the quota of staff they were used to. And so you were involved because you were the unit clerk during the strike and you were trying to coordinate all these people, making sure the care was safely provided. This is called doing unit clerk work with a management eye."

"We got so tired that emotionally we couldn't deal with stuff. We didn't close as many beds as other hospitals, and we went full tilt which I think we should not have done it was very exhausting for all of us - we didn't have enough people to keep the place together with paychecks, meals, laundry, diagnostics for the O.R. - that was bigger than direct care."

Few nurse administrators provided direct patient care, but when they did, they found the experience difficult.

"Staffing in the ECU was abominable and we had to do personal care in there. I have no strength or ability there and my philosophy is not right for it. Anyway, these poor terrible old extended care, non compos mentis people are
the tragedy of their circumstances. I have a very tender gag reflex - when I was in the kitchen doing the flop end of thing, I was gagging, I am gagging at the infectious waste, I am gagging at feces and urine and I gagged through the whole performance. But if there was nursing stuff to be done, we did it."

Many nurse administrators did not feel they had respect from staff nurses for pitching in and carrying out the job.

"I felt humiliated that some of the staff nurses would laugh at me - not with you when you were doing some of the tasks. Some of the physicians also. It wasn’t the work so much though. I never did anything I thought was beneath me, but one day as I was cleaning an ICU bed, some of the nurses, an intern and a physician said ‘Where are your executive clothes?’ I think they were cheerleading but I took it like I was tired. I thought Christ, I have to do this - don’t make fun of me doing it. I never let them know - I just kept the radio cranked up, the linen on the floor - I didn’t care I just wanted to get the job done."

One nurse administrator had a difficult job primarily because she was "thrown in" at her facility just before strike time.

"I had four days orientation, the job action started before I came and then we were into the strike. I was immediately into essential services planning - like, how many nurses do we need on the units? I didn’t even know where the units were!"

Nurse administrators commented often on how in contract nurses devalue their work.

"One day during the strike, I was absolutely livid. I decided that after the strike, I would have nothing more to do with nursing."
livid. I decided that after the strike, I would have nothing more to do with nursing. That total lack of appreciation by a certain segment of nurses at times for nursing administration and management. People would say to me personally, 'We don't need any directors, we don't need any quality assurance, we don't need any research or education—all we need are bedside nurses. Part of me says, 'Oh yeah, go right ahead I would like to see everyone that fills those positions walk away from this place and leave it for a month.' The disaster would be overwhelming."

Nurse administrators had different stresses than did striking nurses—conflict with staff and not enough time with family.

"I cried twice. Once was after an encounter with a nurse and it was just a release. The other was at eight o’clock in the morning. My daughter had cried when I left the house, I was taking out meal trays and blubbering 'I can’t do this anymore'. I was working with two other Directors and we went outside and sat on a little hard bench and I finished crying. They got me a washcloth and we all just got on with it. I was glad it was a bit private."

A nurse administrator married to another administrator in hospital related that neither she nor her husband saw their child for weeks.

"Arranging babysitting and nannies was like doing a staffing schedule. We would come home to see him sleeping in his crib. That was it for weeks."

Some stress stemmed from multiple sources. Nurse administrators would try to manage a situation of limited resources, to trouble shoot problems, and to manage the "games" of the strike.
hold it together, you would be really worried for example, one night I got a call that all the monitors were frozen in the CCU and I was trying to work with the Charge Nurse to get her to call to get someone across the line to fix those, to tell her how to talk on the phone to make sure that she could fix it herself. Somebody needed blood and it had somehow torn it transport. Just holding all together and then one nurse calls me to come STAT and I went over and what she wanted was that she had one lab. sheet to be placed on a chart while all the nurses in the nursing station watched. I remember thinking to myself, if this is nursing, I hope the hell that it does go down the drain...I couldn’t believe that a nurse would do that to another nurse. I could see the boys on the General Motors picket line doing that, but not nurses."

Similar to staff nurses, nurse administrators had difficulty interpreting the issues to their families.

"My family members cannot understand. I deal with two different generations: my father who cannot believe that nurses do very valuable work. He still strongly believes that nurses are doctors’ helpers. I think I have my children educated. At least I thought I did until I went home one night during this strike - they are all teenagers and egocentric. I cried and cried, and cried for about 3 hours. They felt dreadful. They fully understood the issues as much as they could understand. My hairdresser was fully supportive. A lot of people in elevators would figure I was a nurse and say we are behind you all the way. The irony was that I was on the opposite side."

"If I have to go through another strike, my husband tells me I must quit my job or he will leave."

Many administrators had partners who were also administrators or striking staff nurses.

"This was stressful at home. My wife is a
nurse. Because of the hours that we worked (she was declared essential so she worked the entire strike), I hardly saw her. There was an occasion when she started to complain about the union aspect of what was happening an the commitment of money or time or whatever they were demanding and she was telling me about it. I simply said, 'Listen, phone the headquarters that’s where the concern should be directed. We decided not to discuss it anymore after that.'

One nurse administrator commented on the conflict between being married to another non nurse administrator during the strike.

"It was a really interesting phenomena at home. My husband is management too and he was working the same kind of hours as I was. I was standing on the trayline one morning and someone told me that they had closed the Emergency Department at his hospital. I said 'What Bozo would have done that?' She said, 'I think it was your husband'. So I phoned him and said, 'You closed the Emergency Department - are you out of your mind?' I am coming from a nursing perspective and he wasn’t. 'The nurses think you just turned out the lights and walked out'. 'No I didn’t do that', he said. Well, of course, I was worse than the shop stewards because I was so appalled. That really created a tension. Afterward, I programmed him so well, he agreed not to complain about the nurses. We also agreed not to discuss."

Many nurse administrators experienced stress from crossing the picket line.

"I had a very negative experience with a picket line in my childhood. My father’s plant went on strike and it was very difficult for my family...I was afraid it would be like when I was 14 and I had to cross the picket line to get my father....I always felt..."uncomfortable" isn’t a word that isn’t strong enough - sick to my stomach - every time I had to pass through
the picket line."

One administrator told this story:

"I answered the phone in the kitchen from the floor. They wanted bread and a flat of juice. I check all the diet orders and soon I got a phone call from the same ward saying they wanted bread again. 'WHAT ARE YOU DOING WITH THAT BREAD?' I yelled, 'ARE THE NURSES EATING THAT BREAD- YOU ONLY HAVE 2 PATIENTS!' She said 'Maybe we don't need the bread' To this day, I am sure she wonders who she was talking to. Good example of how when one person does several jobs you get to see the whole picture!"

There were creative ways of relieving stress, mostly by humor:

"The closest I came to being really hysterical was after my 36 hour shift. Towards the end, I felt a little giddy. I was making beds and trying to cover mattresses which have a plastic cover over them. The first end broke up. I lay on the bed and howled in front of a room full of patients. Totally inappropriate, but I couldn't help it."

"You know those meal carts with trays on them. I was in my usual hurry, and I was steering the cart by myself. I couldn't see around it or above it. I ran into a little old lady in a wheelchair, here I was pushing this lady with her leg stuck under the tray and she was trying to say 'Stop, stop'. Finally the lady from Radiology caught me just in time. I just lost it. I never saw a thing, I guess she would have got ironed into the wall."

One nurse administrator believed she found the strike less stressful. This was her philosophy.

"Everybody reacted differently. There was a game to be played here. They would play their part in the game. My function in this game would be to be MANAGER and I would ensure that
would be to be MANAGER and I would ensure that
the patients would get cared for. That’s how I
would talk and I expected them to see that role
and if they didn’t know that then they would
have to go learn that just like I had to. I
didn’t take any responsibility for their game
or feel sorry for them. I didn’t get into any
dilemmas like trying to keep the nurse together
as well as trying to get on with trying to keep
patient care together. Sometimes I knew what
would put them on a guilt trip – but that is
the game. That is how I was different from
other nurse administrators."

Discussion. There has been no studies available on
the effects of nurses’ strikes on nurse administrator,
nor is there information available for resources that
would help in short term management of strike stress.

Post Job Action Administrators Subproblem 7.0. How did
nurse administrators feel about the BCNU during the
strike?

Findings. Nurse administrators all believed that
organization of the strike was poor. Nurse
administrators were as unhappy with the union
organization and leadership as were striking nurses.
In spite of their distance from union’s organizational
activities, nurse administrators lamented the ineptness
of the BCNU to manage the issues, the strike, the
media, the leadership.

In terms of leadership, nurse administrators
reflected on them and thus found the image to be nearly as important to them as it was to contract nurses.

Union disorganization accompanied by lack of experience caused contract nurses to turn to their administration, who were supposedly their "adversaries" during strike time for advice, direction, and

"I think they weren't as well organized since this was the first strike. I think their labor relations officers were wiped out and they were beyond saying appropriate things. They kind of lost it. They were very paralyzed and couldn't make up their minds about anything - they had to go to the head office for everything."

"The union needs to be blasted out of water for the disorganized way they went about this strike."

"I was very disappointed. I thought Gee guys, if you are going to have a strike can't you do better than this. As a manager, I thought the process was awful and I was embarrassed to be a nurse."

Nurse administrators often caught themselves organizing for the staff because of union disorganization.

"At first I would pop into union headquarters and ask for some nurses, asking how do I get them? Then I wondered who is running this show. Am I the hospital employer or are they?"

Comments often surrounded the issue of poor organization of the planning of Essential Services as well as the contract negotiations.

"Here was this one person doing the Essential Services for the whole province by HERSELF without any assistance whatsoever. That is a
huge organization and what a Mickey Mouse way
of handling things. From my standpoint, it was
wonderful. They didn’t know what they were
doing. I got more staff than I needed at the
beginning. We asked for it and we got it. That
is the whole part of negotiations—you ask for
it—with a high bid and negotiate it. We
got what were asked for without negotiating! We
didn’t hold them to that—we weren’t
miserable. But, it bothered me that they
weren’t handling it professionally.”

Nurse administrators commonly believed that more
expertise was required by the union for its
negotiations.

“It bothered me that they weren’t bringing in
high powered people—they could afford it!
They felt they could handle this on a very low
level. Part of the reason they couldn’t handle
the negotiations was that they lacked the
expertise. This is big time stuff and they
didn’t have their act together.”

A few nurse administrators were philosophical about the
role they played during the strike.

“I recognize we are both puppets being pulled
on strings but there are choices and we must go
on with it. You have to survive as well.”

“Oh, I didn’t expect any more from BCNU during
the strike. I had it clearly in my mind that
was the way it was going to be during the
strike and I didn’t expect any more from them
than I would the IWA. I learned a long time
ago that this is how unions operate and the
BCNU is not any different. When push comes to
shove, when the chips fall, they have only one
way—if their members are not compliant, they
are threatening to their members. The unions
has to maintain control and the BCNU did not do
that very well. So I just separate that union
stuff from the professional stuff and that
makes it easier for me personally. That wasn’t
the same as my colleagues felt, though.”
makes it easier for me personally. That wasn’t the same as my colleagues felt, though.”

Many nurse administrators were critical of the leadership of the BCNU. Many of them mentioned the physical appearance particularly the weight of the president.

“The BCNU President is a fat lady, and that was not what I wanted to represent me. She lost all her credibility when she flip-flopped. I think she represented nursing in that she was over her head, she couldn’t articulate things, and she didn’t know what she wanted.”

There were a few others who were empathetic to the President’s situation and the lack of support of the infrastructure within the BCNU.

“I felt sorry for Pat Savage because I feel she was pushed in front of microphones and TV’s much more than she should have been and Glen Smale (the CEO) was rarely seen. The whole media thing was badly managed.”

Nurse administrators had to stand back and watch the dissent of nurses related to the disorganization of the union. Many administrators spoke of their “counselling role” during and after the strike.

“As soon as nurses got it together, they felt angry and betrayed. And then we fell into the counselling role again. The nurses were angry at the union and head nurses and instructors wanted out of the contract. And they were right.”

“They had procedural type questions. They had questions about how I would feel if this or
One of the nurse administrators had forewarnings of what she believed would be long term effects of the BCNU's "behaviour".

"The fact of the matter is that the Ministry of Health is in the background constantly. Whatever behaviours are viewed at that time are going to have long term implications. Certainly the union's behaviour will."

Discussion. Roberts, Cox, and Baldwin (1985) described the fear on the part of hospital administrators as "bordering on paranoic when they were approached with any idea of broaching the subject of unionism in any form" (p. 29). They recommend that management be more proactive in changing working conditions, not for the sake of trying to get rid of the union, but for the sake of good management practices.

Post Job Action Administrators Subproblem 8.0. Did nurse administrators expect unionized nurses to reject the negotiated offer? If so, why? If not, why not?

Findings. The spirit of the "NO" vote was no surprise to most nurse administrators. However, many nurse administrators believed that saying no would be a pointless exercise since they believed that the government barrel was empty and that public opinion and other internal management support was at risk.
What seemed to elude the nurse administrators as a group was the strength of nurses' resistance to being bullied by anyone - particularly unions, employers, and government. Most nurse administrators were not surprised that nurses voted to reject the contract, although they were hopeful that the contract would be settled.

"I wasn't surprised really. Everyone was tired but the management group was disappointed and said a lot of negative comments about nurses, 'They don't know what they are doing.' 'How is this package different from the first one?'"

"I felt nurses had to vote no. Their union erred very much in not allowing them to recognize senior people so how else could they vote? I think it was what the union DIDN'T do - that will have to be sorted out."

There were administrators who agreed with the message of the NO group but were not impressed with the "NO" group's methods.

"I thought they (the NO group) had a right to say what they did (about the BCNU negotiators and leadership). I thought they portrayed themselves very poorly and some people really took the limelight and enjoyed it. If I had been a member of the NO group particularly at VGH, I would have really been mad because they weren't very professional at times. I am really referring to Stringer and McPherson. In terms of how they looked and nor did they make an attempt to look physically professional. I felt that they didn't recognize other members of their group's contribution and that they were taking the credit and nominating themselves as spokespersons... at times I felt them very critical of their own union - which is fair - but the media is not the forum for
them very critical of their own union—which is fair—but the media is not the forum for them to do that in."

A few administrators admired the "risk-taking" qualities of the NO group, particularly Stringer and McPherson.

"They really are the risk-takers. We need more of them. Time will tell whether they did the wrong thing or not. One part of me said 'Give it up' because I was tired and the other part of me said 'Go for it! This is the time now, if you back down now, you have destroyed any groundwork for the future.' It took guts and I admire them for that."

One nurse administrator was thoughtful about the reason for the strength of the "NO" vote.

"I was surprised they voted 'NO' so strongly at this hospital. They weren't militant on the picket line, they weren't militant in relationship to dealing with job action or us. Maybe it was the only way they could show their militancy was on the dotted line privately with that vote."

Discussion. The reasons for voting to reject a contract proposal would probably elude managers in the same way that the reasons that nurses cited for striking were not congruent with what managers thought they would be (Bloom, Parlette and O'Reilly, 1980). In some cases, nurse administrators believed that they nurses were making mistakes by not accepting the contract offer. This is reminiscent of Grand (1974) who describes employeeism as the counterpart of paternalism
in which the position expressed by the employers is that they know what is best for the employees.

Post Job Action Administrators Subproblem 9.0 What gender issues were apparent to nurse administrators during job action?

**Findings.** Some nurse administrators believed that nurses who were primarily women would have to strike to be heard.

"I don’t think there is another way to make changes in nursing. It bothers me a whole lot that only because we are all women profession are we treated the way we are. Management hasn’t stuck up for nursing always."

A male nurse administrator had a similar perspective as female administrators that nurses are considered to be nurturers.

"Sometimes we try to fit that mould as women that other people see us as - the feminine nurturing, caregiver as opposed to the educated manager of care. It is difficult for nurses to live with that. I think it is that social perspective that comes in about women and nurturing and that kind of thing that is the core of the problem in nursing."

One administrator believed that "nurturing" role was in direct conflict with the nurses' goals of gaining personal entitlements through job action.

"I think the behaviours of steward to nurse, nurse to nurse and nurse to manager during this strike were stereotypical behaviours of women. People in charge of care were telling the other
what about the public..?' It became that nurturing role that interfered with the union's goal. One was dying to nurture and then the union monitor would have more power and say you can't have more staff and this would cause a conflict. They started with a common goal but it went to hell in a basket".

One male nurse administrator describes how he uses the gender issue in his favour:

"I use the feminine nurturing approach in terms of my dealing with head nurses etc. to my benefit. For those of us who trained along time ago, that was the approach that was taken. For those who have gone the educational route, that is what USED to be. The new trend and new school won't buy into that."

Nurses were believed to be less assertive during the strike because of being women.

"Nurses as women skirt around issues. The union didn't say here is the way it is. Why go around the mulberry bush to get there?"

A male nurse administrator described how he told other administrators who are non nurses about the refusal to accept the first contract:

"I said to them, 'Women are cats.' I used that kind of analogy. You can't get two women nurses to agree on the same thing."

Female nonnurse administrators were described as being perhaps more punitive than men after the strike, because of the dynamics between women.

"I find it mostly women managers of other disciplines who are just vile. I think that the way women treat other women has a play in it. The men aren't any better, but they don't seem to have that 'Damn you, you aren't ever
going to have that extra nurse because I have seen those staff in Emergency, and I KNOW, I know, I have seen it myself."

An observation from a nurse administrator who felt that staff nurses were not conscious of feminist issues particularly in British Columbia.

"This place is incestuous – there is no new blood, no new ways of thinking. The only people who are talking about feminist issues right now are the nurse directors or VPs of Nursing, if there are any talking about those issues. I do not see nursing in this province going down the drain, because the rest of the world will drag them forward."

Another point of view similar to the previous one:

"People in Vancouver particularly, and perhaps in this province is lulled into thinking it is a great privilege working here. That women somehow worked in B.C. until the last decade secondary to their husband’s income for the most part and that it (working) is sort of an afterthought. An embellishment to your house, and garden, and kids, and you chalet at Whistler to ski. It has changed drastically. It is more obvious elsewhere that there is a greater move for women to be unified in the city and the rural areas and here you don’t get that sense. They don’t see themselves as one; they look down their noses at those in the city or vice versa. People are more concerned about the Murray Pezins of the world than they are the issues. They are battered. They aren’t there yet."

Discussion. These results correspond to the results in which only 52% consider of unionized nurses considered themselves to be feminists.

A number of issues were raised which were interesting and worthwhile exploring further. First,
A number of issues were raised which were interesting and worthwhile exploring further. First, is British Columbia less conscious of feminist issues related to nursing than some other parts of the country and, if so, are there some steps which need to be further taken to bring about a metamorphosis? What role do male nurse administrators play in this issue of feminism and nursing? For that matter what role do female nurse administrators play in the issue? If nurses are (as one administrator said) "battered", then who are their advocates? The results of this question in this study and the implications cannot be ignored: nursing needs to get its act together in terms of advancing the cause of women in the profession.

Roberts (1983) claims that nursing leaders "have represented an elite and marginal group who have been promoted because of the allegiance to maintenance of the status quo" (p. 28). These leaders have been called "queen bees" (Grissum and Spengler, p.102) and "Aunt Janes" - the female version of Uncle Tom (Cleland, 1971, p. 1544). She calls on nursing leaders to stop blaming the victim, to develop leadership from the grass roots, and to continue efforts to rediscover the cultural heritage of nursing.
between nurses had?

Findings. Nurse administrators knew that dissension between nurses caused them to be less powerful at both the local level and the broader, global level. Energy was misdirected and common goals of contract nurses were not realized during job action.

There is great discomfort with the discussion of issues related to the cultural mix of nurses (and other hospital employees and physicians). More discussion and attention must be paid to the issues since it cannot only be present at times of job action, but must have an effect on quality and safety at times of normal operations.

One administrator described how long term relationships disintegrated during strike time.

"I hear and see that relationships between nurses at the unit levels have been destroyed. The staff who have been casual and who have been loyal are not longer loyal anymore. Same with the head nurse relationships. Some relationships are not there now because people perceived each other differently before the strike than how they perceived them after the strike. Whatever years it took to build those relationships, it took a very short time to dismantle them."

Administrators often pointed out the conflict between nurses to other nonnursing colleagues as well as to nursing administrators.

"I was discouraged when I heard two of the
secretaries say, 'Gee it is kind of interesting being considered a low life' I said. 'What do you mean?' They said the nurses were calling them, 'Hey you, get here and clean this or that.' I thought is that just now or are nurses treating them this way all the time? Or playing tricks on management."

"Certain wards were worse than others - areas that ran well were less problematic. They have been powerless to change some of the things that happen like in Emergency. They can be very angry at senior management and I can kind of understand it - we haven't fixed the problem yet."

One nurse administrator spoke of tension related to cultural mix.

"There were problems that I noticed during the strike that I never noticed before that related to nurses who were of a different cultural background. WASP nurses hold power over these nurses and do not work well with them. There is a lot of tension and anger between these groups and so alot of problems with patient care. Also in the strike, the Chinese nurses felt very badly that I, as an "authority figure" would be doing garbage and other similar tasks and expressed that. Some had trouble being on the picket line too."

The feeling that nurses would be more powerful with union organization and cooperation was frequently expressed.

"When they stop looking outside for advice on what to do, when they stopping fighting as women, when they have less factions within, favoritism - when they stop all this, then God help us, then we administrators may start shaking in our boots in terms of administration."

Discussion. Roberts (1983) calls warfare within the
Discussion. Roberts (1983) calls warfare within the nursing group "horizontal violence" (p.27) and points out that this is a safe way to release tension when the actual aggression is meant for the oppressor. Roberts calls on nursing leaders to promote unity and dialogue.

Post Job Action Administrators Subproblem 11.0. What impact did nurse administrators feel that the job action had on the nonnursing administration?

Findings. Nurse administrators felt that although there were two other unions on strike - the focus was on nursing and nurse administrators felt a heavy responsibility to "carry the load" in the hospital. This will always be true for any strike in which nurses, for whatever reason reduce their services. Patient care is the raison d'etre for hospitals and nurses are key to the care of patients. Other work can be carried out in some way by another person, but the provision of patient care by others is much more difficult.

Nonnursing management often comes from industries which are completely different from hospitals. These managers more often than not have little knowledge of
patient care. The strike provided these managers with a different perspective of their business and put them in touch with their product. The positive aspect of this was that nonnursing management would probably gain insight into the problems and difficulties associated with patient care and the impact of their decisions on the front line. It was also enlightening for managers to discover that nursing was indeed the cog of the wheel.

Nurse administrators often felt they carried the load during the strike, since it was a nurses' strike and it was an unwritten decree that they had to pull their load - sometimes even more than their load.

"There were some people who I have a little more respect for and some I have a little less respect for. We did a little parody afterwards and gave away placards to those who were a little lightweight in their activities."

Nonnursing managers had difficulty conceptualizing the activities required to keep the hospital in working order and the consequences of not carrying out various activities. The "whole picture" was not a problem for nurse administrators.

"You get comments that they (nonnursing managers) are only doing four hours in the kitchen and then they will be finished. 'Well I have no idea what it is like to worry about staffing or patient care.' Or, 'That's not our problem'. Well it is our problem, because we have a thousand nurses out there that want a
they were looking for. People who delivered trays didn’t have any idea what a patient looked like - their role in life was computer stuff. How could you expect them not to feel queasy when they were with patients? We weren’t very good at explaining that stuff. We assumed they would understand."

There was a feeling that nurses were seen in a different light that previous to strike time by other administrators who were non nursing.

Some nurse administrators believed that non nurse administrators would have had a glimpse into patient care and the problems that stem from trying to provide care that they would never have opportunity to experience previously.

"They saw things that nurses had to put up with. I was paired up with a person from corporate planning and because they were directly involved with patient care they would say 'Oh listen, the curtain doesn't work', or 'you can't get the wheelchair into the bathroom' - those kinds of things that I think they had begun to appreciate what nurses had to work with from day to day."

"I think there was some viewing of the strike differently from how a nurse would. Department heads would say, "I had alot more respect for nurses before; if this is the way they behave, they have gone down in my estimation. I thought nurses were polite and pleasant and courteous and they are not."

Some nurse administrators felt that there would be retribution or punishment for strike action.

"I believe when it comes budget time nursing will have a lot harder time because there are lots of notions that were solidified during the
strike from the perspective of other managers from other departments and divisions. Now there will be no compunction to say that nursing is overstaffed because they could manage on less staff during the strike. For me it has frightening implications - nurses did themselves in by agreeing to certain staffing levels and by the way they handled themselves during the strike with certain managers not realizing that those people do have part of the approval process when it comes to budget. It is a very small 'P' politics but if it happened here, it happened in other places."

Managers blamed nurses for "sitting around", but nurses were unsure of how much patient contact they were to have or their role during job action. Other administrators found it difficult to understand the position of staff nurses.

"A lot of the department heads were not angry at us personally, but were angry at the strike scenario - like WHAT is wrong with the nurses, why don't they do A, B, or C? So then you felt you should explain the nurses' position, but you really didn't understand it yourself. A lot of times we would just have to say, 'I don't know why they are doing that, I just don't understand it. I feel as angry as you do and as disappointed as you do'."

Many expressed a feeling of being sandwiched in between management and striking nurses.

"We were all tired. On the unit level were the expressions of frustration with both the management and the union at the same time. Management was angry at the union for taking so long to complete the process, and the union were angry at management because the patients were still here."

One nurse administrator with nonnursing colleagues made
some decisions which were not only unpopular with striking nurses, but with the public, physicians, and probably the government. The decision to close an Emergency Department had potentially grave consequences. An example at one hospital of how some nurses viewed their nursing administrators to be more committed to the organization than to safe patient care follows. For this administration, an unpopular decision made during the strike caused a high price to pay by administration in a hospital for a long time following.

"Some nursing staff leaked that there was going to be a reduction of essential services here. We decided to take a stand and show them (the union) that we meant business. So we closed the Emergency Department. They couldn't believe that Administration would take that step. We wouldn't be crippled by the union. That raised eyebrows - particularly physician's. People were more against administration after that than against nursing. That was the most tense part of the strike for me. And the union didn't let them do anything on their own after that. We have never heard the end of it, either."

Discussion. Rothman (1987) writes about the impact of strikes on hospitals saying that strikes seriously affect the non-striking workers left in the hospital, the physicians and the patients, but does not mention the impact on nursing administration and other management. This obviously needs further exploration.
The downside of this strike for managers was that the work carried out during job action was neither voluntary nor the type of work managers would be comfortable with and managers directed their resulting discomfort and displeasure at nurses. It may also be that this short glimpse without knowledge could give managers the misguided sense that they now have in-depth understanding of nursing work and this may have a negative influence in decisionmaking.

**Post Job Action Administrators Subproblem 12.0.** How did nurse administrators feel about physician support and understanding of unionized nurses during job action?

**Findings.** Physicians, who are essentially entrepreneurs in the health care/hospital system, have conflicting goals with those who administer the budget provided by the government for patient care. For nurse administrators, it is a losing situation. While many are at least as educated and experienced in health care as physicians, they are not valued or respected by physicians. Nurse administrators have qualities which allow them to be discounted from a physician’s point of view: they are nurses, administrators and mostly women.

Most administrators felt that physicians had little appreciation for the value of administrative work.
compared to clinical work.

"Clinical nurses and doctors have no understanding what an administrative job is and they really badly judge you by your ability to work in the area. That (clinical work) is what gives you validity to them."

"I felt a grudging respect from physicians - like: 'There - you can do it'."

Nurse administrators generally agreed that lack of physician preparation for the strike had been a problem and it was primarily their job to deal with physician issues.

"Certainly the doctors were getting a little hysterical at the end. When we had to close the beds, the physicians came out of the wood work to help. They didn't know what to do."

Occasionally, nurse administrators saw the abuse by physicians to nurses.

"We have had incidences when physicians have been reprimanded because they have been nasty to nurses during the strike."

Nurse administrators largely attributed the lack of support in some physician quarters to lack of financial income.

"There was one physician who was anti-union and anti-nurse who expressed the fact that he couldn't have his patients come in and he would not have money this month. Others would slam their charts down in frustration and say very little. There were definitely surgeons who made comments on how they were going to survive the next month because of their income being cut."

"One anesthetist got carried away and decided
"One anesthetist got carried away and decided he could swing the slate a little differently. We let him talk to the head of the union for our area and she said she would pull all the OR staff. He saw the light then. It was money that was their main concern. Surgeons, anesthetists, and obstetricians really felt it."

"Their cut in income though they found to be an injustice."

Some administrators observed that nurses as women are oppressed by medicine and particularly in British Columbia.

"In this province, nurses are more battered and put down here. The nursing body are fearful of speaking against physicians here. They are afraid of taking a feminist view."

There were fears expressed about the power of medicine over the power of nursing to gain from contract negotiation, primarily because nurses were for the most part, women.

"What I fear is the old boys regime - meaning from Bill Vanderzalm on down - it will never dawn on them to even think about nursing. They will worry about medicine, but jump on the bandwagon to make medicine happy because they always have and it will be at the expense of nursing. Nursing will stand to lose a great deal down the road."

Less frequently, nurse administrators described a supportive group of physicians.

"The physicians were quite supportive at the unit level on the whole. There were one or two physicians that emphatically told the nurses
that they were wasting their time and they really needed to get on with looking after their patients. The general feeling was 'Keep it up girls'.

Discussion. Rothman (1987) claims that the effect of strikes on physicians can be severe since they have reduced income and less beds, admissions and elective surgery available to them even to the point where physicians were taking a harder look at what could be done outside of hospital permanently on an ambulatory basis.

Nurse administrators are not excluded from the lower status provided to them because of their gender and their profession. In some cases, the fact that they are administrators may be of detriment to them vis a vis physicians since the language and culture of administration is different than and sometimes less respected by physicians than is that of the clinical culture.

Post Job Action Administrators Subproblem 13.0. What did nurse administrators feel about actions of RNABC during the strike?

Findings. The majority of nurse administrators were of the belief that the RNABC should have been active during the strike in various ways. Most nurse
missed an opportunity at at best had a role in the responsibility to assist nurse administrators and facilities in ensuring safe care.

Administrators more often focused the source of perceived conflict on the union's feelings about the RNABC; whereas it was more common in contract nurses to focus the source of conflict on the RNABC. An interesting point is that contract nurses often consider the RNABC to be the "Administrators' Organization" and yet some of the sharpest criticism of the RNABC came from the nursing administrators themselves.

One nurse administrator felt that the RNABC had not a grasp of the issues.

"The professional association hasn't got their act together with respect to the issues. So the union has grabbed ahold of it. The age old story holds: if you are not going to do your job properly, someone else will do it for you."

Most nurse administrators lamented that the RNABC had either not "done their job" or had missed an opportunity. Each one had an opinion as to what the RNABC might have done during job action.

"In a certain respect, I felt that RNABC had missed a golden opportunity to help the strife that nurses felt."

"I think they were very wrong in what they did
- sitting back. I was really disappointed. I think they could have taken a much higher profile. Essentially most of the issues that were being discuss were professional issues - they were not union jurisdiction and they should have at least called the union on that. And made it known to the members as well. When we called them there was no one available. I would have loved one of them to come out and not to say 'Ain't it awful?' But look, this is the real world. But they weren't available, they just went for cover....I will have trouble dealing with the RNABC after this."

"There was probably a zillion potential discipline issues that could have arisen. Where was that Department - they could have been out there on site? They must have been getting calls from the public. Why weren't they following that up?"

"I think it is an opportunity for the RNABC. RNABC shouldn't be making great statements during the strike. They have to now provide opportunities for staff nurses too. RNABC has to be more visible in terms of what they are doing."

"It was very irritating that they didn't come out with a stand about where they stood. They knew the strike was coming like everyone else. I think it would have been good to have said something. They chose to play a very silent role. I talked to them on the telephone during the strike, they were very sympathetic but they didn't do anything to help. A mailing would have helped to show caring and empathy."

"I understand what a difficult position the RNABC was put in. I did think they did the right thing to stay quiet. By being quiet and saying nothing it doesn't expose you to a position of any kind - not even a neutral one. However, I think once the NO vote had taken place, they may have said something encouraging to the community of people to understand where they stood in terms of patient care."

Only a few nurse administrators disagreed and felt that
Only a few nurse administrators disagreed and felt that the RNABC should not have a role during job action.

"It is very strange that administrators asked to have the professional association come to their facility during a strike. It would be like slapping nurses in the face. That is naivete."

"Maybe nurses wanted warm fuzzies from them. One could do that as individuals I suppose, but they (RNABC) would have to be very careful about what they did formally in that respect. To expect them to bring their little care packages around is ridiculous."

Unionism and professionalism were occasionally raised as reasons for the lack of activity by the RNABC.

"Professionalism and unionism is incongruent. I am sure that the RNABC chose to do nothing. That was a decision on their part. Whether or not that is right, I am not sure. My colleagues attempted to get some direction from RNABC and did not get anywhere with it."

One nurse administrator was unhappy with nurses’ criticism of the RNABC role during the strike.

"If the nurses want that professional association to function in the long term, they had better not throw it out on the basis of a 17 day strike."

Many nurses and many administrators commented on what they perceived as conflict between the RNABC and the BCNU.

"The union has a real thing against the RNABC. I don’t understand that mentality."

Discussion. There has been previous discussion
about the viewpoint of staff nurses who believe that 
the professional associations of nurses are made up of 
administrators and educators. At this time, the bias 
was not in either the staff nurse, nor the 
administrator's favour; the belief was that the 
nonaction of the RNABC was inappropriate.

Post Job Action Administrators Subproblem 14.0. What 
were the positive aspects of the strike?

Findings. Many administrators got new insight into 
some of the work normally carried out by non nursing 
union members who supported the striking nurses.

"I tell you I found out so many things during 
this strike that I would never have found out 
if I had been there for 20 years. I had the 
living experience. I tell people that this was 
the best orientation I could have ever had. 
Physically being there and going through all 
that - there was the TRUTH."

Gaining insight into the details of the operation was 
was invaluable for some administrators.

"It was a wonderful learning experience for me. 
I also know intimate details of everything that 
happens here. Which is why nurses end up as 
VP's and the head of laundry do not. You see 
the overall function of the hospital. I 
understand the consequences of casually 
flipping something into the wrong garbage and 
having it cost $100,000 more."

The realization of the importance of nursing care in 
hospital was galvanized during the strike.
"The biggest lesson that I learned out of it all was that nursing really ran the hospital and that if anybody didn't think that was true all they had to do was watch during that strike. You realized that the wheel was the patient and the cog in the wheel was the nurse and without it the patient care could not function."

Discussion. Nurse administrators did not share the wealth of positive feelings related to camaraderie and empowerment that the contract nurses experienced throughout the same strike. Nurse administrators primarily gained knowledge of a clinical world in which many have limited experience and insight. When this happened, it was appreciated by nursing staff. The message here was that nurse administrators should have a better working knowledge of the clinical area at times of regular operations.

Post Job Action Nurse Administrators Subproblem 15.0

How did nurse administrators feel about receiving compensation/privileges for their work during job action?

Findings. Nurse administrators commonly felt that was appropriate to receive some kind of compensation for the long hours and responsibility that they shouldered during job action. Most nurse administrators did not receive large compensation
"I got less money than normally, there was no overtime, no privileges, no bonus. We didn’t have those kind of perks, but our group spirit kept us going. I think it is appropriate for some kind of acknowledgment. I don’t think a party is appropriate, unless it is a party for everyone to meld back together. But I think during the time, it would have been very appropriate to walk up to us and say this is a dinner certificate for you after this is over."

A large reward for administrators was the bonding that happened between them during strike time.

"Those 50 people became more important to me some days than my husband. I saw how war worked. They gave me hugs, told jokes, cheerleaded. We have had parties since and they are just a different flavour, alot more fun."

Top executives who were "team builders" were able to get mileage from their managers.

"The CEO was incredibly lucky or else talented. You would crawl into that meeting at ten a.m. and think I can’t go on any longer. He would say, ‘Go and buy yourself a pair of running shoes; I will buy you a pair’. Well! I thought he had given me a million dollars. Oh, I thought, someone thinks I am important and worth it. Oh where shall I buy my running shoes? Or he would give us a special lunch once a week. Well you would think it was the dinner party of the year. Oh, are we having LASAGNA for lunch?!!"

"I think that nurses are not going to let go of this thing and quite frankly, I hope that they continue to press. If they get this organized in the right way, then they have more of an opportunity to effect change than I do as a single voice."

Discussion. Nurse administrators have the same
need to be recognized and valued for what they do as do contract nurses. Administrators needed to be compensated for what they did during the strike in the same way that nurses want to be compensated for the work they do. Acknowledgement and rewards are important. Those executive directors who did not acknowledge and reward their managers during and after the job action lost an opportunity. The only consideration should be is: given the context of the situation, what is appropriate recognition and how shall monetary compensation be awarded?

Most would agree that salary plus overtime would be acceptable in terms of monetary compensation. Modest gifts would also seem reasonable, such as T-shirts, running shoes. Lavish parties for management only and large compensations showed insensitivity to the issues of the strike and could only lead to further bad feelings and decreased organizational commitment after the settlement.

Summary

Both nurse administrators and nurses lost their innocence in the summer of 1989. Each saw a side of the other, never seen before. Nurse administrators saw a group of women who, although were in high conflict in
their situation, were directed and committed to make themselves heard to bring about change in their worklife. Some administrators heard the message, some did not. Some administrators will be able to bring about change, some will not. Those who cannot bring about change will not survive.

Front line nurses need understand their role in taking on more responsibility and seek assistance in developing that role from those who are experienced and knowledgeable.

The relationship between administrator and nurse may be summarized by a story told by a nurse administrator.

"The scorpion wanted to cross the stream on top of the frog. The frog said 'No, you will bite me.' The scorpion said 'why would I do that- I would drown?' The frog said, 'Fine, hop on my back.' Away they went until they got half way across the stream when the scorpion bit the frog. 'Why did you do that?' The dying frog said. 'Because I had to', said the drowning scorpion."

Conclusions

Some conclusions were drawn from this chapter. They are outlined below.

1. Most nurse administrators did not think that the system should allow nurses to strike. They believed that there should be better options available to them. Since the system did allow
nurses to strike, however, they were accepting of it.

2. Nurse administrators felt that the strike brought to the fore the essential nature of nurses' roles in the hospital.

3. Half of the nurse administrators were in agreement with unionized nurses that the strike was about professional issues more than it was about wages; the other half believed that the strike was about money, primarily.

4. The majority of nurse administrators believed that conditions for nurses had to change, but they were unable to see their role in effecting that change.

5. Most nurse administrators were concerned about unsafe patient care and poor quality of care during the strike.

6. Some nurse administrators felt the role of the RNABC should have been to monitor safety standards during the strike.

7. Nurse administrators were pleased that nonnursing duties would be removed from nurses. Nurse administrators wanted nurses to have more time to allocate to nursing activities so that there would be a higher standard of care.

8. Some nurse administrators used the strike as an
opportunity to gain credibility with their staff and to close the gap with staff by "rolling up their sleeves" in the clinical areas.

9. Most nurse administrators gained valuable insight into the details of the clinical workings of the hospital.

10. Nurse administrators often felt that nonnursing management were resentful of nursing and that this would have detrimental effects in terms of budget decisions.

11. Many nurse administrators felt that there was an unwritten decree that they, rather than their administrative colleagues had the responsibility for carrying the workload during the strike since it was a nursing strike.

12. Nurse administrators frequently reported that nurses asked them advice on job action situations when they felt in conflict with the union.

13. Nurse administrators felt more positive about their role in the strike when the Chief Executive Officer looked upon the strike as a team-building opportunity.

14. Nurse administrators were embarrassed by nursing staff taking job action who were rude and unpleasant to managers during the strike.
15. Nurse administrators cited unsafe conditions that existed because of low staffing levels, poor continuity of care, conflict over nonnursing duties, nurses' anxiety and fatigue, nurses' inability to see the "whole picture", and the belief that nurses could not "afford" to see the situation as it was in reality in case it would jeopardize their conviction to carry out job action.

16. Nurse administrators experienced stress mainly in the area of contact with union officials, crossing the picket line, in their family life, and in their concern for patient safety.
CHAPTER 8
SUMMARY, IMPLICATIONS, AND DISCUSSION

Summary

The point of this study was to examine issues which might bring nurses to job action that included striking and to examine conflicts that nurses experienced during and after job action.

Interviews were conducted with nurses before, throughout, and after job action which included striking. As well, a questionnaire was distributed to a random sample of nurses in 25 hospitals and 8 regions throughout British Columbia. The data were then analyzed according to conflicts related to specific categories: Nurses and Striking, Nurses and Unions, Nurses and their Employers, Nurses and Job Action, Nurses and other Unions, Nurses and Gender Issues, Nurses and Personal Issues. As well, data were analyzed on how nurses voted on the proposed contract offer, their region and their hospital size. Thirty nurse administrators were also interviewed after the job action to discuss their conflict.

The results which appear in Chapters Four, Five, Six and Seven were presented in quotation form as well as tabular form and were followed by a brief commentary.
by the writer.

Discussion

The conflicts uncovered in this study were multiple and multifaceted. Nurses' written and spoken words in this thesis reflect the desperation of 17,000 unionized nurses and their nursing administrators and describes their need to resolve their conflict. The residual effect of that conflict remains long afterward.

Nurses believed their message was simple and straightforward: they wished to be recognized for their value in the health care system. When the majority of nurses in the province of British Columbia tried to draw attention to their message by voting in favour of striking, they had difficulty believing that they would be compelled to draw their strike weapon. When the strength of a strike vote was not enough to be heard, nurses were forced to actually use the dreaded strike weapon for 17 days.

Still unheard, nurses fought on after the strike, refusing to work overtime - an act that caused some hospitals to close beds. Throughout the job action, nurses alienated each other, exhausted their employers, crippled the hospitals, confused the public, frustrated the government, angered the physicians, attacked their
bargaining committee and their union leader, polarized their union, and told the trade union movement to keep out of their business. Their power was even a surprise to them.

However, after the strike, nurses were damaged and scarred. They had sacrificed their leader. They felt mistrustful of each other, used by their employers, devalued by physicians, deceived by their union, patronized by the trade union movement, unrepresented by their professional association, manipulated by the press, threatened by the government and cursed by society's attitudes. And still, their message had not been heard.

The results of this study are both troublesome and dispiriting. Nurses have relentlessly articulated their feelings and concerns via every avenue open to them. Countless studies have recommended ways to improve nurse recognition and satisfaction to little avail. Nurses have increasingly exercised their right to strike to be heard. Yet, there has not been enough action to make a difference.

What transformed this powerful battle and act of moral outrage by nurses into a feeble cry in the dark?

Many theories can be advanced in response to the question, but the issue of caring is at the core. In
nursing, Benner and Wrubel (1989) describe both the primacy of care and the provision of service as both an implicit and explicit assumption. All nursing is caring. And caring, in today's society, is not a fundamental tenet. Providing care in a society in which it is not valued is demoralizing. The reasons for this "undervaluing" of caring are deeply rooted in society and are worth examination. The value system of nursing differs from that of society. Benner (1989) describes nursing and other caring practices as paradoxical and less culturally appealing in this hyperindustrial, high-technology society. Society has reached the point in which people are conditioned to the technical, theoretical approach. The view exists that those, such as nurses, who care are "soft" and thus, less cerebral and therefore, less worthwhile.

As well, the current North American "cult of the body" emphasizes independence and individualism. This trend to preoccupation with health diminishes tolerance for society's need for caring and disemburdens itself with illness. The notion of dependence on caregivers, primarily women, at times of "weakness" may considered a cultural embarrassment. Diers (1986) says nursing is "metaphor for power for helping people with intimate and personal things usually done in privacy and as in
knowing the life secrets such as in life and death, mutilation, pain, agony, terror and hope”.

A societal rite of passage is described in the metaphor “cutting of the apron strings” in which children become adults by detaching themselves from their caregivers. Only when people are pained, disabled, or incapacitated do they return to caregiving. This is viewed in society as a setback, a regression, a disability, a weakness. Nurses may symbolize the perceived shame of illness.

Modern society’s tribute to value differs somewhat from that desired by nurses. It would seem that most peoples’ perceptions revolve around a consumer view in which everything can or should be bought. That includes service and caring for those who are in need. Recognition of value is measured primarily in dollars. That notion of reward may be too simplistic for nurses.

Nurses are not so naive as to believe that financial remuneration is not important. Nurses do believe however, that the practice of caring is fundamental in the context of all else in the world, and yet so complex and diverse that it cannot be reduced to mere dollars. That is what this strike was about. And nurses’ disbelief and rage was directed at a society that had become blind and numb to those
Implications for Further Research

There is no doubt that from this study, that an enormous amount has been learned the sources of conflict in a nurses' strike. As a byproduct of that knowledge, much has been learned about how to reduce the amount of conflict before, during and after a nursing strike, or for that matter, any strike.

From the literature review, it is obvious that a paltry amount of research has been done in any area related to nurses and striking. This study clearly shows the need for research in the area and the research could literally take any direction. There are however, some specific areas which naturally evolve from this particular study that would be of interest. It would be interesting to explore the effect of conflict resolution sessions that would include management and employees before, during and after job action. More exploration is needed to determine if there is a relationship between nurses' job satisfaction and a vote to strike. Do nurses experience less conflict in their second, third or fourth strikes? If so, in what areas?
Or are nurses less likely to vote to strike if they have previously experienced a strike?

There are multiple issues which need researching with respect to nurses' strikes. We live in changing times, and if we are armed with more information, we are less likely to repeat the degree of conflict nurses experienced in this strike.

Conclusions and Future Direction

This study has revealed that it is in best interest of all stakeholders in the health care system: governments, employers, physicians, nursing unions and professional associations and nurses themselves to find concrete ways to recognize, value and respect the work that nurses do: the preventative work needed to avoid strikes.

The Government

Overall, governments must find the will to make resolution of nursing problems a priority. Governments need to ask themselves the question: can they afford NOT to pay for nursing? Hospitals exist to provide care for the sick. More than any other single intervention, nursing care is an essential element of patient care in hospitals. A health care system cannot
survive without its greatest human resource - nurses.

Since hospitals cost too much, the focus is most often on nursing to justify why it uses the largest chunk of noncapital costs. When governments seek information on those costs, they turn to nonnurses who seek to categorize, standardize and neatly decontextualize "softer" nursing into brute data. Nurses who are directly affected by the decisions are onlookers rather than participants. Governments must seek nursing input to sort the issues out to find the answers. No one else but nursing can revolutionize hospital facilities; nobody else is there all the time.

Hospital Labour Relations Association (HLRA)

The HLRA represents philosophy of the government and the face of the nurses' employer at the bargaining table. Care must be taken to ensure that messages before and during the strike are not inflammatory and confrontive. As revealed in this study, these messages may set the tone for a strike as well as to influence strike votes and negotiations.

Hospitals and their Communities

In this study, nurses were very conscious of hospitals in the context of the communities in which they worked. Nurses were also keenly aware and disappointed that hospitals have become budget driven
systems rather than a service to provide caring to their communities. Not only is the service removed, so are the two most important sources of nurse satisfaction: the human connection and a sense of accomplishment through being enabled to practice. If hospitals expect community support and support of their nurse employees, they need to make a concerted effort to return to the caring service to the community.

Employers

Hospital administrators need to operationalize their written management philosophy and values. In most organizations, these values are little more than written words and they change with the latest trends in health care. They act as a crowd pleaser for the board, a must for accreditation.

If, during nonstrike times, the administration followed the caring and valuing practices preached and promised in management value statements the quality of employee relationships, working conditions, patient care and responsible stewardship of funds would take care of themselves.

It is also important to operationalize and to integrate the management values into the administrative strike plan. In this study, only a minority of hospitals and their administrators showed nurses during
job action that they understood the issues and supported them to carry out. Job action by nurses should be seen by administrators as a failing of the system, and not as a personal affront to the players. It is a signal of things gone badly, a reminder that there is work still to be done. It should also be seen by administration as an opportunity for leadership and teambuilding.

Nurses in this study did not believe that hospital administration tried to address some of the issues and act on them to bring about changes which would reduce the concerns of nurses. Employers need to work to ensure that adequate funds exist for nurses to carry out their work effectively. Nurses are tired of "making do" or "coping". They want action; nurses need to be involved in the changes and to see concrete results. They want communication with respect to changes, as well.

Few hospitals recognized the enormous conflict surrounding this action that existed between nurses and other employees, between nurses and their administration, and between the administrators themselves, not to mention the community. Most hospitals looked at the strike as a series of tasks rather than as a process. Few spent the time, energy
and resources to prepare and debrief their groups and to reconcile the differences. This conflict resolution needs to happen before striking, during a strike and debriefing after the strike.

During the strike, it was apparent that physicians controlled nurses' workload by controlling admission, transfer, and discharge of patients in hospitals. Administrators need to give more authority to nurses in this area so they can control their workload and improve the quality of care.

Employers must discontinue the practice of placing nurses in subordinate positions to physicians and others when there is need for decisionmaking related to nursing.

During the strike the study participants identified that nonnursing hospital managers were not familiar with the product: the patient, nor with their business: hospital care. Those managers need more indepth orientation to the product and to the business. Corporate planners, financiers and human resource managers have little or no idea what impact their decisions will have on nurses. Nurses in this study also made it clear that they were not involved in decisionmaking with respect to resource allocation and other policies which have impact on nursing practice.
This needs to change.

Much of the focus of hospital administration today is on budget and it is at the expense of people who give and receive the care. Hospitals will be always be trouble spots until administrators understand that their business is one of service to the patient and their primary role must be to administer to the problems and concerns of the people who provide direct service to the patient.

Management in hospitals is largely invisible and unknown to nurses. Communication is at best, third hand and often loses powerful meaning by removal from the source. Translation can be worthless when provided by others who may not understand the issues. Management should be visible and be familiar with and knowledgeable of the functions and problems in the clinical areas: there should be no reason for "surprises" or enlightenment during job action time.

Hospital organizations need to include nurses at the senior executive level to furnish patient care knowledge and to be key in the decisionmaking process.

A shared governance system should be enacted which should decentralize the power structure so that nurses who provide the care have organizational knowledge and decisionmaking power.
A dramatic finding of this study was the profound energy and delight experienced by the majority of nurses who discovered "networking" on a picket line! Many experienced this for the first time within their working life. Networking and meeting at work is considered commonplace to other disciplines and administrative levels in health care; for staff nurses, networking is rare. There are few opportunities for nurses to escape their clinical responsibilities to meet with other nurses to discuss common issues and concerns. The implications of this for nurses is serious: it prevents nurses from becoming more informed and from obtaining a bigger picture. The lack of networking keeps nurses from making needed changes themselves and from becoming more powerful. Employers must make funds available for staff nurses to be replaced on a regular basis to meet to build their vision, to achieve their goals, and to resolve their problems during working hours. problems during work time.

Nurse Administrators

In this study, nurses did not see their nursing administrators in a positive light. Nurses believed that nurse administrators primarily see their role in terms of meeting the needs of the organization, rather
than advocating for their nursing staff.

While the majority of nurse administrators in this study seemed to be aware of the issues, they seemed to feel distant from and helpless to resolve those issues. Some expressed anger and disdain for nurses who could not seem to solve the problems of nursing themselves. It was apparent that there were nurse administrators who did not have caring and respect for nurses and this seemed to cause a lack of desire or commitment to understand or to deal effectively with the issues.

Staff nurses did not understand the role or responsibilities of administration in their hospitals and how that related to their work. Nor did nonnurse managers understand the complexities of nurses' clinical work. A primary responsibility for nurse administrators then, is to interpret the particular nursing complexities and their implications to other administrators. Conversely, they need to ensure that directives from the Executive and Board are received by and translated to nursing staff in language that staff will understand.

Many nurse administrators were unclear about the relationship of their role in the facilitation of needed changes for nurses in their jurisdiction. For the single nurse administrator in this study whom all
of her staff nurses believed to be caring and supportive, there are some lessons to be learned. Nurse administrators need to create a caring environment; one in which "fosters creativity, professional judgement and nourishes high morale" (The Role of the Nurse Administrator, Canadian Nurses' Association, 1988). Developing the staff nurse and while distributing the power base to the staff may mean that as that nurse administrator put it, nurse administrators "would do themselves out of a job". But it seems the only way to go.

Nurse administrators need to model skilled nursing leadership. They need to promote change, to prepare, develop, and support their staff in such changes as health care practices, new management styles and in the nursing profession and they need to be visible, at hand.

Nurse administrators must have adequate experience and clinical preparation in an academic, administrative and clinical capacity. If nurse administrators are to be advocates for nurses they need to be as competent at the executive table as they are in understanding and speaking about clinical issues and vice versa.

Physicians

Much of the physician-nurse conflict of the strike,
happened because physicians lost income since their hospital practice was limited to emergency care and surgery of patients. Normally, physicians gain their hospital income through admission and care of patients in hospital beds, ambulatory clinics, and when they perform surgery, or deliver babies. The greater the use of these resources, the greater the financial reward for physicians. Simultaneously, the greater the use of these resources, the heavier the workload and the higher the stress on hospital nurses, resources and quality patient care. Similar to that of nonstrike times, strike conflict surrounded hospital utilization because it involved basic incompatibility of these goals.

If there is to be less conflict between nurses and physicians with respect to utilization, program input must come from nurses rather than primarily with physicians. When hospital systems are used by physicians, rules should be developed with input by all members of the health care team. These rules should not be "policed" by nurses as they are now. This sets up an adversarial relationship when the relationship should be a collegial one. Similarly, at strike time physicians should set up a system to effectively monitor their own emergency admissions, surgeries and
discharges.

Physicians have been notoriously naive, unrealistic and in some cases, obstructive about labor relations, particularly job action in hospitals. In terms of strikes, it is physicians' responsibility to gain knowledge through active participation in strike planning and to develop some "etiquette" related to job action.

The real problem of physician-nurse conflict, however, is a deeper one than that of money and utilization and does not have simple solutions. Changes within medicine have not matched other disciplines in the health care system in which changes have become constant in order to meet the demands of limited resources and a consumer-oriented society. Physicians are still socialized in an outworn, traditional structure. The relationship of physicians to government, to organizations, to nurses and other disciplines, as well as to the public needs to be redefined.

**Employers and Physicians**

It was not uncommon for nurses during job action to be recipients of intimidation as well as verbal and physical abuse directed at them by some members of administration and some physicians. The fact that
nurses were angry, yet complained so quietly and privately, is a puzzlement and is surely significant in itself. How far reaching is this abusive behaviour normally? Nurses certainly indicated that they were not shocked by this behaviour. Do nurses accept abuse from these people because of the power structure within these organizations? Is this different from other organizational behaviour?

The attitude and behaviour of many employers and physicians to nurses, who are primarily women, in hospitals is obsolete. Nurses are not employees of physicians and they are not hospital housekeepers. As demonstrated in this study, nurses are professionals who are committed, even throughout job action, to their employing organization. They expect to have professional, collegial relationships with both physicians and administrators.

The private sector has, for some time, addressed societal change of direction with respect to men and women working together in collegial relationships. Hospitals are overdue in this respect. Hospitals need to attend to this cultural lag by changing the structures within the organization and by educating those who are formally or informally part of the organization.
There should be no tolerance for breaches in this societal etiquette. Verbal and physical abuse should be treated as it would in the "real" world - with legal recourse and by withdrawal of privileges, and not by blindness and silence.

The Nursing Union (BCNU)

The message to the BCNU from their members in this study is clear: they do not want their union to carry out a strike in the way they did in 1989. They wanted a change in leadership and a change in union organization. They want to be listened to and to be better informed. But less than half want to be more active in the process.

Nurses wanted accountable leadership. However, this study revealed nurses did not understand the relationship and the role of the paid union executive infrastructure and the elected leadership. The membership had not paid enough attention to who is responsible for the overall direction and plan of their union, who executes the plan and strategies and how that impacts the working and striking nurse. The union needs to educate its members in this area and nurses need to take responsibility for becoming informed. Union members cannot hold union leaders accountable until they are certain who is accountable for what.
Nurses have been adamant that they want strong leadership, that they want to be represented by a leader who looks healthy and who is professional and businesslike. In this study, nurses were surprised and disappointed in their leader's image, and perceived lack of experience, knowledge, poorly developed positions and lack of media sophistication.

Union members, therefore, must be cognizant of whom they are electing to these positions of leadership. Members must know who will speak for them and if their leader's voice, and presentation will be compatible with their own beliefs and desired image. They need to know if their potential leader's philosophy is congruent with theirs in the realm of politics, in relation to unionism, professionalism, collective bargaining, striking, employers, other unions and other disciplines.

Members must review the background of the leader, both educational, philosophically and experientially. As demonstrated in this study, these leaders are powerful and do have the potential to have enormous impact on nurses' lives - working and personal.

Further, it cannot be expected that nurses who are elected as leader will have the required experience or educational background to manoeuvre within the
political scene, to articulate positions, to continuously strategize and to anticipate the implications and consequences of their actions. However, the chief executive officer of a union must have those abilities and must play a key role in providing assistance to an elected union President. This manager should be expected to assist in the development of the elected leader and to complement the elected leader in the presidential position as well as to provide leadership and guidance to the elected board.

The union president described her initiation into office as one of immersion; of trial by fire. There has not been sufficient orientation time for the elected president to familiarize herself with the issues, positions, and mechanics of the position as well as to ease into the public life of a president. A meaningful orientation program is essential for all elected council members, and in particular, the President.

During the strike of 1989, members believed that their President was out of touch with the union membership. Council wanted the President involved in the bargaining, but not as a voting member. The members wanted the President available for daily press
conferences; they wanted the President involved in organization of the strike as well. It is easy to see why the President felt torn in her priorities and exhausted by the strike.

The President cannot be everything to all people. While he or she needs to maintain a high profile with and have access to membership, the President primarily needs information about membership concerns, about bargaining issues, about organization of job action.

The importance of obtaining information on union membership and their issues is central and cannot be emphasized enough. Unions must be less insular and more open to research. The contract negotiations and the job action failed largely because the membership quite rightly believed that the union was not "in touch" with them. Members believed that the union had not heard the issues for which nurses were prepared to strike, the concerns that nurses had nor was the union conscious of the degree of their members' commitment and conviction on various issues. When the union did conduct a poll before the vote on the contract offer, they hired nonnurses to carry out the study. Union members were indignant since they believed that nonnurse researchers were ignorant of their concerns and language and would thus obtain faulty information.
Nursing unions with their membership, must address the differences between nursing unions and industrial unions. They must and educate their own members as well as members of other unions as to the key differences particularly when there is job action involved. Some unions are closer to nursing philosophically because their members are health care professionals (such as the HSA) rather than nonprofessionals (such as those in HEU), or because their members are in other professions (such as the teachers' union, the BCTF). Care must be taken to address these differences in planning job action and bargaining power.

Nurses desire professionalized unions. Professional unions are more cosmopolitan in their thinking, demonstrate more openness to outside groups in terms of communication and networking. A professionalized union has a management system which uses modern organizational concepts, and a value system which includes education of members and research.

During job action, nurses experienced conflicts with other unions when there were differing philosophical viewpoints about professional responsibility to the patient. Nurses and their unions must not allow themselves to be dictated to by trade
unions whose members are not knowledgeable on nursing issues.

A main objective of the union is to be an advocate in the worklife of nurses. To do so, there are issues in relation to job action itself which must be addressed. A union that is not prepared, that does not have a well developed communication system and that has not educated its membership, yet takes its members out on strike, is morally suspect. The pain and suffering experienced by the majority of nurses during the strike has not been forgotten nor forgiven by nurses and should not be considered insignificant and "water under the bridge" by the BCNU. Structural changes in the BCNU are only part of the solution.

The BCNU must organize their job action differently. They must alert their members to potential job action scenarios and prepare their nurses with plans of action for various situations. The union must use language that their members who are not familiar with union activity will understand.

A common complaint made by and about stewards and other local strike organizers was that they were not prepared and often lacked "people skills". That means that stewards must be educated for the work they do both in nonstrike times as well as for times of job
action. There should be workshops and learning packages developed which include a variety of scenarios for problem solving and facilitative approaches.

At the central level as well as at the local level, strike plans must be detailed and explicit for those executing them. There must be guidelines for picketing so nurses feel more comfortable with their picketing "etiquette".

There is no advocacy in a union that demands on one hand that management provide fair and decent working hours for nurses and yet demands that their membership picket for long hours and work either before or afterward. Picketing and working shifts must be scheduled fairly and humanely.

The union needs to revisit its beliefs and actions related to its feminist ideals. It is clear from this study that while nurses were not comfortable with the word "feminism" or "feminists", they were very much aware of the issues related to women and nursing. There are some interesting implications for this. Selling an idea of getting support for an issue may be difficult if there were connections with the word or the more traditional representation of the ideals of feminism.

A union cannot purport to understand and act as an advocate for women's problems in the workplace if their
actions do not reflect this. During the strike, for example, there was no day care set up. Many women with children were expected to put in long hours picketing and working on the same day yet they could not afford daycare because of salary loss. There was no insurance for safety of women on the picket line who were being threatened by physical and verbal abuse. Women found it difficult to be trusting and supportive of each other when, as a result of poor organization by their union, there was no equality and fairness with relation to income, picketing and to shift distribution in essential services. A system should be developed so that those who work as essential services would be required to share their income with others who will not have opportunity to work.

The union must face the issues of conflict and address them openly. Many nurses have considerable discomfort with unionism and job action. BCNU must not ignore this; they must prepare their membership for the conflict and debrief their own membership throughout and after job action. They must not simply evaluate the outcome by looking at tasks.

Facility size and regional differences must be addressed. It is clear that the regions and facilities of the province are not similar in their needs and
concerns. A number of options are available to the union: some would suggest the structuring of union locals would be useful.

Nurses overwhelmingly emphasized their desire to have professional negotiators bargaining for them. HLRA negotiators themselves were "embarrassed" for nurses at the bargaining table and the BCNU President herself said that "there was an apparent willingness of the government to address the problem, but they didn't take it as far as they needed to go". The time has passed for nurses to do their bargaining alone. In this age of specialists, a professional negotiator is required at the bargaining table. This means that BCNU should hire labour lawyers to conduct their bargaining for them. Obviously, nurses who have some expertise in bargaining and who are familiar with the issues should be present to assist in clarification and in interpretation. If this does not happen, once again the membership will review their contract proposal, see the same mistakes, and the chance for rejection of the contract is high.

Many members, in this study, felt the union direction in contract negotiations was controlled by other unions in the trade union movement. Most nurses were unhappy their union being closely aligned with
trade unions that had little in common with nursing when it came to their values and the work itself. Nursing unions must keep this clearly in their vision when deciding the degree of association they will take with other unions or this will surely cause dissension within the membership.

Finally, a solid communication foundation must be in place. It is too late to organize a strategic plan or even a crisis management plan just before or in the middle of a job action. The nurses in this study have testified that the key to a successful job action is in communication.

The Professional Association

Is there a role for the professional association when it comes to job action? Most nurses believe that there is; it is the degree of involvement that is less clear. And silence is unacceptable. All nurses in this study wanted to hear that the RNABC supported collective bargaining and that they were sympathetic to the concerns and conflicts that nurses experienced during job action. During job action, as on a day to day basis, nurses required assistance with decisionmaking on patient care issues. Generally, these issues can be categorized and planned for before job action occurs (nonnursing duties and the like). An
advisory call-in system should be set up during times of job action.

Up to now, the professional association has looked after the interest of the public by licensing nurses and developing standards of practice and employing an educative role to promote those standards. The RNABC has never sought a regulatory role to ensure that standards of nursing practice are met in facilities. This role should be explored not only for times of job action, but for times of normal operations.

**BCNU AND RNABC**

The union and the professional association may have cleanly severed themselves both politically and organizationally in 1975. Nurses however, have been unable to divide themselves in the same quick and clean manner. Throughout job action, nurses who are members of both organizations struggled and walked a fine line in their attempt to meet the goals of patient care, the goals of their union and the goals of their professional association, at the same time compromising the goals of their employer. Nurses experienced great stress and conflict trying to gain personal rights while meeting their professional requirements. Yet this conflict was not acknowledged or appreciated by the professional association, nor the union.
Both administrators and unionized nurses who took part in this study spoke loudly and clearly: the professional association and the union should work together to improve the lot of nurses. Much criticism was directed at both for being unable to find common ground and solutions for nurses.

Pat Cutshall, Executive Director of the RNABC, feels there are basic philosophical differences between members who are attracted to one cohort group or the other. Nevertheless, both groups represent nurses and thus are stakeholders in nursing. How are nurses to reconcile their professional self with their union self if their leadership in both organizations are unable to do so?

There are some important aspects which can be considered to be common ground for both. But the will must first exist between both to enable this to happen. And the membership should hold the leadership of both accountable for this to happen.

Nurses need concrete evidence that the RNABC and the BCNU are concerned for their wellbeing during these times of crisis in nursing as well as in times of extreme conflict and stress during job action.

Both organizations have a long way to go with respect to nursing image, although there does not seem
to be much evidence that either believes this to be so. In this study, it was apparent that nurses were highly concerned about public opinion and about their role and image in the health care system. Clearly, whatever the RNABC and the BCNU are doing with respect to image, it is not appropriate or it is not enough, or both. There needs to be some expert advice in this area and an overall detailed plan to implement.

Both the union and the professional association should consider the impact of building nursing image and heightening public opinion by helping the public become knowledgeable and informed stakeholders in the health care system. This would empower both nursing and the public and would have enormous benefits by bringing the public on side as a common stakeholder in the system. Stepping up the public relations around strike time has the singular appearance of self-interest and a monetary focus.

Similarly, nurses have difficulty meeting standards of care in their agencies during normal times and not just when there is job action. Budgets are paltry for staff development, education and the human and equipment resources are frequently insufficient to meet basic standards. Complementary strategies need to be developed and implemented together by both
organizations to assist nurses to meet these standards.

Nurses

The majority of nurses were not involved in the activities of the professional association or the union. The key to nurses' achieving their goals is to become informed and involved.

Nurses must also reject the negative connotations associated with the "feminist stereotype" and accept some of the basic tenets of feminism such as networking and equality. It is not shameful or degrading to demand that society value caregiving to other human beings. Fighting for rights and entitlements as well as recognition and acknowledgement is not morally wrong.

What is shameful, is that nurses and their representatives are not able to articulate the solutions to help overcome their concerns and problems. What is dishonorable, is for nurses to trust that others will bring about needed changes in nursing and that it is acceptable for nurses to contribute little more than lip service.

There was a best and worst part of this strike. The dispiriting part was that nursing would not be given societal recognition for the life-and-death
responsibilities of caregiving since society does not consider caring legitimate. But there was a powerful outcome of this strike that cannot be escaped nor discounted. Something that nurses themselves can celebrate: nurses still believe in the primacy of caring. And not only will nurses participate in the worthy "language of commitment, meanings, skills, concerns and aspirations" (Benner, 1989) associated with it, they will fight for it.
### TABLE 1

**FREQUENCIES OF NURSES' OPINIONS ON STRIKING**

**BY PERCENTAGE OF TOTAL RESPONDENTS**

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>AGREE</th>
<th>UNDECIDED</th>
<th>DISAGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses should have right to strike</td>
<td>93.2%</td>
<td>2.8%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Strike mainly about wages</td>
<td>39.0%</td>
<td>1.5%</td>
<td>59.5%</td>
</tr>
<tr>
<td>Send a message to public/government: strike was about value</td>
<td>86.9%</td>
<td>1.2%</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

n = 517
### TABLE 2

**STRIKE VOTE**  
**MAY 17, 1989**

<table>
<thead>
<tr>
<th></th>
<th>VOTE TO STRIKE MAY 17, 1989</th>
<th>PREVIOUSLY BEEN ON STRIKE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Actual Union Vote</td>
<td>94.0%</td>
<td></td>
</tr>
<tr>
<td>Respondent's Vote</td>
<td>85.0%</td>
<td>11.3%</td>
</tr>
</tbody>
</table>

### TABLE 3

**FAMILY EXPERIENCE WITH STRIKING AND FAMILY INFLUENCE ON STRIKE VOTE**

<table>
<thead>
<tr>
<th></th>
<th>Parent, child, siblings</th>
<th>Live in partner/spouse</th>
<th>No one belongs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate Family on strike before</td>
<td>21.5%</td>
<td>68.5%</td>
<td></td>
</tr>
<tr>
<td>Family Influence Vote</td>
<td>Yes 8.3%</td>
<td>No 90.6%</td>
<td>N/A 1.2%</td>
</tr>
</tbody>
</table>
TABLE 4

NURSES OPINIONS ON STRIKING AND ON PROFESSIONAL ISSUES
BY MEANS

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>x</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Nurses should have right to strike.</td>
<td>4.674</td>
<td>.782</td>
</tr>
<tr>
<td>2. Strike vote was to send message about value of nurses.</td>
<td>4.775</td>
<td>.707</td>
</tr>
<tr>
<td>3. Strike was mainly about wages.</td>
<td>2.606</td>
<td>1.344</td>
</tr>
<tr>
<td>4. Worry about public opinion on nurses</td>
<td>3.800</td>
<td>1.896</td>
</tr>
<tr>
<td>5. Nurses should concentrate on more important matters than image.</td>
<td>2.550</td>
<td>1.259</td>
</tr>
<tr>
<td>6. Public was supportive of nurses during strike.</td>
<td>4.310</td>
<td>.787</td>
</tr>
<tr>
<td>7. Strike has tarnished the professional image of the nurse.</td>
<td>2.335</td>
<td>1.330</td>
</tr>
<tr>
<td>8. Nurses dressed, acted unprofessionally on picket line.</td>
<td>2.904</td>
<td>1.420</td>
</tr>
</tbody>
</table>

n = 520

* All ratings are based on a Likert Scale which runs from 1 = disagree strongly to 5 = Agree Strongly. x = Mean Score; S.D. = Standard Deviation
<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>AGREE</th>
<th>UNDECIDED</th>
<th>DISAGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worry about Public Opinion</td>
<td>74.7%</td>
<td>5.0%</td>
<td>19.3%</td>
</tr>
<tr>
<td>More input matters than Nursing Image</td>
<td>32.0%</td>
<td>8.1%</td>
<td>60.0%</td>
</tr>
<tr>
<td>Public was supportive</td>
<td>92.9%</td>
<td>1.7%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Strike tarnished professional image</td>
<td>27.5%</td>
<td>8.5%</td>
<td>64.0%</td>
</tr>
<tr>
<td>Nurses unprofessional on picket line</td>
<td>43.9%</td>
<td>11.0%</td>
<td>45.1%</td>
</tr>
</tbody>
</table>

n = 517
TABLE 6

FREQUENCY OF NURSES' OPINIONS
OF THE PROFESSIONAL ASSOCIATION AND THE UNION
BY PERCENTAGE OF RESPONDENTS

BEFORE STRIKE

<table>
<thead>
<tr>
<th>Involvement in BCNU</th>
<th>Involvement in RNABC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>19.0%</td>
<td>18.7%</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>80.6%</td>
<td>81.0%</td>
</tr>
<tr>
<td>No response</td>
<td>No response</td>
</tr>
<tr>
<td>0.4%</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

DESIRE INVOLVEMENT AFTER STRIKE

<table>
<thead>
<tr>
<th>Be more active</th>
<th>Yes</th>
<th>40.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No response</td>
<td>60.0%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes</th>
<th>20.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No response</td>
<td>79.8%</td>
</tr>
</tbody>
</table>

Neither

RNABC or BCNU - 49.9%

n = 517
<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>AGREE</th>
<th>UNDECIDED</th>
<th>DISAGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. RNABC should demonstrate more active support for nurses during strike.</td>
<td>84.4%</td>
<td>9.5%</td>
<td>6.2%</td>
</tr>
<tr>
<td>2. BCNU and RNABC should work more closely together.</td>
<td>89.4%</td>
<td>7.1%</td>
<td>3.4%</td>
</tr>
</tbody>
</table>

**n = 517**
TABLE 8

NURSES' OPINIONS OF PROFESSIONAL ASSOCIATION (RNABC) AND UNION (BCNU) DURING JOB ACTION BY MEANS

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>x</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. RNABC should have demonstrated more support for nursing during strike action.</td>
<td>4.409</td>
<td>.977</td>
</tr>
<tr>
<td>2. BCNU and RNABC should work more closely together.</td>
<td>4.499</td>
<td>.854</td>
</tr>
</tbody>
</table>

n = 521

* All ratings are based on a Likert Scale which runs from 1 = Strongly Agree to 5 = Strongly Disagree. x = Mean Score; S.D. = Standard Deviation.
<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>DISAGREE</th>
<th>UNDECIDED</th>
<th>AGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consider self to be trade unionist.</td>
<td>48.3%</td>
<td>15.6%</td>
<td>36.1%</td>
</tr>
<tr>
<td>2. Familiar with BCNU decision-making.</td>
<td>51.4%</td>
<td>13.8%</td>
<td>34.8%</td>
</tr>
<tr>
<td>3. Pleased with BCNU leadership in strike.</td>
<td>70.1%</td>
<td>7.3%</td>
<td>22.6%</td>
</tr>
<tr>
<td>4. Well informed by BCNU during strike.</td>
<td>72.1%</td>
<td>4.2%</td>
<td>23.7%</td>
</tr>
<tr>
<td>5. BCNU represented nurses' position well to public.</td>
<td>68.7%</td>
<td>6.0%</td>
<td>25.3%</td>
</tr>
<tr>
<td>6. BCNU did not enlighten public on role of nurse.</td>
<td>23.6%</td>
<td>5.6%</td>
<td>70.8%</td>
</tr>
<tr>
<td>7. Non-nursing trade unions have no business commenting on nurses' contract.</td>
<td>13.7%</td>
<td>6.9%</td>
<td>79.4%</td>
</tr>
<tr>
<td>8. Other unions better prepared and informed than BCNU.</td>
<td>14.3%</td>
<td>17.6%</td>
<td>68.1%</td>
</tr>
<tr>
<td>9. Criticism of BCNU was justified.</td>
<td>19.0%</td>
<td>15.3%</td>
<td>65.8%</td>
</tr>
<tr>
<td>10. BCNU did not respect trust of nurses.</td>
<td>25.0%</td>
<td>12.8%</td>
<td>62.3%</td>
</tr>
<tr>
<td>11. Satisfied with BCNU stewards during job action.</td>
<td>26.3%</td>
<td>4.3%</td>
<td>69.5%</td>
</tr>
</tbody>
</table>

n = 517
TABLE 10

NURSES' OPINION OF THEIR UNION (BCNU) DURING JOB ACTION

BY MEANS

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>X</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consider self to be trade unionist.</td>
<td>2.702</td>
<td>1.424</td>
</tr>
<tr>
<td>2. Pleased with BCNU leadership during job action.</td>
<td>2.178</td>
<td>1.268</td>
</tr>
<tr>
<td>3. BCNU did not enlighten public about nurses' roles.</td>
<td>3.689</td>
<td>1.212</td>
</tr>
<tr>
<td>4. BCNU represented nurses' position well to public.</td>
<td>2.261</td>
<td>1.275</td>
</tr>
<tr>
<td>5. Was well informed by union during strike.</td>
<td>2.181</td>
<td>1.348</td>
</tr>
<tr>
<td>6. Familiar with BCNU decisionmaking.</td>
<td>2.710</td>
<td>1.301</td>
</tr>
<tr>
<td>7. Criticism of BCNU was justified during strike.</td>
<td>3.680</td>
<td>1.119</td>
</tr>
<tr>
<td>8. Other unions were better informed and prepared.</td>
<td>3.842</td>
<td>1.163</td>
</tr>
<tr>
<td>9. Nonnursing trade union leaders have no business commenting on nurses' contract offers.</td>
<td>4.208</td>
<td>1.176</td>
</tr>
<tr>
<td>10. Trade unions are unattentive to women and nurses.</td>
<td>3.450</td>
<td>1.207</td>
</tr>
<tr>
<td>11. Satisfied with BCNU stewards during job action.</td>
<td>3.669</td>
<td>1.404</td>
</tr>
<tr>
<td>12. BCNU did not respect trust of nurses.</td>
<td>3.573</td>
<td>1.296</td>
</tr>
</tbody>
</table>

n = 521

* All ratings are based on a Likert Scale which runs from 1 = Strongly Disagree to 5 = Strongly Agree. x = Mean Score; S.D. means Standard Deviation.
<table>
<thead>
<tr>
<th>JOB ACTION PROBLEM</th>
<th>DISAGREE</th>
<th>UNDECIDED</th>
<th>AGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Believed there was equitable shift sharing</td>
<td>28.3%</td>
<td>4.3%</td>
<td>68.4%</td>
</tr>
<tr>
<td>2. Pushed self to limit to give safe care</td>
<td>15.9%</td>
<td>6.5%</td>
<td>77.7%</td>
</tr>
<tr>
<td>3. Adhered to job action</td>
<td>27.8%</td>
<td>4.5%</td>
<td>67.7%</td>
</tr>
<tr>
<td>4. Upset others were doing non-nursing duties during job action</td>
<td>35.0%</td>
<td>12.5%</td>
<td>52.6%</td>
</tr>
<tr>
<td>5. Easier to do non-nursing duties than to ask others</td>
<td>41.4%</td>
<td>5.6%</td>
<td>52.9%</td>
</tr>
<tr>
<td>6. Other nurses watched to see if I were breaking union rules</td>
<td>47.6%</td>
<td>10.1%</td>
<td>42.3%</td>
</tr>
</tbody>
</table>

n = 517
### TABLE 12

**NURSES' OPINIONS ON JOB ACTION**

**BY MEANS**

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>x</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pushed self to limit to provide safe care.</td>
<td>4.120</td>
<td>1.208</td>
</tr>
<tr>
<td>2. There was system of equitable shift sharing.</td>
<td>3.628</td>
<td>1.486</td>
</tr>
<tr>
<td>3. Adhered strictly to job action.</td>
<td>3.661</td>
<td>1.288</td>
</tr>
<tr>
<td>4. Upset that other nurses carried out nonnursing duties.</td>
<td>3.299</td>
<td>1.423</td>
</tr>
<tr>
<td>5. Easier to do nonnursing duties than to ask others.</td>
<td>3.078</td>
<td>1.458</td>
</tr>
<tr>
<td>6. Felt other nurses were watching to see if union rules were followed.</td>
<td>2.858</td>
<td>1.442</td>
</tr>
</tbody>
</table>

\[ n = 521 \]

*All ratings are based on a Likert Scale which runs from 1 = disagree strongly to 5 = Agree Strongly. x = Mean Score; S.D. = Standard Deviation.*
### TABLE 13
PARTICIPANTS' AND AMOUNT OF PICKETING
\( n = 520 \)

<table>
<thead>
<tr>
<th></th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Picketed as directed</td>
<td>260</td>
<td>50.0</td>
</tr>
<tr>
<td>Picketed less than 4 hours</td>
<td>21</td>
<td>4.0</td>
</tr>
<tr>
<td>Picketed more than 4 hours</td>
<td>349</td>
<td>67.1</td>
</tr>
<tr>
<td>Don't believe in picketing</td>
<td>19</td>
<td>3.7</td>
</tr>
</tbody>
</table>

### TABLE 14
PARTICIPANTS' HOURS OF WORK DURING STRIKE
\( n = 520 \)

<table>
<thead>
<tr>
<th></th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worked more hours than usual</td>
<td>48</td>
<td>9.2</td>
</tr>
<tr>
<td>Worked same hours as usual</td>
<td>101</td>
<td>19.4</td>
</tr>
<tr>
<td>Worked less hours than usual</td>
<td>285</td>
<td>54.8</td>
</tr>
<tr>
<td>Did not work any hours</td>
<td>60</td>
<td>11.5</td>
</tr>
<tr>
<td>On vacation/sick leave/other</td>
<td>18</td>
<td>3.5</td>
</tr>
<tr>
<td>No Response</td>
<td>8</td>
<td>1.5</td>
</tr>
</tbody>
</table>

### TABLE 15
PARTICIPANTS' CONSIDERED ESSENTIAL SERVICE
\( n = 520 \)

<table>
<thead>
<tr>
<th></th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential</td>
<td>368</td>
<td>70.8</td>
</tr>
<tr>
<td>Non-essential</td>
<td>147</td>
<td>28.3</td>
</tr>
<tr>
<td>No Response</td>
<td>5</td>
<td>1.0</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Respondents' Vote</th>
<th>Actual Union Vote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voted Yes to Accept</td>
<td>36.0%</td>
</tr>
<tr>
<td>Voted No to Reject</td>
<td>57.3%</td>
</tr>
<tr>
<td>Did Not Vote</td>
<td>6.2%</td>
</tr>
<tr>
<td>No Response</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

**Reasons for Voting No**

- Unfair for nurses' experience: 47.3%
- Not enough money: 42.3%
- Leadership unaware of nurses' bottom lines: 39.6%
- "No" campaign: 21.7%

**Reason for Voting Yes**

- Wanted conflict over with: 16.2%
- Lost faith in bargaining committee: 11.7%
- Wanted to vote with union: 10.8%
- Satisfied with contract: 11.5%

\[n = 521\]
TABLE 17

NURSES WHO VOTED "NO" FELT:

- the "no" campaign gave them confidence to stand up for their rights.
- bargaining committee could have done better with HLRA.
- physicians were verbally supportive but actions were not.
- nursing should be more concerned with more important matters than with nursing image.
- BCNU should have more expert negotiators.
- Strike was a difficult moral decision.

TABLE 18

NURSES WHO VOTED "YES" TO ACCEPT CONTRACT FELT:

- Uncomfortable as a source of conflict.
- BCNU represented the position of nurses well to the public.
- Nurse administrators demonstrated they valued and respect nurses.
- Other unions were better prepared and informed than BCNU.
TABLE 19

CORRELATION BETWEEN NURSES JULY 12, 1989 VOTE ON CONTRACT AND OTHER VARIABLES

<table>
<thead>
<tr>
<th>VARIABLES CORRELATED TO NO VOTE</th>
<th>t</th>
<th>Significance t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Support</td>
<td>-3.443</td>
<td>.0006</td>
</tr>
<tr>
<td>BCNU did not enlighten public</td>
<td>-2.885</td>
<td>.0041</td>
</tr>
<tr>
<td>BCNU criticism justified</td>
<td>-4.240</td>
<td>.0000</td>
</tr>
<tr>
<td>BCNU should not recommend without vote</td>
<td>-4.647</td>
<td>.0000</td>
</tr>
<tr>
<td>Bargaining Committee do better with HLRA</td>
<td>-5.093</td>
<td>.0000</td>
</tr>
<tr>
<td>BCNU needs expert negotiators</td>
<td>-3.898</td>
<td>.0001</td>
</tr>
<tr>
<td>BCNU did not respect nurses' trust</td>
<td>-5.350</td>
<td>.0000</td>
</tr>
<tr>
<td>RN Administrator committed to organization</td>
<td>-2.453</td>
<td>.0146</td>
</tr>
<tr>
<td>Management received privileges</td>
<td>-3.427</td>
<td>.0007</td>
</tr>
<tr>
<td>Physician actions unsupportive</td>
<td>-3.545</td>
<td>.0004</td>
</tr>
<tr>
<td>RNABC should show more support</td>
<td>-3.197</td>
<td>.0015</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VARIABLES CORRELATED TO YES VOTE</th>
<th>t</th>
<th>Significance t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pleased with BCNU leadership</td>
<td>3.969</td>
<td>.0001</td>
</tr>
<tr>
<td>BCNU represented position well</td>
<td>4.344</td>
<td>.0000</td>
</tr>
<tr>
<td>Well informed by BCNU</td>
<td>2.527</td>
<td>.0019</td>
</tr>
<tr>
<td>Committed to employing hospital</td>
<td>2.381</td>
<td>.0177</td>
</tr>
<tr>
<td>RN administrators valued nurses</td>
<td>2.682</td>
<td>.0076</td>
</tr>
<tr>
<td>Uncomfortable being source of conflict</td>
<td>2.478</td>
<td>.0136</td>
</tr>
</tbody>
</table>


TABLE 20

FREQUENCY OF OPINION OF NURSES ON THEIR UNION AND THEIR CONTRACT OFFER

BY PERCENTAGE OF RESPONDENTS

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>DISAGREE</th>
<th>UNCERTAIN</th>
<th>AGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. BCNU should not recommend offer without vote of membership.</td>
<td>18.1%</td>
<td>4.8%</td>
<td>77.0%</td>
</tr>
<tr>
<td>2. Bargaining Committee should have done better with HLRA.</td>
<td>17.9%</td>
<td>17.1%</td>
<td>64.9%</td>
</tr>
<tr>
<td>3. BCNU needs expert negotiators.</td>
<td>6.2%</td>
<td>5.0%</td>
<td>88.8%</td>
</tr>
<tr>
<td>4. &quot;No&quot; campaign made me confident to stand up for my rights.</td>
<td>65.1%</td>
<td>12.1%</td>
<td>22.8%</td>
</tr>
<tr>
<td>5. Dissension between nurses was negative.</td>
<td>25.9%</td>
<td>4.2%</td>
<td>69.9%</td>
</tr>
</tbody>
</table>

n = 517
### TABLE 21

**NURSES' OPINION OF THEIR UNION AND THEIR CONTRACT OFFER**

**BY MEANS**

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>X</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. BCNU should not have recommended offer without membership vote.</td>
<td>4.122</td>
<td>1.335</td>
</tr>
<tr>
<td>2. Bargaining Committee should have been able to do better with HLRA</td>
<td>3.778</td>
<td>1.219</td>
</tr>
<tr>
<td>3. BCNU needs expert negotiators on their bargaining team.</td>
<td>4.485</td>
<td>.941</td>
</tr>
<tr>
<td>4. The &quot;no&quot; campaign made me feel more confident about standing up for my rights.</td>
<td>3.685</td>
<td>1.373</td>
</tr>
<tr>
<td>5. Dissension between nurses was negative.</td>
<td>3.734</td>
<td>1.422</td>
</tr>
</tbody>
</table>

n = 520

*All ratings are based on a Likert Scale which runs from 1 = Strongly Disagree to 5 = Strongly Agree. X = Mean Score; S.D. = Standard Deviation.*
<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>DISAGREE</th>
<th>UNDECIDED</th>
<th>AGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Occupational problems of nurses related to those of women.</td>
<td>25.0%</td>
<td>5.8%</td>
<td>69.2%</td>
</tr>
<tr>
<td>2. Trade Unions unattentive to women, nurses.</td>
<td>24.5%</td>
<td>20.0%</td>
<td>55.6%</td>
</tr>
<tr>
<td>3. Consider self to be feminist.</td>
<td>34.9%</td>
<td>13.0%</td>
<td>52.1%</td>
</tr>
</tbody>
</table>

\( n = 517 \)
<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>X</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Occupational problems of nurses related to those of women generally.</td>
<td>3.613</td>
<td>1.358</td>
</tr>
<tr>
<td>2. Consider myself to be a feminist.</td>
<td>3.155</td>
<td>1.400</td>
</tr>
<tr>
<td>3. Trade unions are unattentive to women; nurses.</td>
<td>3.450</td>
<td>1.207</td>
</tr>
</tbody>
</table>

n = 321

* All ratings are based on a Likert Scale which runs from 1 = Strongly Disagree to 5 = Strongly Agree. x = Mean Score; S.D. = Standard Deviation.
**TABLE 24**

**FREQUENCY OF OPINIONS ON PHYSICIANS DURING JOB ACTION**

**BY PERCENTAGE OF RESPONDENTS**

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>DISAGREE</th>
<th>UNDECIDED</th>
<th>AGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Physicians understood respected nurses' reasons for striking.</td>
<td>33.6%</td>
<td>4.6%</td>
<td>61.8%</td>
</tr>
<tr>
<td>2. Physicians verbally supportive; actions unsupportive.</td>
<td>21.0%</td>
<td>8.9%</td>
<td>70.1%</td>
</tr>
<tr>
<td>3. Physicians affected financially were least supportive.</td>
<td>10.7%</td>
<td>22.4%</td>
<td>66.9%</td>
</tr>
</tbody>
</table>

\[ n = 517 \]
<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>X</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Physicians understood and respected nurses' reasons for striking.</td>
<td>3.222</td>
<td>1.342</td>
</tr>
<tr>
<td>2. Physicians verbally supported nurses, but actions unsupportive.</td>
<td>3.728</td>
<td>1.191</td>
</tr>
<tr>
<td>3. Physicians affected financially were least supportive.</td>
<td>4.000</td>
<td>1.155</td>
</tr>
</tbody>
</table>

\( n = 521 \)

* All ratings are based on a Likert Scale which runs from 1 = disagree strongly to 5 = Agree Strongly. \( x \) = Mean Score; S.D. = Standard Deviation.
<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>DISAGREE</th>
<th>UNDECIDED</th>
<th>AGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Administration works with nurses to improve working conditions.</td>
<td>51.7%</td>
<td>7.5%</td>
<td>40.9%</td>
</tr>
<tr>
<td>2. Administration justified in concern for patient safety.</td>
<td>47.2%</td>
<td>5.2%</td>
<td>47.6%</td>
</tr>
<tr>
<td>3. Management exploits nurses' commitment.</td>
<td>29.0</td>
<td>10.6</td>
<td>60.4</td>
</tr>
<tr>
<td>4. Nursing Administration demonstrated value and respect for nurses</td>
<td>50.4</td>
<td>7.3%</td>
<td>42.2%</td>
</tr>
<tr>
<td>during job action.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Nurse administrators were more committed to organization than to</td>
<td>28.0</td>
<td>14.3%</td>
<td>57.6%</td>
</tr>
<tr>
<td>nurses.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Unfair for Administration to receive compensation/privileges for</td>
<td>22.6</td>
<td>10.8</td>
<td>66.5</td>
</tr>
<tr>
<td>work during job action.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I am committed to hospital where I am employed.</td>
<td>27.4</td>
<td>10.2</td>
<td>62.3</td>
</tr>
</tbody>
</table>

n = 317
### Table 27

**NURSES' OPINIONS OF THEIR EMPLOYERS**

**BY MEANS**

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>x</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hospital administration works with nursing staff to improve conditions.</td>
<td>2.752</td>
<td>1.436</td>
</tr>
<tr>
<td>2. I feel committed to hospital at which I am employed.</td>
<td>3.529</td>
<td>1.358</td>
</tr>
<tr>
<td>3. Nurse administrators showed they valued and respected nurses during strike.</td>
<td>2.857</td>
<td>1.495</td>
</tr>
<tr>
<td>4. Nurse administrators were more committed to their organization than to nurses during strike.</td>
<td>3.493</td>
<td>1.385</td>
</tr>
<tr>
<td>5. Hospital administration was justified in their concerns for patient safety during strike.</td>
<td>2.919</td>
<td>1.543</td>
</tr>
<tr>
<td>6. Management exploited nurses' commitment to patient care during strike.</td>
<td>3.515</td>
<td>1.431</td>
</tr>
<tr>
<td>7. Unfair that management received compensation and privileges for strike work.</td>
<td>3.873</td>
<td>1.403</td>
</tr>
</tbody>
</table>

n = 521

*All ratings are based on a Likert Scale which runs from 1 = Disagree Strongly to 5 = Agree Strongly. x = Mean scores; S.D. = Standard Deviation.*
### TABLE 28

**FREQUENCY RATES OF NURSES' OPINIONS ON PERSONAL ISSUES**

**BY PERCENTAGE OF RESPONDENTS**

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>DISAGREE</th>
<th>UNDECIDED</th>
<th>AGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strike difficult moral decision</td>
<td>37.6%</td>
<td>2.3%</td>
<td>60.1%</td>
</tr>
<tr>
<td>Felt Powerless and lacking control</td>
<td>41.2%</td>
<td>4.4%</td>
<td>54.3%</td>
</tr>
<tr>
<td>Uncomfortable as a Source of conflict</td>
<td>34.2%</td>
<td>5.2%</td>
<td>60.6%</td>
</tr>
<tr>
<td>Meeting other nurses a positive experience</td>
<td>8.5%</td>
<td>2.7%</td>
<td>88.8%</td>
</tr>
<tr>
<td>Nurses more powerful since strike</td>
<td>17.7%</td>
<td>10.5%</td>
<td>71.8%</td>
</tr>
</tbody>
</table>

\( n = 517 \)
**TABLE 29**

**NURSES' OPINIONS ON PERSONAL ISSUES RELATED TO STRIKING**

**BY MEANS**

<table>
<thead>
<tr>
<th>PERSONAL ISSUE</th>
<th>X</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Striking was difficult moral decision</td>
<td>3.395</td>
<td>1.607</td>
</tr>
<tr>
<td>2. Felt powerless and lacking control</td>
<td>3.141</td>
<td>1.563</td>
</tr>
<tr>
<td>3. Meeting and talking with other nurses was positive</td>
<td>4.443</td>
<td>1.005</td>
</tr>
<tr>
<td>4. Felt uncomfortable as source of conflict</td>
<td>3.388</td>
<td>1.488</td>
</tr>
<tr>
<td>5. Nurses more powerful since striking</td>
<td>3.798</td>
<td>1.218</td>
</tr>
</tbody>
</table>

\[ n = 521 \]

*All rating are based on a Likert scale which runs from 1 = Strongly Disagree to 5 = Strongly Agree. x = Mean Score; S.D. = Standard Deviation.*
<table>
<thead>
<tr>
<th></th>
<th>LOW</th>
<th>MODERATE</th>
<th>HIGH</th>
<th>N/A</th>
<th>NO ANSWER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Public Service</td>
<td>30.9</td>
<td>41.7</td>
<td>22.6</td>
<td>4.1</td>
<td>.6</td>
</tr>
<tr>
<td>Heavy Workload</td>
<td>15.4</td>
<td>24.4</td>
<td>49.2</td>
<td>10.2</td>
<td>.8</td>
</tr>
<tr>
<td>Non-nursing Duties</td>
<td>24.4</td>
<td>40.9</td>
<td>32.3</td>
<td>1.8</td>
<td>.6</td>
</tr>
<tr>
<td>Picketing</td>
<td>44.7</td>
<td>27.8</td>
<td>24.8</td>
<td>2.0</td>
<td>.8</td>
</tr>
<tr>
<td>Union Organization</td>
<td>27.4</td>
<td>29.7</td>
<td>36.8</td>
<td>5.3</td>
<td>.8</td>
</tr>
<tr>
<td>Uncertain Strike Time</td>
<td>13.8</td>
<td>36.2</td>
<td>49.4</td>
<td>-</td>
<td>.6</td>
</tr>
<tr>
<td>Decreased Income</td>
<td>33.3</td>
<td>27.8</td>
<td>32.7</td>
<td>5.5</td>
<td>.8</td>
</tr>
<tr>
<td>Conflict Employer/Union</td>
<td>43.5</td>
<td>29.3</td>
<td>23.0</td>
<td>3.5</td>
<td>.6</td>
</tr>
<tr>
<td>Colleague Stress</td>
<td>15.7</td>
<td>49.2</td>
<td>33.7</td>
<td>.6</td>
<td>.8</td>
</tr>
<tr>
<td>Family Attitude</td>
<td>68.5</td>
<td>14.0</td>
<td>10.4</td>
<td>6.5</td>
<td>.6</td>
</tr>
<tr>
<td>Friend/Social Attitude</td>
<td>60.4</td>
<td>26.2</td>
<td>10.0</td>
<td>2.8</td>
<td>.6</td>
</tr>
<tr>
<td>Doctor Attitude</td>
<td>48.4</td>
<td>33.3</td>
<td>15.2</td>
<td>2.6</td>
<td>.6</td>
</tr>
<tr>
<td>Administration Attitude</td>
<td>40.4</td>
<td>31.1</td>
<td>26.2</td>
<td>1.8</td>
<td>.6</td>
</tr>
<tr>
<td>HEU/HSA Attitude</td>
<td>41.5</td>
<td>30.9</td>
<td>25.6</td>
<td>1.4</td>
<td>.6</td>
</tr>
<tr>
<td>Concern Legislation</td>
<td>33.9</td>
<td>39.4</td>
<td>26.0</td>
<td>.2</td>
<td>.6</td>
</tr>
</tbody>
</table>

n = 508
TABLE 31

FREQUENCY RATING OF
HEAD NURSES AND STRESS
BY PERCENTAGE

<table>
<thead>
<tr>
<th></th>
<th>LOW</th>
<th>MODERATE</th>
<th>HIGH</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declared Non-essential</td>
<td>21.7</td>
<td>22.5</td>
<td>49.3</td>
<td>6.5</td>
</tr>
<tr>
<td>Conflict Administration/</td>
<td>17.1</td>
<td>25.7</td>
<td>57.2</td>
<td>-</td>
</tr>
<tr>
<td>Union/Staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Union Disrespectful</td>
<td>29.9</td>
<td>19.3</td>
<td>46.7</td>
<td>4.1</td>
</tr>
<tr>
<td>Direct Patient Care</td>
<td>70.9</td>
<td>11.5</td>
<td>7.4</td>
<td>10.2</td>
</tr>
</tbody>
</table>

HEAD NURSES AND DESIRE TO BE EXCLUDED FROM CONTRACT
BY PERCENTAGE

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wanted out of contract before</td>
<td>26%</td>
<td>74%</td>
</tr>
<tr>
<td>strike</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wanted out of contract after</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>strike</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

n=124 (24.4% of total participants)
TABLE 32

AGREEMENT OF OPINIONS OF NURSES ON JOB ACTION

BY ELEVEN HIGHEST MEANS IN RANK ORDER

<table>
<thead>
<tr>
<th>SUBPROBLEM</th>
<th>MEAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The strike was a message about the value of nurses.</td>
<td>4.775</td>
</tr>
<tr>
<td>2. Nurses should have the legal right to strike.</td>
<td>4.674</td>
</tr>
<tr>
<td>3. BCNU and RNABC should work more closely together.</td>
<td>4.499</td>
</tr>
<tr>
<td>4. BCNU needs more expert negotiators to bargain.</td>
<td>4.485</td>
</tr>
<tr>
<td>5. Meeting and talking with nurses was a positive experience.</td>
<td>4.443</td>
</tr>
<tr>
<td>6. RNABC should have demonstrated more active support during strike.</td>
<td>4.409</td>
</tr>
<tr>
<td>7. Public was generally supportive of nurses during strike.</td>
<td>4.310</td>
</tr>
<tr>
<td>8. Nonnursing trade union leaders have no business commenting on nurses' contracts.</td>
<td>4.208</td>
</tr>
<tr>
<td>9. BCNU should not have recommended offer without membership vote.</td>
<td>4.122</td>
</tr>
<tr>
<td>10. Pushed self to limit to provide safe patient care.</td>
<td>4.120</td>
</tr>
<tr>
<td>11. Physicians affected financially were least supportive of nurses.</td>
<td>4.000</td>
</tr>
</tbody>
</table>

n = 521

* All ratings are based on a Likert Scale which runs from 1 = Strongly Disagree to 5 = Strongly Agree.
### TABLE 33

**AGREEMENT OF NURSES’ OPINIONS ON JOB ACTION**

**BY LOWEST MEANS MEANS IN RANK ORDER**

<table>
<thead>
<tr>
<th>Subproblem</th>
<th>Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pleased with BCNU Leadership during job action.</td>
<td>2.178</td>
</tr>
<tr>
<td>2. Well informed by union during strike.</td>
<td>2.181</td>
</tr>
<tr>
<td>3. BCNU represented nurses' position well to publice.</td>
<td>2.261</td>
</tr>
<tr>
<td>4. Strike tarnished nurses' professional image.</td>
<td>2.335</td>
</tr>
<tr>
<td>5. Nurses should forget about image and concentrate on more important matters.</td>
<td>2.550</td>
</tr>
<tr>
<td>6. Strike was mainly about wages.</td>
<td>2.606</td>
</tr>
<tr>
<td>7. Consider self to be feminist.</td>
<td>2.702</td>
</tr>
<tr>
<td>8. Familiar with BCNU decisionmaking.</td>
<td>2.710</td>
</tr>
<tr>
<td>9. Hospital administration works with nurses to improve working conditions.</td>
<td>2.752</td>
</tr>
<tr>
<td>10. Nurse administrators showed they valued and respected nurses during strike.</td>
<td>2.857</td>
</tr>
<tr>
<td>11. Nurses dressed, acted unprofessionally on picket line.</td>
<td>2.904</td>
</tr>
<tr>
<td>12. Hospital administrators were justified in their concern for patient safety.</td>
<td>2.919</td>
</tr>
</tbody>
</table>

n = 521

*All ratings are based on a Likert Scale which runs from 1 = Strongly Disagree to 5 = Strongly Agree.*
**Table 34**

**Least Difference in Opinions Between Nurses on Job Action**

**By Six Lowest Standard Deviations**

<table>
<thead>
<tr>
<th>Subproblem</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The strike was a message to the government and the public about the value of nurses.</td>
<td>.707</td>
</tr>
<tr>
<td>2. Nurses should have the legal right to strike.</td>
<td>.782</td>
</tr>
<tr>
<td>3. The public was supportive of nurses during the strike.</td>
<td>.787</td>
</tr>
<tr>
<td>4. BCNU and the RNABC should work more closely together.</td>
<td>.854</td>
</tr>
<tr>
<td>5. BCNU needs more expert negotiators.</td>
<td>.941</td>
</tr>
<tr>
<td>6. RNABC should demonstrate more active support for nurses during strike.</td>
<td>.977</td>
</tr>
</tbody>
</table>

\( n = 521 \)

*All ratings are based on a Likert Scale which runs from 1 = Strongly Disagree to 5 = Strongly Agree.*
TABLE 35

AREAS OF STRONGEST AND LEAST DIFFERENCE OF OPINION ON JOB ACTION BY NURSES

BY MEANS AND STANDARD DEVIATIONS

<table>
<thead>
<tr>
<th>SUBPROBLEM</th>
<th>x</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. BCNU and RNABC should work more closely together.</td>
<td>4.499</td>
<td>.854</td>
</tr>
<tr>
<td>2. RNABC should demonstrate more active support for nurses during strike.</td>
<td>4.409</td>
<td>.977</td>
</tr>
<tr>
<td>3. BCNU needs more expert negotiators.</td>
<td>4.485</td>
<td>.941</td>
</tr>
<tr>
<td>4. Nurses should have legal right to strike.</td>
<td>4.674</td>
<td>.782</td>
</tr>
<tr>
<td>5. Strike was a message about value of nurses.</td>
<td>4.775</td>
<td>.707</td>
</tr>
<tr>
<td>6. Public was supportive of nurses during strike.</td>
<td>4.310</td>
<td>.787</td>
</tr>
</tbody>
</table>

n = 521

* All ratings are based on a Likert Scale which runs from 1 = Strongly Disagree to 5 = Strongly Agree. x = Mean Scores; S.D. = Standard Deviation.
TABLE 36

GREATEST DIFFERENCES OF OPINIONS BY NURSES ON JOB ACTION

BY TWELVE HIGHEST STANDARD DEVIATIONS

<table>
<thead>
<tr>
<th>SUBPROBLEM</th>
<th>STANDARD DEVIATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Worried about public opinion.</td>
<td>1.896</td>
</tr>
<tr>
<td>2. Strike vote difficult moral decision.</td>
<td>1.607</td>
</tr>
<tr>
<td>3. Felt powerless, lacking control.</td>
<td>1.563</td>
</tr>
<tr>
<td>4. Administration justified in concern for patient safety.</td>
<td>1.543</td>
</tr>
<tr>
<td>5. Nurse administrators valued and respected nurses during strike.</td>
<td>1.495</td>
</tr>
<tr>
<td>6. Felt uncomfortable as source of conflict.</td>
<td>1.488</td>
</tr>
<tr>
<td>7. There was system of equitable shift sharing.</td>
<td>1.486</td>
</tr>
<tr>
<td>8. Easier to do nonnursing duties than to ask others.</td>
<td>1.458</td>
</tr>
<tr>
<td>9. Hospital administration works with staff to improve conditions.</td>
<td>1.436</td>
</tr>
<tr>
<td>10. Consider self to be trade unionist.</td>
<td>1.424</td>
</tr>
<tr>
<td>11. Dissension between nurses was negative.</td>
<td>1.422</td>
</tr>
<tr>
<td>12. Nurses dressed, acted unprofessionally on picket line.</td>
<td>1.420</td>
</tr>
<tr>
<td>13. Consider self to be feminist.</td>
<td>1.400</td>
</tr>
</tbody>
</table>

n = 521

* All ratings are based on a Likert Scale which runs from 1 = Strongly Disagree to 5 = Strongly Agree.
### Table 37

**Areas of Strongest Opinions and Greatest Disagreement Between Nurses on Job Action**

<table>
<thead>
<tr>
<th>Subproblem</th>
<th>X</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Administration justified in concern for patient safety.</td>
<td>2.919</td>
<td>1.543</td>
</tr>
<tr>
<td>2. Nurse administrators respected and valued nurses during job action.</td>
<td>2.857</td>
<td>1.495</td>
</tr>
<tr>
<td>3. Consider self to be feminist.</td>
<td>2.702</td>
<td>1.400</td>
</tr>
<tr>
<td>4. Hospital administration works with staff to improve working conditions.</td>
<td>2.752</td>
<td>1.436</td>
</tr>
<tr>
<td>5. Nurses were unprofessional on picket line.</td>
<td>2.904</td>
<td>1.420</td>
</tr>
</tbody>
</table>

n = 521
TABLE 38 (i)

DIFFERENCES BETWEEN REGIONS

One Way Analysis of Variance and Tests of Significant Differences
Multiple Range Test - Tukey/HSD Procedure : Alpha @.05

<table>
<thead>
<tr>
<th>PROBLEM: Public were supportive.</th>
<th>South Island</th>
<th>North Island</th>
<th>North-west</th>
<th>Vancouver</th>
<th>Fraser Valley</th>
<th>Kootenay</th>
<th>Okanagan</th>
<th>Central</th>
<th>F. Ratio</th>
<th>F. Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>( \bar{x} )</td>
<td>4.5217</td>
<td>4.4444</td>
<td>4.4167</td>
<td>4.1406</td>
<td>4.3778</td>
<td>4.2800</td>
<td>4.3540</td>
<td>4.1429</td>
<td>2.0941</td>
<td>.0426</td>
</tr>
<tr>
<td>S.D.</td>
<td>.6090</td>
<td>.5774</td>
<td>.5149</td>
<td>.9026</td>
<td>.6963</td>
<td>.8340</td>
<td>.7061</td>
<td>1.1127</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Vancouver differed from S. Island.

<table>
<thead>
<tr>
<th>PROBLEM: BCNU did not enlighten public about nurses' role.</th>
<th>South Island</th>
<th>North Island</th>
<th>North-west</th>
<th>Vancouver</th>
<th>Fraser Valley</th>
<th>Kootenay</th>
<th>Okanagan</th>
<th>Central</th>
<th>F. Ratio</th>
<th>F. Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>( \bar{x} )</td>
<td>3.2464</td>
<td>3.9630</td>
<td>3.6667</td>
<td>3.8288</td>
<td>3.8068</td>
<td>3.6400</td>
<td>3.6549</td>
<td>3.5714</td>
<td>2.2117</td>
<td>.0320</td>
</tr>
<tr>
<td>S.D.</td>
<td>1.4492</td>
<td>.8540</td>
<td>1.1547</td>
<td>1.0840</td>
<td>1.1730</td>
<td>1.3815</td>
<td>1.1709</td>
<td>1.1362</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Vancouver differed from S. Island.

<table>
<thead>
<tr>
<th>PROBLEM: Problems of nurses related to women's problems.</th>
<th>South Island</th>
<th>North Island</th>
<th>North-west</th>
<th>Vancouver</th>
<th>Fraser Valley</th>
<th>Kootenay</th>
<th>Okanagan</th>
<th>Central</th>
<th>F. Ratio</th>
<th>F. Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>( \bar{x} )</td>
<td>3.2464</td>
<td>4.0741</td>
<td>3.6667</td>
<td>3.8125</td>
<td>3.5333</td>
<td>3.6000</td>
<td>3.7788</td>
<td>2.7857</td>
<td>3.4297</td>
<td>.0014</td>
</tr>
<tr>
<td>S.D.</td>
<td>1.4184</td>
<td>.9971</td>
<td>.8876</td>
<td>1.3325</td>
<td>1.3755</td>
<td>1.3702</td>
<td>1.3211</td>
<td>1.4747</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Central differed from Okanagan, Vancouver and N. Island.

* Significant differences @ 0.05 level
### Table 38-ii

**Differences Between Regions**

**One Way Analysis of Variance and Tests of Significant Differences**

**Multiple Range Test - Tukey/HSD Procedure: Alpha @ 0.05**

<table>
<thead>
<tr>
<th>PROBLEM: Nurses unprofessional on picket line.</th>
<th>South Island</th>
<th>North Island</th>
<th>North-west</th>
<th>Vancouver</th>
<th>Fraser Valley</th>
<th>Kootenay</th>
<th>Okanagan</th>
<th>Central</th>
<th>F. Ratio</th>
<th>F. Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>𝜇</td>
<td>2.9855</td>
<td>2.5556</td>
<td>2.5833</td>
<td>2.7969</td>
<td>3.0000</td>
<td>2.8400</td>
<td>3.2124</td>
<td>2.1786</td>
<td>2.3740</td>
<td>.0214</td>
</tr>
<tr>
<td>S.D.</td>
<td>1.4297</td>
<td>1.2810</td>
<td>1.4434</td>
<td>1.3653</td>
<td>1.3981</td>
<td>1.5434</td>
<td>1.4420</td>
<td>1.2781</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Okanagan differed from Central.

<table>
<thead>
<tr>
<th>PROBLEM: Trade Unions unattentive to women.</th>
</tr>
</thead>
<tbody>
<tr>
<td>S.D.</td>
</tr>
</tbody>
</table>

* S. Island differs from Vancouver and N. Island.

<table>
<thead>
<tr>
<th>PROBLEM: Non-nursing trade union leaders - no business nurse contract.</th>
</tr>
</thead>
<tbody>
<tr>
<td>S.D.</td>
</tr>
</tbody>
</table>

* Central differed from N. Island, Vancouver, Fraser Valley.

* Significant differences @ 0.05 level
**TABLE 38 -iii**

**DIFFERENCES BETWEEN REGIONS**

*One Way Analysis of Variance and Tests of Significant Differences*

*Multiple Range Test - Tukey/HSD Procedure : Alpha 0.05*

**PROBLEM: Pleased with BCNU leadership.**

<table>
<thead>
<tr>
<th>Region</th>
<th>South Island</th>
<th>North Island</th>
<th>North-west</th>
<th>Vancouver</th>
<th>Fraser Valley</th>
<th>Kootenay</th>
<th>Okanagan</th>
<th>Central</th>
<th>F. Ratio</th>
<th>F. Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>X</strong></td>
<td>3.0735</td>
<td>1.7778</td>
<td>2.5455</td>
<td>1.7266</td>
<td>1.9667</td>
<td>2.7600</td>
<td>2.0973</td>
<td>2.2143</td>
<td>10.9692</td>
<td>.0000</td>
</tr>
<tr>
<td><strong>S.D.</strong></td>
<td>1.4175</td>
<td>1.0127</td>
<td>1.2933</td>
<td>.9938</td>
<td>1.2035</td>
<td>1.3486</td>
<td>1.1723</td>
<td>1.1974</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* S. Island differed from N. Island, Vancouver, Fraser Valley, Okanagan and Central.
  Kootenays differed from N. Island, Vancouver, Fraser Valley, Okanagan (but not Central).

**PROBLEM: BCNU represented nurses' position.**

<table>
<thead>
<tr>
<th>Region</th>
<th>North Island</th>
<th>Vancouver</th>
<th>Fraser Valley</th>
<th>Kootenay</th>
<th>Okanagan</th>
<th>Central</th>
<th>F. Ratio</th>
<th>F. Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>X</strong></td>
<td>2.9130</td>
<td>1.9297</td>
<td>2.0444</td>
<td>2.8800</td>
<td>2.2124</td>
<td>2.0000</td>
<td>6.7811</td>
<td>.0000</td>
</tr>
<tr>
<td><strong>S.D.</strong></td>
<td>1.4115</td>
<td>1.0881</td>
<td>1.1795</td>
<td>1.4518</td>
<td>1.2353</td>
<td>1.0377</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* S. Island differed from N. Island, Vancouver, Fraser Valley, Okanagan and Central.
  Kootenays differed from Vancouver, Okanagan and Fraser Valley.

**PROBLEM: Well informed by Union.**

<table>
<thead>
<tr>
<th>Region</th>
<th>North Island</th>
<th>Vancouver</th>
<th>Fraser Valley</th>
<th>Kootenay</th>
<th>Okanagan</th>
<th>Central</th>
<th>F. Ratio</th>
<th>F. Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>X</strong></td>
<td>2.6377</td>
<td>2.1641</td>
<td>1.8889</td>
<td>2.7800</td>
<td>1.9646</td>
<td>2.1786</td>
<td>5.1328</td>
<td>.0000</td>
</tr>
<tr>
<td><strong>S.D.</strong></td>
<td>1.4750</td>
<td>1.3208</td>
<td>1.1846</td>
<td>1.5292</td>
<td>1.2459</td>
<td>1.4415</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* S. Island and Kootenays differed from N. Island, Fraser Valley and Okanagan.

* Significant differences @ 0.05 level
### Table 38 - iv

**Differences Between Regions**

**One Way Analysis of Variance and Tests of Significant Differences**

**Multiple Range Test - Tukey/HSD Procedure; Alpha  <  0.05**

<table>
<thead>
<tr>
<th>PROBLEM:</th>
<th>Other unions prepared better than BCNU.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>South Island</td>
</tr>
<tr>
<td>δ</td>
<td>3.5507</td>
</tr>
<tr>
<td>S.D.</td>
<td>1.2070</td>
</tr>
</tbody>
</table>

* Vancouver differed from S. Island and Kootenays.

<table>
<thead>
<tr>
<th>PROBLEM:</th>
<th>BCNU criticism justified.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>δ</td>
</tr>
<tr>
<td></td>
<td>3.2174</td>
</tr>
</tbody>
</table>

* Kootenay and S. Island differed from N. Island, Okanagan, Fraser Valley and Vancouver.

<table>
<thead>
<tr>
<th>PROBLEM:</th>
<th>BCNU should not recommend offer without vote.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>δ</td>
</tr>
<tr>
<td></td>
<td>3.7246</td>
</tr>
</tbody>
</table>

* Vancouver and N. Island differed from S. Island and Kootenays. Okanagan differed from Vancouver.

* Significant differences < 0.05 level
TABLE 38 - v

DIFFERENCES BETWEEN REGIONS

One Way Analysis of Variance and Tests of Significant Differences
Multiple Range Test - Tukey/HSD Procedure : Alpha 0.05

<table>
<thead>
<tr>
<th>PROBLEM: Bargaining Committee should do better with HLRA.</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( \bar{\mu} )</td>
<td>S.D.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N. Island</td>
<td>4.4545</td>
<td>.8202</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vancouver</td>
<td>4.7188</td>
<td>.6866</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fraser Valley</td>
<td>4.5111</td>
<td>.9391</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kootenay</td>
<td>3.8800</td>
<td>1.3037</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Okanagan</td>
<td>4.5310</td>
<td>.9168</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central</td>
<td>4.5714</td>
<td>.8789</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Ratio</td>
<td>6.4033</td>
<td>.0000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Significant differences at 0.05 level

<table>
<thead>
<tr>
<th>PROBLEM: BCNU needs expert negotiation.</th>
<th>South Island</th>
<th>North Island</th>
<th>North-west</th>
<th>Vancouver</th>
<th>Fraser Valley</th>
<th>Kootenay</th>
<th>Okanagan</th>
<th>Central</th>
<th>F. Ratio</th>
<th>F. Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>( \bar{\mu} )</td>
<td>4.1912</td>
<td>4.9259</td>
<td>4.4545</td>
<td>4.7188</td>
<td>4.5111</td>
<td>3.8800</td>
<td>4.5310</td>
<td>4.5714</td>
<td>6.4033</td>
<td>.0000</td>
</tr>
<tr>
<td>S.D.</td>
<td>1.0403</td>
<td>.2669</td>
<td>.8202</td>
<td>.6866</td>
<td>.9391</td>
<td>1.3037</td>
<td>.9168</td>
<td>.8789</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Kootenays differed from N. Island and Vancouver - also Fraser Valley, Okanagan and Central.
S. Island differed from N. Island and Vancouver.

<table>
<thead>
<tr>
<th>PROBLEM: Satisfied with BCNU Stewards.</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>( \bar{\mu} )</td>
<td>3.7206</td>
<td>4.0741</td>
<td>4.1667</td>
<td>3.3438</td>
<td>3.7556</td>
<td>4.1800</td>
<td>3.6161</td>
<td>3.5926</td>
<td>2.6271</td>
<td>.0113</td>
</tr>
<tr>
<td>S.D.</td>
<td>1.2678</td>
<td>1.4657</td>
<td>1.1146</td>
<td>1.4604</td>
<td>1.3846</td>
<td>1.1373</td>
<td>1.4780</td>
<td>1.3376</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Vancouver differed from Kootenays.
TABLE 38 - vi

DIFFERENCES BETWEEN REGIONS

One Way Analysis of Variance and Tests of Significant Differences
Multiple Range Test - Tukey/HSD Procedure : Alpha @ .05

<table>
<thead>
<tr>
<th>PROBLEM: No group gave confidence - rights</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>S.D.</td>
</tr>
</tbody>
</table>

* Vancouver differed from S. Island, Kootenays and Okanagan.

<table>
<thead>
<tr>
<th>PROBLEM: BCNU did not respect nurses' trust.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>S.D.</td>
</tr>
</tbody>
</table>

* Vancouver and N. Island differed from Northwest, Kootenays and S. Island.
* Vancouver differed also from Okanagan. Fraser Valley differed from S. Island and Kootenays.

<table>
<thead>
<tr>
<th>PROBLEM: Administration works with nurses to improve conditions.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>S.D.</td>
</tr>
</tbody>
</table>

* Central differed from Vancouver, Fraser Valley, Okanagan, N. Island and Northwest.
* Kootenays and S. Island differed from Vancouver, Fraser Valley and Okanagan.

* Significant differences @ 0.05 level
# TABLE 38 - vii

## DIFFERENCES BETWEEN REGIONS

**One Way Analysis of Variance and Tests of Significant Differences**

Multiple Range Test - Tukey/HSD Procedure : Alpha 0.05

<table>
<thead>
<tr>
<th>PROBLEM: Committed to employing hospital.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$\bar{x}$</td>
<td>3.3088</td>
</tr>
<tr>
<td>S.D.</td>
<td>1.4274</td>
</tr>
</tbody>
</table>

* Fraser Valley differed from Central.

<table>
<thead>
<tr>
<th>PROBLEM: Nurse Administration value/respect nurses.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$\bar{x}$</td>
<td>2.0735</td>
</tr>
<tr>
<td>S.D.</td>
<td>1.3307</td>
</tr>
</tbody>
</table>

* Fraser Valley differs from Vancouver.

Okanagan, Fraser Valley differ from S. Island, Kootenays and Central.

N. Island differs from S. Island and Central.

<table>
<thead>
<tr>
<th>PROBLEM: Nurse Administration more committed to organization.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$\bar{x}$</td>
<td>3.8529</td>
</tr>
<tr>
<td>S.D.</td>
<td>1.3633</td>
</tr>
</tbody>
</table>

* S. Island differed from Fraser Valley.

* Significant differences @ 0.05 level
### Table 38 - viii

**Differences between Regions**

*One Way Analysis of Variance and Tests of Significant Differences*

*Multiple Range Test - Tukey/HSD Procedure: Alpha 0.05*

| Problem: Administration exploits nurses' commitment. |  
| --- | --- |
| **S.D.** | 1.3418 | 1.7255 | 1.5050 | 1.1311 | 1.4402 | 1.5680 | 1.5295 | 1.2188 | .0000 |

*Vancouver and S. Island differed from N. Island, Fraser Valley and Okanagan.*

| Problem: Unfair privileges - administration. |  
| --- | --- |
| | South Island | North Island | North-west | Vancouver | Fraser Valley | Kootenay | Okanagan | Central | F. Ratio | F. Probability |
| **S.D.** | 1.3567 | 1.4307 | 1.6214 | 1.9777 | 1.3152 | 1.5687 | 1.5923 | 1.0905 |  |

*Vancouver differed from Okanagan.*

| Problem: Doctors understood/respected nurses. |  
| --- | --- |
| |  
| **X** | 3.7243 | 3.3704 | 2.8333 | 3.0859 | 3.3889 | 2.9800 | 3.4554 | 3.3929 | 2.3928 |
| **S.D.** | 1.1231 | 1.4974 | 1.1934 | 1.4199 | 1.2869 | 1.3323 | 1.3416 | 1.3427 | .0205 |

*Vancouver differed from S. Island.*

*Significant differences @ 0.05 level*
### TABLE 38 - ix

**DIFFERENCES BETWEEN REGIONS**

One Way Analysis of Variance and Tests of Significant Differences

Multiple Range Test - Tukey/HSD Procedure: Alpha 0.05

<table>
<thead>
<tr>
<th>PROBLEM:</th>
<th>Doctors affected financially - least supportive.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$\bar{x}$</td>
</tr>
<tr>
<td></td>
<td>Island</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.1899</td>
</tr>
</tbody>
</table>

* S. Island differed from all except Northwest.

<table>
<thead>
<tr>
<th>PROBLEM:</th>
<th>Equitable shift sharing.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>South Island</td>
</tr>
<tr>
<td></td>
<td>$\bar{x}$</td>
</tr>
<tr>
<td></td>
<td>S.D.</td>
</tr>
</tbody>
</table>

* S. Island and Vancouver differed from Northwest, Fraser Valley and Kootenays.

<table>
<thead>
<tr>
<th>PROBLEM:</th>
<th>Upset - others did non-nursing duties.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$\bar{x}$</td>
</tr>
<tr>
<td></td>
<td>S.D.</td>
</tr>
</tbody>
</table>

* Kootenays and Fraser Valley differed from Vancouver and Central.

* Significant differences @ 0.05 level
### Differences

#### One Way Analysis of Variance

<table>
<thead>
<tr>
<th>Problem</th>
<th>Region</th>
<th>Okanagan</th>
<th>Kootenay</th>
<th>Okanagan</th>
<th>Vancouver</th>
<th>Fraser</th>
<th>North Island</th>
<th>West Island</th>
<th>South Island</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncomfortable as source of conflict</td>
<td>2000</td>
<td>3.7924</td>
<td>1.3798</td>
<td>1.5397</td>
<td>1.5039</td>
<td>1.4018</td>
<td>1.8571</td>
<td>3.8000</td>
<td>4.3035</td>
</tr>
<tr>
<td>Powerless</td>
<td>2000</td>
<td>3.7924</td>
<td>1.3798</td>
<td>1.5397</td>
<td>1.5039</td>
<td>1.4018</td>
<td>1.8571</td>
<td>3.8000</td>
<td>4.3035</td>
</tr>
</tbody>
</table>

Significant differences @ 0.05 level

---

**TABLE 38**
**TABLE 38 - XI**

**DIFFERENCES BETWEEN REGIONS**

*One Way Analysis of Variance and Tests of Significant Differences*

*Multiple Range Test - Tukey/HSD Procedure: Alpha @ 0.05*

---

**PROBLEM: I Vote.**

<table>
<thead>
<tr>
<th></th>
<th>South Island</th>
<th>North Island</th>
<th>North-west</th>
<th>Vancouver</th>
<th>Fraser Valley</th>
<th>Kootenay</th>
<th>Okanagan</th>
<th>Central</th>
<th>F. Ratio</th>
<th>F. Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>( \bar{x} )</td>
<td>.5397</td>
<td>.3200</td>
<td>.2727</td>
<td>.1597</td>
<td>.2963</td>
<td>.5000</td>
<td>.6019</td>
<td>.2963</td>
<td>9.7569</td>
<td>.0000</td>
</tr>
<tr>
<td>S.D.</td>
<td>.5024</td>
<td>.4761</td>
<td>.4671</td>
<td>.3678</td>
<td>.4595</td>
<td>.5053</td>
<td>.4918</td>
<td>.4653</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*S. Island, Okanagan, Kootenays differed from Vancouver.*

---

**PROBLEM: N Vote.**

<table>
<thead>
<tr>
<th></th>
<th>South Island</th>
<th>North Island</th>
<th>North-west</th>
<th>Vancouver</th>
<th>Fraser Valley</th>
<th>Kootenay</th>
<th>Okanagan</th>
<th>Central</th>
<th>F. Ratio</th>
<th>F. Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>( \bar{x} )</td>
<td>.7861</td>
<td>.0370</td>
<td>.3333</td>
<td>.0000</td>
<td>.3000</td>
<td>1.0000</td>
<td>.5841</td>
<td>?</td>
<td>72.3849</td>
<td>.0000</td>
</tr>
<tr>
<td>S.D.</td>
<td>.4251</td>
<td>.1925</td>
<td>.4924</td>
<td>.0000</td>
<td>.4608</td>
<td>.0000</td>
<td>.4951</td>
<td>?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Okanagan differed from Vancouver, N. Island, Fraser Valley. Northwest differed from Vancouver. Fraser Valley differed from Vancouver, N. Island. S. Island differed from all others except Kootenays. Kootenays differed from all other.*

---

* Significant differences @ 0.05 level
### TABLE 39 - i

**BETWEEN MEANS BY HOSPITAL SIZES**

**ONE WAY ANALYSIS OF VARIANCE AND TESTS OF SIGNIFICANT DIFFERENCES**

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>TERTIARY</th>
<th>MEDIUM</th>
<th>SMALL</th>
<th>LONG TERM CARE</th>
<th>F RATIO</th>
<th>PROBABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other things more important than nursing image</td>
<td></td>
<td>2.4973</td>
<td>2.8070</td>
<td>2.4667</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>2.4950</td>
<td>2.4450</td>
<td>2.4667</td>
<td>2.7984</td>
<td>.0396</td>
</tr>
<tr>
<td></td>
<td>S.D.</td>
<td>1.2833</td>
<td>1.3077</td>
<td>1.2898</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>133</td>
<td>109</td>
<td>45</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Tertiary differs from small hospitals.

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>TERTIARY</th>
<th>MEDIUM</th>
<th>SMALL</th>
<th>LONG TERM CARE</th>
<th>F RATIO</th>
<th>PROBABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pleased with BCNU leadership</td>
<td></td>
<td>2.1200</td>
<td>2.1263</td>
<td>2.8889</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>2.0211</td>
<td>2.1213</td>
<td>2.1200</td>
<td>6.5577</td>
<td>.0002</td>
</tr>
<tr>
<td></td>
<td>S.D.</td>
<td>1.2039</td>
<td>1.2009</td>
<td>1.2735</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>190</td>
<td>182</td>
<td>100</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Long Term Care differs from all other hospital sizes.

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>TERTIARY</th>
<th>MEDIUM</th>
<th>SMALL</th>
<th>LONG TERM CARE</th>
<th>F RATIO</th>
<th>PROBABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCNU represented nurses' position well</td>
<td></td>
<td>2.1263</td>
<td>2.2800</td>
<td>2.8889</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>2.1200</td>
<td>2.2527</td>
<td>2.2200</td>
<td>4.5023</td>
<td>.0039</td>
</tr>
<tr>
<td></td>
<td>S.D.</td>
<td>1.2039</td>
<td>1.2222</td>
<td>1.2759</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>190</td>
<td>182</td>
<td>100</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Long Term Care differs from all other hospital sizes.

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>TERTIARY</th>
<th>MEDIUM</th>
<th>SMALL</th>
<th>LONG TERM CARE</th>
<th>F RATIO</th>
<th>PROBABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well informed by union</td>
<td></td>
<td>2.1137</td>
<td>2.2600</td>
<td>2.6444</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>2.1263</td>
<td>2.2527</td>
<td>2.2200</td>
<td>4.5023</td>
<td>.0039</td>
</tr>
<tr>
<td></td>
<td>S.D.</td>
<td>1.3762</td>
<td>1.2281</td>
<td>1.3380</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>191</td>
<td>182</td>
<td>100</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Long Term Care differs from all other hospital sizes.

* Significant differences between paired means.

**NOTE:** RATING FOR PROBLEMS WAS: 1 (DISAGREE) -- 5 (AGREE)

Multiple Range Test: Tukey-HSD Procedure Alpha @0.05
TABLE 39 - ii

BETWEEN MEANS BY HOSPITAL SIZES

ONE WAY ANALYSIS OF VARIANCE AND TESTS OF SIGNIFICANT DIFFERENCES

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>TERTIARY</th>
<th>MEDIUM</th>
<th>SMALL</th>
<th>LONG TERM CARE</th>
<th>F RATIO</th>
<th>PROBABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other unions better prepared/informed</td>
<td>x</td>
<td>3.9476</td>
<td>3.9066</td>
<td>3.8081</td>
<td>3.1778</td>
<td>5.7915</td>
</tr>
<tr>
<td></td>
<td>S.D.</td>
<td>1.1085</td>
<td>1.1010</td>
<td>1.1577</td>
<td>1.4348</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>191</td>
<td>182</td>
<td>99</td>
<td>45</td>
<td></td>
</tr>
</tbody>
</table>

* Long Term Care differs from all other hospital sizes.

| BCNU Criticism justified                     | x        | 3.7696 | 3.7403| 3.6300         | 3.2222  | 3.2313      | .0222 |
|                                              | S.D.     | 1.0999 | 1.0822| 1.0978         | 1.2411  |             |      |
|                                              | n        | 191    | 181   | 100            | 45      |             |      |

* Tertiary and medium differed from Long Term Care hospitals.

| BCNU should not recommend offer without vote| x        | 4.4241 | 3.9835| 4.0606         | 3.5556  | 6.9089      | .0001 |
|                                              | S.D.     | 1.1301 | 1.3725| 1.3837         | 1.6033  |             |      |
|                                              | n        | 191    | 183   | 99             | 45      |             |      |

* Tertiary differs from medium and Long Term Care hospitals.

| Bargaining committee could do better - HLRA  | x        | 4.0524 | 3.5604| 3.8000         | 3.4889  | 6.2072      | .0004 |
|                                              | S.D.     | 1.0797 | 1.2935| 1.2309         | 1.2177  |             |      |
|                                              | n        | 191    | 182   | 100            | 45      |             |      |

* Tertiary differs from medium and Long Term Care hospitals.

* Significant differences between paired means.

NOTE: RATING FOR PROBLEMS WAS: 1 (DISAGREE) --> 5 (AGREE)
Multiple Range Test: Tukey-HSD Procedure  Alpha @0.05
### TABLE 39 - iii

**BETWEEN MEANS BY HOSPITAL SIZES**

**ONE WAY ANALYSIS OF VARIANCE AND TESTS OF SIGNIFICANT DIFFERENCES**

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>Tertiary</th>
<th>MEDIUM</th>
<th>SMALL</th>
<th>LONG TERM CARE</th>
<th>F RATIO</th>
<th>PROBABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfied BCNU Stewards</td>
<td>( \bar{x} )</td>
<td>3.4368</td>
<td>3.5912</td>
<td>4.0400</td>
<td>4.1333</td>
<td>6.0516</td>
</tr>
<tr>
<td></td>
<td>S.D.</td>
<td>1.4081</td>
<td>1.4865</td>
<td>1.2220</td>
<td>1.1794</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>190</td>
<td>181</td>
<td>100</td>
<td>45</td>
<td></td>
</tr>
</tbody>
</table>

* Small hospitals differed from **Tertiary** and medium hospitals.

* Tertiary differed from small and Long Term Care hospitals.

| No group confident - rights                 | \( \bar{x} \) | 3.9468 | 3.4365 | 3.7300        | 3.5455  | 4.5589      | .0037       |
|                                              | S.D.     | 1.2697 | 1.4347 | 1.3170        | 1.4540  | 44          |
|                                              | n        | 188    | 181    | 100           | 44      |

* Tertiary differed from medium hospitals.

| BCNU did not respect nurses' trust           | \( \bar{x} \) | 3.7632 | 3.4862 | 3.6100        | 3.0444  | 4.2286      | .0057       |
|                                              | S.D.     | 1.2136 | 1.2936 | 1.3401        | 1.4135  | 45          |
|                                              | n        | 190    | 181    | 100           | 45      |

* Tertiary differs from Long Term Care hospitals.

| Administration works with nurses to improve conditions | \( \bar{x} \) | 2.5368 | 2.7790 | 3.3700        | 2.2222  | 10.1809     | .0000       |
|--------------------------------------------------------| S.D.     | 1.3515 | 1.4590 | 1.4679        | 1.1656  | 45          |
|--------------------------------------------------------| n        | 190    | 181    | 100           | 45      |

* Small hospitals differ from all other hospitals.

* Significant differences between paired means.

**NOTE**: RATING FOR PROBLEMS WAS: 1 (DISAGREE) --> 5 (AGREE)

Multiple Range Test: Tukey-HSD Procedure  Alpha @0.05
### TABLE 39 - iv

**BETWEEN MEANS BY HOSPITAL SIZES**

**ONE WAY ANALYSIS OF VARIANCE AND TESTS OF SIGNIFICANT DIFFERENCES**

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>TERTIARY</th>
<th>MEDIUM</th>
<th>SMALL</th>
<th>LONG TERM CARE</th>
<th>F RATIO</th>
<th>PROBABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committed to employing hospital</td>
<td>3.3560</td>
<td>3.4615</td>
<td>3.9700</td>
<td>3.6136</td>
<td>4.8854</td>
<td>.0023</td>
</tr>
<tr>
<td></td>
<td>1.3684</td>
<td>1.3528</td>
<td>1.2428</td>
<td>1.3677</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>191</td>
<td>182</td>
<td>100</td>
<td>44</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Small hospitals differ from all other hospitals.

| Nurse administration value/ respect nurses | 2.4084   | 3.1099 | 3.3500| 2.6889         | 12.0196 | .0000       |
|                                            | 1.3806   | 1.4973 | 1.4728| 1.4744         |         |             |
|                                            | 191      | 182    | 100   | 45             |         |             |

* Small and medium differ from Long Term Care and Tertiary hospitals.

| Nurse administration more committed to organization than to nurses | 3.7644   | 3.2637 | 3.2245| 3.8222         | 6.3816  | .0003       |
|                                                                     | 1.2782   | 1.4051 | 1.4890| 1.2484         |         |             |
|                                                                     | 191      | 182    | 98    | 45             |         |             |

* Tertiary and Long Term Care differ from small and medium hospital.

| Administration exploits nurses commitment | 3.8953   | 3.1703 | 3.2347| 3.8667         | 10.7485 | .0000       |
|                                          | 1.2437   | 1.5336 | 1.4630| 1.2173         |         |             |
|                                          | 191      | 182    | 98    | 45             |         |             |

* Tertiary and Long Term Care differ from medium and small hospitals.

Long Term Care differs from medium hospitals.

* Significant differences between paired means.

**NOTE:** RATING FOR PROBLEMS WAS: 1 (DISAGREE) --> 5 (AGREE)

Multiple Range Test: Tukey–HSD Procedure  Alpha @0.05
TABLE 39 - v

BETWEEN MEANS BY HOSPITAL SIZES

ONE WAY ANALYSIS OF VARIANCE AND TESTS OF SIGNIFICANT DIFFERENCES

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>TERTIARY</th>
<th>MEDIUM</th>
<th>SMALL</th>
<th>LONG TERM CARE</th>
<th>F RATIO</th>
<th>PROBABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unfair privileges to administration</td>
<td>4.1152</td>
<td>3.6503</td>
<td>3.8400</td>
<td>3.8000</td>
<td>3.5420</td>
<td>.0146</td>
</tr>
<tr>
<td></td>
<td>1.2128</td>
<td>1.5002</td>
<td>1.4545</td>
<td>1.5166</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>191</td>
<td>182</td>
<td>100</td>
<td>45</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>* Tertiary differs from medium hospitals.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctors not supportive in actions</td>
<td>3.8586</td>
<td>3.7760</td>
<td>3.4700</td>
<td>3.5455</td>
<td>2.7978</td>
<td>.0396</td>
</tr>
<tr>
<td></td>
<td>1.1406</td>
<td>1.2131</td>
<td>1.2509</td>
<td>1.1093</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>191</td>
<td>183</td>
<td>100</td>
<td>44</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>* Tertiary differs from small hospitals.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.5412</td>
<td>1.5212</td>
<td>.9288</td>
<td>1.1985</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>189</td>
<td>183</td>
<td>98</td>
<td>45</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>* Tertiary differs from all others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medium differed from small and Long Term Care hospitals.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.1041</td>
<td>1.3335</td>
<td>1.2086</td>
<td>.8950</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>180</td>
<td>171</td>
<td>95</td>
<td>45</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>* Tertiary and Long Term Care differed from medium hospitals.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Significant differences between paired means.

NOTE: RATING FOR PROBLEMS WAS: 1 (DISAGREE) --> 5 (AGREE)
Multiple Range Test: Tukey-HSD Procedure Alpha @0.05
### Table 39 - vi

**Between Means by Hospital Sizes**

**One Way Analysis of Variance and Tests of Significant Differences**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Tertiary</th>
<th>Medium</th>
<th>Small</th>
<th>Long Term Care</th>
<th>F Ratio</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Upset - others doing non-nursing duties</strong></td>
<td>( \bar{x} )</td>
<td>3.6296</td>
<td>3.2000</td>
<td>2.8673</td>
<td>3.2043</td>
<td>7.0018</td>
</tr>
<tr>
<td></td>
<td>S.D.</td>
<td>1.2843</td>
<td>1.4964</td>
<td>1.4116</td>
<td>1.4237</td>
<td></td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>189</td>
<td>180</td>
<td>98</td>
<td>44</td>
<td></td>
</tr>
</tbody>
</table>

* Tertiary differs from medium and small hospitals.

| Felt powerless | \( \bar{x} \) | 3.1000 | 3.3536 | 2.8000 | 3.2000 | 2.7924 | .0399 |
|----------------| S.D.     | 1.5449 | 1.5765 | 1.5308 | 1.5754 |         |       |
|                | n        | 190    | 181   | 100   | 45     |         |       |

* Medium differed from small hospitals.

| Nurses' dissention negative | \( \bar{x} \) | 3.9158 | 3.8462 | 3.2400 | 3.6000 | 5.7113 | .0008 |
|-----------------------------| S.D.     | 1.2779 | 1.4214 | 1.5117 | 1.5869 |         |       |
|                             | n        | 190    | 182   | 100   | 45     |         |       |

* Tertiary and medium differed from small hospitals.

* Significant differences between paired means.

**Note:** Rating for Problems was: 1 (Disagree) --> 5 (Agree)

Multiple Range Test: Tukey-HSD Procedure Alpha \( \alpha = 0.05 \)
### TABLE 40  
**AGE OF PARTICIPANTS**  
*n = 520*

<table>
<thead>
<tr>
<th>AGE</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 - 30 years</td>
<td>75</td>
<td>14.4</td>
</tr>
<tr>
<td>31 - 40 years</td>
<td>191</td>
<td>36.7</td>
</tr>
<tr>
<td>41 - 50 years</td>
<td>194</td>
<td>37.3</td>
</tr>
<tr>
<td>Over 50 years</td>
<td>55</td>
<td>10.6</td>
</tr>
<tr>
<td>No Response</td>
<td>5</td>
<td>1.0</td>
</tr>
</tbody>
</table>

### TABLE 41  
**MARITAL STATUS OF PARTICIPANTS**  
*n = 520*

<table>
<thead>
<tr>
<th>Status</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>97</td>
<td>18.7</td>
</tr>
<tr>
<td>Married</td>
<td>369</td>
<td>70.9</td>
</tr>
<tr>
<td>Divorced</td>
<td>40</td>
<td>7.7</td>
</tr>
<tr>
<td>Widowed</td>
<td>10</td>
<td>1.9</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>0.8</td>
</tr>
</tbody>
</table>

### TABLE 42  
**GENDER OF PARTICIPANTS**  
*n = 520*

<table>
<thead>
<tr>
<th>Gender</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>490</td>
<td>94.2</td>
</tr>
<tr>
<td>Male</td>
<td>30</td>
<td>5.8</td>
</tr>
</tbody>
</table>

### TABLE 43  
**NUMBER OF DEPENDANTS OF PARTICIPANTS**  
*n = 520*

<table>
<thead>
<tr>
<th>None</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>95</td>
<td>18.3</td>
</tr>
<tr>
<td>More than one</td>
<td>195</td>
<td>37.5</td>
</tr>
<tr>
<td>No Response</td>
<td>4</td>
<td>0.8</td>
</tr>
</tbody>
</table>
### TABLE 44
PARTICIPANTS' POSITION HELD DURING STRIKE
\( n = 520 \)

<table>
<thead>
<tr>
<th>POSITION</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Nurse</td>
<td>395</td>
<td>76.0</td>
</tr>
<tr>
<td>Assistant Head Nurse</td>
<td>16</td>
<td>3.1</td>
</tr>
<tr>
<td>Head Nurse</td>
<td>61</td>
<td>11.7</td>
</tr>
<tr>
<td>Supervisor</td>
<td>15</td>
<td>2.9</td>
</tr>
<tr>
<td>Other</td>
<td>31</td>
<td>6.0</td>
</tr>
<tr>
<td>No Response</td>
<td>2</td>
<td>.4</td>
</tr>
</tbody>
</table>

### TABLE 45
YEARS OF GRADUATION FROM NURSING
\( n = 520 \)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before 1960</td>
<td>48</td>
<td>9.2</td>
</tr>
<tr>
<td>1960 - 1970</td>
<td>175</td>
<td>33.7</td>
</tr>
<tr>
<td>1970 - 1980</td>
<td>173</td>
<td>33.7</td>
</tr>
<tr>
<td>1980 - 1985</td>
<td>77</td>
<td>14.8</td>
</tr>
<tr>
<td>After 1985</td>
<td>44</td>
<td>8.5</td>
</tr>
<tr>
<td>No Response</td>
<td>3</td>
<td>.6</td>
</tr>
</tbody>
</table>

### TABLE 46
PARTICIPANTS' YEARS OF CONTINUOUS NURSING PRACTICE
\( n = 520 \)

<table>
<thead>
<tr>
<th>YEARS</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 2 years</td>
<td>22</td>
<td>4.2</td>
</tr>
<tr>
<td>2 - 5 years</td>
<td>60</td>
<td>11.5</td>
</tr>
<tr>
<td>5 - 10 years</td>
<td>121</td>
<td>23.3</td>
</tr>
<tr>
<td>10 - 15 years</td>
<td>121</td>
<td>23.3</td>
</tr>
<tr>
<td>More than 15 years</td>
<td>193</td>
<td>37.1</td>
</tr>
<tr>
<td>No Response</td>
<td>3</td>
<td>.6</td>
</tr>
</tbody>
</table>
### TABLE 47
**PARTICIPANTS’ EDUCATION PREPARATION**
*n = 520*

<table>
<thead>
<tr>
<th>EDUCATION LEAVE</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diploma RN</td>
<td>467</td>
<td>89.8</td>
</tr>
<tr>
<td>Baccalaureate BSN</td>
<td>60</td>
<td>11.5</td>
</tr>
<tr>
<td>Enrolled BSN</td>
<td>31</td>
<td>6.0</td>
</tr>
<tr>
<td>Enrolled Graduate MSN</td>
<td>8</td>
<td>1.5</td>
</tr>
<tr>
<td>Enrolled Graduate Studies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Non-nursing</td>
<td>19</td>
<td>3.7</td>
</tr>
<tr>
<td>Post Basic Nursing Program</td>
<td>119</td>
<td>22.9</td>
</tr>
<tr>
<td>Other</td>
<td>57</td>
<td>11.0</td>
</tr>
</tbody>
</table>

### TABLE 48
**TYPE OF EMPLOYMENT**
*n = 520*

<table>
<thead>
<tr>
<th>TYPE</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full time</td>
<td>374</td>
<td>71.9</td>
</tr>
<tr>
<td>Part time</td>
<td>91</td>
<td>17.5</td>
</tr>
<tr>
<td>Casual</td>
<td>53</td>
<td>10.2</td>
</tr>
<tr>
<td>No Response</td>
<td>2</td>
<td>.4</td>
</tr>
</tbody>
</table>

### TABLE 49
**PARTICIPANTS’ DEPENDENCE ON EMPLOYMENT**
*n = 520*

<table>
<thead>
<tr>
<th>DEPENDENCE</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Withdrawal of any salary creates financial distress</td>
<td>166</td>
<td>31.9</td>
</tr>
<tr>
<td>Uncomfortable salary withdrawn more than two weeks</td>
<td>226</td>
<td>43.5</td>
</tr>
<tr>
<td>Forego luxury if salary withdrawn</td>
<td>124</td>
<td>23.8</td>
</tr>
<tr>
<td>No Response</td>
<td>4</td>
<td>.8</td>
</tr>
</tbody>
</table>
### Table 50
**Length of Employment - Hospital**

<table>
<thead>
<tr>
<th>Years</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 2 years</td>
<td>81</td>
<td>36.7</td>
</tr>
<tr>
<td>2 - 5 years</td>
<td>125</td>
<td>24.0</td>
</tr>
<tr>
<td>5 - 10 years</td>
<td>143</td>
<td>27.5</td>
</tr>
<tr>
<td>More than 10 years</td>
<td>169</td>
<td>32.5</td>
</tr>
<tr>
<td>No Response</td>
<td>2</td>
<td>.4</td>
</tr>
</tbody>
</table>

### Table 51
**Participants' Type of Employing Hospital**

<table>
<thead>
<tr>
<th>Type</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tertiary</td>
<td>191</td>
<td>36.7</td>
</tr>
<tr>
<td>Medium</td>
<td>183</td>
<td>35.2</td>
</tr>
<tr>
<td>Small</td>
<td>100</td>
<td>19.2</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>45</td>
<td>8.7</td>
</tr>
<tr>
<td>No Response</td>
<td>1</td>
<td>.2</td>
</tr>
</tbody>
</table>

### Table 52
**Specialty Area of Participant**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td>45</td>
<td>8.7</td>
</tr>
<tr>
<td>Critical Care</td>
<td>79</td>
<td>15.2</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>61</td>
<td>11.7</td>
</tr>
<tr>
<td>Operating Room</td>
<td>39</td>
<td>7.5</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>17</td>
<td>3.3</td>
</tr>
<tr>
<td>Medical/Surgical</td>
<td>144</td>
<td>27.7</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>42</td>
<td>8.1</td>
</tr>
<tr>
<td>Maternal/Newborn</td>
<td>23</td>
<td>4.4</td>
</tr>
<tr>
<td>Other</td>
<td>63</td>
<td>12.1</td>
</tr>
<tr>
<td>No Response</td>
<td>7</td>
<td>1.3</td>
</tr>
<tr>
<td>SOURCE</td>
<td>FREQUENCY</td>
<td>PERCENT</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------</td>
<td>---------</td>
</tr>
<tr>
<td>Essential Shifts</td>
<td>358</td>
<td>68.8</td>
</tr>
<tr>
<td>Picket Pay</td>
<td>50</td>
<td>9.6</td>
</tr>
<tr>
<td>On Call Pay</td>
<td>26</td>
<td>5.0</td>
</tr>
<tr>
<td>Not Paid</td>
<td>23</td>
<td>4.4</td>
</tr>
<tr>
<td>Supported by Family</td>
<td>161</td>
<td>31.0</td>
</tr>
<tr>
<td>Borrowed</td>
<td>23</td>
<td>4.4</td>
</tr>
<tr>
<td>Savings</td>
<td>134</td>
<td>25.8</td>
</tr>
</tbody>
</table>
APPENDIX I
Ms. Pat Savage  
President  
British Columbia Nurses’ Union  
100 - 4259 Canada Way  
Burnaby, B.C.  
V5G 1H1  

April 10, 1989  

Dear Ms. Savage,  

A few weeks ago, I briefly discussed a research proposal on "Job Action - Attitudes and Actions of Nurses" on the telephone with you. You suggested that I send more information to you with a letter so that you may present it to the Council in April, 1989.

As I explained, I am completing the requirements for my Master’s Thesis in Education at Simon Fraser University. My interest lies in the area of professionalism and unionism. I am a member of both the BCNU and the RNABC and I must tell you that I feel no bias either way.

In 1987, Patricia Munton completed a study on teachers and their attitudes towards unions and strike action. Ms. Munton worked under Dr. Norman Robinson and in cooperation with the BCTF. The BCTF supported Ms. Munton by providing her with information and names of teachers in specific districts as well as having input and final say regarding the questionnaire she sent out to 1000 members.

In return, the BCTF gained valuable information about teachers how many teachers voted to strike but actually crossed the picket line, how they felt about unionism, what they knew about the issues.

The study carried out on teachers is an interesting basis for this study. However, I feel that there are important differences between teachers and nurses - that nurses are "a breed apart" from all workers as some writers say. This difference, I feel, is deeply rooted and may have something to do with the way nurses feel about their image, the interruption of the caring process or other reasons.

The purpose of this study would be to obtain rich description on the roots of conflict that nurses feel during about job action and how they work through the conflict. It is also to provide more specific information on how nurses feel about unionism, professionalism and how this influences the job action that they do or do not carry out.
There are almost no studies done on actual labor disputes with nurses. The advantages of doing this study to BCNU, its members, as well as to other nursing unions are that better insight may be obtained as to why some nurses are more or less likely to take job action. The study results may not only be helpful through planning for essential service coverage and process, but for BCNU to help their members deal with some of the real reasons why nurses are perhaps reluctant to take job action for good causes.

This is what I would like to propose:

1. In the event of job action (such as a strike), I would like to have the opportunity to interview a few nurses in selected areas who have withdrawn their services and those who have not; also those who have picketed and who have not picketed.

2. Whether there is job action or not, I would still like to interview some members regarding their feelings about job actions. In addition, I would like to develop a questionnaire with the assistance of an assigned member of your staff and an elected member perhaps from your Council. I would like to have your permission to distribute these questionnaires to members in several regions of the province. It would be helpful to have advice on this as to logistics from your Council as well.

I wish to say that I am very aware that the BCNU is actively seeking settlement with the HLRA at this time and that the BCNU is bargaining in good faith that the outcome will be positive. I recognize that this is somewhat sensitive, since to agree to such a study might seem that the intent of BCNU were to take job action. With regard to the interview during a strike action, I am willing to take a "wait and see" approach. In the meantime, I would appreciate being given permission to go ahead on principle and would be willing to discuss this further with your advice.

Sincerely,

Gina Dingwell, R.N.
June 12, 1989

Ms. Sue Rothwell
President
Registered Nurses Association of
British Columbia
Vancouver, B.C.

Dear Sue,

As requested, I am forwarding a description of the research project in which I am currently engaged as required for my Master's Thesis in Education at Simon Fraser University. I trust it is in a form suitable for your presentation to the RNABC Board of Directors on June 15, 1989.

As I explained to you, my thesis examines the possible conflict between the concepts of professionalism and the concepts of unionism among nurses. In a preliminary survey, I interviewed approximately 20 nurses in both large and small hospitals, in the Lower Mainland and in the Interior of B.C. The interviews demonstrated nurses are feeling a deep rooted conflict between aspects of their professionalism and their current negotiating situation, including a strike vote, job action and the possibility of an actual strike. It is the intention of my research to examine and document these points of view.

The purpose of the study is to obtain information about nursing attitudes and behaviours surrounding strike voting and job action in British Columbia in 1989. The study would examine strike propensity or how willing the individual nurse was to vote for strike action. If a strike were to occur, the relationship of strike compliance to strike propensity would also be examined. Specifically, how much job action nurses actually did take? Did nurses actually cut back their service, cross the picket line, stand on a picket line, etc?

Similar studies already exist in other professional fields such as physicians, engineers, social workers, and university faculty. In 1987, Patricia Munton completed a similar research project with teachers under the supervision of Dr. Norman Robinson at Simon Fraser University. This study was done with the cooperation of the British Columbia Teachers' Federation. The BCTF supported Ms. Munton including providing her with names of teachers in specific districts which allowed her to send questionnaires to 1000 members. In return, the BCTF gained valuable information about their teacher members.

I am requesting, therefore, that the RNABC assist my research in the same way the BCTF supported the study by Ms. Munton. That is, I require access to a compilation of nurses involved in current job action. As to the best way this access may be
accomplished, I am most willing to discuss that with you. My research advisor, Dr. Robinson, is also available for any discussion should it be desirable.

If you wish further information, please let me know at your earliest convenience. As I am sure you understand, given the current status of negotiations, I am feeling some urgency to get things underway. I look forward to your reply.

Sincerely,

Gina Dingwell, R.N.

10271 Algonquin Drive
Richmond, B.C.
V7A 3A5
phone: 274-8597
APPENDIX III
Please Circle your answer.

1. How many years of nursing experience do you have?
   1. Less than one year
   2. 1 - 2 years
   3. 4 - 6 years
   4. 7 - 14 years
   5. 15 or more years

2. What type of contract do you have at present?
   1. Full time
   2. Permanent part time
   3. Casual
   4. Other (e.g. Maternity leave, sick leave, etc.)

3. What position do you presently have?
   1. Staff nurse
   2. Assistant Head Nurse
   3. Head Nurse
   4. Supervisor
   5. Instructor
   6. Nurse Clinician
   7. Clinical Nurse Specialist

4. What type of agency are you employed in?
   1. Large tertiary care hospital
   2. Community hospital
   3. Rural / outpost hospital
   4. Long term care hospital
   5. Occupational health setting
   6. Community/ Public Health Agency
   7. Rehabilitation Centre

5. If employed in an acute care hospital, indicate your specialty area.
   1. Medical/Surgical
   2. Emergency
   3. Critical Care (e.g. ICU, CCU, SCN)
   4. Operating Room
   5. Oncology
   6. Outpatient/Daycare
   7. Other (please indicate)________________________
6. What is your educational preparation?

1. Diploma R.N.
2. BSN
3. Enrolled in BSN program
4. Master's degree
5. Enrolled in Master's program in nursing
6. Enrolled in university program OTHER than nsg.
   (please specify)__________________________
7. Post basic Clinical Specialty Program > 3 months
8. Hospital program of extended orientation for
   clinical specialty area 6 weeks or more.
9. OTHER (please specify)____________________
PLEASE INDICATE YOUR ANSWER BY CIRCLING THE NUMBER WHICH MOST ACCURATELY REFLECTS HOW YOU FEEL. ALL ANSWERS ARE REPRESENTED BY THE NUMBERS BELOW.

5 = Strongly Agree, 4 = Agree, 3 = Undecided, 2 = Disagree, 1 = Strongly Disagree.

Nurses should have increased financial compensation for the 24 hour nature of their work.

Nurses should have increased financial compensation for the amount of responsibility in their work.

Nurses should have increased financial compensation for physical and emotional stress associated with their work.

Nurses should be financially compensated for educational and special clinical preparation.

Nurses should have contractual rights to remedy patient care and working conditions which do not meet minimum standards established by the nursing profession.

Patient care and working conditions have deteriorated during the last five years.

Nurses must have the ability to address on-the-job hazards of all kinds.

Nurses should have expanded provisions for leaves of absence relating to education.

There should be greater flexibility in scheduling with better provisions for off-duty time.

Nurses should have major involvement in decisionmaking in their workplace.

Nurses are entitled to upgrading of benefits and sick leave improvements.
Nurses should have more job security based on seniority in the event of layoffs and technological change.  

Increased wages for nurses are necessary and justified.  

Legislation should allow nurses the right to strike.  

A major goal of the nursing profession should be to improve the public image of the profession.  

Withdrawal of nursing service succeeds only in diminishing the public image of the nursing profession.  

No issue is important enough to my nursing service from patients.  

If I withdraw my nursing service, patients would be placed at risk.  

Withdrawal of my nursing service would be unprofessional.  

Nurses must become more militant in order to improve wages and working conditions.  

Nurses cannot give to others unless they are provided for.  

If I did not withdraw my nursing service, and my nursing colleagues did, I would worry about my relationship with them afterward.  

I think that the BCNU should not support the position on Entry to Practice by the year 2000,
Please circle yes or no to the following questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCNU spends too much time opposing the government.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>BCNU should work more closely with the RNABC</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Nurses should abide by the majority decision of the BCNU</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>If I had the choice, I would not belong to BCNU</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>In general, I am satisfied with the leadership of the BCNU</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>The BCNU represents the majority of its members through its decisionmaking structures.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>The BCNU attempts to exercise too much control over individual members</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I do not feel I am an integral part of the BCNU.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>My level of interest in the affairs of the BCNU is high.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I attend local union meetings on a regular basis.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I am presently a member of a BCNU committee.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I am a member of a BCNU executive committee.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I have served in the past in either of the above two capacities.</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>If I had the choice, I would not belong to RNABC</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>The RNABC should work more closely with the BCNU.</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>
In general, I am satisfied with the leadership of the RNABC.

I do not feel I am an integral part of the RNABC.

My level of interest in the affairs of the local RNABC chapter is high.

I attend local RNABC chapter meetings on a regular basis.

I am a member of an RNABC Committee.

I am a member of an RNABC professional practice group.

I am an executive member of an RNABC chapter/committee.

I have served in the past in either of the above three capacities.
APPENDIX IV

STRIKE INTERVIEW GUIDELINES

1. Should nurses have the right to strike?

2. From your point of view, are the issues in this strike?

3. How much of this strike is related to wages?

4. How supportive do you think the public is?

5. Does the opinion of the public concern you?

6. Do you have any concerns about the "professional" image of nurses as they strike?

7. How much does this strike have to do with being a "female" profession?

8. How do you feel about unionism generally?
9. How do you feel about the BCNU and the strike?

10. How do you feel about your employer?

11. Have physicians shown ways of support in this strike?

12. How do you feel about picketing?

13. How do you feel about withdrawing/limiting service?

14. How is it for you "inside" when you work as an essential nurse?

15. How has this affected your private life?

16. How will this affect you financially?

17. Can you tell me what aspects, if any, of this strike do you find stressful?

18. May I ask how you voted?

19. Did anyone in particular influence your vote?
Dear Colleague,

I am asking you to take a few minutes of your time to assist me with the development of this questionnaire. J.R. Westgate has offered to distribute them randomly throughout B.C.C.H. so that the survey will be prepared to distribute throughout the province afterward.

The purpose of the questionnaire is to collect information for my Master's thesis in Education at Simon Fraser University. The questionnaire explores the types of conflict that nurses experienced during the recent labor dispute. I have developed these questions based on interviews with about 150 nurses.

The conflicts lie in the areas of unionism, professionalism, the professional working within a bureaucracy, physician/nurse, gender role and personal aspects of conflict.

It would help me greatly if you filled the questionnaire out and gave me feedback on the following.

1. WAS THE QUESTIONNAIRE TOO LONG? YES ___ NO ___

2. PLEASE PUT AN "X" BY THE QUESTIONS THAT ARE NOT IMPORTANT, IN YOUR OPINION.

3. PLEASE PUT A CHECK MARK WHERE YOU THINK QUESTIONS ARE GOOD QUESTIONS.

4. WOULD YOU WRITE A QUESTION MARK ? BY QUESTIONS WHICH DO NOT MAKE SENSE, OR ARE NOT UNDERSTANDABLE TO YOU.

5. PLEASE FEEL FREE TO WRITE ANY COMMENTS BESIDE A QUESTION IF YOU WISH TO IMPROVE OR ADD ANYTHING.

6. OTHER COMMENTS?? - have I missed anything or stressed something too little or too much?

Thank you - I appreciate your time and commitment to my project. If you are interested in the results of my thesis, please give your name and address to J.R. Westgate and I will mail you a summary.

Sincerely,

Gina Dingwell, R.N.

*** WHEN YOU HAVE FINISHED, PLACE THE COMPLETED QUESTIONNAIRE IN THE ENVELOPE PROVIDED, SEAL IT, AND RETURN IT TO J.R. WESTGATE'S MAILBOX IN I.C.U.*** This provides you with anonymity.

QUESTIONS? YOU MAY TELEPHONE ME AT 274-8597
Below are several statements on ideas and opinions about nurses, professionalism, unionism, and job action. Everyone thinks differently and this scale is an attempt to allow you to express those opinions/beliefs. Respond to each of the items as follows:

| Agree very strongly | +3 |
| Agree strongly      | +2 |
| Agree               | +1 |
| Disagree very strongly | -3 |
| Disagree strongly   | -2 |
| Disagree            | -1 |

CIRCLE THE NUMBER WHICH BEST REPRESENTS HOW YOU FEEL.

Legislation should allow nurses the right to strike.  
-3  -2  -1  +1  +2  +3

Nurses should find options other then striking to express dissatisfaction.  
-3  -2  -1  +1  +2  +3

The strike vote was mainly a message to government that it was time to recognize the value of nursing.  
-3  -2  -1  +1  +2  +3

The nursing strike was mainly about wages.  
-3  -2  -1  +1  +2  +3

The public expects too much of nurses in terms of commitment and dedication today.  
-3  -2  -1  +1  +2  +3

I feel committed to my career in nursing.  
-3  -2  -1  +1  +2  +3

Nurses cannot give to their patients unless they are provided for.  
-3  -2  -1  +1  +2  +3

I worry about public opinion of nurses.  
-3  -2  -1  +1  +2  +3

Generally, the public was supportive of nurses during the strike.  
-3  -2  -1  +1  +2  +3

The strike has tarnished the professional image of the nurse.  
-3  -2  -1  +1  +2  +3
<table>
<thead>
<tr>
<th>Statement</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>The nursing shortage has not affected me personally.</td>
<td>-3</td>
</tr>
<tr>
<td>I was frequently unable to give reasonable care during the strike.</td>
<td>-2</td>
</tr>
<tr>
<td>I pushed myself to the limit to give reasonable care during the strike.</td>
<td>-1</td>
</tr>
<tr>
<td>Our facility did not cut back enough on service during the strike.</td>
<td>+1</td>
</tr>
<tr>
<td>I consider myself to be a trade unionist.</td>
<td>+2</td>
</tr>
<tr>
<td>Some nurses looked like &quot;teamsters&quot; during the strike.</td>
<td>+3</td>
</tr>
<tr>
<td>Looking like a &quot;teamster&quot; is inappropriate for a nurse.</td>
<td></td>
</tr>
<tr>
<td>The problems of nursing are the problems of women generally.</td>
<td></td>
</tr>
<tr>
<td>I consider myself a feminist.</td>
<td></td>
</tr>
<tr>
<td>In general, I am pleased with the union leadership.</td>
<td></td>
</tr>
<tr>
<td>BCNU leadership gave direction which was weak and indecisive during the</td>
<td></td>
</tr>
<tr>
<td>labor dispute.</td>
<td></td>
</tr>
<tr>
<td>Overall, I felt well informed by the union during the labor dispute.</td>
<td></td>
</tr>
<tr>
<td>During the strike, an equitable system of shift sharing was set up.</td>
<td></td>
</tr>
<tr>
<td>The bargaining committee did the best they could do with the HLRA.</td>
<td></td>
</tr>
<tr>
<td>BCNU needs more expert negotiators on the bargaining team.</td>
<td></td>
</tr>
<tr>
<td>Besides money, contracts should reflect that other nursing problems have</td>
<td></td>
</tr>
<tr>
<td>been solved at the bargaining table.</td>
<td></td>
</tr>
</tbody>
</table>
BCNU did not stand up strongly to the government.  

This labor dispute shows that neither the government or the employer care about nurses.  

Non-nursing trade union leaders have no business telling nurses what kind of contract they should take.  

Actions by militant union members embarrassed me.  

The "NO" campaign made me feel more confident about standing up for my rights.  

My hospital administration works with its nursing staff to improve nurses' working conditions.  

I feel committed to the hospital in which I am employed.  

I am employed in a hospital which is highly committed to quality patient care.  

Nursing administrators showed that they valued and respected nurses during the labor dispute.  

Nursing management was more committed to the organization than to staff nurses during the strike.  

Reports by management of lack of safe patient care during job action were accurate and justified.  

Physicians showed that they valued and respected nurses during this strike.  

Physicians stated verbally that they supported the strike but their actions were non-supportive.
Some nurses were verbally abused and physically threatened by physicians on the picket line.

Physicians who were inconvenienced by the strike had a right to be abusive to nurses.

Despite difficult conditions during the strike, nurses tried to accommodate physicians.

Management exploited nurses' commitment to quality patient care during the strike.

Administrators flaunted their privilege by accepting bonuses, dinners, cruises etc.

I feel guilty that the strike inconvenienced the hospital, the physicians, and the patients during job action.

The BCNU and the RNABC should work more closely together.

RNABC should have demonstrated more active support for staff nurses during the strike.

Other labor unions were better prepared and informed than BCNU.

The BCNU leadership represented the position of nurses well to the public.

BCNU led its membership into a fight for a good contract, then backed down.

BCNU leadership and bargaining committee attempted to sell an unfair settlement to its members.

After nurses rejected the contract, I worried that the leadership might punish the membership.
I am familiar with the way BCNU makes its decisions. -3 -2 -1 +1 +2 +3

I adhered strictly to job action. -3 -2 -1 +1 +2 +3

I was upset that other nurses continued to carry out nonnursing duties. -3 -2 -1 +1 +2 +3

I was fearful of punishment if I rejected nonnursing duties. -3 -2 -1 +1 +2 +3

It is easier to carry out non-nursing duties myself rather than to raise a fuss by asking others. -3 -2 -1 +1 +2 +3

I felt other nurses were watching me to see if I were following union rules. -3 -2 -1 +1 +2 +3

BCNU should not have publicly recommended a negotiated offer without holding a membership vote. -3 -2 -1 +1 +2 +3

This contract provides the nurse with opportunity for major involvement in decision making in the workplace. -3 -2 -1 +1 +2 +3

Nurses must become more militant in order to improve wages and working conditions. -3 -2 -1 +1 +2 +3

I personally feel uncomfortable when I am in a situation of conflict. -3 -2 -1 +1 +2 +3

Taking strike action was one of the most difficult moral decisions I have made. -3 -2 -1 +1 +2 +3

This labour dispute has been a highly frustrating experience. -3 -2 -1 +1 +2 +3

As a nurse, I am accustomed to resolving conflict, not being the source of conflict. -3 -2 -1 +1 +2 +3

Nurses have become a more powerful group since taking strike action. -3 -2 -1 +1 +2 +3
The binding arbitration result will change working conditions for nurses.

Meeting and talking with other nurses during the strike was a positive experience.

Nurses showed sensitivity, support, and generosity to other nurses during the strike.

I feel closer to other nurses as a result of this labour dispute.

Please circle the answer which best applies to you.

1. Have you ever been on strike before?
   a) Yes
   b) No

2. Does any of your immediate family belong to a union?
   a) Parent
   b) Live-in partner or spouse
   c) None of my family belongs

3. Did he/she ever strike before?
   a) Yes
   b) No
   c) Does not apply

4. How did you vote on May 17, 1989?
   a) I voted YES to strike
   b) I voted NO to striking
   c) I did not vote

5. Was your immediate family/husband/partner supportive of the way voted on May 17/89?
   a) Yes
   b) No
   c) Does not apply to me
6. HOW DID YOU VOTE ON JULY 12, 1989?
   a) I voted yes, to accept the offer.
   b) I voted no, to reject the offer.
   c) I did not vote.

7. IF YOU VOTED NO, WHY DID YOU VOTE TO REJECT THE OFFER?
   (Circle all that apply)
   a) The contract was not a fair one for nurses.
   b) No one was going to push nurses into accepting an offer which was not what they asked for.
   c) The union leadership was out of touch with the nursing membership.
   d) The nurses in the "NO" campaign continued the momentum that nurses had already developed.
   e) OTHER:

8. IF YOU VOTED YES, WHY DID YOU VOTE TO ACCEPT THE OFFER?
   (Circle all that apply)
   a) I was satisfied with the contract.
   b) I felt loyalty to BCNU’s bargaining committee.
   c) I wanted the conflict to be over with.
   d) I lost faith in the bargaining committee’s ability to achieve a better settlement.
   e) The advice nurses received from other unions influenced my vote.
   f) I did not want to vote against my union leadership’s recommendation.
   g) OTHER:

9. HOW MUCH DID YOU PICKET DURING THE STRIKE?
   (Circle all that apply)
   a) I picked as directed by the strike committee.
   b) I picketed less than 4 hours.
   c) I picketed more than 4 hours.
   d) I was too tired to picket.
   e) I do not believe nurses should picket.

10. HOW MANY HOURS DID YOU WORK DURING THE STRIKE?
   a) I worked more hours than I usually do.
   b) I worked the same hours as I usually do.
   c) I worked less hours than I usually do.
   d) I did not work any shifts.
   e) I was on sick leave/ WCB/vacation/other LOA.
PLEASE ESTIMATE HOW MUCH STRESS YOU FELT WAS RELATED TO EACH OF THE FOLLOWING?

INDICATE: "H" FOR HIGH STRESS; "M" FOR MODERATE STRESS; "L" FOR LOW STRESS N/A for not applicable.

___ Not providing the usual service to the patients (e.g. outpatient care, surgery, psychiatry)

___ Not cutting far enough back on "essential" services to the public (pt.load unchanged - not all with lifethreatening conditions)

___ Providing minimal care to patients.

___ Heavy workloads, minimal staff and high responsibility.

___ Trying to adhere to elimination of nonnursing duties.

___ Picketing

___ The way the picketing, scheduling, and essential services were organized.

___ Uncertainty about length of strike time.

___ Decreased income.

___ Feeling torn between expectations of my employer and expectations of my union.

___ Attitude of family members during strike.

___ Attitude of friends and social contracts during strike.

___ Attitude of physicians to nurses during strike.

___ Attitude of hospital administrators during strike.

___ Attitude of HEU/HSA union members during strike/job action.

___ Inconvenience to the people in the community I live in.

IF YOU ARE A HEAD NURSE, SUPERVISOR OR INSTRUCTOR:

___ being considered nonessential

___ Feeling sandwiched between administration and staff.

___ Feeling ignored by the union.

___ Having to return to direct patient care.
PLEASE CIRCLE THE APPROPRIATE ANSWER:

1. SEX:  M    F

2. MARITAL STATUS  S  M  D  W  OTHER

3. NUMBER OF DEPENDENTS
   a) none
   b) one
   c) more than one

4. AGE
   a) 19 - 30
   b) 31 - 40
   c) 41 - 50
   d) over 51 years

5. YEAR OF GRADUATION
   a) before 1960
   b) 1960 - 1970
   c) 1970 - 1980
   d) 1980 - 1985
   e) after 1985

6. YEARS OF CONTINUOUS NURSING PRACTICE
   a) under 2 yrs.
   b) 2 - 5 years
   c) 5 - 10 years
   d) 10 - 15 years
   d) over 15 years

7. WHAT IS YOUR EDUCATIONAL PREPARATION?
   (CIRCLE ALL THAT APPLY)
   a) Diploma RN
   b) BSN
   c) Enrolled in BSN program
   d) Enrolled/graduated from Master's program
   e) Enrolled/graduated in university program other than
      nursing
   g) Post basic nursing program > 3months
   h) Other:

8. WHAT TYPE OF EMPLOYMENT DO YOU HAVE?
   a) Full time
   b) Part Time
   c) Casual
9. HOW FINANCIALLY DEPENDENT ON EMPLOYMENT ARE YOU?

a) Withdrawal of any of my salary would place me in financial distress.
b) I would find it uncomfortable to withdraw my salary longer than a two week period.
c) I would have to forego luxury items if my salary were withdrawn.

10. WAS YOUR PERSONAL SOURCE OF INCOME DURING THE STRIKE MAINLY
(Circle all that apply)

a) earned through essential work shifts
b) earned through picket pay
c) earned through on call pay
d) I did not get paid
e) My husband/family supported me.
f) I borrowed money
g) I used savings

11. WHAT POSITION DO YOU CURRENTLY HOLD?

a) Staff Nurse
b) Assistant Head Nurse
c) Head Nurse
d) Supervisor
e) Other

12. IN WHICH TYPE OF HOSPITAL ARE YOU EMPLOYED?

a) Large tertiary care facility
b) medium community acute care facility
c) small acute care facility
d) long term care facility

13. WHAT IS YOUR AREA OF SPECIALTY?

a) Emergency  e) Pediatric  i) Other
b) Critical Care  f) Medical/surgical
c) Geriatric  g) Psychiatry
d) Operating Room  h) Maternal/Newborn

14. HOW LONG HAVE YOU BEEN EMPLOYED IN THE HOSPITAL IN WHICH YOU WORK NOW?

a) Less than 2 years
b) 2 - 5 years
c) 5 - 10 years
d) over 10 years
15. IF YOU WERE CONSIDERED "ESSENTIAL SERVICE", DID YOUR PATIENT ACUITY AND WORKLOAD CHANGE ANY DURING THE STRIKE?

   a) patient acuity was higher and workload heavier
   b) patient acuity and workload was unchanged
   c) patient acuity and workload lower.
   d) I was not considered essential service.

16. WHAT WERE THE MOST POSITIVE ASPECTS OF THE STRIKE?

17. WHAT WERE THE MOST NEGATIVE ASPECTS OF THE STRIKE?
CHECK "YES" OR "NO" TO YOUR UNION/PROFESSIONAL EXPERIENCE

1. WERE YOU ACTIVE IN THE UNION BEFORE THE STRIKE?
   a. ___ Yes  b. ___ No

2. WERE YOU INTERESTED IN THE AFFAIRS OF THE UNION BEFORE THE STRIKE?
   a. ___ Yes  b. ___ No

3. ARE YOU INTERESTED IN BECOMING MORE ACTIVE IN THE UNION SINCE THE STRIKE?
   a. ___ Yes  b. ___ No

4. WERE YOU ACTIVE IN THE RNABC BEFORE THE STRIKE?
   a. ___ Yes  b. ___ No

5. WERE YOU INTERESTED IN THE AFFAIRS OF THE RNABC BEFORE THE STRIKE?
   a. ___ Yes  b. ___ No

6. ARE YOU INTERESTED IN BECOMING MORE ACTIVE IN THE RNABC SINCE THE STRIKE?
   a. ___ Yes  b. ___ No

ARE THERE ANY STORIES OR COMMENTS THAT YOU WOULD LIKE TO TELL ME ABOUT YOUR FEELINGS ABOUT THE STRIKE OR YOUR EXPERIENCES DURING THIS LABOR DISPUTE?
APPENDIX VI
DEAR COLLEAGUE,

I am a nurse who is presently conducting research about the recent nursing strike in B.C. as part of my Master's studies in Education at Simon Fraser University.

The purpose of the questionnaire is to explore the types of conflict that nurses experienced during the recent labor dispute. It is hoped in future, when job action is a possibility, that nurses will be surveyed and that their attitudes and opinions will be taken into consideration.

The questions were developed on the basis of interviews with about 200 nurses before, during, and after the strike. If you volunteer to take part in the study, it should take you about a half hour to complete the questionnaire. The nurses who tested the questionnaire insisted that each question was important in order to cover all the territory.

The study is funded by myself, thus there are a limited number of questionnaires being distributed, so your response to this survey is important. I would appreciate your COMPLETING THE QUESTIONNAIRE AND RETURNING IT WITHIN THE WEEK so that information is fresh and timely. Place your responses in the addressed, postage - paid envelope provided and send it to me.

For computer purposes, there will be a code number on the questionnaire to identify the facility in which you work since certain facilities were chosen for sampling because of their voting patterns. Your individual response however, will be completely anonymous. I will not be able personally to remind you to respond - but I trust that if you offer, you will respond.

I welcome any questions or discussion you may have about this study; I may be reached at 274-8597 in Richmond, B.C. Dr. Norman Robinson, my supervisor, may be reached at 291-4165 if you wish to discuss any aspect of this study with him.

I realize your free time is limited and precious; however, I believe your input is invaluable. I thank you for your time and your thoughts, I know this will be of benefit for everyone.

Sincerely,

Gina Dingwell, R.N.
JOB ACTION AND NURSE'S CONFLICTS

Below are several statements on ideas and opinions about nurses, professionalism, unionism, and job action. Please respond to each of the items as follows:

Agree strongly +2
Agree somewhat +1
Undecided 0
Disagree somewhat -1
Disagree strongly -2

PLEASE CIRCLE THE NUMBER WHICH BEST REPRESENTS HOW YOU FEEL.

A. STRIKING AND NURSES

Nurses should have the legal right to strike. -2 -1 0 +1 +2

The strike vote was a message to government that it was time to recognize the value of nursing. -2 -1 0 +1 +2

The nursing strike was mainly about wages. -2 -1 0 +1 +2

I worry about public opinion of nurses. -2 -1 0 +1 +2

Nursing should forget about trying to create a good public image and concentrate on more important matters. -2 -1 0 +1 +2

I feel the public was generally supportive of nurses during the strike. -2 -1 0 +1 +2

BCNU did not enlighten the public as to the role of the nurse in health care. -2 -1 0 +1 +2

The strike has tarnished the professional image of the nurse. -2 -1 0 +1 +2

The occupational problems of nurses are related to the problems of women generally. -2 -1 0 +1 +2
| Agree strongly | +2 |
| Agree somewhat | +1 |
| Undecided | 0 |
| Disagree somewhat | -1 |
| Disagree strongly | -2 |

B. UNIONS AND NURSES

I consider myself to be a trade unionist.

Some nurses dressed and acted unprofessionally on the picket line.

Trade unions are not attentive to the needs of women generally, and, in particular, nurses.

Non-nursing trade union leaders have no business telling nurses what kind of contract they should take.

During job action, I was pleased with the BCNU leadership.

The BCNU leadership represented the position of nurses well to the public.

I felt well informed by the union during the labor dispute.

Other labor unions were better prepared and informed than BCNU.

I am familiar with the way BCNU makes its decisions.

Much of the recent criticism of the BCNU is justified.

BCNU should not have publicly recommended a negotiated offer without holding a membership vote.

The bargaining committee should have been able to do better with the HLRA.

BCNU needs more expert negotiators on the bargaining team.
I was satisfied with the manner in which local BCNU stewards conducted job action affairs. 

The "NO" campaign made me feel more confident about standing up for my rights.

BCNU did not respect the trust that nurses placed in their hands.

C. EMPLOYER/NURSE

My hospital administration works with its nursing staff to improve nurses' working conditions.

I feel committed to the hospital in which I am employed.

Nursing administrators showed that they valued and respected nurses during the labor dispute.

Nursing management was more committed to the organization than to staff nurses during the strike.

My hospital administration were justified in being concerned about patient safety during job action.

Management exploited nurses' commitment to quality patient care during the strike.

It was unfair for administrators to receive financial and/or other privileges for their strike work.
### D. Physician/Nurse

<table>
<thead>
<tr>
<th>Agree strongly</th>
<th>+2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree somewhat</td>
<td>+1</td>
</tr>
<tr>
<td>Undecided</td>
<td>0</td>
</tr>
<tr>
<td>Disagree somewhat</td>
<td>-1</td>
</tr>
<tr>
<td>Disagree strongly</td>
<td>-2</td>
</tr>
</tbody>
</table>

I felt physicians understood and respected the reasons for strike actions by nurses.

Physicians stated verbally that they supported the strike but their actions were not supportive.

Physicians who were affected financially were the least supportive of this nursing strike.

### E. Job Action

During the strike, an equitable system of shift sharing was set up.

I pushed myself to the limit to give safe care during the strike.

I adhered strictly to job action.

I was upset that other nurses continued to carry out nonnursing duties.

It is easier to carry out non-nursing duties myself rather than to raise a fuss by asking others.

I felt other nurses were watching me to see if I were following union rules.

### F. Nursing Associations

The BCNU and the RNABC should work more closely together.

RNABC should have demonstrated more active support for staff nurses during the strike.
G. PERSONAL

Taking strike action was one of the most difficult moral decisions I have made. -2 -1 0 +1 +2

I felt powerless and lacking control of my life during this job action. -2 -1 0 +1 +2

Dissention between nurses was a negative aspect to this strike. -2 -1 0 +1 +2

I felt uncomfortable being a source of conflict rather than one who resolves conflict. -2 -1 0 +1 +2

Meeting and talking with other nurses during the strike was a positive experience. -2 -1 0 +1 +2

I consider myself a feminist. -2 -1 0 +1 +2

Nurses have become a more powerful political group since taking strike action. -2 -1 0 +1 +2
H. PLEASE ESTIMATE HOW MUCH STRESS YOU FELT DURING JOB ACTION WAS RELATED TO EACH OF THE FOLLOWING?

INDICATE: "H" FOR HIGH STRESS; "M" FOR MODERATE STRESS
"L" FOR LOW STRESS; N/A for not applicable.

- Not providing service that the public was used to.
- Heavy workloads, minimal staff and high responsibility caused by job action.
- Trying to adhere to elimination of nonnursing duties.
- Picketing
- Union organization of picketing, scheduling, and essential services.
- Uncertainty about length of strike time.
- Decreased income.
- Feeling torn between expectations of my employer and expectations of my union.
- The stress my nursing colleagues were feeling.
- Attitude of family members during strike.
- Attitude of friends and social contacts during strike.
- Attitude of physicians to nurses during strike.
- Attitude of hospital administrators during strike.
- Attitude of HEU/HSA union members during job action.
- Concern re: legislation back to work.

IF YOU ARE A HEAD NURSE, SUPERVISOR OR INSTRUCTOR:

- Being considered nonessential
- Feeling torn between administration, union and staff.
- Feeling ignored, disrespected by the union.
- Having to return to direct patient care.

BEFORE THE STRIKE, I would have liked to come out of contract.

  a) Yes
  b) No

AFTER THE STRIKE, I would have liked to come out of contract.

  a) Yes
  b) No
I. STRIKE EXPERIENCE:

PLEASE CIRCLE THE ANSWER WHICH BEST APPLIES TO YOU.

1. HAVE YOU EVER BEEN ON STRIKE BEFORE?
   a) Yes
   b) No

2. DOES ANY OF YOUR IMMEDIATE FAMILY BELONG TO A UNION?
   a) parent, child, sibling
   b) live-in partner or spouse
   c) none of my family belongs

3. DID HE/SHE EVER STRIKE BEFORE?
   a) Yes
   b) No
   c) Does not apply

4. DID YOU VOTE TO STRIKE ON MAY 17, 1989?
   a) I voted YES to strike
   b) I voted NO to striking
   c) I did not vote

5. DID ANY OF YOUR FAMILY MEMBERS HAVE INFLUENCE ON HOW YOU VOTED?
   a) Yes
   b) No

   COMMENTS?

6. HOW DID YOU VOTE ON THE CONTRACT OFFER ON JULY 12, 1989?
   a) I voted yes, to accept the offer.
   b) I voted no, to reject the offer.
   c) I did not vote.

7. IF YOU VOTED NO, WHY DID YOU VOTE TO REJECT THE OFFER?
   (Circle all the reasons you feel apply)
   a) The contract was not a fair to a nurse of my experience/education.
   b) There was not enough money in the contract.
   c) The union leadership did not seem aware of nurses' bottom lines.
   d) The nurses in the "NO" campaign continued the momentum that nurses had already developed.

   OTHER:
8. IF YOU VOTED YES, WHY DID YOU VOTE TO ACCEPT THE OFFER? 
(Circle all the reasons you feel apply)
   a) I was satisfied with the contract.
   b) I wanted the conflict to be over with.
   c) I lost faith in the bargaining committee's ability to achieve a better settlement.
   d) I wanted to vote with my union's recommendation.
   OTHER:

9. HOW MUCH DID YOU PICKET DURING THE STRIKE? 
(Circle all that apply)
   a) I picked as directed by the strike committee.
   b) I picketed less than 4 hours.
   c) I picketed more than 4 hours.
   d) I do not believe nurses should picket.

COMMENTS:

10. HOW MANY HOURS DID YOU WORK DURING THE STRIKE?
   a) I worked more hours than I usually do.
   b) I worked the same hours as I usually do.
   c) I worked less hours than I usually do.
   d) I did not work any shifts.
   e) I was on sick leave/ WCB/vacation/other LOA.

PERSONAL AND FINANCIAL INFORMATION MAY TELL US MORE 
INFORMATION ABOUT HOW NURSES MADE CHOICES DURING THE LABOR DISPUTE.

PLEASE CIRCLE THE ANSWER(S) WHICH APPLIES TO YOU:

11. SEX: M F
12. MARITAL STATUS S M D W OTHER
13. NUMBER OF DEPENDENTS
   a) none
   b) one
   c) more than one
14. AGE
   a) 19 - 30
   b) 31 - 40
   c) 41 - 50
   d) over 51 years
15. **YEAR OF NURSING GRADUATION**
   
a) before 1960  
b) 1960 - 1970  
c) 1970 - 1980  
d) 1980 - 1985  
e) after 1985

16. **YEARS OF CONTINUOUS NURSING PRACTICE**
   
a) under 2 yrs.  
b) 2 - 5 years  
c) 5 - 10 years  
d) 10 - 15 years  
e) over 15 years

17. **WHAT IS YOUR EDUCATIONAL PREPARATION?**  
(Circle all that apply)

   a) Diploma RN  
b) BSN  
c) Enrolled in BSN program  
d) Enrolled/graduated from Master's program  
e) Enrolled/graduated in university program other than nursing  
f) Post basic nursing program > 3 months  
g) Other:

18. **WHAT TYPE OF EMPLOYMENT DO YOU HAVE?**
   
a) Full time  
b) Part Time  
c) Casual

19. **HOW FINANCIALLY DEPENDENT ON EMPLOYMENT ARE YOU?**
   
a) Withdrawal of any of my salary would place me in financial distress.  
b) I would find it uncomfortable to withdraw my salary longer than a two week period.  
c) I would have to forego luxury items if my salary were withdrawn.

20. **WAS YOUR PERSONAL SOURCE OF INCOME DURING THE STRIKE MAINLY:**  
(Circle all that apply)

   a) earned through essential work shifts  
b) earned through picket pay  
c) earned through on call pay  
d) I did not get paid  
e) My husband/family supported me.  
f) I borrowed money  
g) I used savings
21. IN WHICH TYPE OF HOSPITAL ARE YOU EMPLOYED?
   a) large tertiary care facility
   b) medium acute care facility
   c) small acute care facility
   d) long term care facility

22. WHAT POSITION DID YOU HOLD DURING THE STRIKE?
   a) Staff Nurse
   b) Assistant Head Nurse
   c) Head Nurse
   d) Supervisor
   e) Other:

23. WHAT WAS YOUR AREA OF SPECIALTY?
   a) Emergency
   b) Critical Care
   c) Geriatric
   d) Operating Room
   e) Pediatric
   f) Medical/surgical
   g) Psychiatry
   h) Maternal/Newborn
   i) Other:

24. HOW LONG HAVE YOU BEEN EMPLOYED IN THE HOSPITAL IN WHICH YOU WORKED DURING THE STRIKE?
   a) Less than 2 years
   b) 2 - 5 years
   c) 5 - 10 years
   d) over 10 years

25. DURING THE STRIKE, WERE YOU CONSIDERED "ESSENTIAL SERVICE"?
   a) Yes
   b) No

PLEASE ELABORATE ABOUT YOUR UNION/PROFESSIONAL EXPERIENCE - PLACE A CHECK IN THE SPACE BESIDE THE QUESTION.

26. WERE YOU ACTIVE IN THE UNION BEFORE THE STRIKE?
   a) Yes
   b) No

27. WERE YOU ACTIVE IN THE RNABC BEFORE THE STRIKE?
   a) Yes
   b) No

28. SINCE THE STRIKE, ARE YOU INTERESTED IN BECOMING MORE ACTIVE IN:
   a) THE RNABC
   b) BCNU
   c) Neither
29. WHAT WERE THE MOST POSITIVE ASPECTS OF THE STRIKE?

30. WHAT WERE THE MOST NEGATIVE ASPECTS OF THE STRIKE?

PLEASE FEEL FREE TO SHARE ANY STORIES OR COMMENTS THAT WOULD FURTHER HELP TO CAPTURE YOUR FEELINGS ABOUT THE STRIKE OR YOUR EXPERIENCES DURING THIS LABOR DISPUTE.
This to advise you that Gina Dingwell, R.N. is currently embarked on a research project entitled "Job Action - Attitudes and Actions of Nurses". This project is being completed for her Master's Thesis in Education at Simon Fraser University. Her interest lies in the area of professionalism and unionism.

"The purpose of this study would be to obtain a rich description on the roots of conflict that nurses feel during job action and how they work through the conflict. It is also to provide more specific information on how nurses feel about unionism, professionalism and how this influences the job action that they do or do not carry out."

Gina has been advised that the Union will not give out addresses or telephone numbers of its members. In view of that fact, the BCNU Council has endorsed the posting of a notice to advise members that if they would like to participate in this project they may reach Gina at 274-8597 in Richmond, B.C.

/sb/otcu:15
August 25, 1989

PLEASE POST
October 2, 1989

Dear

Finally! Here are the questionnaires that I spoke with you about over the telephone. I have sent ____ questionnaires to your facility.

I very much appreciate your distributing the questionnaires. There are a few things about your distribution that will help make the study results more successful:

1) Please distribute them to nurses who are in contract and who were at your facility during the strike.

   Responses from a variety of nurses is preferable: Head Nurses, Staff Nurses, Occupational Health Nurses, Supervisors, Instructors etc. as well as responses from a variety of specialty areas i.e. Medical, Surgical, Emergency, O.R., Obstetrics, etc. -- also nurses who are active in the union and those who are not active in the union.

2) Give them to nurses who would like to participate rather than talk someone into doing a questionnaire just to get rid of them!

3) REMINDERS! Some people will need gentle reminders to return their questionnaires. I won't be able to personally send reminder cards to participants since I won't know who they are.

   However, I will send you a reminder shortly so that you may either post it or distribute it personally to those nurses who agreed to take part in the study.

Once again, I am grateful for your help, if there are any questions, please feel free to call me at 274-8597.

Sincerely,

Gina Dingwell, R.N.
APPENDIX IX

Interview Guide - Nurse Administrators

1. How do you feel about nurses taking job action, including striking?

2. What do you think are the reasons for which nurses took strike action?

3. What do you think of the image of striking nurses?

4. Had you any concerns for public safety during the time of job action?

5. How do you view your relationship with nurses during the time of job action?

6. What were the sources of stress that you experienced during job action?

7. How did you feel about the BCNU during the strike?

8. Did you expect nurses to accept or reject the negotiated offer? Why?

9. What, if any, gender issues were apparent to you during job action?

10. What effect do you feel that the dissension between nurses will have?

11. Do you believe that this job action will have any impact on nonnursing management?

12. How much support and understanding of physicians did you feel that nurses had during job action?

13. How did you feel about the role of the RNABC during the strike?

14. What were the positive aspects of the strike?

15. How did you feel about any compensation/privileges that you might have had for your work during job action?
References


Ingram, E.J. (1965). Member Involvement in the Alberta Teacher Association. In Munton, P.A. Unpublished Master of Education project. Simon Fraser University, Burnaby, B.C.


