

**THE GENDERED WORKINGS OF CLASS IN
POSTINDUSTRIAL, SERVICE SECTOR CAPITALISM:
THE EMERGENCE AND EVOLUTION OF THE BRITISH
COLUMBIA NURSES UNION, 1976-1992**

by

Mark Roth
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APPROVAL

Name: Mark Roth
Degree: Master of Arts
Title of Thesis: The Gendered Workings of Class in Postindustrial, Service Sector Capitalism: The Emergence and Evolution of the British Columbia Nurses Union, 1976-1992

Examining Committee:

Chair: Jack Little
Chair, Professor of History

Mark Leier
Senior Supervisor
Professor of History

Gary Teeple
Professor of Sociology

Geoffrey Mann
External Examiner
Assistant Professor of Geography

Date Defended/Approved: July 15, 2009



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ABSTRACT

This thesis explores the emergence and initial evolution of the British Columbia Nurses Union from 1976 to 1992. The thesis argues that class and gender framed interrelated processes of organizational change, labour action, and political consciousness for British Columbia's nurses. These changes took place in the context of a historical struggle between professionalism and trade unionism in nursing, and during a turbulent and transformative era for western capitalism and the role of the capitalist state in the 1970s and 1980s. This thesis argues that class, as a socioeconomic relationship and as lived experience, was the driving force behind organizational, economic, and political change in the nursing occupation. This central assertion stands in sharp contrast to claims that class has ceased to be of socioeconomic or political importance in postindustrial, capitalist society.

DEDICATION

Dedicated to my parents, for their support and encouragement.

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I would like to sincerely thank my thesis supervisors. My senior supervisor, Professor Mark Leier of the Department of History, provided unwavering support and encouragement. His insight and constructive criticism provided great help at every stage of this thesis, and gave me a solid understanding of the historical writing process. Professor Gary Teeple of the Department of Sociology and Anthropology also supervised this thesis and provided vital questions and suggestions in the final stages of the writing process. His help led to a greatly refined thesis, especially in the areas of political economy and the role of the state. When I defended this thesis, Assistant Professor Geoff Mann of the Department of Geography posed constructive questions that made me think about how my thesis interacts and engages with other works in an academic sense. Professor Jack Little of the Department of History posed questions that made me think critically about my work and approach to historical research. This ultimately produced a better thesis and understanding of historical writing, and I would like to sincerely thank them as well. Finally, I would like to thank all of the staff at the British Columbia Nurses Union headquarters in Burnaby, British Columbia, where I conducted most of my research. Despite their constantly busy schedules, they did not hesitate to provide help in locating or reproducing items from the BCNU archives.

TABLE OF CONTENTS

Approval	ii
Abstract	iii
Dedication.....	iv
Acknowledgements	v
Table of Contents.....	vi
Chapter 1: Theory and context: class, gender and organizational issues in nursing from the late 19 th century to the early 21 st century	1
Chapter 2:“We are sitting on dynamite:” The limitations of the professionalization strategy and the shift to trade unionism, 1976- 1983	37
Chapter 3: The limitations of collective bargaining and the emergence of a gendered class consciousness, 1985-1988	71
Chapter 4: Beyond the bargaining table and beyond rhetoric: the BCNU strike and rank and file rebellion of 1989	98
Conclusion:	119
Reference List	127

CHAPTER 1: THEORY AND CONTEXT: CLASS, GENDER AND ORGANIZATIONAL ISSUES IN NURSING FROM THE LATE 19TH CENTURY TO THE EARLY 21ST CENTURY

In 1980, André Gorz bade farewell to the working class in his book of the same title. Gorz claimed that the traditional working class had been replaced by a “post-industrial neo-proletariat”.¹ This group worked jobs that were temporary, deskilled, and meaningless, and did not produce material aspects of society in a post-industrial, service economy.² These workers no longer identified with their work, which was now a “blank interval on the margins of life to be endured in order to earn a little money.”³ Because work was a marginal activity, workers did not identify with any form of class identity, or any form of class politics or organization since work was beyond their scope and control.⁴ In these ways, the post-industrial neo-proletariat formed a non-class that merely needed reduced working hours so that it could focus on activities and identities that lay outside work.⁵ Class had ceased to be of political or social importance. Subsequently, a

¹ André Gorz, Farewell to the Working Class: An Essay on Post-Industrial Socialism (London: Pluto Press, 1980), 69. Gorz was influenced by the economic and political assaults on the working class in the 1970s, and the decline of the traditional blue-collar working class - issues that are addressed later in this chapter.

² Gorz, Farewell to the Working Class, 73.

³ Gorz, Farewell to the Working Class, 70.

⁴ Gorz, Farewell to the Working Class, 70-71.

⁵ Gorz, Farewell to the Working Class, 73.

growing volume of academic literature took the death of class as a given truth.⁶

With class and work out of the picture, other human identities such as culture and lifestyle were worthy of academic inquiry, but were ultimately too fluid and fragmented to form any collective social or political identity.⁷

But the story of nurses in Canada since the 1970s contradicts the arguments and assumptions of those who have discarded class as a form of analysis for contemporary, postindustrial society.⁸ As the death of class was proclaimed in academic circles, nurses engineered a dramatic shift away from their professional associations to class-based organization and action in the form of unions and strikes. Nurses formed independent unions throughout Canada for

⁶ The political and social obsolescence of class is explicitly put forward by Jan Pakulski and Malcom Waters, The Death of Class (London: Sage, 1996), vii. The authors argue that in the postindustrial world, class inequalities have been replaced by status inequalities rooted in culture – including consumption patterns and preferences, value commitments, and access to information. Other works that reject class include Ernesto Laclau and Chantal Mouffe, Hegemony and Socialist Strategy: Towards a Radical Democratic Politics (London: Verso, 1985), which was released in a second edition in 2001, and Zygmunt Bauman, Intimations of Postmodernity (London: Routledge, 1992). The notion that various social groups with different interests have replaced class divisions in a now affluent society is not a new argument, and can be found in a number of post-World War II works such as Ralf Dahrendorf, Class and Class Conflict in Industrial Society (Stanford: Stanford University Press, 1959).

⁷ Ellen Meiksins Wood, “What Is the ‘postmodern’ Agenda?” in Ellen Meiksins Wood and John Bellamy Foster, eds., In Defense of History: Marxism and the Postmodern Agenda (New York, 1997), 7. A central argument in The Death of Class, 155, is that social groups and identity were formed by “a virtually infinite overlap of associations and identifications that are shifting and unstable,” and that quality of life was a matter of personal experience and background, and not constrained by external forces. In this context, a collective political or social identity could not accurately reflect the sheer diversity of people’s experience.

⁸ There is considerable debate and range of opinion over the term postindustrial. This thesis draws on the definitions sketched by Dennis Dworkin, Class Struggles (London: Pearson Educated Limited, 2007), 73, and Patrick Joyce, ed., Class (Oxford: Oxford University Press, 1995) 3-4, to loosely define postindustrial as a shift in capitalist economies - from centralized manufacturing and production to a more diverse service sector and retail economy based on consumption in the 1970s. This should not be mistaken for the end of capitalism, because although the content of jobs and appearance of society have changed, the fundamental socioeconomic relationship did not: waged workers continue to depend on an employer to make a living, while the employer depends on waged labour to generate profits. Indeed, the actions of nurses during this time demonstrated that class and class struggle remained pivotal for social, economic and political change.

the first time in the 1970s and 1980s and went on strike between 1988 and 1991 in Alberta, British Columbia, Quebec, and Manitoba. Nurses again demonstrated their collective power when they went on strike in Saskatchewan, Quebec, and Newfoundland in 1999, and in British Columbia in 2001. In these more recent strikes, provincial governments passed legislation that ordered the nurses back to work after strikes ranging from nine days in Newfoundland to twenty-three days in Quebec.⁹ Weary of escalating a healthcare dispute that saw the public supportive of nurses, each government also provided wage increases for nurses and met a number of their other demands.¹⁰ Although these concessions fell short of nurses' total demands, the strikes sent a sharp warning: nurses could and did engage in effective collective action as workers against governments and employers.¹¹ Collective class action and organization carried the day for nurses, despite two decades of government and employer assaults against the rights of labour and the accompanying academic rhetoric on the death of class. The labour actions of nurses demand an inquiry into the emergence and development of nursing unions in Canada, and a revision of the claim that class ceased to matter as a social relationship or experience during this time.

⁹ "Nurses back to work in Newfoundland," CBC News, <http://www.cbc.ca/canada/story/1999/04/02/nurses990402.html>. "Quebec nurses strike new deal," CBC News, <http://www.cbc.ca/canada/story/2000/03/17/qnurses000317.html>.

¹⁰ "Saskatchewan nurses end strike," CBC News, <http://www.cbc.ca/canada/story/1999/04/18/sasknurse990418.html>. "BC legislates Health Care Cooling Off Period," CBC News, http://www.cbc.ca/canada/story/2001/06/20/bc_health010620.html.

¹¹ The above sources also provide the following overall details:
Newfoundland: 4500 nurses involved, 9 days, legislated back to work; 7% raise, 39 months;
Saskatchewan: 8,000 nurses, 10 days, legislated back to work; 6 and 8% in benefits;
Quebec: 50,000 nurses, 23 days, declared illegal;
BC: wildcatted after legislated back to work, 23.5%, 3 years.

This thesis is a case study that explores the formation and development of the British Columbia Nurses Union from 1976 to 1992. It will ask how and why did nurses shift their strategy from professionalization to trade unionism, and will argue that class and gender framed uneven processes of organizational change, political struggle, and political consciousness. These processes led to labour action and organizational and political change in nursing. These changes began in the late 1970s as the Labour Relations Division of the Registered Nurses Association of British Columbia began to experiment with collective labour strategies. The subsequent emergence of an independent trade union in a period of state-led class warfare, and the union's actions during this period, led to implicit and explicit changes in how nurses thought about the subordinating effects of gender and class. A subjective and gendered class identity emerged that nurses then interpreted and acted on at a grassroots level, which produced concrete changes in unionism and nursing. This had important implications for the role of the RNABC and professionalism, which historically had been the principal organization and strategy for nurses.

Structurally, this thesis is organized chronologically. The remainder of this chapter situates this thesis within the larger historiography on nursing and summarizes the labour issues faced by nurses before 1976, when the RNABC formed an autonomous Labour Relations Division. Chapter two explores how the economic climate of the 1970s led to new labour strategies and a full separation of the Labour Relations Division, which formed the independent British Columbia Nurses Union in 1981. The chapter then considers how the economic and

political climate of the early 1980s conditioned a distinct trade union identity and approach to labour relations for the BCNU. Chapter three explores the limitations of centralized unionism and state-mediated collective bargaining in a climate hostile to labour, and the emergence of a heightened political awareness that included an explicit consideration of nursing as a gendered occupation. Chapter four examines how nurses then rejected state-mediated collective bargaining and centralized trade unionism in 1989 with a provincial strike and a mutiny against the union bargaining committee. The subsequent reorganization of the union along more democratic lines is then explored along with its implications for the relationship between professionalism and unionism in nursing. Together, this analysis sheds light on how independent nursing unions emerged in the 1970s and how they continued to change during the 1980s. These processes are not treated as natural or inevitable, but rather as a continued interplay between nursing leaders and the rank and file in response to changing perceptions of gender and class, internal union dynamics, and political and economic conditions.

Time and space limits on this thesis meant that a limited period had to be chosen for study. The choice of 1976-1992 was not arbitrary, however, and reflects the focus of this study: the emergence and initial evolution of the BCNU. It was in 1976 that the Registered Nurses Association of British Columbia created the BCNU's predecessor, the Labour Relations Division of the RNABC. The BCNU's evolution in the 1980s culminated in a dramatic 1989 strike, with significant implications for the union's organization and its relationship with

professionalism and the RNABC. For this reason, it was appropriate to conclude the period of study with the 1989 strike and its aftermath in the early 1990s. It was also during this initial stage of evolution in the 1980s that the BCNU faced daunting challenges from the state and Social Credit Party. The 1990s, while certainly not without conflict, did not see relentless assaults on nurses' rights with the New Democratic Party in power. Many of the issues that nurses and the BCNU faced in the 1980s have returned in the 2000s with the Liberal Party in power – attacks on labour rights and privatization efforts threaten nurses' wages and working conditions. This is more appropriate for contemporary criticism than for a historical thesis, but certainly, this thesis hopes to provide a background for these contemporary issues and struggles. An analysis of the BCNU from the mid 1990s to the present would be a fruitful exercise, but time and space limits and the topic of this thesis exclude that time period from this study.

The BCNU's newsletter has been utilized as a central source for this thesis. Of considerable length and published roughly every two months, the newsletter provided detailed information on issues such as strikes, collective bargaining, policy debates, political campaigns, and the opinions of leaders and rank and file nurses. As with any historical source, the newsletter cannot be treated uncritically, and this thesis makes no claim that it presents an objective history of the BCNU. Rather, the newsletter is utilized to trace how the BCNU and its leaders interpreted and responded to key events. Whether rank and file nurses shared the union's views has been assessed where possible, and indeed, their role proved pivotal on a number of occasions. But because this is a history

of the views and practices of an institution, rank and file actions are considered only in relation to union matters. Not all nurses were active members, but the union represented nurses on the political scene, at the bargaining table, and in the workplace. The union was the nurses' collective vehicle for social and economic struggle, and this thesis addresses this collective aspect. Other sources utilized include newspapers, academic monographs, journal articles, unpublished academic theses and unpublished union documents from the BCNU archives and library.

Because this thesis will use the concepts of gender and class, it is important to sketch working definitions of these concepts here. Class can be defined as a social and economic relationship, determined by whether one works for a wage, what one does for work and how that work is organized, and whether one is subservient to a manager or employer.¹² If that definition is a bit formulaic for the historian, it is because class is more about how these aspects can interact with other factors to form identities, experiences, and forms of action, all of which can drive historical events. This interactive process is ever-changing, and class as lived experience varies greatly according to historical context.¹³ It does not automatically imply class consciousness, a political awareness of an exploitative socioeconomic relationship. The same can be said for gender: it is less about a rigid objective category and more about how it exists as a human social relationship, how it is experienced, and what its effects are. Gender can be

¹² Wright, Class, Crisis and the State (London: Verso, 1978), 73-74.

¹³ E.P. Thompson, The Making of the English Working Class (New York: Vintage Books, 1966), 9-10.

defined as a central form of social organization that involves an unequal power relationship between women and men in which men typically dominate. Gender is central to social organization because uneven power relationships between women and men are a central part of institutions, economies, and socioeconomic relationships. It frames what opportunities are available in work and careers, helps to form identities and expected social roles, and directly affects lived experience.¹⁴ It could be argued that gender produces class positions in some contexts and vice versa in others. This thesis treats the concepts of gender and class as inextricably linked and central to the process and interplay of historical events.

Closely linked to the concepts of gender and class is the concept of class consciousness. If class and gender are defined by economic and social relations, class consciousness is the way in which people handle their class and gender positions in cultural terms: with ideas, values, organizations, and institutions.¹⁵ This does not mean that productive relations automatically produce an explicit class consciousness, but rather that they play a prominent role in shaping the social and cultural world of human beings, which includes gender relations, politics, and ideology. Class consciousness can be defined as an explicit political awareness of an exploitative socioeconomic relationship, an awareness which can then take concrete form in social institutions and

¹⁴ Joan Acker, Class Questions, Feminist Answers (Lanham: Rowman and Littlefield Publishers, 2006), 5-6. I paraphrase Joan Acker's definition because it is useful as an objective definition but also allows for fluctuation and change according to historical and social context. Ava Baron echoes this approach in her earlier work, "Gender and Labor History: Learning from the Past, Looking to the Future," in Ava Baron, ed., Work Engendered: Towards a New History of American Labor (Ithaca: Cornell University Press, 1991), 36-37.

¹⁵ Thompson, The Making of the English Working Class, 10.

organizations, actions, and ideas. These in turn can provide the basis for action that can challenge and change an exploitative socioeconomic relationship. Class consciousness and its social and economic forms are not static features and change in appearance alongside socioeconomic conditions. In summary, this thesis primarily treats class and gender as power relationships that play a prominent role in forming the social world, politics, and consciousness, which in turn can produce change in socioeconomic organization and relationships. But first, it is instructive to review how the concepts of gender and class have been applied to the historiography on nurses, their work, and their struggles.

Nurses remain a rare topic in academic works that utilize or advocate class and gender as categories of historical inquiry. This is curious, given the traits of the occupation: nursing remains overwhelmingly female, subordinate to the historically male medical profession, and has struggled for adequate recognition of its work in a trend reminiscent of other occupations dominated by women. While nursing has enjoyed a higher status than other areas of female service work, efforts to give it the power, pay, and status of a profession have not put nursing on par with the male medical profession. At the same time, nurses have fought adamantly for wages and working conditions with unionization, protests and strikes. Nurses' demands for adequate value of their work complement feminist demands that women's work be valued and not subordinate to the interests of capitalist patriarchy.¹⁶ Indeed, nurses offer an example of how

¹⁶ For an intellectual history on the relationship between feminist thought and nursing, see Joan Roberts and Thetis Group, Feminism and Nursing: An Historical Perspective on Power, Status, and Political Activism in the Nursing Profession (Westport: Praeger, 1995).

gender differences cannot be ignored and are constitutive of class.¹⁷ These characteristics offer a rich area of inquiry for labour and gender issues, but nursing has been a rare choice for historians concerned with these topics.

Works that do address nurses do not usually consider other occupations. But these works have applied insights from the wider debates on gender and class that so often exclude nursing. As early as 1974, Judi Coburn asked why “the professional drive of nurses has improved their educational standards but has not been reflected in their working conditions, their degree of power, security, or in their wages” and called for “an alliance between skilled and unskilled alike to completely abolish the divide and rule of professionalism”.¹⁸ Coburn was onto something here, because a handful of profoundly insightful works on the history of nursing followed her call to address these issues. These works introduced the critical concepts of class and gender to the history of nursing. In the American context, Barbara Melosh criticized the shortcomings of professionalization and nursing leaders in The Physician’s Hand: Work Culture and Conflict in American Nursing. Susan Reverby’s 1987 book, Ordered to Care: The Dilemma of American Nursing, 1850-1945, supported Melosh’s critique of professionalization but also argued that patriarchal society did not adequately value caring, which

¹⁷ This approach is advocated by Alice Kessler-Harris in Gendering Labor History (Urbana: University of Illinois Press, 2007), 10-11. Like many key works concerned with gender and class, the book provides potential theoretical insights for the history of nursing but does not address the subject: another example is Ava Baron, ed., Work Engendered: Toward a New History of American Labor. For a clear theoretical overview of how Canadian nurses and public hospitals are affected by capitalist values and practices see Rennie Warburton and William Carroll, “Class and Gender in Nursing,” in B. Singh Bolaria and Harley Dickinson, eds., Health, Illness and Health Care in Canada (Toronto: Harcourt, 1994), 556-568.

¹⁸ Judi Coburn, “I see and I am Silent: A Short History of Nursing in Ontario,” in Janice Acton *et al.*, eds, Women at Work: Ontario, 1850-1950 (Toronto: Canadian Women’s Educational Press, 1974), 158.

was not the fault of nursing leaders. JoAnn Whittaker demonstrated how gender thwarted the professionalization efforts of nursing leaders with her 1990 MA thesis, “A Chronicle of Failure: Gender, Professionalization and the Graduate Nurses’ Association of British Columbia, 1912-1935,” and criticized the failure of these leaders to explore alternatives. In 1996 Kathryn McPherson explored the interplay of gender, class, and ethnicity in Bedside Matters: The Transformation of Canadian Nursing, 1900-1990. Collectively, these works criticized the professionalization strategy of nursing leaders; examined nursing as women’s work to explain its historical subordination to medicine; and asked whether nurses’ socioeconomic status benefited more from alternate strategies such as trade unionism. Professionalization can be defined as the struggle to establish control over a type of work, in practice and in regulation, in order to make it a profession: the ability to charge fees from clients instead of dependence on an employer for wages, and control of licensure, educational requirements and training, work content, self-regulation and discipline.¹⁹ Doctors were successful in this struggle, but nurses were not. Nonetheless, from the late 19th century onwards, nursing leaders vigorously insisted on the pursuit and achievement of professional status while rank and file nurses engineered other strategies for socioeconomic advancement and in turn forced nursing leaders to compromise their own. The historiography on how class and gender framed the origins and development of the nursing occupation thus deserve a brief review. This review

¹⁹ Barbara Melosh, The Physician’s Hand: Work Culture and Conflict in American Nursing (Philadelphia: Temple University Press, 1982), 18-19.

must begin with the central role of professionalism in nursing's 19th century origins.

Professionalism in western societies emerged in the later half of the 19th century with the development of industrial capitalism, which brought profound social and economic change. Concentrated urban centers began to grow, traditional social roles changed, and many occupations were mechanized and changed into wage labour. Men of high social standing – military officers, members of public office, and businessmen - sought to establish a type of work that held higher status and promised valuable services to others in this rapidly changing socioeconomic environment.²⁰ This was the aim of aspiring public servants such as male practitioners of medicine. This group was able to establish its work as a domain of important expertise and valuable specialized knowledge. They were also able to self-regulate their occupation by setting their own standards for education and certification, which established careful criteria as to who could practice.²¹ These practitioners enjoyed considerable autonomy in their work and could charge fees from individuals instead of relying on wages from employers. It was these characteristics, accomplished by the late 19th century, which placed these practitioners firmly in the middle class – that is, neither as employers or employees of productive labour.

²⁰ Robert Wiebe, The Search for Order: 1877-1920 (New York: Hill and Wang, 1967), 112-113. Juane Clarke, Health, Illness and Medicine in Canada, 3rd ed. (Oxford, 2000), 239. Magali Larson, The Rise of Professionalism (Berkeley: University of Berkeley Press, 1977), 5. In The Paradox of Professionalism: Reform and Public Service in Urban America, 1900-1940 (New York: Greenwood Press, 1986), pp.1-7 and 179-181, Don Kirschner notes that this emerging public service group, who aspired to be professionals, did so out of a desire to reform society according to their own vision, and to cure what they viewed as the evils of urbanization: health problems, poverty, and chaotic living conditions.

²¹ Wiebe, The Search for Order: 1877-1920, 112-113.

But this achievement of occupational autonomy, central to middle class status, did not happen naturally or because of an intrinsic value in the knowledge of such practitioners. Scientific medical knowledge, technology and practice in the 19th century was not as refined as it would become in the 20th century, or universally accepted by recipients as the only legitimate means for healing.²² Ineffective, highly dangerous, and unscientific therapies were commonplace among physicians in the first half of the 19th century.²³ Indeed, male allopathic practitioners competed with other health practitioners ranging from herbal pharmacists to midwives, and in 1859 homeopathy became the first legalized, self-regulating profession. Allopathic practitioners achieved this only in 1869 with the Ontario Medical Act.²⁴ The success of both groups of male medical practitioners in their quest for professional status was thus the result of a successful social struggle to exclude other practitioners of healing, especially women.²⁵ Such male practitioners were ideally positioned for this struggle: as men of high social standing connected with members of government, these men were able to shut out other health workers by pressing for legislation that allowed control of licensure and educational requirements.²⁶ These requirements

²² Pat Armstrong, "Women's Healthcare Work: Nursing in Context," in Pat Armstrong, Jacqueline Choiniere, and Elaine Day, eds., Vital Signs: Nursing in Transition (Toronto: Garamond Press, 1993), 21.

²³ Magali Sarfatti Larson, The Rise of Professionalism: A Sociological Analysis, 20.

²⁴ Juane Nancarrow Clarke, Health, Illness and Medicine in Canada (Oxford: Oxford University Press, 2000), 241.

²⁵ For a full discussion of this exclusionary strategy, and of how healing was largely women's work that men effectively stole and monopolized in the 19th century, see Thetis Group and Joan Roberts, Nursing, Physician Control, and the Medical Monopoly: Historical Perspectives on Gendered Inequality in Roles, Rights and Range of Practice (Indianapolis: Indiana University Press, 2001), 37-74.

²⁶ Armstrong, "Women's Healthcare Work: Nursing in Context," in Vital Signs, 23 and Larson, The Rise of Professionalism, xv.

typically involved lengthy university programs, which other practitioners were not likely to endorse or be able to afford after learning their skills informally. By the late 19th century, male allopathic practitioners of medicine had won a social struggle to control not only their own work but the entire division of labour in medicine.²⁷ Though they originated from the upper social strata of pre-industrial society, their successful struggle to control their occupation placed them firmly in the urban middle class of industrial capitalist society.²⁸

Upper strata women from the same pre-industrial upper social strata who belonged to a loosely defined nursing occupation sought to form a profession alongside that of male medicine. As with medicine, nursing in the 19th century was not a homogenous occupation. While it generally involved care for the sick in some form, its practitioners ranged from nursing superintendents and poorly paid female aides in hospitals to women performing unpaid work at home. Nursing superintendents, usually from families of high social ranking, sought to establish nursing as a morally respectable and paid occupation, distinct from the work of informally trained working class women and the unpaid work of women in the domestic sphere. Nursing superintendents called for female recruits of high social standing, and began to emulate the strategy of male medical practitioners.²⁹ Professional notions of altruism and service appealed to upper strata nurses because they were compatible with Victorian middle class values

²⁷ Kathryn McPherson, Bedside Matters (Toronto: Oxford University Press, 2003), 13. See also Group and Roberts, Nursing, Physician Control, and the Medical Monopoly, 105-146, for a detailed description of this process.

²⁸ For a discussion on the emergence and impact of an urban middle class in the United States see Wiebe's chapter, "The New Middle Class," in The Search for Order, 111-132.

²⁹ Melosh, The Physician's Hand, 30.

and ideals of femininity such as obedience, servility and morality.³⁰ The idea of a nursing profession under the authority of male medicine also mirrored the structure of the bourgeois family: the nurse would provide vital and obedient assistance to the doctor, as wife did to husband.³¹ And from a socioeconomic perspective, professionalism seemed to offer a route to establish nursing as a respectable and paid occupation for women. But this was to be an occupation informed by pre-existing gender roles, which suggested a status different from male medicine.

The emergence of nursing as a female occupation subordinate to male medicine demonstrates how gender relations can have a causal impact on class relations; that is, certain class positions may only emerge because of pre-existing gender relations.³² In this line of argument, nursing emerged as an occupation in the late 19th century because it mirrored the broader gender role of women as helpful but subservient wives in the home. Male doctors required medical assistants who did not threaten the status of their profession, so existing gender roles facilitated the emergence of a subordinate, female nursing occupation. As Kessler-Harris argues, “since neither household nor wage work is independent of the other, gender participates in class formation just as wage work participates in gender formation.”³³ Thus gender roles of the time suggested that professional

³⁰ Veronica Strong-Boag, “Making a Difference: The History of Canada’s Nurses,” Canadian Bulletin of Medical History Vol. 8 (1991), 237.

³¹ Terry Wotherspoon, “Nursing Education: Professionalism and Control,” in B. Singh Bolaria and Harley Dickinson, eds., Health, Illness and Health Care in Canada (Toronto, 1994), 577.

³² Erik Olin Wright, “A Conceptual Menu for Studying the Interconnections of Class and Gender,” in Janeen Baxter and Mark Western, eds., Reconfigurations of Class and Gender (Stanford: Stanford University Press, 2001), 30-31.

³³ Kessler Harris, Gendering Labor History, 138.

status for nurses meant something different than professional status for male doctors. The male medical profession was an affirmation of middle class men's expected roles: mastery and control over skilled non-wage work in the public sphere, and work that was of a higher status in terms of pay and perceived value. But for women, the professional career presented a contradiction. While public service and morality were acceptable pursuits, their primary role was still in the domestic sphere.³⁴ If they did wish to work, this was a temporary arrangement until they married and not a path to independence; therefore, they did not require the wages that men did. In keeping with these carefully defined gender roles, middle class nursing leaders accepted nursing as subordinate to medicine. Nursing was to be a middle class profession, but an inherently gendered one defined by obedience to male doctors, female virtue, caring, sacrifice and lower pay. The effects of this arrangement on nurses would be felt for decades to come, which the remainder of this chapter will explore.

Although nursing leaders accepted nursing as subordinate to male medicine, they emulated medicine's strategy to establish itself as a profession. For it was certainly not their intention to establish nursing as an impoverished profession. By the late 19th and early 20th centuries, upper strata nurses across North America formed associations that campaigned for legal control over who could nurse, standards for training and education, and registration that entitled the use of the label Registered Nurse or RN.³⁵ Nursing leaders hoped this

³⁴ Melosh, The Physician's Hand, 26-27.

³⁵ Wotherspoon, "Nursing Education: Professionalism and Control," in Health, Illness and Health Care in Canada, 578. The RNABC, originally named the Graduate Nurses Association of British Columbia, formed in 1918.

strategy would eliminate informally trained practitioners and move what was sometimes women's unpaid domestic work into the realm of paid medical labour.³⁶ These two goals were largely accomplished by the 1920s.³⁷ Nursing associations continued to upgrade their educational and training requirements, with the assumption that higher qualifications would give nursing a professional status similar, if still subordinate, to medicine.

For the majority of working nurses who were not superintendents or association leaders, the occupation remained firmly in the realm of women's service work with poor working conditions and low wages.³⁸ The assumption that nursing could achieve professional status akin to medicine proved deeply flawed due to constraints of gender and class. Put succinctly, "What nurses and other women striving for more traditional professions failed to recognize was that the criteria that they were trying to meet were established by men... by accepting these criteria, and striving to meet them, nursing was supporting the existing

³⁶ Not surprisingly, resistance and refusal to meet these standards was commonplace among most nurses who faced a marginalized socioeconomic existence. In the American context, see Susan Reverby, Ordered to Care: The Dilemma of American Nursing, 1850-1942 (New York: Cambridge University Press, 1982), Chapter 7.

³⁷ McPherson, Bedside Matters, 76. Just as it became paid work, nursing, like most occupations, suffered greatly during the Great Depression from chronic underemployment. But this was further exacerbated by the hospital training system endorsed by professional associations: a handful of paid graduate nurses would supervise large numbers of students, who upon graduation, had to look to private duty for employment. Since few nurses worked in hospitals, the result was an oversupply of nurses in private duty who had to compete for dwindling numbers of patients. For a concise overview of this situation, see McPherson's chapter "An Occupation in Crisis: The Third Generation of Graduate Nurses, 1920-1942," in Bedside Matters, 115-163.

³⁸ McPherson, Bedside Matters, 138, includes the findings of George Weir, Survey of Nursing Education in Canada (Toronto: Toronto University Press, 1932) who found the average annual income of private duty nurses to be \$1,022 while minimal living costs, including basic necessities, ranged between \$1,386 and \$1,590.

patriarchal order.”³⁹ Nursing leaders had not considered that the success of male medical practitioners was due to social power that preceded their achievement of professional benchmarks. Intertwined with this gendered subordination were the class interests of doctors and hospital administrators. The medical profession required the permanent subordination of nursing to maintain autonomy and control over the division of labour in medicine.⁴⁰ Hospital administrators had an interest in this subordinate arrangement as well. Nurses provided inexpensive labour, and with their emphasis on caring, helped to transform the hospital from an institution where people went to die to a profitable one where people went for treatment and recovery.⁴¹ Hospitals were also the training centers for nurses, with the full approval of nursing associations, and could rely on student nurses for free labour as recently as the 1970s.⁴² Nursing leaders accepted hospital training because it offered a secure place in the medical division of labour, formal instruction, standardized curricula, and a physical space where the moral conduct of female trainees could be monitored.⁴³

³⁹ Judith Wuest, “Professionalism and the Evolution of Nursing as a Discipline: A Feminist Perspective” Journal of Professional Nursing 10, Num. 6 (1994), 361.

⁴⁰ Armstrong, “Women’s Healthcare Work: Nursing in Context,” in Vital Signs, 26, provides a succinct summary of this dilemma: “Following the doctors’ example of seeking state sanction for their right to admit and certify members did not help the nurses acquire the same kinds of power that doctors enjoyed, however. Nurses’ power was restricted by the fact that doctors were already in a position to have an important influence on the definition of nursing and the extent of nurses’ rights. Moreover, the doctors’ strategy for gaining power failed to work for nurses because most nurses were employees rather than independent employers like doctors and thus had little direct control over their working environments. Furthermore, the fact that nurses were women in a patriarchal society severely limited their access to power. Thus, the certification strategy initially served more to strengthen the hierarchy than it did to strengthen nurses in their daily work.”

⁴¹ Wotherspoon, “Nursing Education: Professionalism and Control,” in Health, Illness and Health Care in Canada, 577.

⁴² Armstrong, “Women’s Healthcare Work: Nursing in Context,” in Vital Signs, 25.

⁴³ Wotherspoon, “Nursing Education: Professionalism and Control,” in Health, Illness and Health Care in Canada 578.

But this arrangement only continued a cycle of subordinate status. Even in the private duty sector, nurses faced chronic unemployment and often depended on doctors' referrals for work.⁴⁴

Despite the above obstacles to professional status, nursing association leaders strove for occupational control and increased educational standards in the interwar era. In British Columbia, the Registered Nurses Association of British Columbia achieved control over educational requirements and criteria for proper training facilities in the 1920s, and pushed for ever higher qualifications thereafter.⁴⁵ But working conditions for private duty nurses were serious enough to warrant an investigation on a national scale by the Canadian Medical Association and the Canadian Nurses Association, which resulted in the 1932 Weir Report. Under the authority of the provincial government in British Columbia, an Advisory Committee on Labour Conditions under Miss Rex Eaton launched an investigation into the working conditions of hospital nurses in that province in 1937. Both investigations found nurses underpaid in deplorable working conditions.⁴⁶ This situation hardly suggested a professional status, and demonstrated a gap between the aspirations of nursing leaders and the actual socioeconomic conditions faced by working nurses. Nurses had turned to the

⁴⁴ David Coburn, "Professionalization and Proletarianization: Medicine, Nursing and Chiropractic in Historical Perspective," Labour History 34 (1994), 152.

⁴⁵ Whittaker, "A Chronicle of Failure," 126 and Armstrong, "Women's Healthcare Work: Nursing in Context," in Vital Signs, 26.

⁴⁶ Nurses who were employed worked 43-65 hours per week with a half-day off weekly, and in the case of night duty, 48-84 hours per week. The report recognized that these hours, combined with physical and emotional strain and considerable responsibilities, were contributing to a fatigue and deterioration of health not typical of the average worker – and that under these conditions, the contraction of tuberculosis and other diseases was a very real threat. Miss Rex Eaton, Report of the Advisory Committee, 12-37 as cited in Goldstone, "The Origins and Development of Collective Bargaining by Nurses in British Columbia", 33.

government for help and not the RNABC, which did not even initiate its own inquiry or plan for help at a time when both were sorely needed.⁴⁷

Working nurses, particularly those in private duty, responded to the failure of professionalization to address their marginalized socioeconomic status. They criticized nursing superintendents and nursing associations for failing to help working nurses.⁴⁸ But in British Columbia it was hospital nurses who most directly challenged the strategy of professionalism espoused by their professional association. In 1939, nurses at St. Joseph's Hospital in Comox launched the first nurses' strike in the province's history. After a full week of job action, the hospital board granted the nurses' demands for an eight hour day, a six day work week, two weeks annual vacation and sick leave, improved meal quality, and \$2.50 per month for laundry. The nurses had conducted the strike without RNABC involvement, and it was soon clear why. The Executive Council of the RNABC quickly condemned the strike and decided that "...a letter be sent to the nurses who left the hospital...drawing to their attention the seriousness of their action and disapproval of the council and that a copy of this letter be formulated by the Association lawyer and the whole matter be referred to the Legislation Convenor."⁴⁹ Forced to take a stance by the nurses' tactics, the RNABC made it clear that trade union tactics such as the strike were unacceptable in a

⁴⁷ McPherson, Bedside Matters, 150.

⁴⁸ Such dissent was highly evident in the Canadian Nurse magazine in the 1920s, which is particularly well documented in Kathryn McPherson's PhD thesis, "Skilled Service and Women's Work: Canadian Nursing, 1920-1939," pp.357-70 and Chapter 6.

⁴⁹ *Executive Council Minutes* May 19, 1939 as cited in Goldstone, "The Origins and Development of Collective Bargaining by Nurses in British Columbia", 37. The hostile reaction of RNABC leadership is also well documented in JoAnn Whittaker, "The Comox Nurses Strike of 1939", BC Historical News 22 No.4 (1989), 18-20.

professional association – even if this meant tangible improvements in the working conditions of nurses.

Hardly unique to British Columbia, the failure of professionalization to advance the socioeconomic status of nurses in the interwar era was common across North America.⁵⁰ Working nurses voiced frustration and pioneered alternative strategies to improve their marginalized socioeconomic status. The Weir Report, the Eaton Report, and the 1939 strike at Comox demonstrated that even though professionalization had done little to address the working conditions and socioeconomic status of nurses, nursing leaders failed to organize alternate strategies – and condemned the successful alternatives of working nurses. Working nurses had begun to rebel against the middle class, professional orientation of nursing leaders, and would soon force major changes in the nursing occupation.

Indeed, the strike at Comox in 1939 foreshadowed a shift in the occupation that forced nursing associations to reconsider their strict adherence to professionalism. During World War II, hospital work replaced private duty as the main area of employment for nurses. This shift intensified the conflict between nursing as an aspiring profession and as a working class occupation. With this shift, class became an explicit organizational and identity issue in nursing. Objective changes in nursing work seemed to firmly place nurses in the working class. This was not entirely negative; nurses made tangible gains such as regularly paid work and employment in an institution, unlike the erratic demands

⁵⁰ Melosh, The Physician's Hand, 34, 76.

of families in the interwar private duty market. In the hospital, nursing work and medical work became more interdependent which qualified the amount of authority doctors held over nurses.⁵¹ As medical knowledge and specialization expanded, a number of tasks previously restricted to doctors were reallocated to nurses, such as prescribing and administering new drugs like penicillin and pituitrin, blood transfer and banking, and close monitoring of patients in post-surgery rooms.⁵² Hospitals hired auxiliary workers to perform what were deemed less skilled tasks, previously done by nurses, so nurses could focus on their new responsibilities. These auxiliary workers, which included men, came under the authority of nurses who seemed to now occupy a firm middle position in the hospital hierarchy.⁵³ But the shift to hospital employment also brought a considerable degree of proletarianization to nurses' work. Proletarianization can be defined as the application of capitalist labour relations and modes of production to an occupation, such as wage labour, routinization, and managerial control of the workplace.⁵⁴ Via this definition, nurses experienced proletarianization with the switch to institutional employment under a third party, managerial supervision and authority, waged labour, and scientific management – all of which cut into the amount of control nurses had over their work.⁵⁵ Although they shared in a general wartime increase in wages, working conditions remained extremely taxing with long hours under heavy workloads that nurses

⁵¹ Melosh, The Physician's Hand, 189.

⁵² McPherson, Bedside Matters, 220-221.

⁵³ McPherson, Bedside Matters, 223.

⁵⁴ McPherson, Bedside Matters, 8.

⁵⁵ McPherson, Bedside Matters, 227-231. Coburn, "Professionalization and Proletarianization," Labour History, 351.

did not control. The nursing shortage that persisted throughout the war was due to these very conditions, according to rank and file nurses, since other jobs opened for women in the context of a wartime economy.⁵⁶ By these standards, nurses had more in common with the working class than with professionals who set their own fees and workloads.

At the same time, a class split occurred in the occupation itself. While general duty nurses worked directly with patients, others became nurse-managers and performed administrative duties. A two-tiered class structure emerged amongst hospital nurses, with general duty RNs coming under the authority of nurse-manager RNs.⁵⁷ Both types of nurses were members of professional associations such as the RNABC.

The shift to wage work for general duty nurses in hospitals and the emergence of nurse-managers created a difficult organizational and identity question. While some nurses were managers who were more likely to identify with traditional professionalism over trade unionism, a growing number of nurses worked as employees in hospitals. Could nursing associations, dominated by a managerial and educational elite, continue to pursue a professionalization strategy exclusive from trade unionism?⁵⁸ The Canadian Nurses Association, which represented both managerial and general duty nurses, grappled with this issue. The CNA continued to stress the professional image of the nurse with

⁵⁶ Melosh, *The Physician's Hand*, 195. This was common sentiment among American nurses. Diana Mansell also notes a gap emerged between professional goals and practical rank and file demands at this time in *Forging the Future* (Ann Arbor: Thomas Press, 2004), 169.

⁵⁷ McPherson, *Bedside Matters*, 230.

⁵⁸ Coburn, "Professionalization and Proletarianization," *Labour History* 34, 153.

ideals of service and duty, but general duty nurses began to join non-nursing labour unions.⁵⁹ This was a sign that due to changes in their work, general duty nurses subjectively identified themselves as working class - or at least in need of working class strategies such as trade unionism. The CNA quickly condemned this possibility, as did the RNABC during the Comox nurses' strike in 1939. But the migration of general duty nurses to labour unions was not a trend that could be ignored by professional associations, and the provincial associations soon needed a national policy statement on the relationship between professional associations and trade unions. By 1944, the Canadian Nurses Association reversed its position and recommended that the provincial professional associations endorse and begin to conduct collective bargaining.⁶⁰ Given the passage of PC 1003 in the same year, professional associations had little choice if they wanted to maintain organizational unity for the nursing occupation. This was because PC 1003 introduced compulsory collective bargaining: if a union could prove to a labour relations board that it represented the majority of employees, it became their legally certified bargaining agent.⁶¹ Nursing associations realized that nurses would come under the jurisdiction of hospital unions, so they endorsed collective bargaining to keep nurses in their professional associations. In British Columbia, for example, the RNABC rejected the endorsement of collective bargaining in 1944. But when the Hospital Employees Union set up the Nurses and Professional Worker's Union Local 126

⁵⁹ Mansell, Forging the Future, 158.

⁶⁰ Mansell, Forging the Future, 158; Elaine Day, "The Unionization of Nurses," in Vital Signs, 94.

⁶¹ Craig Heron, The Canadian Labour Movement: A Short History (Toronto: James Lorimer & Company, 1996) 72. This was enshrined by 1948 with the Industrial Relations and Disputes Investigation Act. Heron, The Canadian Labour Movement, 76.

at Vancouver General Hospital in 1946, which included nurses, the RNABC reversed its policy and campaigned to become the bargaining agent for all hospital nurses in the province. This reversal of policy came as RNs joined the HEU at several hospitals, and the RNABC convinced nurses to come back under its bargaining jurisdiction.⁶² While PC 1003 was the legal spark for the RNABC's endorsement of collective bargaining, this evolution in policy also reflected the shift to hospital employment and the demand by working nurses for forms of representation that recognized their class position as employees in institutions.

This was a significant shift because in prior decades, a managerial and educational elite stifled union organization and steered nursing towards a professional identity and organization of service, duty, and altruism.⁶³ But working nurses continued to force professional associations to adapt to occupational changes, and began to steer a much more militant course. In 1957 and 1959, nurses at major British Columbian hospitals took a strike vote. This was a radical rejection of RNABC policy that stated that strike action would never be used to settle a collective agreement.⁶⁴ In the event of a dispute over contract settlement, the RNABC maintained that it would always accept the terms of conciliation boards; but in 1957 and 1959, employers at a number of hospitals

⁶² Peter Dent, "The Beginnings," Unpublished Paper, BCNU Archives, 1982, 7-10. Peter Dent was the BCNU Labour Education Officer in 1982 and wrote a brief history of the RNABC and labour issues based on archival material and interviews with former leaders and labour activists in nursing. The HEU regarded the return of nurses to the RNABC as a major setback to the unionization movement in healthcare: Patricia Webb, The Heart of Healthcare: The Story of the Hospital Employees Union (Vancouver: HEU, 1994), 24-25.

⁶³ Coburn, "Professionalization and Proletarianization," Labour History 34, 153.

⁶⁴ Dent, "The Beginnings," 17.

rejected the terms of conciliation boards.⁶⁵ Under pressure from rank and file nurses who were concerned over wages, the RNABC changed its anti-strike policy and backed the decision of nurses to conduct a strike vote.⁶⁶ In 1968, nurses threatened to strike on a province-wide scale even though the employer, now the provincial government's BC Hospitals Association, had accepted the terms of a conciliation board. For a second time nurses rejected RNABC policy by conducting a strike vote for the purpose of economic gain, not because the employer refused conciliation terms. The RNABC again accepted this pressure from the grassroots.⁶⁷ BC hospital nurses voted to strike again in 1974 and 1980 over economic issues, and provincial government nurses did the same over their first contract in 1976. While nurses had only voted to strike twice in the twenty years between 1946 and 1967, they voted to strike three times in the twelve years between 1968 and 1980. Increasing strikes and strike votes were a national trend in the 1970s, and nurses formed independent unions in every Canadian province between 1973 and 1981 except Quebec and PEI, where they formed unions in 1987 and 1988.⁶⁸ This process of militancy and change represented a shift in the class interests that drove nursing. While middle class professional concerns drove the emergence and development of nursing from

⁶⁵ Goldstone, "The Origins and Development of Collective Bargaining," 66.

⁶⁶ Goldstone, "The Origins and Development of Collective Bargaining," 74-6.

⁶⁷ Dent, "The Beginnings," 26, and Goldstone, "The Origins and Development of Collective Bargaining," 79. Goldstone notes here that the pressure to change strike policies came from a grassroots level due to their concern over securing satisfactory contracts and the timid stance of Association leaders.

⁶⁸ Marjorie McIntyre and Carol McDonald, "Unionization: Collective Bargaining in Nursing" in McIntyre, Thomlinson and McDonald, eds., Realities of Canadian Nursing: Professional, Practice and Power Issues (Philadelphia, 2006), 305. McPherson, Bedside Matters, 253.

the late 19th century through the interwar era, working nurses engineered their own major changes in the occupation from World War II onwards.

Nursing had firmly moved into the realm of trade unionism. But professional nursing associations and their strategies did not disappear. Two types of organizations with two different strategies now sought to advance the socioeconomic status of nurses. Professional associations pursued traditional goals, such as higher certification standards, with renewed vigour in the 1970s and 1980s, including a push for university training.⁶⁹ At the same time, nursing unions fought for better wages and working conditions with collective bargaining and strikes. The two strategies were not necessarily compatible. Once the organizations became independent from each other, professional associations did not support strikes, and unions did not support professional association plans for higher credentials. For instance, unions did not support professional association plans to make a Baccalaureate Degree the minimum requirement for entry into practice because many nurses did not hold university degrees.⁷⁰ In part, the two different strategies continued the two-tiered structure in nursing that had emerged after World War II: nurse managers wanted increased credentials to secure and advance their status, while general duty nurses moved towards trade unionism.

⁶⁹ Merle Jacobs, "Nursing, A Pink Collar Ghetto? From Semi-Professional to Professional," in Jacobs and Bosanac, eds., The Professionalization of Work, 130.

⁷⁰ Mansell, Forging the Future, 195-196. The BCNU did not support the RNABC goal of the Baccalaureate degree as mandatory for entry into practice, and the RNABC's failure to support the BCNU during its 1989 strike led to enormous tension between the two organizations. This issue is explored in detail in chapter four.

By the 1970s, then, class again became an explicit organizational and identity question in nursing. The conflicting strategies of trade unionism and professionalization pointed to a debate over class that was not limited to the nursing occupation. In the 1970s, nursing was one of a number of emerging occupations deemed part of the new middle class or service class.⁷¹ These terms generally referred to the white collar service class that was replacing the traditional blue collar workforce centered in manufacturing. Considerable debate emerged over whether this service class was new, middle class, or significantly different from the blue collar working class after all.⁷² Perhaps most usefully, these debates refined objective class definitions and allowed for ambiguities.⁷³ Erik Wright put forth the notion of “objectively contradictory class positions” in the emerging service class – positions that had characteristics of both control and subordination in the labour process.⁷⁴ Of these positions, general duty hospital nurses occupied that of the semi-autonomous employee, those who neither owned nor controlled the means of production but maintained control of their own labour power, putting them between the proletariat and petty-bourgeoisie.⁷⁵

⁷¹ Nicholas Abernethy and John Urry drew a distinction between white collar workers, deemed to be working class, and an emerging service class, deemed to be middle class due to their frequent employment in bureaucracies where promotions entailed greater control over the labour process, Capital, Labour and the Middle Classes (London, 1983), 118-119.

⁷² Wright, in Class, Crisis and the State, 44, argued against Poulantzas’ notions that the new service class performed unproductive labour, and that its ideological and political factors mattered more than economic relations. Wright, Class Crisis and the State, 81, sided with Braverman in that most of the emerging white collar work was subject to proletarianization.

⁷³ Building on his initial work, Wright has more recently noted that subjective class experience can be affected by “degrees of autonomy, closeness of supervision, levels of responsibility, cognitive complexity of tasks, physical demands of work, promotion prospects...reflecting a specific form of distribution of the rights and powers over the process of production”. Erik Wright, “Foundations of a neo-Marxist Class Analysis in Erik Wright, ed., Approaches to Class Analysis (Cambridge: Cambridge University Press, 2005), 15.

⁷⁴ Wright, Class, Crisis and the State, 61-62.

⁷⁵ Wright, Class, Crisis and the State, 82.

General duty nurses came under the authority of management and doctors, but also had authority over auxiliary hospital workers. Management nurses, meanwhile, did not own the means of production - the hospital - but had a greater scope of decision-making and controlled the labour power of others, including general duty nurses. Via these definitions, general duty nurses enjoyed an elevated status within the working class, perhaps on their way to something higher, while management nurses occupied a middle class status – the long time goal of professional associations and their leaders.

But as Harry Braverman cautioned in Labor and Monopoly Capital, an occupation should not be deemed middle class just because it shares characteristics of both employer and employee – for instance, a position that is waged labour but also holds authority over other workers, as was the case for both managerial and general duty nurses.⁷⁶ What, then, defines the working class? Under capitalism, the working class is large, diverse, and stratified with various levels of pay and control over their work. Despite these variations, working class people share important characteristics that define their social and economic position: they do the direct work of production of goods or services, and depend on selling their labour power to an employer for wages in order to make a living.⁷⁷ The working class is constantly being created and recreated according to the needs of capitalism, which means that jobs can shift in content and appearance. But these ongoing changes do not change the fundamental

⁷⁶ Harry Braverman, Labor and Monopoly Capital: The Degradation of Work in the Twentieth Century (New York: Monthly Review Press, 1974), 407.

⁷⁷ Michael Zweig, The Working Class Majority: America's Best Kept Secret (Ithaca: Cornell University Press), 34.

social and economic relationship in capitalism: workers still depend on selling their labour power to an employer for a wage, and capitalists require this waged labour to make profits.⁷⁸ For example, although the expanding white collar occupations of the 1970s such as nursing may have enjoyed some initial higher status within the working class, they were soon subject to the pressures of proletarianization: limited control of the workplace, a downwards pressure on wages, labour rationalization, and managerial control.⁷⁹ This is vital for capital to maintain its control of the division of labour, which is central to its profit-making abilities. Thus for Braverman, whatever the middle class trappings of occupations such as nursing, “the proletarian form begins to assert itself and to impress itself upon the consciousness of these employees”.⁸⁰

It might be countered that in Canada, nurses do not fit into an analysis of capitalism and class because they are employed in the public sector. Nursing in Canada would be deemed unproductive labour in Braverman’s terms, as it does not directly contribute to surplus value, or profits. But this form of labour has grown rapidly in the private sector as manufacturing technology becomes more sophisticated and requires fewer production line workers; thus labour that allows the realization of profits has grown.⁸¹ Hospitals and their employees are vital for the realization of capitalist profits because they consume commodities from the

⁷⁸ Braverman, Labor and Monopoly Capital, 377-378.

⁷⁹ Braverman, Labor and Monopoly Capital, 408.

⁸⁰ Braverman, Labor and Monopoly Capital, 408.

⁸¹ Braverman, Labor and Monopoly Capital, 414-415. Braverman notes here that this type of labour includes distribution, packaging, sales, advertising and so on – jobs typical of the service economy.

pharmaceutical and medical equipment industries.⁸² But on a deeper level, public sector workers such as nurses do not exist outside the capitalist socioeconomic order – rather, they are at its centre. This is because nurses are employees of an institution that is essential to capitalism’s ability to function: the state. Capitalism and so-called free enterprise fundamentally depend on the state for legal protection, ideological promotion, and perhaps most importantly, financial grants and investment from tax money – a substantial amount of which comes from personal income tax on workers.⁸³ Thus on an indirect level, the spending and taxing priorities of the state exploit state workers because their primary aim is to support private enterprise: not the creation of jobs, but rather private sector profit accumulation. Taxes also subsidize areas of industry that are not profitable for private enterprise but are vital to its functioning, such as initial investment and infrastructure.⁸⁴ At a more direct level, public sector work organization is modelled after the exploitation of wage labour in the private sector

⁸² Warburton and Carroll, “Class and Gender in Nursing,” in Health, Illness and Health Care in Canada, 557.

⁸³ This view comes from rigorous study on the role of the state by the Quebec Federation of Labour (Fédération des travailleurs de Québec) entitled “The State Is Our Exploiter,” trans. Claude Hénault in Daniel Drache, ed., Québec – Only The Beginning: The Manifestoes of the Common Front (Toronto: New Press, 1972) 157-8. Taxes that come primarily from workers and sales tax, and not corporate tax, form substantial government grants of public money to private sector companies. These grants assist private profit accumulation instead of job creation and sound economic development, and are particularly well-documented with financial evidence pp. 165-203. Another full-length study of the capitalist economy and state based on financial evidence, how this system exploits workers, and how unions can fight to change capitalist society, is available in Quebec Labour: The Confederation of National Trade Unions Yesterday and Today (Montréal: Black Rose Books, 1972). Similar research by the BC Federation of Labour would provide a sound basis for criticism of state spending policies and a useful overall perspective for state workers.

⁸⁴ “The State Is Our Exploiter,” trans. Claude Hénault in Daniel Drache, ed., Québec – Only The Beginning, 204.

and corporate notions of efficiency and cost-accountability.⁸⁵ This entails the subordination of nurses to managerial and administrative structures in hospitals, which aim to get the most amount of work out of nurses for the least amount of cost – with often disastrous results for nurses and their patients.⁸⁶ This is because the state’s financial and ideological priorities, as noted above, lie elsewhere. As a result, public sector workers fit very well into an analysis of class and capitalism because they work for the state – an institution that supports an economic system that exploits workers. Public sector workers remain waged labourers who depend on an employer to make a living, and are not exempt from the proletarianization of white collar jobs in the private sector.⁸⁷ They are not public servants, but rather workers for an institution that is central to capitalism’s ability to function.

Braverman would have angered professional nursing associations and their leaders who sought a middle class status for nursing, but his assertions about white collar occupations proved accurate. Independent nursing unions emerged and resonated in Canada in the 1970s and 1980s, which suggested that nurses were feeling the effects of proletarianization and that professionalization had some shortcomings that unions addressed. Indeed, research on nursing work pinpoints the 1970s and 1980s as a vital transformative

⁸⁵ Warburton and Caroll, “Class and Gender in Nursing,” in Health, Illness and Health Care in Canada, 560.

⁸⁶ This is particularly well researched in detail by two former nurses, Janet Rankin and Marie Campbell, in Managing to Nurse: Inside Canada’s Health Care Reform (Toronto: University of Toronto Press, 2006).

⁸⁷ Bob Carter provides a succinct study how managerial practices borrowed from the private sector effectively ended the autonomy enjoyed by nurses in Britain’s National Health System; again, this was in the interest of cost control and economies of scale. Bob Carter, Capitalism, Class Conflict and The New Middle Class (London: Routledge & Kegan Paul, 1985), 142-150.

era. During this time, managerial reform and rationalization efforts had an enormous impact on nurses and their work as health care costs escalated amidst a worsening economic situation. Nursing labour, a large part of hospital budgets, was a key target, and nurses experienced an increased workload and less control over their work settings.⁸⁸ Managerial reforms that sought to redefine the role of nursing in institutional settings thwarted professional goals of autonomy.⁸⁹ This only intensified the push for professionalization, viewed by some nursing leaders as the only way to escape this increasing managerial authority and deterioration of working conditions. This push focused on the interrelated development of a unique body of therapeutic knowledge, stricter regulation and certification standards, university training for Registered Nurses, and the establishment of categories above the Registered Nurse such as the Nurse Practitioner.⁹⁰

But as with the professionalization efforts earlier in the 20th century, the efforts that began in the 1970s and 1980s have been heavily criticized by

⁸⁸ Janet Rankin and Marie Campbell, Managing to Nurse: Inside Canada's Health Care Reform, 28. Armstrong, "Women's Healthcare Work: Nursing in Context," in Vital Signs, 43-49.

⁸⁹ Paul Parkin has explored how general managers in the British National Health Service Trusts have the political mandate and power to redefine nursing's role, and that managerial reform has largely thwarted professional goals of greater autonomy, authority and status: "Nursing the Future: A Re-Examination of the Professionalization Thesis in The Light of Some Recent Developments," Journal of Advanced Nursing 21 (1995), 565. Keith MacDonald, in The Sociology of the Professions (London: Sage Publications, 1995), 143, notes that "...the Thatcherite emphasis on a market orientation in public service means that the managerial ethos has been strengthened, and professionalism disadvantaged....hospital managerialism aims at the routinization and deskilling of nursing tasks, in the search for greater cost-effectiveness."

⁹⁰ Parkin also notes how nursing leaders have strived to develop a body of knowledge that is separate from medicine and emphasizes a unique blend of caring and science which nursing contributes to the therapeutic process, 563. See also Damien Brennan, "The Social Construction of 'woman's work': Nursing Labor and Status," Journal of Nursing Management 13 (2005), 283-284. Brennan asks whether the development of nursing research and knowledge will succeed when "caring labor continues to be devalued in contemporary society," 284.

academics in nursing. An uncritical acceptance of what constitutes a profession has meant the continuation of a historical trend where nursing seeks the same traits as medicine such as a specialized body of knowledge, university training, and occupational autonomy.⁹¹ Although these goals may be partially fulfilled, this does not translate into professional status for nursing on par with that of medicine. As in prior decades, this has continued a process where doctors pass off tasks to nurses so that nurses become junior doctors instead of professional nurses.⁹² This is because the medical establishment has remained in control of the division of labour and of medical knowledge.⁹³ Feminist scholars have pointed out the futility in the continued drive to emulate the traditional medical model of professionalism since it is “imbued with the mark of masculinity, and nursing has been constructed as an adjunct to this masculinized model of a profession.”⁹⁴ Others argue the lasting impact of nursing’s 19th century middle class origins has been detrimental. With an emphasis on nursing as a profession of morality and womanly virtue, which has remained central to occupational

⁹¹ Bernard Yam, “From Vocation to Profession: The Quest for Professionalization of Nursing,” British Journal of Nursing 13 No. 16 (2004), 979.

⁹² Peter Morrall, Sociology and Nursing (London: Routledge, 2001), 97.

⁹³ Peter Morrall, Sociology and Nursing, 98.

⁹⁴ Celia Davies, Gender and the Professional Predicament in Nursing (Buckingham: Open University Press, 1995), 134. Rather than rejecting the strategy of professionalization outright, Davies argues for a dislodging of the historically gendered model of professionalism in favour of a much more interactive model that brings to the foreground, and does not trivialize, a type of feminine nurturing that blends caring and science. Other authors maintain that the devaluation of women’s work remains an enormous obstacle not likely to be solved by professionalization efforts: Damien Brennan, “The Social Construction of ‘Women’s Work’: Nursing Labor and Status,” Journal of Nursing Management No.13, 2005, pp. 282-285; Florence Melchior, “Feminist Approaches to Nursing History,” Western Journal of Nursing History No.26, 2004, 340-345; Judith Wuest, “Professionalism and the Evolution of Nursing as a Discipline: A Feminist Perspective,” Journal of Professional Nursing No.6 Vol.10 November-December 1994, 357-367.

identity, nursing work is devalued as innate, unskilled work.⁹⁵ Nurses continue to define their work with notions of virtue via a “caring script,” instead of how they contribute to a therapeutic healing process. This leaves nurses vulnerable to hospital administrators and governments seeking to cut all but essential health services. Nurses remain employees of institutions and do not participate in controlling or directing the organizational structure of the hospital.⁹⁶

While these more contemporary works provide some vital insights into changes in nursing work in the 1970s and 1980s, historical works on nursing give minimal attention to this time period – precisely the time when nurses shifted away from the professional model critiqued in the literature, formed independent unions across Canada, and went on strike and engaged in widespread political protest.⁹⁷ The question of what professional associations accomplished for the status of rank and file nurses during this time, and whether independent nursing unions have done more, remains a contentious one.⁹⁸ Independent unions, strikes, and renewed professionalization efforts all emerged in the 1970s as

⁹⁵ Suzanne Gordon and Sioban Nelson, “Moving beyond the Virtue Script in Nursing: Creating a Knowledge-Based Identity for Nurses” in Sioban Nelson and Suzanne Gordon, eds., The Complexities of Care: Nursing Reconsidered (Ithaca: Cornell University Press, 2006), 19.

⁹⁶ Dana Weinberg, “When Little Things Are Big Things: The Importance of Relationships for Nurses’ Professional Practice” in The Complexities of Care, 38-39.

⁹⁷ McPherson, Bedside Matters, 7.

⁹⁸ Merle Jacobs, “Nursing, A Pink Collar Ghetto? From Semi-Professional to Professional,” in Jacobs and Bosanac, eds., The Professionalization of Work (Whitby: de Sitter Publications, 2006), 130. Jacobs notes that the proposal for a university degree requirement was regarded as elitist by rank and file nurses in Ontario in the early 1980s, a view echoed by the BCNU. Canadian nursing textbooks recognize the tensions between professional associations and unions, and some suggest that strikes have had the largest influence on socioeconomic gain and public awareness of problems in nursing: Marjorie McIntyre and Carol McDonald, “Unionization: Collective Bargaining in Nursing” in McIntyre, Thomlinson and McDonald, eds., Realities of Canadian Nursing: Professional, Practice and Power Issues (Philadelphia: Lippincott Williams and Wilkins, 2006), 311.

responses to increasingly difficult working conditions. But which strategy most accurately represents nurses? Which strategy or identity should nurses aspire to? The debate rages on. This thesis will not argue which strategy nurses should pursue, but will instead ask what happened historically and why: that is, why an independent nursing union emerged, how it developed, and how it resonated as an organizational and political model. An historical approach to this topic can explore how class and gender framed the experiences of nurses, which in turn led to changing forms of labour organization and political identity. It can also shed light on the debate between professionalism and unionism in nursing by accounting for wider socioeconomic factors. The changes in the nursing occupation and the profound socioeconomic changes in western capitalist societies during the 1970s and 1980s make this period an important gap to fill in the historiography.

CHAPTER 2: “WE ARE SITTING ON DYNAMITE”: THE LIMITATIONS OF THE PROFESSIONALIZATION STRATEGY AND THE SHIFT TO TRADE UNIONISM, 1976-1983

By the early 1970s, the RNABC’s approach to labour relations had changed considerably from its condemnation of strike action by Comox nurses in 1939. World War II, the shift to hospital employment and the exodus of nurses into non-nursing labour unions and into other occupations required new forms of organization. Professional associations such as the RNABC could only retain nurses by adopting a number of trade union functions such as collective bargaining and strike action. It appeared that professional associations had successfully adapted trade union functions, if reluctantly, in the interests of organizational unity. But this arrangement proved temporary. Independent nursing unions emerged by the end of the 1970s to exist uneasily with professional associations that were now devoid of any role in labour relations. The careful post-war compromise between professionalization and unionization in nursing disappeared in less than a decade.

In the case of the RNABC, conflicting views of nurses’ class position threatened the compromise between professionalization and unionization. The evolving labour strategies of the newly formed RNABC Labour Relations Division viewed nurses as skilled workers in institutions, whereas the continuing professional functions of the RNABC treated nurses as middle class

professionals with autonomy in their work. Tension began to grow between these different views and realities of class in the socioeconomic context of the late 1970s, as a major dispute at Vancouver General Hospital in 1977 called into question professional strategies. A degree of proletarianization began to press itself into nurses' work situation and consciousness as the role of the state, and its treatment of public employees, changed alongside the needs of capital. Nurses responded to these pressures with new class-based forms of action that began to effectively address nurses' work needs in ways that professional functions did not. The role and organization of the RNABC changed significantly as labour functions clashed with professional functions. External political realities of class, in the form of the state's anti-labour policies, provided stark confirmation that nurses were state workers and conditioned new approaches to labour relations and politics for nurses. Together, these events framed a major organizational, strategy, and identity shift away from professionalism, with lasting consequences.

Initial signs of this shift were evident as professional associations adapted their approach to include trade union functions as explored in the previous chapter. However, a 1973 Supreme Court of Canada decision threatened this arrangement and raised the possibility of independent trade unionism for nurses. The Supreme Court ruled that the Saskatchewan Registered Nurses Association could be dominated by management nurses and therefore could not be the bargaining agent of general duty nurses. General duty nurses then formed their

own independent union, which excluded management nurses.¹ While this was a legal catalyst for the formation of nursing unions in some provinces, it was not the root cause. In British Columbia for example, the RNABC avoided a similar split when it formed a Labour Relations Division in 1976 that was autonomous in labour matters including collective bargaining.

Although this Supreme Court decision gave legal precedent, it was the socioeconomic context of the 1970s and how this affected nurses and their work that is vital for understanding the emergence of independent nursing unions in Canada. The 1970s are now widely recognized as the beginning of a transformative period for capitalism from nationally based economies to internationalized capital flow, production and exchange.² This was sparked by a long term and systemic decline in the rate of profit in domestic markets, which matured into the worldwide economic recession that began in 1974.³ Corporations responded to falling rates of profit and recession by investing capital on an international scale not previously seen, and by shifting jobs to the cheap labour of third world countries. Under corporate pressure and guidance, governments shifted taxes onto workers and created a climate of public spending cutbacks and anti-union activity. Thus the post-war welfare state, which emerged with post-war nationally based economies, quickly became

¹ McPherson, Bedside Matters, 251.

² Gary Teeple, Globalization and the Decline of Social Reform: Into the Twenty-first Century (New York: Humanity Books, 2000), 5.

³ Kim Moody, US Labor in Trouble and Transition (New York: Verso, 2007), 13.

incompatible with the increasingly global orientation of capital, production, and exchange.⁴

As a result, Western nation states adapted to and assisted the changing needs of capital in a process referred to as neoliberal reform. Governments dismantled or downsized the Keynesian welfare state and removed barriers to the unfettered exchange, investment and rule of capital. Previously the welfare state, when pushed by labour, intervened to ameliorate the economic, social and health problems produced by the corporate-dominated marketplace in the interests of social stability. This in turn allowed secure conditions for the investment of capital. But by the 1970s, corporations regarded state intervention in the economy as a hindrance to the unrestricted movement of international capital and profit-making. In the context of state fiscal crisis – as governments became unable to meet expenditures without accumulating deep deficits⁵ - corporations and the state viewed social services as simply another financial burden that needed to be diminished or moved to the private sector, where they would hopefully create profits.

Neoliberal policies meant that for state social services such as healthcare, governments scaled back and reorganized funding. In Canada, the federal government introduced Established Programs Financing in 1977 that cancelled cost sharing and implemented a fixed-sum annual transfer to the provinces.⁶ This created a funding crisis in an already fiscally strained service, and hospitals

⁴ Teeple, Globalization and the Decline of Social Reform, 16-19.

⁵ Teeple, Globalization and the Decline of Social Reform, 48.

⁶ Rankin and Campbell, Managing to Nurse, 28.

and provincial governments scrambled to reduce costs.⁷ The implications for class relations in the hospital were significant. A key area for cost reduction was nursing labour. Managerial reforms, such as the introduction of patient classification systems, were central to an effort to reorganize work in the hospital. In this system, management decided the needs of each patient and the time allotted for a nurse to address these needs. This was intended to intensify and speed up the labour process, and assumed that patients had standard needs that could be identified objectively. Previously, a head nurse had made decisions about appropriate staffing levels for her ward; now, this became a managerial prerogative based on supposedly objective measurement.⁸ Of course, patient needs are never identical and did not always appear in categories established by patient classification charts, and nurses continued to perform duties not officially in their job descriptions. At the same time, the patient classification system provided standards to which nurses could be compared, and not meeting these standards could mean accusations of incompetence and slow work – and firings.⁹ The reorganization of healthcare was not based on solving problems in providing social services, but rather on private sector managerial practices and notions of cost efficiency.¹⁰

⁷ Jerry White, Hospital Strike: Women, Unions and Public Sector Conflict (Toronto: Thompson Educational Publishing, 1990), 19-20.

⁸ Rankin and Campbell, Managing to Nurse, 29-30 and chapter one generally. Rankin and Campbell note that patient classification systems were intended to make the most efficient use of nursing labour – maximum coverage of patients with the smallest number of personnel - and assumed that patients had standard needs that could be identified objectively.

⁹ Rankin and Campbell, Managing to Nurse, 32-33.

¹⁰ Carter, Capitalism, Class Conflict and The New Middle Class, 142-144.

Managerial reforms designed to intensify the labour process thus involved greater managerial control of workplace settings, which nurses resented. This was a direct attack on any aspirations for professional status, as it represented a further incursion into independent decision-making and autonomy in the workplace.¹¹ Nurses were prepared to fight back, and the power struggle over increasing managerial control produced a major confrontation between nurses and hospital management at Vancouver's General Hospital (VGH) in late 1977. Over 60 documented complaints focused on too few staff to deliver safe care, a misallocation of staff resulting in patients being abandoned at the end of nurses' shifts, and a lack of lower and upper level authority to deal with these issues.¹² Nurses wanted control of practice settings, but they did not have it. By November 1977, having received no feedback from hospital management, nurses turned to the Registered Nurses Association of British Columbia for help with inadequate practice settings that were affecting patient care.

The RNABC informed Vancouver General Hospital administration of the lack of feedback, the Canadian Council on Hospital Accreditation, and provincial Health Minister Bob McClelland who then called for meetings. Initially, responses from each party seemed to point to a quick solution. VGH President Larry Truitt announced a review of the hospital's nursing administrative structure, a study of nursing staff allocation, and more money to call in extra nurses. The

¹¹ In his study of nurses under Britain's National Health System in Capitalism, Class Conflict and The New Middle Class, 144, Carter emphasizes that "One casualty of this increasing managerialism was the autonomy gained by nursing under nationalization, which had accorded it parallel status to that of medicine and administration."

¹² "Nurses Fight to Improve Care at BC's Major Referral Hospital," *RNABC News*, June-July 1978, 3.

Canadian Council on Hospital Accreditation granted VGH a two year accreditation providing that VGH met its recommendations on nursing, which the RNABC assumed would be done quickly. But rarely are major conflicts between employees and management solved so easily, and this was to be no exception.

While VGH President Truitt did announce reforms in late January of 1978, these reforms were strictly on the administration's terms. There was no consultation with nursing staff.¹³ Truitt announced the creation of four vice presidencies: general operations, finance, corporate planning, and medical and educational affairs. The director of nursing came under the vice president of general operations – which included an array of non-medical services such as food and laundry.¹⁴ This arrangement was unacceptable because it put the director of nursing three steps down from the top administrator, which was the main problem to begin with: the 60 documented complaints emphasized lack of access to top management decisions that affected nursing practice, combined with lack of lower level authority.¹⁵ A director of nursing underneath a vice president of operations meant the highest ranking nurse was still too far removed from the decision making process to address issues such as staffing levels. Previously, the most senior nurse reported directly to the top administrator to

¹³ "Nurses Fight to Improve Care at BC's Major Referral Hospital," *RNABC News*, June-July 1978, 4.

¹⁴ "Nurses Fight to Improve Care at BC's Major Referral Hospital," *RNABC News*, June-July 1978, 4.

¹⁵ "Nurses Fight to Improve Care at BC's Major Referral Hospital," *RNABC News*, June-July 1978, 3.

participate in forming institutional policies, including those affecting patient care. Nurses voiced alarm over this dramatic change.¹⁶

Surgical Nursing Director Bonnie Lantz led and represented the concerned nurses - but she was fired in mid-April without notice.¹⁷ In June, three other clinical nursing directors were fired without notice for disagreeing with management.¹⁸ After Lantz's firing, nurses formed a Committee of Concerned Nurses which directly petitioned President Truitt for a vice president of nursing, a temporary nursing committee to ensure safe care levels, and Truitt's written assurance that high nursing standards would be maintained. Truitt refused each request, and after the three nursing directors were fired in June, the RNABC met with the hospitals' board of trustees to press the nurses' requests.¹⁹ Although none of the requests were met, the Board recommended reinstatement of the clinical directors of nursing who had been dismissed. President Truitt, however, attached conditions to their reinstatement that revised their job descriptions by putting strict limits on their decision making power.²⁰ It was clear that the administration, led by Truitt, was sticking with its own program of reform. According to the RNABC, senior nurses began to resign over "administrative indifference, unsafe staffing patterns, and inadequate inservice education."²¹

¹⁶ "VGH Finally Boils Over," *RNABC News*, August-September 1978, 1. This arrangement, which Truitt removed, was typical of major Canadian hospitals.

¹⁷ "Nurses Fight to Improve Care at BC's Major Referral Hospital," *RNABC News*, June-July 1978, 4.

¹⁸ "VGH Finally Boils Over," *RNABC News*, August-September 1978, 6.

¹⁹ "VGH Finally Boils Over," *RNABC News*, August-September 1978, 6.

²⁰ "VGH Finally Boils Over," *RNABC News*, August-September 1978, 6.

²¹ "Month by Month Summary of Year Long Hospital Dispute," *RNABC News*, 5.

Only at this point did Health Minister Bob McClelland intervene. He dismissed the VGH board of trustees, reassigned Truitt to external affairs, and appointed Peter Bazowski as public administrator of the hospital in August of 1978. In charge of day to day operations and an official investigation, Bazowski reinstated the fired nursing directors, met with nursing staff, and found each of their concerns well-founded. He noted that nurses lacked a “vehicle through which to express their general concerns since the Nursing Advisory Committee ceased to function in any meaningful way...plus the fact that there is no senior head nurse who can represent all nurses at the senior management level.”²² Nurses were also correct to point to “insufficient nursing staff at this hospital”, and the need for “a much more extensive orientation program.”²³ Health Minister McClelland acted on all of Bazowski’s recommendations and created a vice president of nursing affairs who answered directly to the president of the hospital, sixty new full time nursing positions with consideration for more, and a professional advisory committee to provide hospital trustees with input directly from hospital staff.²⁴

One year after the implementation of these and other reforms, opinions among nurses at VGH varied. Some nurses were impressed with improved communication with administration, consultation about bed closures, expanded orientation programs, and additional staff. But other nurses contended that these

²² “Bazowski Comments on VGH Scene,” *RNABC News*, November 1978, 4.

²³ “Bazowski Comments on VGH Scene,” *RNABC News*, November 1978, 4.

²⁴ “Health Minister Acts on VGH Problems,” *RNABC News*, November 1978, 3.

reforms were “typical of band-aid solutions at the hospital”.²⁵ Another noted that the resignation of nurses during the dispute, and the fact that it took a major confrontation and two years to obtain basic improvements, were indicative of the entire nursing occupation: “People are leaving nursing by leaps and bounds because they are not going to put up with the conditions we have worked with for so long. And they can’t be bothered to go through what we did just to get reasonable improvements....we are sitting on dynamite.”²⁶

Indeed, nurses were showing signs that they were prepared to confront the proletarianization and increasing managerial control of their work in public sector hospitals. VGH nurses were trying to address problematic work settings and gain greater control of workplace settings. This struggle did not concern only VGH nurses, because it represented a direct challenge to the wider gendered ethos that had historically been built into nurses’ identity and class position: nurses should carry out their duties in an obedient manner, subordinate to the orders and procedures of male administrators and doctors.²⁷ Now nurses challenged the validity of this arrangement, especially as it adversely affected their ability to perform their jobs. They wanted more control. But without a concrete path of collective action, this challenge produced ambiguous results. RNABC recommendations and pressure tactics on VGH administration had proven costly, time-consuming, and ultimately dependent on outside authorities -

²⁵ “VGH Revisted: Are Things Better One Year after Major Surgery?,” *RNABC News*, November-December 1979, 6.

²⁶ “VGH Revisted: Are Things Better One Year after Major Surgery?,” *RNABC News*, November-December 1979, 7.

²⁷ Warburton and Caroll, “Class and Gender in Nursing,” in Health, Illness and Health Care in Canada, 563-564.

the provincial health minister and Canadian Council on Hospital Accreditation - for any solution. This was not a model for future disputes. The professional approach had proven ambiguous at VGH. Nurses were not autonomous middle class professionals, and could not effectively use strategies that assumed them to be so. As waged female state employees under predominantly male managerial authority, nurses required concrete and permanent forms of redress for workplace settings – in other words, class-based strategies that recognized and advocated the needs of nurses’ work situation in the hospital. Although ambiguous in its outcome, the challenge at VGH inspired a search for new ways to challenge nurses’ gendered class position as state workers in public institutions.

One new way was the contract obtained under collective bargaining. The dispute at VGH suggested that this too had shortcomings, since the RNABC had conducted collective bargaining since 1946.²⁸ However, obtaining a contract was one thing; being able to enforce its terms was another. The Labour Relations Division of the RNABC, formed in 1976, turned its focus to this issue of enforcement. The Division CEO, Nora Patton, noted that typically, management ignored aspects of the collective agreement in the belief that nurses would do little about it.²⁹ But she also noted that the newly formed Labour Relations Division was changing management’s attitude. The Division provided a concrete course of redress for nurses to deal with work grievances. If management failed to respond to a nurses’ grievance, a Labour Relations Division staff

²⁸ “A History of the RNABC Labour Relations Program,” (BCNU, undated), 3.

²⁹ “Making Certain Nurses’ Agreements are Met,” *RNABC News*, October 1977, 4.

representative put the grievance in writing. The collective agreement obliged management to reply in writing, and if still unresolved, the issue could go to mediation or binding arbitration.³⁰ The Labour Relations Division received about five new grievances per day, and in its first year, fifty-one of these had to go to arbitration or mediation. The Division had 115 certifications for bargaining units with 15 obtained in its first year, and oversaw 18 separate contracts. The rapidly growing role of the Labour Relations Division and the protracted dispute at Vancouver General Hospital both demonstrated the growing need for a permanent, enforceable course of redress for nurses' work grievances.

The role of the Labour Relations Division was growing rapidly, and in ways that the RNABC did not anticipate. The formation of the Labour Relations Division was originally an effort by the RNABC to deal with labour issues but to keep them under the umbrella of the professional association.³¹ But it was an experiment that began to take on a life and momentum of its own as labour issues and the need to address them grew in the socioeconomic context of the 1970s. The role of the state, and its organization of workers in the public sector, was changing dramatically. Although at first the growing labour role of the Labour Relations Division was seen as compatible, tensions soon developed between it and the professional functions of the RNABC. In late 1976, the RNABC Board of Directors announced its decision to implement a Safety to

³⁰ "Making Certain Nurses' Agreements are Met," *RNABC News*, October 1977, 4-5. An example of a case that went to binding arbitration was management's refusal to pay and in some cases provide meal times for on-call nurses, who worked 7.5 hour days. Both on-call and regular nurses often had to work during meal times but were not compensated.

³¹ This was called the umbrella concept – maintaining the Labour Relations Division under the RNABC, its constitution and bylaws. "Unanimous Vote Begins Process," *RNABC News*, March 1981, 2.

Practice Program. This program was to monitor the practice abilities of individual nurses and to ensure that they were up to occupational standards, which the RNABC had the right to define as a professional association. It could also discipline nurses who failed to meet occupational standards. To monitor and enforce occupational standards for nursing more efficiently under the Safety to Practice Program, the RNABC successfully petitioned legislature to pass the Registered Nurses Amendment Act in June 1977. The RNABC newsletter explained to nurses that “essentially, the Amendment streamlined and made easier the disciplinary process so it could be carried out by a smaller group.”³² A ten-person member disciplinary committee would now conduct the hearings instead of the RNABC Board of Directors, who were presumably busy with other affairs; and there were now more disciplinary options. Instead of suspending or revoking registration, the committee could also reprimand or censure a member, limit where the member could work, and permit the member to work only under supervision. Notably absent from the Amendment and the Safety to Practice Program was a concrete way to “increase emphasis on assisting members to take effective action to ensure that the settings in which they practice make competence possible.”³³ Both managerial and general duty nurses had expressed great concern over this issue when the Safety to Practice Program was originally announced.³⁴ It remained unaddressed in the final product.³⁵ This

³² “How RNABC’s Disciplinary System will Work for the Public, the Profession and the Nurse,” *RNABC News*, August-September 1977, 4.

³³ “Boards Adopts Program to Assure Safety to Practice,” *RNABC News*, December 1976, 6.

³⁴ “Boards Adopts Program to Assure Safety to Practice,” *RNABC News*, December 1976, 6.

produced a rather awkward situation. The RNABC disciplinary process was set up as if nurses were fully autonomous professionals, when in reality most were waged hospital employees who did not control their work settings. The Labour Relations Division, meanwhile, functioned with the view that nurses were indeed working class employees of the state.

These different functions represented contradictory views and functions of class for nurses, a situation that was bound to produce tension. In part, a professional disciplinary process could do little to include consideration of work settings in any concrete way; its task was to determine if an individual nurse was performing competently, not to ensure safe working conditions in a hospital. But could these two considerations always be easily separated? The question became all the more pertinent in the very year that the Safety to Practice Program began, for it was also in 1977 that VGH nurses documented major concerns over the safety of work settings in their hospital. These focused on staffing levels that were inadequate to ensure safe patient care and inappropriate staff allocation by management that resulted in lack of continuity in care. If a patient's condition worsened because management had not assigned enough staff for a nurse to get there in time, whose fault was it? Since management nurses were usually present on disciplinary boards, how sympathetic would they be to rank and file nurses? The Safety to Practice Program did not include enforcement of safe practice settings at a time when they were becoming

³⁵ The failure to include workplace settings in the disciplinary process became an issue of debate between the BCNU and RNABC, and a major source of contention between the organizations in 1990. See chapter four.

increasingly inadequate. But it did expand the disciplinary functions of the RNABC, functions that assumed nurses to be middle class professionals in control of work settings. Nurses voiced concern over the timing and nature of this arrangement, especially as the increasingly active Labour Relations Division began to provide a concrete course of redress for practice settings via contract enforcement.

The RNABC pondered the compatibility of these increasingly different views and functions of class – that is, its newly expanded disciplinary functions and the growing activities of its Labour Relations Division. At the annual convention in May 1977, outgoing RNABC President Thurdy Duck told delegates that “neither unionism or professionalism can be regarded as mutually exclusive. One is as essential to the RNABC to the other, and both must operate effectively to complement each other.”³⁶ She cited Canadian Nurses Association President Joan Gilchrist who spoke of an “increased compatibility” between the two roles.³⁷ But the dispute at VGH that erupted six months later in November 1977 and the growing role of the Labour Relations Division suggested that trade union functions were taking priority. It remained to be seen whether these professional and union roles were compatible after all.

With these developments in mind, the Labour Relations Division entered contract negotiations in November 1979. This was the first time the Labour Relations Division conducted negotiations as an autonomous part of the RNABC.

³⁶ “Nurses Should Give Equal Support to RNABC Professional, Labour Activities,” *RNABC News*, 8.

³⁷ “Nurses Should Give Equal Support to RNABC Professional, Labour Activities,” *RNABC News*, 9.

It was an opportunity for the Division to further prove itself as an effective advocate for nurses' working conditions. With the recent dispute at VGH and the growing role of the Labour Relations Division in mind, nurses were at something of a crossroads: should they continue to press forward with working class strategies, or should they fall back and rely on professional strategies? Some form of action seemed likely as the Labour Relations Division's CEO, Nora Patton, surveyed the mood of nurses: "We will conduct a strike vote so that management can learn how angry nurses are. There should be no mistaking how serious this situation is. BC has never had a provincial nurses' strike, but BC nurses have never gotten as raw a deal as they're getting now".³⁸

Nurses strongly agreed with this assessment. On 26 February 1980, over 11,000 of 12,500 nurses, or 88 percent, voted to strike.³⁹ This was a response to the HLRA's bargaining position, which refused to acknowledge that nurses needed a wage catch-up and refused to discuss non-cost items until the Labour Relations Division acknowledged this.⁴⁰ But federal wage and price controls capped hospital nurses to a net 7% wage increase in the last round of negotiations in 1976. To make up for this lost ground, nurses wanted a 30% wage increase.⁴¹ As a direct result of the VGH dispute, they also wanted an

³⁸ "Hospital Nurses Taking Strike Vote," *RNABC News*, January-February 1980, 1.

³⁹ "Contract Settlement Reached," *RNABC News*, March-April 1980, 3. Over 11,000 of 12,500 eligible nurses voted.

⁴⁰ "Hospital Nurses Taking Strike Vote," *RNABC News*, January-February 1980, 1.

⁴¹ *RNABC News*, September 1979, 4.

article that would establish patient care committees in each hospital to determine fixed patient-nurse and workload ratios.⁴²

The prospect of a province-wide nurses' strike convinced the HLRA to return to the bargaining table on 3 March, several days after the overwhelming strike vote. On 26 March, the parties reached a settlement with a 44% increase in salaries from 1 January 1980 to 31 March 1982 with an additional 5% in other benefits. Patient care committees were not obtained in the end, but nurses ratified the contract with 95% in favour of it.⁴³

But the health care contract negotiations of 1980 did not end with the hospital nurses in March. The Labour Relations Division also bargained for government nurses, covered by a separate contract.⁴⁴ This was a particularly important round of bargaining for these nurses, who had held a strike vote in 1977 and received a contract after 18 months of intense bargaining.⁴⁵ A 1978 contract went to binding arbitration and was not resolved until negotiations opened again for 1980.⁴⁶ Nurses were frustrated and angry, as their Senior Relations Labour Officer Glen Smale noted: "Within the past 48 months, we have spent 42 months in negotiations, mediation or arbitration...government nurses

⁴² *RNABC News*, September 1979, 4.

⁴³ This issue became a key demand in negotiations throughout the 1980s, and was to be one of the issues nurses decided to strike over in 1989.

⁴⁴ Government nurses were also Registered Nurses but worked outside of major hospitals in community care facilities, in the employment of the provincial government. The Labour Relations Division represented about 1200 of these nurses and 1500 Registered Psychiatric Nurses, who worked in mental hospitals and had their own representatives on the LRD bargaining committee. Noted in *RNABC News*, January-February 1980, 13.

⁴⁵ *RNABC News*, April-May 1977, 7.

⁴⁶ "BC Government Nurses Start Talks," *RNABC News*, January-February 1980, 13.

will not hesitate to strike in 1980.”⁴⁷ The hospital nurses’ contract, announced 26 March 1980, gave government nurses a clear target of wage parity. Determined to achieve this, they voted 98% in favour of a strike on the same day.⁴⁸

As with the hospital contract, the Labour Relations Division soon reached an impasse over wages. Government nurses wanted approximate parity with the 44% wage increase received by hospital nurses. Undaunted by the strike vote, the Government Employee Relations Bureau maintained its position of a 26% increase over three years. The matter went to non-binding arbitration, and Supreme Court Justice Henry Hutcheon recommended a 25.6 per cent increase over two years.⁴⁹ Nurses rejected this package by 91 per cent, and the GERB refused to resume negotiations. Nurses began job action on May 16th. The Labour Relations Division organized effective job action. Provincial and local strike committees, comprised of nurses, submitted their plans for essential services to the Labour Relations Board. The Board approved and adopted the model put forth by nurses, which specified staff allocation and essential tasks.⁵⁰ This was a demonstration that nurses were both willing and capable of organizing their own strike plans, and did not require outside assistance. Management quickly discovered their dependence on nurses and the GERB returned to the bargaining table in five days for the first time since March, and

⁴⁷ “BC Government Nurses Start Talks,” *RNABC News*, January-February 1980, 13.

⁴⁸ “Governmentt nurses serve strike notice,” *RNABC News*, March-April 1980, 10.

⁴⁹ “May 16: Government Nurses Begin Strike,” *Nursing Labour Reports* June-July 1980, 2.

⁵⁰ “Nurses ‘N Labour: The Lesson to Remember is Dare to Win,” *Nursing Labour Reports*, June-July 1980, 4.

nurses won a settlement in another five.⁵¹ It featured a 42.9 per cent wage increase, more vacation time and higher academic bonuses.⁵²

This strike and its successful outcome had a significant impact on nurses and the Labour Relations Division. Senior Labour Relations Officer Glen Smale noted that the job action produced a real sense of solidarity and accomplishment and a feeling that “they did it on their own”.⁵³ While hospital nurses did not have to undertake job action, they too formed committees in each hospital that conducted strike votes and formed essential services plans, showing that they were prepared to strike if necessary.⁵⁴ Nurses had begun to identify and fight as state workers and found that in doing so, their demands were answered in a more immediate and concrete form.

The Labour Relation Division’s first experience with collective bargaining for hospital nurses was largely successful. Although patient care committees were not obtained in 1980, they represented an effort by the Labour Relations Division to achieve professional goals via the collective bargaining process. Patient care committees, comprised equally of nurses and members of hospital administration, set binding patient-nurse ratios to regulate nurses’ workload. The Division also sought a second professional clause that would allow nurses to

⁵¹ “Nurses ‘N Labour: The Lesson to Remember is Dare to Win,” *Nursing Labour Reports*, June-July 1980, 4.

⁵² “Nurses ‘N Labour: The Lesson to Remember is Dare to Win,” *Nursing Labour Reports*, June-July 1980, 1.

⁵³ “Nurses ‘N Labour: The Lesson to Remember is Dare to Win,” *Nursing Labour Reports*, June-July 1980, 1.

⁵⁴ “Nurses ‘N Labour: The Lesson to Remember is Dare to Win,” *Nursing Labour Reports*, June-July 1980, 1.

refuse any orders that might leave them liable to RNABC disciplinary action.⁵⁵ That nurses were seeking such protection from the professional disciplinary process was telling. And while it does not appear that this was achieved in 1980, the real significance of these professional clauses was their inclusion in the collective bargaining process. They could be achieved in a concrete manner, unlike the RNABC pressure tactics of the 1977 VGH dispute. The Labour Relations Division had instead used a collective class-based strategy to achieve nurses' demands – the strike. Implicitly, this again challenged traditional gender roles, but in a far more assertive manner. The strike and organization also challenged inherent expectations that nurses, as women, passively accepted their socioeconomic status, working conditions, lower pay and few benefits.

The effectiveness of the 1980 strike made it a model for future labour disputes. It demonstrated that the autonomous Labour Relations Division was highly capable in collective bargaining and improving nurses' working conditions. As a result, a fundamental question arose shortly after the 1980 negotiations: could union and professional bodies continue to coexist within the same RNABC structure?⁵⁶ On the surface, this was a legal issue. The Registered Nurses Act allowed for only one constitution and set of bylaws within the Association. When the Labour Relations Division proposed changing its governing document from "special rules" to "constitution and by-laws" to recognize its expanded role after the job action of 1980, the RNABC was put in a legal bind. The RNABC Board of

⁵⁵ "Professional Groups in Collective Bargaining," *Nursing Labour Reports*, January-February 1980, 17.

⁵⁶ "Can Union, Professional Bodies Co-exist in RNABC Structure?," *Nursing Labour Reports*, August-September 1980, 1.

Directors could not allow a second constitution within the Association because of the RN Act; yet the Labour Code required the union arm of the Association to be free of any Board influence, because of the presence of managerial nurses. The 1973 Supreme Court ruling in Saskatchewan had suddenly resurfaced. When the Labour Relations Division proposed its own constitution, the Board of Directors were in a legal bind and stated: "It is our belief that this action by the Division was a deliberate manoeuvre to put the Board of Directors in an impossible situation, that is of existing in conflict of the RN Act."⁵⁷

The Labour Relations Division, now confident that its union strategies were best-suited and effective to advocate nurses' workplace needs, had effectively launched a legal coup d'état to separate fully from the RNABC. Nurses overwhelmingly shared this view: delegates voted unanimously to form a fully separate union at a founding convention in February 1981, and the British Columbia Nurses Union held its first annual convention June 11th and 12th in Victoria.⁵⁸ While this marked the formal, legal separation of the Labour Relations Division from the RNABC, this development was grounded in the events of the preceding four years. Trade union strategies that viewed nurses as semi-autonomous state employees took precedent over problematic approaches and functions that viewed nurses as middle class, autonomous employees. This transition to trade union strategies involved inherent challenges to established gender roles. Nurses found collective class-based forms of action to be the most

⁵⁷ "Can Union, Professional Bodies Co-exist in RNABC Structure?," *Nursing Labour Reports*, August-September 1980, 3. The statement was made on behalf of the Board by Electoral District Director Judy Rothenbueger.

⁵⁸ "Convention Sees BCNU Debut," *Nursing Labour Reports*, July-August 1980, 1.

effective for their occupational interests: collective bargaining and the strike. In these ways, gender and class drove processes of experimentation and action for the Labour Relations Division. The results of these experiments, culminating in the success of 1980, convinced nurses of the utility of an independent trade union free from professional intervention. Nurses had acted as state workers in job action of 1980, found this to be effective, and thus began to organize as state workers by making changes in their representative association.

It remained to be seen how the newly formed BCNU would operate. Formal separation did not automatically mean that the BCNU would be a key organization in nursing or differ from the historically conservative RNABC. Rather, its role and identity would be shaped by the economic and political climate of the early 1980s in which it emerged. This climate was hardly favourable for the emergence of a newly formed union. The worldwide economic recession of 1974 had improved somewhat, but returned in the early 1980s. In British Columbia, inflation stood at 12.97 per cent and unemployment rose from 9.2 per cent in 1982 to 16.1 per cent in 1983.⁵⁹ With a predominantly resource-based economy that centred on timber exports, the province was highly sensitive to global economic recession and change. The timber export industry was in marked decline by the early 1980s as multinational forestry companies shut down local mills and moved operations to the low-wage markets of Asia and

⁵⁹ Allen Garr, Tough Guy: Bill Bennett and the Taking of British Columbia (Toronto: Key Porter Books, 1985), 57. John Schofield, "Recovery Through Restraint? The Budgets of 1983-184 and 1984-1985," in Warren Magnusson *et al.*, eds., The New Reality: The Politics of Restraint in British Columbia (Vancouver: New Star Books, 1984), 43-44.

South America.⁶⁰ Unemployment in the timber sector soared. Membership in the International Woodworkers of America, the heart of labour in the province's crucial timber industry, declined from 40,000 members to 26,000 in just two years.⁶¹ As the private sector collapsed, white-collar, public sector unions, often comprised mostly of women, became the majority in the BC Federation of Labour.⁶² These unions, now the main power bloc of organized labour, would become the target of state neoliberal policies.

These policies came from the Social Credit Party under Bill Bennett, who formulated an economic plan based on the advice and policies of the right-wing Fraser Institute. In February 1982, Bennett explained that limiting government spending and public sector wage increases would cut inflation and interest rates, which in turn would lead to economic recovery.⁶³ These policies did nothing to alleviate economic recession, because their real objective was to eliminate organized labour, public services, and human rights in a political process of

⁶⁰ Bryan Palmer, Solidarity: The Rise and Fall of an Opposition in British Columbia (Vancouver: New Star Books, 1987), 20.

⁶¹ Allen Garr, Tough Guy, 110.

⁶² Allen Garr, Tough Guy, 110.

⁶³ Allen Garr, Tough Guy, 57. Social Credit spending rose by more than 12% as the deficit reached \$1.6 billion, and demonstrated that restraint represented the political and ideological interests of capital. Fiscally, the notion of restraint was not acted upon: while the Social Credit government made wide cuts to public services that were supposedly unaffordable, spending on new mega-projects such as Expo 86 and Northeast Coal ran well into the hundreds of millions of dollars. This quickly exhausted government cash reserves from budget surpluses that, ironically, were produced by the NDP in the 1970s. Palmer, Solidarity, 23; Schofield, "Recovery Through Restraint?" in Magnusson, The New Reality, 51-2.

neoliberal reform that sought to establish a corporate-friendly marketplace and labour force devoid of any protections.⁶⁴

That British Columbia was experiencing a severe recession by the early 1980s was certain. But the Social Credit government's response was not a sound plan for economic recovery. Provincial fiscal policy could do little to save private business in the province's resource sector, which depended on international demand and market activity. Rather, Social Credit plans were part of a larger political and ideological shift as Western governments responded to the needs of capital after the recession and transformation of the 1970s. Because the labour movement represents a check on the power of capital, governments interfered and scaled back labour's rights with legislation by the early 1980s.⁶⁵ State policies cannot fully relieve deep structural problems and transformations within capitalist economies, but attacking the rights of labour is an intentional political effort to protect the class interests of capital. It was into this political and economic environment that the BCNU emerged as a newly formed union in 1981.

Aware of the political climate, the union prepared for 1982 negotiations. BCNU Chairman Wilma Buckley warned nurses that they could not "resume the cycle that raises them from wage-poverty to wage-adequacy, and then drops

⁶⁴ The objectives of neoliberal reform in BC are succinctly described by Palmer as an effort to "liberate capital from the fetters of the post-war settlement, striking out at public sector unionism as the weak link in the chain of trade union defense mechanisms and declaring an abrupt end to state subsidies and protections for the poor, handicapped and underprivileged" in Palmer, Solidarity, 23-4. Advocated by neoliberal economists such as Milton Friedman, it is no accident that Bennett's government received praise alongside Reagan's and Thatcher's in Friedman's book, The Tyranny of the Status Quo.

⁶⁵ Leo Panitch and Donald Swartz, The Assault on Trade Union Freedoms (Toronto: Garamond Press, 1988), 14-15, 29-31; Palmer, Solidarity, 11-14.

them back to wage-poverty for another go 'round."⁶⁶ At the Union's wage and policy conference of October 1981, delegates made clear the need for a professional responsibility clause, a reduction in consecutive workdays from eight to six, better sick leave, weekend premiums and improved education opportunities. They also calculated that a 20 per cent wage increase was necessary for a one-year contract to meet a 14.7 per cent rise in consumer prices in the past year, making BC the most expensive province in Canada to live. Real purchasing power had also dropped 2.2 per cent for top salary levels in 1981.⁶⁷ A 20 per cent wage increase of 1980 level salaries was therefore only a 3.1 percent increase in real wages. Contract negotiations to address these issues began in May.

In June 1982, the Social Credit government launched the first stage in its assault on labour with public sector wage controls. Finance Minister Hugh Curtis introduced the Compensation Stabilization Act, which restricted wage increases to 5 and 6 per cent, a far cry from the union's demand of 20 per cent.⁶⁸ The controls were put into law with the passage of Bill 28. A more direct form of government intervention arrived in July with Bill 11, known as the Compensation Stabilization Amendment Act. This gave the newly created office of Compensation Commissioner the legal power to determine wage increases. The Commissioner was to base these increases solely on the employer's ability to

⁶⁶ "No Fairy Tales from Buckley," *Nursing Labour Reports*, December 1981, 4.

⁶⁷ "No Fairy Tales from Buckley," *Nursing Labour Reports*, December 1981, 4. These figures were according to the union's calculations and are hard to verify independently, but they are likely accurate given the high inflation and decline in real wages that began after 1975.

⁶⁸ Panitch and Swartz, *The Assault on Trade Union Freedoms*, 40.

pay, defined by the employer, increases that were already limited to 5 and 6 per cent.⁶⁹

The legislation had an immediate impact on BCNU negotiations. When Bill 28 was first introduced in May, the Hospital Labour Relations Association offered nurses no wage increase at all and demanded a number of concessions.⁷⁰ When Bill 28 actually passed in June, the HLRA maintained its position and announced its decision to apply for mediation. This effectively stalled negotiations, and on July 26th the HLRA informed BCNU that David McIntyre would mediate. The government delivered an additional blow to the union's situation on the following day when it passed Bill 11, which meant that any negotiated settlement had to be approved by Compensation Commissioner Ed Peck.⁷¹ With government legislation decisively on its side, the HLRA was under very little pressure to bargain seriously. Meanwhile, nurses continued to work under the terms and wage rates of their previous contract. When the parties finally met with mediator David McIntyre on August 31st, he declared that there was no point in continuing negotiations since neither side would compromise their positions.⁷²

Faced with the HLRA's rigid stance and legislation designed to support the employer and undermine labour's ability to bargain collectively, the BCNU bargaining committee consulted its hospital stewards. Because "only a few

⁶⁹ Panitch and Swartz, *The Assault on Trade Union Freedoms*, 41.

⁷⁰ "Hospital Bargaining Begins," *BCNU Reports*, April-May 1982, 1.

⁷¹ "Hospitals in Suspended Animation," *BCNU Reports*, June-July 1982, 1.

⁷² "Negotiations at a Turning Point," *BCNU Reports*, September 1982, 2.

nurses wanted to take more drastic action to get an agreement,⁷³ the bargaining committee opted for binding arbitration in September 1982. Yet even this capitulation did not spell the end. Instead, a lengthy mediation process dragged on and did not deliver a finalized contract until March 1983. Moreover, even with binding arbitration, Compensation Commissioner Ed Peck had the final say in the contract due to Bill 28. To further crush the BCNU in its defeated position, he did not finalize the contract until March 1984 - and dramatically reduced the wage settlement awarded in binding arbitration from 20% over one year to 12.1% over three years.⁷⁴ Other key objectives set out by delegates – a professional responsibility clause, a 35 hour work week, better sick leave and opportunities for education – were not met. The BCNU had clearly suffered under legislation motivated by political class interest, and the future of the union was uncertain. Ed Peck had amply demonstrated the state's ability to crush collective bargaining and contract settlements for unions that did not fight back.

The legislation and intervention of government was an effort to undermine collective bargaining in the public sector. But this was part of a much broader political program of neoliberal reform. While Bills 11 and 28 soured the contract negotiations of 1982 for the BCNU, the legislation introduced on July 7th 1983 was nearly unprecedented in its attack on human and labour rights in Canada. The package aimed to remove almost all regulations to the unrestricted

⁷³ "Trying to Beat A Stacked Deck," *BCNU Reports*, October 1982, 1.

⁷⁴ "Peck Rules on Second Year Hospital Wages," *BCNU Reports*, March-April 1984, 2.

investment and accumulation of capital.⁷⁵ Its key aims were to undermine public sector unionism to establish a low-wage market; remove most human rights; reduce state assistance for poor, elderly and handicapped persons; and open up public services such as healthcare to privatization. Bill 2, the Public Service Labour Relations Amendment Act, removed the right of BC Government Employees to negotiate anything but wages. Bill 11 was renewed to extend wage controls indefinitely. Bill 3, the Public Sector Restraint Act, enabled public sector employers to fire workers upon the expiration of a collective agreement. Of additional concern for healthcare was Bill 24, the Medical Services Act, which allowed doctors to leave Medicare. Bill 27, the Human Rights Act, repealed the Human Rights Code and closed the Human Rights Commission.⁷⁶

This abrupt assault on labour and human rights produced a vast and diverse wave of extra-parliamentary opposition. The BC Federation of Labour organized a formal campaign against the legislation and budget with representatives from all of the province's unions, a movement named Operation Solidarity. The BC Nurses Union joined Operation Solidarity in mid-July. This was the first time that an organization representing nurses in British Columbia had joined the wider union movement. The BCNU's Executive Council made the decision to join Operation Solidarity in an emergency executive meeting, a decision not voted on by membership. Council also authorized an initial

⁷⁵ Panitch and Swartz, The Assault on Trade Union Freedoms pp.41-43, note that this was part of a larger trend whereby Western governments sought to assist the corporate sector, which required increasing concessions after the recession of the 1970s: this assistance came in the form of major subsidies, tax breaks, and a use of state coercive power against the labour movement.

⁷⁶ Palmer, Solidarity, 21-2 and Panitch and Swartz, The Assault on Trade Union Freedoms, 41-43.

contribution of \$83,000 to Operation Solidarity. BCNU CEO Nora Patton joined the twenty-member Operation Solidarity Committee, and President Wilma Buckley strongly condemned the Social Credit legislation in a public speech outside parliament on July 27 where some 25,000 people gathered to protest against the government.⁷⁷

The executive decision to join a wider union movement surprised many nurses who did not identify with the wider labour movement and viewed their occupation as a unique profession. Members did not shy away from voicing this view in the union's newsletter:

As nursing professionals, we feel that we would rather have the non-partisan RNABC speak out and make statements on our behalf. We, as nurses, are members of a professional association first, and members of a union second. We are only members of the union because it was deemed legally necessary as a collective bargaining tool.⁷⁸

Reflecting on Operation Solidarity a year later in October 1984, President Buckley defended the decision to join and acknowledged the internal opposition to this executive decision:

However, many nurses did not support Solidarity. Many of those opposed expressed the view that they favoured the restraint, that Solidarity participations should be put to a membership vote and that such "political action" actually interfered with the individuals right to vote for the political party of his or her choice....(but) the union maintains that this year's support is aimed at influencing government priorities.⁷⁹

⁷⁷ "Buckley: Nurses are for the People," *BCNU Reports*, September-October 1983, 3.

⁷⁸ *BCNU Reports*, June-July 1984, 7. The statement was submitted by 25 Nanaimo area nurses.

⁷⁹ "Solidarity after One Year," *BCNU Reports*, October 1984, 9.

But there were also elements of support among membership for Solidarity. During the summer of 1983, nurses made their own contributions in the form of leafleting, participation in rallies, and letters to MLAs on a scale that was “too broad to document.”⁸⁰ Another indication was a vote by delegates at the 1984 annual convention to continue official participation in Solidarity and to continue economic support, which totalled \$126,745 in the 1983 budget year.⁸¹ If significant elements of opposition existed within the union regarding Solidarity, so too did elements of support.

The mixed reaction of membership represented the continuation of a struggle to reconcile a subjective professional identity with political and economic developments that were degrading the nursing occupation. Although nurses identified with a unique occupational identity, they suddenly found themselves subject to the same erosion of rights and degradation of working conditions as other workers in the province. Social Credit policies were changing what it meant to be a nurse employed in the public sector. These policies provided stark confirmation that nurses were not professionals, and rather that nurses were state workers subject to the changing role of capitalism and the state. Social Credit policies made it clear that the state was an institution that exploited workers with its political and fiscal priorities and its own employment practices, all aimed at undermining labour and assisting private profit accumulation. This forced nurses to choose between traditional notions of professionalism and a

⁸⁰ “Buckley: Nurses are for the People,” *BCNU Reports*, September-October 1983, 4.

⁸¹ “Solidarity after One Year,” *BCNU Reports*, October 1984, 8. The vote count is unavailable, but before the approval, delegates also defeated a resolution that membership vote on continued involvement in Operation Solidarity.

trade union identity that meant confronting employer and government cutbacks. BCNU leaders chose political confrontation and involvement in the wider labour movement, even if this meant upsetting some nurses who continued to identify themselves as professionals.⁸² But union leaders also realized that they had to reach out to the rank and file in a meaningful way that went beyond justification of their actions. Union leaders needed to establish that their approach to nursing and labour relations was the most appropriate in the changing political climate. And so they moved to establish a strategy for nurses that was informed by the recent processes of change driven by gender and class.

But a trade union strategy for nursing had to be more than just a rejection of traditional and gendered notions of professionalism and political neutrality. It also had to offer a model that celebrated high standards of nursing work and patient care, so important to nurses' status and subjective identity. Union leaders thus urged nurses to reconceptualize the relationship between professional identity and unionism, not unlike RNABC leaders had done in the decade prior. But this time, the emphasis was on union functions and opposition to dangerous working conditions as strategies for quality nursing care. In a landmark speech at the 1985 annual convention, President Colleen Bonner explained this reconceptualization. Collective bargaining, she noted, was a strategy that could enhance quality care:

⁸² In *The Rise of Professionalism: A Sociological Analysis*, 236, Magali Sarfatti Larson argues that the subjective professional identity and unease with trade unionism, evident here, forms a trap for subordinate professionals such as nurses. Subordinate professionals may associate union participation with the working class and a loss of status, making them unwilling to participate; yet they lack alternate means of overcoming their subordinate status.

The next item on my list may surprise some of you. It is collective bargaining, a traditional trade union function that can enhance professionalism. Yes, many people tend to think of negotiations only in terms of wages, benefits and working conditions. However, that is a very limited point of view. First, nurses' working conditions are inevitably patient care conditions. Let's take one example of a bargaining issue that affects both nurses and patients. It is the clause that can be used to make hospital nurses work eight consecutive shifts. We all know what it feels like by the 8th day; exhaustion does not make for the best possible nursing care. We need to change this in negotiations. Another example is the professional responsibility clause which allows nurses to question employer decisions which affect care but not necessarily working conditions. BC does not yet have this clause which 5 other provinces do.⁸³

Noting the political and economic climate in BC, she also explained how mere acceptance of employer and government policies amounted to a false professionalism:

Unfortunately, some people think differently. Their code consists of making do, of enduring passively, and of accepting without question the dictates of so called higher authority. These people say that the employer, the physician, the government always know best. They say that nurses should cope with whatever they're given and do what they're told. These people say any other response to our problems is a lack of professionalism. Well, I say talk like that is naive at best, and dangerous at worst. It amounts to false professionalism, the false pride of the oppressed. And here is what it means in the real world of nursing, where you and I work with real patients.

False professionalism means there's nothing wrong with assigning a float nurse to an unfamiliar specialty ward without any orientation. False professionalism means it's all right for a school nurse to report for work with a serious viral infection, because her employer refuses to provide relief staff for sick leave absences. False professionalism means a long term care nurse should lift heavy patients alone, because she has no help or appropriate lifting

⁸³ "What is a Nurses' Union?," *BCNU Reports*, June-July 1985, 16.

equipment. The sad truth is that false professionalism threatens to become a way of life for nurses in BC.⁸⁴

Bonner's message was clear: the traditional and gendered sense of professionalism that emphasized service, duty, and sacrifice was obsolete in an economic and political climate that gave nurses "fewer and fewer resources to do their jobs properly."⁸⁵ Because government and employer policies were responsible for this, passivity was no longer an option – nor was it professional. The notion that professionalism was a form of oppression that prevented nurses from raising legitimate concerns was put forth as early as 1976 when Nora Patton noted in the *RNABC News* that "If nurses do react (to managerial non-compliance with items established by the collective agreement), management pulls a long face and suggests, 'that's not a very professional attitude'. Which is simply untrue. Being professional doesn't mean that you can be pushed around."⁸⁶ Now in 1985, President Bonner called for this approach to be the cornerstone of a union strategy and political conscience. More than an occupational internal struggle, Bonner's speech was a recognition that Social Credit legislation and changing employment conditions had changed what it meant to be a nurse working in the public sector. Nurses' class position interacted with the changing role of the state and a historic struggle between professionalism and unionism to produce organizational change. This process, which included strikes, impacted nurses' view of themselves, or class consciousness. They began to see themselves as state workers, something

⁸⁴ "What is a Nurses' Union?," *BCNU Reports*, June-July 1985, 16-17.

⁸⁵ "What is a Nurses' Union?," *BCNU Reports*, June-July 1985, 17.

⁸⁶ "Making Certain Nurses' Agreements are Met," *RNABC News*, October 1977, 4.

dramatically confirmed by Social Credit policies. Nurses began to develop new approaches to labour relations and politics as a result. An organizational shift from professionalism to unionism had taken place, and union leaders advocated a parallel shift in strategy and identity. Far from perfected, the union's role would be tested and criticized by members in new ways as the political and economic challenges of the 1980s deepened.

CHAPTER 3: THE LIMITATIONS OF COLLECTIVE BARGAINING AND THE EMERGENCE OF A GENDERED CLASS CONSCIOUSNESS, 1985-1988

When BCNU President Bonner advocated collective bargaining as the principle way forward for quality nursing in June 1985, the nurses' union was in the midst of contract negotiations. Thus it was a vital test for the union to prove its claims that unionism and the collective bargaining process, and not traditional notions of professionalism, were the best strategies for nurses. However, this approach did not take into account the limitations to collective bargaining and unionism designed and mediated by the state. Nurses had begun to act and to see themselves as state workers, but this evolving class consciousness did not automatically imply a parallel evolution in socio-political structure, that is, in the union. By 1986, the BCNU had to resort to pragmatic strategies in collective bargaining that revealed internal weaknesses in the union structure that nurses quickly criticized. Despite organizational problems and setbacks in collective bargaining, class consciousness continued to evolve in the realm of union politics and ideas on the status of the nursing occupation. The union's persistence as an outspoken and active organization in nursing had fundamental consequences for the continuing evolution of nurses' class conscience and sense of militancy – even without a parallel evolution in union structure and organization.

The negotiations of 1985 and 1986 promised to be as challenging as the previous round of collective bargaining in 1982, which was thwarted by

government legislation. Indeed, the Compensation Stabilization Program remained in effect in 1985. Nonetheless, the BCNU bargaining committee went to the table determined to win nurses' demands. The continuing economic recession meant wage increases from previous negotiations were effectively neutralized: a 13.6% rise in the Consumer Price Index from 1982 to 1985 eclipsed the net 12% raise nurses received for the same period.¹ A wage increase that addressed the issue of inflation was therefore a key demand put forth by nurse delegates, along with reduced hours of work, weekend premiums and better shift differentials.² Initial meetings between the BCNU and the HLRA in March did not look promising, however. The HLRA refused the union's bargaining goals and instead sought rollbacks in current contract provisions. The HLRA demanded a wage freeze; no sick pay for the first four days of sick leave; the elimination of a 40% payout of sick leave credits to which nurses were entitled to upon retirement; and the elimination of all supplementary vacation for nurses with over 25 years of service.³ Nurses thus found their demands rejected outright and existing contract provisions under threat.

The HLRA position remained rigid into July, at which point the BCNU appealed to provincial government mediator Jack Chapelas. After three days of meetings in early July with the mediator, the HLRA was not willing to concede any worthwhile items.⁴ BCNU Senior Labour Relations Officer Pat Fraser noted

¹ "What's at Stake in Negotiations," *BCNU Reports*, June-July 1985, 3.

² "Hospital Nurses Chart Course for Negotiations," *BCNU Reports*, January-February, 4.

³ "Stalemate in Hospital Negotiations," *BCNU Reports*, August-September 1985, 1.

⁴ "Recess for Hospital Talks," *BCNU Reports*, June-July 1985, 2. According to the Union, it conceded 36 cost and non-cost items by late May; the HLRA, by comparison, conceded 2 non-cost items.

that “Our bargaining committee was not prepared to give up anymore without some real movement by HLRA”.⁵ A recess began after the failed meetings with Chapelas, and continued into August.

From September to December, the BCNU bargaining committee conducted meetings across the province to inform nurses of the status of negotiations and to obtain feedback. Nurse delegates told the bargaining committee that HLRA demands for rollbacks and a zero wage increase were unacceptable.⁶ Negotiations did not resume until March 1986, a full year after they began. Jack Chapelas again mediated the talks. The union bargaining committee refused concessions, as instructed by delegates. Rank and file members approved this stance; in a survey, 84% of nurses told the bargaining committee not to budge if employers tried to “change collective agreements by reducing employee benefits or working conditions.”⁷ With this in mind, Pat Fraser warned the HLRA that a lack of movement would likely result in a strike vote. The HLRA responded with a 3% wage increase over three years, on the condition that nurses accepted all other benefit rollbacks. This would easily negate the 3% increase, which in any case fell 7.8% below projected inflation rates.⁸ The HLRA did not move from this position, and the BCNU bargaining committee scheduled a province-wide strike vote for May 21st, 1986.

⁵ “Recess for Hospital Talks,” *BCNU Reports*, June-July 1985, 3.

⁶ “Nurses would lose with hospital demands,” *BCNU Reports*, December 1985, 3.

⁷ “Nurses to BCNU: Don’t Give an Inch,” *BCNU Reports*, March 1986, 1.

⁸ “Time to Stand Up and Be Counted,” *BCNU Reports*, April-May 1986, 1.

The strike vote passed with a resounding 91%.⁹ Nurses followed this up with public rallies. Conducted across the province, the rallies were to inform the public that British Columbia had to provide adequate financing and working conditions for the province's healthcare system and its workers, or the system would deteriorate beyond repair.¹⁰ The first rally was at Prince George Regional Hospital where the BCNU was holding its annual convention, and rallies followed at Langley Memorial, Mills Memorial, Penticton Regional, Royal Inland Kampoops, Royal Jubilee Victoria, Trail Regional, and Vernon Regional. Shaugnessy Hospital acted as a gathering point for Lower Mainland nurses, who distributed thousands of pamphlets to the public on the growing nursing shortage. In the East Kootenay region, nurses conducted a rally in Cranbrook as Labour Minister Terry Segarty and provincial secretary Grace McCarthy arrived to open the BC Summer Games.¹¹ These rallies marked an effort to pressure the government and employer into a satisfactory settlement by equating the terms of the settlement with the health interests of the public.

Leadership was supportive of these developments, and seemed prepared to initiate job action. At the 1986 annual convention, BCNU President Colleen Bonner told delegates:

Dear colleagues: we have great worth, and we must stand up and defend it. I believe BCNU members are more comfortable with that fact than ever before. I know that not only from personal conversations, but from other more concrete evidence. The best example is last month's 91% strike vote...Our employers refuse to

⁹ "Getting Ready for a Fair Contract," *BCNU Reports*, June-August 1986, 1.

¹⁰ "BC's Largest Newspaper Supports Nurses," *BCNU Reports*, June-August 1986, 2.

¹¹ "Showing Determination," *BCNU Reports*, June-August 1986, 3.

negotiate realistically, so we must act on our strike mandate. We must use our strength with determination and responsibility.¹²

Before the union could begin legal job action, however, mediator Jack Chapelas had to officially report to Labour Minister Terry Segarty. But the Labour Minister refused to accept the report and instead appointed Vince Ready as a new mediator to make non-binding recommendations. This move came as the BCNU served strike notice served at all HLRA facilities, and delayed possible strike action.¹³ The union nonetheless received important guarantees: its strike mandate was extended from 90 days to however long the mediation would last, and the Labour Minister would accept Ready's report whether or not it produced a contract.¹⁴ But the HLRA maintained its hard-line position, and when four days of talks ended in September without results, it was clear that Vince Ready's attempts at mediation had led nowhere.¹⁵ State-mediated collective bargaining had been unproductive and only prolonged deadlocked negotiations.

Despite the considerable build-up of militancy among delegates and rank and file members and the rhetoric of the president, nurses did not strike. Instead, the bargaining committee withdrew from talks and appealed directly to provincial premier Bill Vander Zalm. During a forty-five minute meeting with the premier, union leaders warned that government and employer efforts to limit collective bargaining had dire implications for the healthcare system. Nurses had to receive an attractive settlement if the healthcare system were to be saved. In

¹² "Maintaining a Strong Union," *BCNU Reports*, June-August 1986, 14.

¹³ "Getting Ready for a Fair Contract," *BCNU Reports*, June-August 1986, 1.

¹⁴ "Getting Ready for a Fair Contract," *BCNU Reports*, June-August 1986, 1.

¹⁵ "Negotiators Try a Third Option," *BCNU Reports*, September-October 1986, 1.

particular, they argued that healthcare was in crisis due in large part to a provincial nursing shortage, which meant that adequate patient care could not be provided. BC needed to provide attractive working conditions and compensation for nurses, and had to use the widest latitude with wage controls to retain and recruit nurses. Union leaders emphasized that the premier's direct intervention was necessary to prevent job action.¹⁶

This move was timed for 23 September, one day before the premier called a provincial election. This was a strategic effort to use political pressure in order to obtain a contract. Given the publicity and media coverage of the rallies conducted by nurses over the previous months, the premier could not ignore the possibility of a province-wide strike and its potential political impact on the eve of a provincial election. It is almost certainly with this in mind that the premier announced that the HLRA's position would change.¹⁷ And change it did. After the premier met with the BCNU and the HLRA, Vince Ready tabled a new proposal that was agreed to by both sides in early October. It was a considerable improvement over anything the HLRA had offered.¹⁸ Features included a 12.8% wage increase by November 1st 1987, increased shift differentials, responsibility pay, local union-management meetings to discuss patient care issues, and a maximum of seven consecutive shifts instead of

¹⁶ "Negotiators Try a Third Option," *BCNU Reports*, September-October 1986, 1. BCNU also published a detailed twelve page article for the government outlining problems and solutions for health care services, entitled "Health Care in Crisis: A BCNU Pre-Election Statement, October 1986" (BCNU, 1986).

¹⁷ "Negotiators Try a Third Option," *BCNU Reports*, September-October 1986, 2.

¹⁸ The HLRA made a final wage offer of a 0, 1 and 2 per cent wage increase over three years.

eight.¹⁹ The union had used political pressure during the Operation Solidarity campaign and the rallies of 1986, and now applied the lessons to collective bargaining. Members voted on the contract and approved it, although the union withheld the final results of the vote.²⁰ The union had escaped initial HLRA cutbacks demands and made some minor gains, but there were signs that not all nurses were content with the contract.

Indeed, the withholding of the vote result suggested that the contract had not won a landslide approval. The decision to avert the strike and to appeal to the premier angered among some of the rank and file. Some nurses were frustrated with the union's adherence to state-mediated negotiations, and the union's failure to act on member militancy such as the strike vote and public rallies. One nurse wrote:

It seems my fellow nurses have done it again. We have proved ourselves to be gutless wonders, a suppressed group, quick to accept any crumbs thrown our way....I feel we have been sold down the river by our bargaining unit. But, somehow, they have convinced us we were travelling upstream in a luxury liner....Most of all, the apathy of the BC RNs appals me. We are really great in our protests and objections in the cafeteria over lunch or on coffee breaks. But how many of us made the effort to come out and vote November 6th? I worked the poll at my hospital and I know how many did not show...There was an overwhelming strike vote and once again we collapsed...We now have a four year package we had to wait 19 months for. Perhaps next time it will be 6 years then 10 years, then why bother? Just leave it sit forever and ever because nurses don't take a firm stand and fight. To our bargaining unit – thanks for pushing the first offer you were handed and recommending acceptance. You intimidated a lot of people and

¹⁹ "The Nurses' Verdict is Yes," *BCNU Reports*, November 1986, 2.

²⁰ "The Nurses' Verdict is Yes," *BCNU Reports*, November 1986, 1-2.

made them feel compelled to vote yes. I am one of the many who feel betrayed.²¹

Another nurse commended the above letter, and similarly criticized the union and fellow members:

....Understandably, the threat of strike action may intimidate those who are solely responsible for their families' financial obligations. However – to others who voted “yes,”[to the contract], please don't bring up the tired, standard complaint about Safeway cashiers making better wages than nurses. Please don't complain at all. You asked for it, you got it. To receive the message that something is better than nothing from our union paper makes me understand why “nurses accept crumbs.” I believe nurses are worth more.²²

The nurses condemned the bargaining committee and leadership's failure to act on the strike vote. They were angry that the bargaining committee avoided job action, allowed six months of unproductive bargaining, and in the end appealed to the premier with highly disappointing results – especially given nurses' initial determination with a high strike vote and public rallies. Nurses' level of class consciousness and militancy had grown beyond what the union's structure and leaders were able, or willing, to do.

It is possible that the bargaining committee avoided job action because of a centralized, bureaucratic union structure that was poorly suited for rank and file job action. The union's structure remained the same as that of the Labour Relations Division under the RNABC, formed in 1976 with the objective of

²¹ Eileen Kanik, “Nurses quick to accept any crumbs,” *BCNU Reports*, December 1986, 8. Other opinion pieces written in the newsletter showed that nurses felt they had no other choice but to strike, and others commended Kanik's letter.

²² Dale C Henry, “Dismayed By Response,” *BCNU Reports*, January-February 1987, 8.

keeping it within a professional association.²³ The union structure lacked local administrative units, or locals. Shop stewards were working nurses who were solely responsible for all union duties including administration.²⁴ This gave them little time to involve local membership on any kind of consistent basis. These same stewards were responsible for the implementation and supervision of essential services plans in the event of a strike; although the plans were set out in manuals, stewards were on their own to setup these plans in practice.²⁵ But few received the formal training needed to accomplish this. In a survey of its stewards, the union found that 50% of them received no orientation for stewardship, and wanted training in leadership, occupational health and safety, grievance handling, contract interpretation, and member involvement.²⁶

The lack of locals was a structure that favoured and relied upon a strong, central executive. This structure was left over from the RNABC when it was a professional association only minimally involved in enforcing trade union matters. The union's provincial Executive Council had the exclusive power to make decisions and the nine regional divisions had little input or responsibility. The regional divisions, arranged on geographic lines, held meetings where stewards and members had input into union matters.²⁷ Here, nurses set down proposals for what they wanted in contracts. But collective bargaining was only conducted

²³ "Role and Functions: The Changing Face of BCNU," *BCNU Reports*, November-December 1990, 7.

²⁴ "Role and Functions: The Changing Face of BCNU," *BCNU Reports*, November-December 1990, 8.

²⁵ "Role and Functions: The Changing Face of BCNU," *BCNU Reports*, November-December 1990, 9.

²⁶ "The Importance of Union Stewardship," *BCNU Reports*, June-August 1988, 1.

²⁷ "Role and Functions: The Changing Face of BCNU (Roles of Regions and Committees)," *BCNU Reports*, November-December 1990, 8.

every few years and did not involve members on any consistent basis. Stewards reported that 50 per cent of members did not read posted union bulletins; 60% of the stewards indicated that three or less local meetings were held over a year; 93% said members needed to be more involved in the union; and 83% were “frustrated by member apathy.”²⁸

In sum, the structure that the union inherited from the Labour Relations Division of the RNABC was not one that rallied or involved membership on a local basis or prepared them for job action. This helps to explain the frustration expressed by the nurses in the above letters, and by union stewards. Members were quite vocal with their 91% strike vote and rallies across the province, but without a democratically organized union that could act quickly on this momentum, these protests evaporated. A full six months later, union leaders joined the bargaining committee in a direct appeal to the premier. In the view of some nurses, the contract obtained was both unsatisfactory and forced upon members without real participation. The course of negotiations demonstrated the damaging effects of Social Credit and employer policies, and the inability of a centralized bureaucratic union to fight these – even if members wanted to.

Collectively, these events revealed problems with trade unionism that were not unique to nursing or the BCNU. A centralized union structure that relied on a handful of officials to obtain a satisfactory collective contract, and not rank and file involvement, reflected the nature of industrial relations that emerged in

²⁸ “The Importance of Union Stewardship,” *BCNU Reports*, June-August 1988, 3.

the post-war era.²⁹ Defined by the Canadian state, this was a system of industrial legality that channelled employer and union relations into official legal procedures and away from broad-based rank and file actions. This system required highly bureaucratic structures and labour officials trained in law and industrial relations.³⁰ The collective contract, the cornerstone of an industrial legality aimed to maintain labour peace, became the focal effort of unions.³¹ Collective bargaining was most efficiently conducted by a small group of specialized officials from the union and from the employer. This had the effect of creating centralized, bureaucratic unions that did not need grassroots connections and organization – characteristics more suitable to rank and file job action, which the collective bargaining process aimed to avoid.³² In this highly structured system of industrial relations, union officials and bureaucrats played a central role in capping rank and file militancy. Union leaders have often shied away from actions outside the confines of industrial legality, and even legal strikes.³³ Such actions can lead to fines and the legal persecution of union leaders, and strike action can be difficult to control. Labour leaders have a

²⁹ For a general discussion of the development of industrial legality and bureaucratized unions, see Craig Heron, The Canadian Labour Movement: A Short History, pp.75-83. Heron advocates the view that legal and bureaucratic industrial relations severely restrained worker control and resistance and ultimately helped to co-opt labour into capitalism, 79.

³⁰ Two pieces of federal legislation came to define labour relations in the 1940s. P.C. 1003, passed in 1944, was a wartime act that recognized the right of Canadian workers to organize and conduct collective bargaining, with the objective of labour peace. This was enshrined in permanent legislation with the Industrial Relations And Disputes Investigation Act in 1948, partly due to the post-war strike wave as the state sought to co-opt worker militancy.

³¹ Peter McInnis, Harnessing Labour Confrontation: Shaping the Postwar Settlement in Canada, 1943-1950 (Toronto: University of Toronto Press, 2002), 6, 8. McInnis cautions that although industrial legality limited union abilities to fight employers, it was also tempting for union leaders who found some security in the collective contract, 7.

³² McInnis, Harnessing Labour Confrontation, 190.

³³ Kim Moody, US Labor in Trouble and Transition, 196-8, 204.

structural interest in maintaining labour peace because their positions depend on this. As a paid layer of officials, their task is to secure concessions from employers and ensure that union members abide by the agreement.³⁴ Failure to do so threatens the structural function of labour bureaucrats, so they prefer centralized negotiation that is under their control, even if this results in an unsatisfactory contract.³⁵ It is equally important to note that employers and governments have a vested interest in a labour bureaucracy able to control and contain its members. As Friedman succinctly notes: “The surest way to win concessions from capitalists and governments, indeed, often the only way, is to bargain away the workers’ militancy; capitalist and government officials accept and even value unions and socialist parties precisely because they are undemocratic and, therefore, can maintain and enforce agreements against the wishes of the rank and file.”³⁶ The BCNU bargaining committee and leadership displayed these tendencies when it failed to act on a 91% strike vote, public rallies, the president’s rhetoric, and five more months of unproductive mediation. The subsequent appeal to Premier Vander Zalm was a final attempt to keep bargaining centralized and within the confines of industrial legality.

³⁴ Friedman, Reigniting the Labor Movement: Restoring Means to Ends in A Democratic Labor Movement (London and New York: Routledge, 2008), 4.

³⁵ Friedman, Reigniting the Labor Movement, 116.

³⁶ Friedman, Reigniting the Labor Movement, 6-7.

Although bureaucratic unionism was not new, it had drastic consequences for labour in the 1980s.³⁷ Bureaucratic unions that conducted collective bargaining with a handful of officials proved ill-equipped to meet employer and government attacks on their working conditions and collective bargaining rights.³⁸ Collective bargaining became a drawn-out process and contracts suffered, as the BCNU discovered in 1986. Employer and government policies were a problem, but equally damaging was that the BCNU itself avoided job action and effectively capped rank and file militancy due to issues that were endemic to union leadership and organization that were the products of class relations in the post-war era - an era now dead and replaced by class warfare, not accommodation. The changing role of the state in class relations had rendered non-militant collective bargaining unproductive, and the union's reluctance to act on member militancy left some nurses disenchanted with this form of bargaining – and keenly aware that their own union was part of the problem. Nurses' militancy and class consciousness had evolved quickly, but union structures had not, with the result that leadership and bargaining officials hindered the action that nurses wanted.

³⁷ It was during and after World War II that federal legislation helped to cement a system of industrial relations that reinforced trade union bureaucracy, but union bureaucracy is evident much earlier. In Red Flags and Red Tape: The Making of a Labour Bureaucracy (Toronto: University of Toronto Press, 1995), Mark Leier traces the development a union bureaucracy in the Vancouver Trades and Labour Council from 1889 to 1910. In Reigniting the Labor Movement, 4, 94, Gerald Friedman also dates the development of union bureaucracy to the 1880s, when organizers sought to maintain and build on the militancy of that decade by creating institutions – unions and socialist parties – that instead drifted towards conservative class compromise with tendencies of authoritative control of the rank and file.

³⁸ Unions suffered in the face of employer and government assaults, as Panitch and Swartz have amply demonstrated in The Assault on Trade Union Freedoms. But Kim Moody's concluding point in US Labor in Trouble and Transition, 246, is that internal weaknesses played an equally significant role in organized labour's decline in the 1980s: conservative leadership, bureaucratic structures that cap rank and file militancy, failure to organize in new industries, and a commitment to business unionism.

But the failure of union organization to keep pace with nurses' sense of militancy did not lead to a general disillusionment with trade unionism or collective class strategies. The union continued to operate as a key organization for class and gender issues in nursing in the realm of politics and ideas. It joined a legal boycott of government anti-labour legislation beginning in 1987, and in 1988 produced an explicit report on how nursing faced challenges as a gendered occupation. Membership showed support for these developments, which in turn led to a growing grassroots political awareness of the effects of class and gender in the nursing occupation. Instead of a period of stagnation after the disappointing contract results of 1986, important trends of class consciousness continued to evolve among members and in the union's actions.

A political climate of class warfare continued to be a central threat for the BCNU after 1986, and began to take the union in new directions. The Social Credit government renewed its legislative attack on labour in 1987. Passed in legislature as Bill 19, the Industrial Relations Reform Act of June 1987 allowed unprecedented government intervention in collective bargaining. The legislation gave sweeping new powers to Ed Peck, who was in charge of the ongoing Compensation Stabilization Program. As commissioner of a newly formed Industrial Relations Council, Peck could now intervene at any stage of the bargaining process by appointing a mediator, a Public Interest Inquiry Board or an arbitration board.³⁹ Chosen by Peck, these third parties could make

³⁹ The new Industrial Relations Council that Peck controlled consisted of an Industrial Relations Adjudication Division and a Disputes Resolution Board, which replaced the Labour Relations Board and the Mediation Services Branch respectively. Clearly, this was designed to remove any hindrances to Peck's ability to impose a settlement.

recommendations for a settlement that Peck could then impose. Wage controls and an employer-defined ability to pay were the criteria for any settlement. If a union voted to strike, Peck could order a forty day back-to-work cooling off period if he deemed the strike to be against the public interest. This was accompanied by a clause that broadened the definition of essential services to include nearly all workers in both the public and private sector.⁴⁰

This legislation effectively removed any incentive or obligation for employers to engage in collective bargaining, since Ed Peck could intervene at any point and dictate a settlement that favoured the employer. In addition, proposed elements of the legislation attempted to curtail union successor rights - the right of a union to continue to represent employees at a place of work after a collective contract expired and had to be renewed - in an effort to open public services, including healthcare, to privatization.⁴¹ With the future of collective bargaining, unions, and public services at risk, the need for counteraction by labour was clear. The BC Federation of Labour began a campaign of official opposition, which the BCNU Executive Council decided to join in April when Bill 19 was first proposed.⁴² The campaign began with a one-day work stoppage involving some 300,000 workers, and once Bill 19 passed in legislature, a legal

⁴⁰ "Bill 19 – Not Free, Not Collective, and No Bargain for BC," *BCNU Reports*, May 1987, 4-5. This was a BCFL publication, reprinted in full in this BCNU newsletter.

⁴¹ "Restrictions on Organizing, Collective Bargaining and Union Affairs," Summary of Legislation Restricting Collective Bargaining and Trade Union Rights in Canada 1982-2004 (NUPGE, 2006), 15. Panitch and Swartz, 77-79. Jonathan Goldberg-Hiller, "The Boycott of the Law and the Law of Boycott: Law, Labour, and Politics in British Columbia," Law and Social Inquiry Vol 21 No.2 (Spring 1996), 327-329, 350.

⁴² "Campaign to Oppose Bill 19," *BCNU Reports*, May 1987, 1-2. A program to educate BCNU membership on Bill 19 began at this time along with a financial contribution to BC Federation of Labour advertising efforts.

boycott. This meant non-compliance with the legislation and bureaucratic structures set down by the Bill. Unions were to ignore IRC orders, the appointment of mediators, and any potential back-to-work legislation from commissioner Ed Peck.⁴³ In May, BCNU membership voted 81% to support the boycott of Bill 19.⁴⁴

As with Operation Solidarity in 1983, the BCNU Executive Council made the initial decision to join a BC Federation of Labour opposition campaign. But this time there were no letters of disapproval in the union's magazine, and a remarkable 81% of nurses supported the decision. Nor did union leaders have to justify their actions. Rather, President Bonner observed that

What the vote result and nurses' response tells me is that we are maturing as union members, that our members are coming to understand the true purpose of trade unionism. It is basic struggles like the one we are in now against Bill 19 which prove that belonging to a union doesn't have meaning only when contracts are being negotiated. It means ensuring our rights are upheld all the time, 365 days a year.⁴⁵

According to the President, nurses were more comfortable with political action in 1987 than they had been during Operation Solidarity, when members' reactions were diverse. This support was a nod to union leaders that despite the results of 1986, collective bargaining remained vital to the nursing occupation, and had to be free of oppressive labour legislation that allowed employers to dictate conditions of work.

⁴³ "The Boycott of Bill 19 Begins," *BCNU Reports*, June-August 1987, 3.

⁴⁴ "The Boycott of Bill 19 Begins," *BCNU Reports*, June-August 1987, 3.

⁴⁵ "Bonner Speaks on Bill 19," *BCNU Reports*, June-August 1987, 18.

Membership's approval of the legal boycott of Bill 19 was an indication to union leaders that this tactic was more in line with their evolving class consciousness and feelings of militancy that had been displayed in the negotiations and aftermath of the 1986 contract. Furthermore, Bill 19 came at a time when the provincial nursing shortage reached record levels, which the union blamed directly on inadequate contract provisions and the Compensation Stabilization Program.⁴⁶ The new legislation meant the continuation of a problematic cycle. Government cuts and policies undermined the collective bargaining process and produced unsatisfactory contracts that did not attract persons into the occupation or retain the nurses who were there. This was not an abstract observation. From June 1985 to June 1986 alone, over 1800 nurses left their jobs in British Columbia.⁴⁷ This exodus from the occupation increased the pressure on nurses who remained in the workforce. BC had the lowest number of paid nursing hours per patient day in Canada by 1985, while patient numbers and demands continued to rise.⁴⁸ As nurses left the workforce, inadequate staffing levels developed to deal with this demand. This produced heavier workloads and higher rates of fatigue for nurses who remained in the workforce, which in turn encouraged them to leave. Bill 19 aimed to dissolve collective bargaining and with it, according to the union, any solutions to the nursing shortage and its related problems. For these reasons, it was clear why

⁴⁶ "Healthcare in Crisis: A BCNU Pre-Election Statement, October 1986," 5. *BCNU Reports* supplement, October 1986.

⁴⁷ "The Issue is Understaffing," *BCNU Reports*, March-April 1987, 6-7. also RNABC stats in the publications

⁴⁸ "Healthcare in Crisis: A BCNU Pre-Election Statement, October 1986," 6. *BCNU Reports* supplement, October 1986.

most nurses supported the union's resistance to the bill and found it compatible with their evolving class consciousness.

Despite the disappointing 1986 contract results, the conservative approach of leaders during negotiations, and internal organizational problems, nurses had not abandoned unionism or collective bargaining. The subsequent nursing shortage and renewed neoliberal policies of the Social Credit government had not produced an air of defeatism for the BCNU or nurses. Rather, these developments seemed to heighten an awareness that nurses, as state workers, were vulnerable to the existing political economic climate of class warfare. Membership support for the BC Federation of Labour boycott was a recognition that Social Credit policies targeted an entire class that nurses were a part of, and had to be confronted collectively. Instead of abandoning collective class strategies, nurses strengthened their resolve in these strategies.

It was also in this climate of state-led class warfare, union opposition and political resolve that the BCNU refined its understanding of the challenges facing the nursing occupation. In doing so, the union helped to channel nurses' concerns into criticism and a more explicit class consciousness. The union's analysis of nursing matured to consider factors beyond the immediate political and economic climate, with important consequences for how nurses perceived their occupation. The union explicitly considered the implications of nursing as a women's occupation and as a deeply gendered one. Academics have debated the utility of women's history versus gender history in explaining power

relationships, but elements of both came across in the union's consideration of nurses' gendered class status.⁴⁹

An October 1988 union presentation explained occupational issues to the Compensation Research Centre of Canada.⁵⁰ BCNU CEO Glen Smale, who led the presentation, explained why nursing had to be a viable career choice for women:

....women, who make up 98 per cent of our membership, have more career options, and fewer Canadian women are choosing nursing as their career. Nursing today must compete with those other choices and, unless the health care system can offer well-paid, secure employment, alternate careers will be selected. What will remain – and in fact already exists almost everywhere – are facilities that are understaffed with nurses who are overworked, undervalued, and underpaid.⁵¹

Employers had to recognize that women needed the same career opportunities as men. Women were increasingly staying in the workforce after marriage, after

⁴⁹ While gender history has generally been viewed as more theoretically refined than women's history, Joan Sangster warned a decade ago that "the emphasis on identity construction (which is central to the postmodern discourse that informs gender) is linked to a post-structuralist inclination to deconstruct 'woman,' emphasizing the fractured and multiple identities of women, rather than identifying some of the objective and material structures of economic and state power which so clearly shape women's lives in an oppressive manner", in "Beyond Dichotomies: Reassessing Gender History and Women's History in Canada," *Left History* 3 No.1 (1995), 115. Franca Iacovetta and Linda Kealey responded that this assessment of gender was an unfair generalization and that "gender history proponents insist that by making categories like "experience" problematic, we are able to dissect the elements involved and thus to get at how power works through various discourses that set limits, draw boundaries and make hierarchies seem natural" in "Women's History, Gender History and Debating Dichotomies", *Left History* 3 No.2 (1996), 229. Both discourses as defined here can illuminate women's subordinate status, and both were evident in the union presentation considered below.

⁵⁰ Formed in 1976, The Conference Board of Canada is a consulting organization that seeks to provide solutions in business and public policy based on multiple perspectives. <http://www.conferenceboard.ca/who.asp>

⁵¹ "Conference Board Hears BCNU's Views," *BCNU Reports*, November-December 1988, 9. Glen Smale began his career as a nurse in the 1960s, and became active in the RNABC's Labour Relations Division soon after its formation in 1976.

childbirth, and as individual wage earners, making nursing a lifetime career. Recognizing these changing roles meant providing worksite childcare centres for working mothers. Funding for ongoing education was also crucial. Nurses took unpaid leave to learn new medical developments and procedures that changed rapidly, yet this vital ongoing education was not considered an employer responsibility.⁵² If employers ignored these needs, they could expect the nursing shortage to continue, the union insisted.⁵³ Making nursing an attractive career option for women also meant bringing salary levels up to those of men. As female employees, nurses faced devaluation within the healthcare sector itself. Wage gaps between nursing and predominantly male occupations were a serious issue. A nurse with six years experience earned \$2,844 per month; a hospital plumber, \$2,852; an electrician, \$2,941; an air condition mechanic, \$2,946, and a biomedical electronic technician \$3,060.⁵⁴ Smale noted that “Obviously, for nurses, pay equity must be addressed at the bargaining table next year.”⁵⁵ In other words, nursing had match the prospects offered by traditionally male careers.

This argument clearly recognized that social and economic inequality existed for nursing as a women’s occupation, and had to be addressed. Although the union presentation did not explicitly state why this gendered wage gap existed, it had touched the tip of a deep issue. The notion that women are

⁵² Conference Board Hears BCNU’s Views,” *BCNU Reports*, November-December 1988, 11.

⁵³ Alice Kessler Harris parallels this argument and notes that recognizing the social roles traditionally ascribed to women, instead of subverting them to enable women to compete in a workplace favourable to men, can be beneficial for equality. For instance, acknowledging and valuing familial roles via workplace accommodation: *Gendering Labour History*, 204-207.

⁵⁴ “Conference Board Hears BCNU’s Views,” *BCNU Reports*, November-December 1988, 10.

⁵⁵ “Conference Board Hears BCNU’s Views,” *BCNU Reports*, November-December 1988, 10.

'naturally' nurses and care because they are women denies the acquired knowledge and complex skill that nursing work actually requires.⁵⁶ Nurses provide a key example of how employers utilize concepts of gender to justify lower wages. Administrators depended on nurses' commitment to patients in order to provide fewer auxiliary staff and pay salaries that recognize only medical tasks, and not the numerous other tasks performed by nurses.⁵⁷ Nurses themselves emphasized the caring aspect of their work, which can be hard to categorize as a medical task and often goes unrecognized, even though it is a central part of the therapeutic and medical healing process. These gendered assumptions served to lower nurses' pay and status. Although the union presentation did not put forth this exact reasoning, it nonetheless identified the gendered wage gap and insisted that it be addressed. Adjustments had to be made to the gendered inequalities faced by a predominantly female occupation.

Furthermore, the presentation recognized how the nursing occupation was deeply gendered in a way that kept nurses subordinate to employers and doctors. Specifically, there was a marked contradiction between the idealized notion of the feminine nurse and the actual conditions in which nurses worked:

Working conditions in this labour-intensive occupation have always been difficult, with long hours, weekend and shift work, heavy lifting, exposure to death and disease, and an authoritarian hierarchical structure in which nurses often feel powerless. They are expected to be nurturing, feminine, kind and supportive, and do

⁵⁶ Joan Stelling, "Staff Nurses' Perceptions of Nursing: Issues in a Woman's Occupation" in Bolaria and Dickinson, eds., Health, Illness and Health Care in Canada, 611.

⁵⁷ Joan Stelling, "Staff Nurses' Perceptions of Nursing: Issues in a Woman's Occupation" in Bolaria and Dickinson, eds., Health, Illness and Health Care in Canada, 623.

error-free work in an efficient and competent manner, while never complaining, and never, never confronting a doctor.⁵⁸

This passage captured how the medical profession and employers expected nurses to remain subordinate and obedient, both traits of a male-defined notion of femininity. But CEO Glen Smale explained that a lack of input into decision-making in the process was an area of increased concern for nurses, and that professional responsibility clauses would be sought to give nurses greater control over the “...consequences of understaffing and other practices that reduce nurses’ ability to give the care they are legally responsible to provide.”⁵⁹ The message here was that nurses could not be treated as obedient female servants, and the union would increase their control of workplace decision-making via collective bargaining.

The presentation thus demonstrated how gendered inequalities were adversely affecting the nursing occupation. This was a greatly refined explanation of nurses’ subordinate status, because it explicitly fused together the problems nurses faced as semi-autonomous employees and as gendered employees: nurses needed more autonomy and resources in their work and workplace, but this ran against the gendered norms of subservience and obedience for women. Implicitly, then, the union’s desire to establish more autonomy for nurses via collective bargaining was also a challenge to established gender roles, not unlike the labour strategies pioneered by the Labour Relations Division in the late 1970s. The presentation warned that an

⁵⁸ “Conference Board Hears BCNU’s Views,” *BCNU Reports*, November-December 1988, 9.

⁵⁹ “Conference Board Hears BCNU’s Views,” *BCNU Reports*, November-December 1988, 11.

awareness of how gender was fused with class could only increase nurses' determination at the bargaining table. Smale concluded that

Perhaps as never before, nurses across Canada are fully prepared to stand up for their rights...As proven in Alberta, nurses in the late 80s are willing and able to take decisive steps in the bargaining process, whether or not their actions are determined to be legal. And now that nurses are discovering the strength they have in their unions, their resolve should not be underestimated.⁶⁰

It is important to note that this was the assessment of BCNU leadership. But the demands and tone put forth by nurse delegates at the BCNU Wage and Policy Conference in December 1988 suggested that militant stirrings were indeed present among the rank and file. The main demands of the nurse delegates deserve attention here, because they reflected the arguments made in the union's presentation: that problems in nursing were issues of both gender and class, and had to be addressed as such. Thus delegates put forth demands that reflected their concerns as gendered, semi-autonomous employees of institutions, and as career women:

The value of nursing - Increased compensation taking into account BCNU member education, expertise and responsibility; the 24 hour nature of their jobs, and the physical and emotional stresses of nursing.

Professional development - expanded provisions for leaves of absence related to continuing education, including sabbaticals.

Professional responsibility - contractual rights for nurses to remedy patient care problems such as unsafe workloads.

Workplace safety - enhancing nurses' ability to address on the job hazards of all kinds.

⁶⁰ "Conference Board Hears BCNU's Views," *BCNU Reports*, November-December 1988, 12.

Health and welfare benefits - upgrading extended health, dental, long term disability and group life insurance coverage, benefits for retiring nurses, and sick leave improvements.

Job security - better contract language governing seniority, lay offs and technological change.

Family concerns - improved provisions covering maternity and other leaves.

Casual employees - providing this group with important existing contract protections already granted regular employees.

Scheduling - greater flexibility and better provisions for off duty time.

Employee rights - clarification of the grievance procedure, better job posting procedures and protection for probationary employees.

Union rights - protection from contracting out, expanded scope for union management meetings, new provisions for excluded positions and other issues.⁶¹

Proposals were so extensive that delegates spent 28 hours developing demands into the above bargaining priorities. Militant stirrings were clearly present as calls for “decisive action” to achieve these proposals came “again and again” from the conference floor and from the head table.⁶² BCNU President Pat Savage opened the conference with a speech that strongly criticized the anti-labour legislation and spending policies of the provincial government, acknowledged the shortcomings of the 1986 contract, and that arbitration was

⁶¹ “Value Nurses’ Work: For the Health of It,” *BCNU Reports*, January-February 1989, 1-2.

⁶² “Value Nurses’ Work: For the Health of It,” *BCNU Reports*, January-February 1989, 2-4.

not an option for the BCNU in 1989.⁶³ Invited as a guest speaker, Executive Director Chris Rawson of the Saskatchewan Nurses Union then spoke on the successful Saskatchewan nurses' strike, and the new sense of pride and accomplishment this gave nurses.⁶⁴ The tone of the conference suggested that nurses were ready as never before to take militant action.

This explicit consideration of class and gender as sources of subordination was part of a larger trend of union feminism. Working class women played a pivotal role in the revitalization of the women's movement in the 1960s and 1970s, and helped to introduce a working-class, union-based feminism that drew attention to the needs of women in the workplace.⁶⁵ It could be argued that the heightened militancy and political awareness of Canadian nurses in the late 1980s was due to "the particular combination of unionization, feminism, and professional development that occurred in the post-1968 era."⁶⁶ Thus, while nursing had always been subordinate to the medical profession and hospital administration via gender and class, the emergence of an independent nursing union provided the political terrain on which to develop an explicit critique of this

⁶³ "Giving It Our All in '89 Negotiations," *BCNU Reports*, January-February 1989, 6-8. Savage identified lagging wages and lack of defined input into patient care issues as major shortcomings. She also noted that the BCNU could not afford to let the HLRA hide behind the provincial government this time, who ultimately controlled the purse strings; and asked why 600 million dollars was being spent on a new Vancouver Island Highway by a Social Credit government claiming to exercise restraint.

⁶⁴ "Wage and Policy Meeting Theme: It's Time for Nurses to Take Off the Gloves," *BCNU Reports*, January-February, 4. Rawson explained that good public support was maintained due to months of Union efforts at publicizing nurse and healthcare issues, with a hotline for concerned citizens. This helped to bring about an 18.1% wage increase and improved professional rights.

⁶⁵ Meg Luxton, "Feminism as a Class Act: Working-Class Feminism and the Women's Movement in Canada", *Labour* 48 (2001), 8-9.

⁶⁶ Kathryn McPherson, *Bedside Matters*, 251. McPherson concludes here that collective forms of organization, namely unions, were vital to this process of heightened political awareness and militancy. The developments explored in this chapter support that assessment.

subordinate relationship. The union did not necessarily inject this identity into rank and file nurses. But it did provide a central forum of discussion for the gendered nature of the problems facing nursing, problems that did concern nurses and their delegates. Beyond the realm of ideas, the union was also an organization that channelled these concerns into achievable demands via collective bargaining – even though the union might need to toughen its approach in this area, as nurses at the conference demanded.

After initial organizational changes within the RNABC and the subsequent formation of the independent BCNU in 1982, nurses' class consciousness and militancy continued to develop. By 1986, it had outpaced and outgrown the capabilities of the BCNU's organizational structure with the result that union leadership and officials capped member militancy. Nurses' sense of themselves as state workers was evolving quickly, but this did not automatically mean a parallel evolution in union structure. The negotiations of 1986 made this readily apparent. Nevertheless, nurses' class consciousness continued to evolve after the unsatisfactory contract of 1986 and actually became more explicit in the political and ideological spheres. Here the BCNU played a key part with its boycott of Bill 19, explicit feminist dialogue, and ability to channel nurses' concerns. Gender and class framed a process of militant identity formation for nurses in that state and employer policies denied nurses' demands, which the union publicly insisted was a devaluation of their work as women. Nurses agreed with this assessment, but also took note of their own union's failure to confront

these issues in 1986.⁶⁷ There were limitations to collective bargaining and unionism defined and mediated by the state, particularly as the class interests of the state began to change. Outspoken demands for decisive action from the conference floor demonstrated concern and anger that the union might fail to act on member militancy as it did in 1986 – and accept an inadequate contract instead. Militancy was growing, and the tone and demands of delegates in 1988 suggested that the BCNU would have to move beyond centralized collective bargaining and state mediation in 1989.

⁶⁷ The argument that class consciousness and effective forms of organization and action must be learned by workers via first-hand experience has been expressed for some time, perhaps most notably by Rosa Luxemburg and Karl Kautsky. For an overview of the importance of democratic experience for effective working class action for these authors, see Friedman, Reigniting the Labor Movement, pp. 3-4 and 61-66.

CHAPTER 4: BEYOND THE BARGAINING TABLE AND BEYOND RHETORIC: THE BCNU STRIKE AND RANK AND FILE REBELLION OF 1989

By 1989, nurses had fought against political attacks on their labour rights, experienced three rounds of collective bargaining that failed to achieve desired contract provisions, and listened to union rhetoric that told nurses they deserved more as women and were right to demand it. The union was the central organization in all of these developments, and was itself the evolving product of changing approaches to gendered class relations by nurses in the 1970s. This was an imperfect process of evolution. Although the union supported and contributed to nurses' evolving class consciousness and sense of militancy in rhetoric and in ideology, its own organization and structure did not change to support potential action. A built-in tension emerged between nurses' militant class consciousness, which union leaders sometimes shared, and the position of union leaders and officials as labour bureaucrats in an institution that aimed to prevent, not facilitate, militant labour action. The gap between the union's organization and nurses' militancy grew to a breaking point in 1989. Even though the BCNU launched strike action, it was not enough. Nurses effectively stepped outside the union's structure and engaged in grassroots action to achieve results that were in line with their level class consciousness. Nurses' class consciousness provided the basis for action that directly challenged an exploitative socioeconomic relationship. Nurses challenged not only their

employer and the state, but also their own union and its leaders. Because this grassroots nurses' movement confronted problematic union organization and gender and class power issues in a critical manner, it produced concrete changes in the union's organization, nurses' contract conditions, and the relationship between unionism and professionalism in nursing. In short, a gendered rank and file class consciousness framed processes of democratic action in 1989 that produced significant changes in the union's structure and the nursing occupation.

Initially, the 1989 negotiations between the BCNU and the HLRA followed a now familiar, depressing pattern. Between February and May, little progress was made as the HLRA again demanded concessions and no wage increases.¹ This time the union did not allow matters to drag on, and conducted a strike vote on May 17th. Union members turned out in force at 81 per cent, and decisively voted in favour of strike action with 94 per cent.² The HLRA declared the strike vote illegal because the Industrial Relations Council, boycotted by the union, did not monitor the strike vote. The BC Federation of Labour and the BCNU avoided this challenge by allowing the otherwise boycotted IRC to monitor the strike vote, which was then legally recognized. On 21 May, nurses began a limited withdrawal of services. This had some impact on the HLRA, which returned to the bargaining table under the direction of private mediator John Kinzie. The HLRA conceded two items: pay for nurses on workers compensation leave and

¹ Valerie Casselton, "Nurses Demands Put at 500 Million," *Vancouver Sun*, February 23, 1989, A3.

² Valerie Casselton, "BC Nurses Vote for Strike," *Vancouver Sun*, May 18, 1989, A1.

the long sought-after professional responsibility clause.³ By June 7th, the union also obtained thirty weeks maternity leave, employer-provided orientation, employment portability, and scheduling demands.

The strike vote and the limited withdrawal of services convinced the HLRA to alter its hard-line position somewhat. But the employer had a counter-strategy. On June 9th, some hospitals cut admissions for non-essential surgery. They cited the possibility of a full-scale nurses' strike, even though the union had confirmed services for patients admitted for surgery before job action. These developments led the union to suspect that the HLRA informed hospital management of a negotiating strategy: an unacceptable wage offer and then legal action to break the strike. This is precisely what followed. The HLRA made a final wage offer of 18% over three years. BCNU responded with its original demand of 33%.⁴ Negotiations broke off as the union banned overtime and implemented essential services plans at twelve major HLRA facilities employing more than 6,000 nurses.⁵ Confirming BCNU suspicions, the HLRA then went to the BC Supreme Court with accusations that nurses were not providing essential services. But the strike was not declared illegal, and Labour Minister Lyall Hanson appointed IRC Commissioner Ed Peck to set essential service levels with the HLRA. The BCNU maintained its boycott of the IRC and Ed Peck,

³ "Two Main Issues Settled in Nurses Talks," *Vancouver Sun*, May 29, 1989, A2.

⁴ "A Chronology of the Dispute," *BCNU Reports*, July-October 1989, 6.

⁵ "A Chronology of the Dispute," *BCNU Reports*, July-October 1989, 6.

whose findings did not change the essential services levels previously set by arbitrator Stephen Kelleher.⁶

This move signified the failure of the HLRA's attempt to break the BCNU strike via the Supreme Court and the IRC. Both sides returned to the bargaining table with private mediator John Kinzie, and intense talks produced a tentative settlement on June 26th. Highlights included a 29.5% wage increase with 8% in other monetary benefits over three years. An improvement over the HLRA's initial offer of 18%, this was still a far cry from original demands of 33% in wages and 43% in other benefits. Nonetheless, the BCNU bargaining committee agreed to end job action and to conduct a vote on the offer on July 12th.⁷

The proposed settlement, the decision of the BCNU bargaining committee to accept it and to end job action produced a sudden wave of internal opposition.⁸ The union's decisions spurred the rank and file into immediate action. The gendered class consciousness that the union itself had helped to condition now took on a life of its own among the rank and file, with unexpected consequences. On 27 June, some 700 nurses confronted BCNU president Pat Savage and demanded that the recommendation to ratify be withdrawn, that picketing resume, and that the voting date be moved forward.⁹ The president agreed to these demands, but publicly withdrew this agreement two days later

⁶ "A Chronology of the Dispute," *BCNU Reports*, July-October 1989, 7.

⁷ "A Chronology of the Dispute," *BCNU Reports*, July-October 1989, 7.

⁸ The BCNU back-to-work agreement also angered the HEU and HSA who were on strike at a number of the same facilities and had not reached a settlement at this point: Patricia Webb, Heart of Healthcare: The Story of the Hospital Employees Union, 88. Would the BCNU strike have been more successful if the union maintained solidarity with these allied health unions?

⁹ "A Chronology of the Dispute," *BCNU Reports*, July-October 1989, 8.

and explained that only the bargaining committee had the authority to take such actions.¹⁰ This angered the nurses further. On the same day that the president retracted her comments, some 150 nurses forced a meeting with union leaders by storming the boardroom at BCNU headquarters. These nurses again demanded an earlier ratification vote and a presentation of the contract to members without a recommendation to accept from the bargaining committee. The group wanted members to read the contract and decide for themselves, and an immediate ratification vote instead of a two-week delay.¹¹ The union was now divided as a dissident group of members emerged to challenge the bargaining committee, which continued to strongly recommended ratification.¹²

This dissident faction had a decisive impact on the events that followed. The group consisted of nurses from Vancouver General Hospital and St. Paul's Hospital, under the leadership of Bernadette Stringer and Debra McPherson, the BCNU chairwoman for Vancouver. The group organized oppositional action because they felt the tentative contract had critical shortcomings, and that the bargaining committee had therefore made a serious error in recommending the contract to members. The group specified what the critical shortcomings were: the three year term; failure to attain all the objectives set by delegates at the December 1988 wage and policy Conference; failure to make the profession more attractive to solve the nursing shortage; and failure to achieve parity with

¹⁰ Justine Hunter and Valerie Casselton, "Nurses Chief admits Error in Retracting Acceptance," June 29, 1989, A1.

¹¹ Jane Coutts, "BC Nurses Demand Early Vote on Contract," *The Globe and Mail*, June 30, 1989, A5.

¹² According to the union, this group involved about 700 Vancouver area nurses at this point: "A Chronology of the Dispute," *BCNU Reports*, July-October 1989, 8.

male-dominated occupations.¹³ The BCNU itself became the target of the rank and file gendered class consciousness, because it pressed a contract that did not achieve the gendered class demands put forth in 1988.

The criticisms of the contract resonated with other nurses across the province, who also expressed discontent with the contract and the bargaining committee.¹⁴ It became clear that the Vancouver-based nurses were not an isolated minority. Tension now increased between the Vancouver-based faction and the bargaining committee. In the two weeks before the July 12th ratification date, both sides embarked on campaigns across the province to rally support for their respective positions. President Pat Savage and the bargaining committee urged nurses to ratify the contract, while Vancouver-based nurses raise several thousand dollars to send Bernadette Stringer and Debra McPherson on a province-wide Vote No campaign.¹⁵

While Stringer and McPherson's criticisms of the contract resonated with a large number of nurses outside of Vancouver, they also asked members about their own concerns with the contract. This stood in important contrast to the approach of the bargaining committee, which strongly recommended ratification with little consultation or discussion. Many nurses found the bargaining committee condescending, unresponsive to their concerns, and adamant that there was no alternative to the proposed contract. In meetings with the bargaining committee, nurses found that "There was a heavy atmosphere of

¹³ "A Chronology of the Dispute," *BCNU Reports*, July-October 1989, 9.

¹⁴ Justine Hunter and Valerie Casselton, "Nurses Chief admits Error in Retracting Acceptance," *Vancouver Sun*, June 29, 1989, A1.

¹⁵ "A Chronology of the Dispute," *BCNU Reports*, July-October 1989, 9.

intimidation and threats that a lot of us found quite unsettling.”¹⁶ This resentment towards the bargaining committee, along with genuine concerns about the contract, resulted in 65% of members rejecting the contract on July 12th in a 77% turnout.¹⁷ The Vote No campaign had acted more democratically at a grassroots level, which is what nurses wanted after the union’s centralized, conservative actions in the 1986 negotiations. The Vote No campaign was in tune with the gendered class consciousness and demands of nurses, while the union bargaining committee represented an attempt to cap these demands by pressing an unsatisfactory contract.

Significantly, the dissident grassroots Vancouver faction now represented the majority of nurses within the union. The union and the bargaining committee recognized the vote, which was a display of discontent with both the contract and the bargaining committee’s actions. Caught off guard with these results, the bargaining committee appealed to Premier Vander Zalm the day after nurses rejected the contract. This time the Premier declined to intervene and provide a settlement as he had in 1986 – there was no election imminent this time.¹⁸ Over a month passed, during which time nurses continued a ban on overtime and non-nursing duties. The union’s Executive Council did not agree to demands to replace the bargaining committee, and instead merely added one nurse from the Vote No group. When BCNU and HLRA finally met mediator Vince Ready on

¹⁶ Suzanne Fournier, “Scare Bid by BCNU Alleged,” *The Province*, July 7, 1989, 3. A union spokesperson claimed that there was a draft for back to work legislation in Victoria, but this was never confirmed.

¹⁷ Justine Hunter, “Union Asks to Meet Vander Zalm after 65% No Vote: Nurses Reject Contract,” *Vancouver Sun*, July 13, 1989, A1.

¹⁸ Justine Hunter, “Union Asks to Meet Vander Zalm after 65% No Vote: Nurses Reject Contract,” *Vancouver Sun*, July 13, 1989, A1.

August 8th, the talks adjourned after only four hours. On the following day the premier told the parties to settle within a week or face intervention, and both sides agreed to binding recommendations which Vince Ready announced on August 18th. The contract was for two years instead of three, and it raised wages by 20.9%. It maintained the professional responsibility clause, and forbade any potential employer discipline against nurses for job action.¹⁹

The contract pleased neither faction within the union. President Pat Savage stated that the package did not address the critical nursing shortage and meant immediate preparation for the next round of bargaining. Debra McPherson, co-leader of the Vote No group, noted the unsatisfactory history with arbitration and that delegates at the 1988 wage and policy conference had specified not to enter any form of binding arbitration.²⁰ Union stewards and rank and file nurses found strike action unorganized and highly stressful. Stewards found themselves uncertain on how to direct job action, while rank and file nurses criticized the union for lack of communication and planning.²¹ Although the degree of militancy and gendered class consciousness was high among members, union organizational problems had hindered job action. While there was some recognition of internal union problems after the negotiated settlement of 1986, the effects of these problems during the 1989 job action were

¹⁹ Justine Hunter, "Nurses agree to binding contract; Mediator Ready to disclose his recommendations Friday; Union consents to binding arbitration, ending long dispute; Nurses agree to deal," *Vancouver Sun*, August 16 1989, A1.

²⁰ Justine Hunter, "Nurses agree to binding contract; Mediator Ready to disclose his recommendations Friday; Union consents to binding arbitration, ending long dispute; Nurses agree to deal," *Vancouver Sun*, August 16 1989, A1.

²¹ Georgina Dingwell, "An Analysis of Conflicts Experienced by Nurses During the 1989 Nurses' Strike," MA thesis (SFU, 1991), 338.

immediate. The strike of 1989 revealed in full the shortcomings of the union's centralized, undemocratic structure. The erratic appointment and training of stewards and the lack of locals meant poor training for job action. This was exacerbated by the lack of a formal communications structure between the union bargaining committee and membership.²² This communication was crucial, because the bargaining committee set essential services levels for job action with the HLRA and a private mediator. Essential services levels were set too high, so that most nurses remained at work and a decisive withdrawal of labour did not occur.²³ Financial Director Jack Scott reported that in 17 days of strike action, only \$119, 810 in strike pay was paid out.²⁴ By comparison, the Hospital Employees Union paid out \$1.5 million to its members over the same period.²⁵

In agreeing to high essential services levels that limited the effects of job action, the bargaining committee and Central Executive were able to maintain control of the rank and file during contract negotiations. This was important for union officials in charge of centralized collective bargaining, since strikes can escalate and undermine union leadership's legally defined role in the collective bargaining process.²⁶ The bargaining committee thus pressed hard for

²² "President's Address, Annual Convention," *BCNU Reports*, November-December 1990, 2.

²³ Valerie Casselton, "You Didn't Ask, Rank and File tells BCNU," *The Vancouver Sun*, November 1 1989, B1.

²⁴ Valerie Casselton, "You Didn't Ask, Rank and File tells BCNU," *The Vancouver Sun*, November 1 1989, B1.

²⁵ Webb, *The Heart of Healthcare*, 89. According to HEU bargaining bulletins from 1989, no facility had essential services levels for nurses set at less than 80 per cent of normal staffing levels.

²⁶ Friedman, *Reigniting the Labour Movement*, 117.

ratification when they obtained a mediated contract offer on June 26th.²⁷ But members resented this pressure and identified with the Vote No campaigners who actively condemned the bargaining committee. The success of the Vote No campaign signified a rejection of a centralized, undemocratic union model. This model was more effective for its ability to end strikes than to fight them, and to control the actions of union members – aspects favourable for employers.²⁸ Nurses recognized that this model could not achieve their demands or support their militancy when the BCNU failed to coordinate committed job action, and when the bargaining committee pressed them to ratify a contract that fell short of their demands defined by gender and class. Because the union capped nurses' demands, it became a target of nurses' gendered class consciousness and militancy.

The problem was therefore not with strike action itself, but with a centralized, undemocratic trade union model and collective bargaining process that favoured compromise and labour peace.²⁹ Chaotic and limited though it

²⁷ In his examination of the structural restraints on business unionism, Gerald Friedman notes that "Once concessions are won, the union itself becomes responsible for maintaining the agreement, for enforcing the social peace on the union membership. It is, therefore, in the nature of the union to discourage strikes and to substitute centralized negotiation, by bureaucrats and officials, for rank and file participation," in Reigniting the Labour Movement, 116.

²⁸ Friedman, Reigniting the Labour Movement, 133. "Business unionism did not triumph because it provided something special for the workers; instead it has achieved nearly universal success (acceptance) because it represented a viable class compromise." Friedman, Reigniting the Labour Movement, 134.

²⁹ Kim Moody, in US Labor in Trouble and Transition, 110, 196-7, 204 also notes how union bureaucrats often shied away from effective confrontation with employers. Since the 1980s, such efforts have come from the rank and file. But union leaders have condemned these efforts, because they represent a threat to bureaucratic corporate unionism, which depends on hierarchal organization and control. This form of unionism evolved from labour-management cooperative programs in the 1980s, a common union survival strategy that curtailed worker militancy and surrendered workplace control to management.

was, the 1989 strike produced the fastest settlement for the BCNU since 1980. It achieved the long sought-after professional responsibility clause, first attempted in 1980 negotiations and viewed as a key goal in the union's 1988 presentation on gender and women's issues in nursing. The contract was also the largest public sector settlement in BC, in wages and benefits, since BCNU's 1980 contract.³⁰ By confronting class and gender issues via a collective class strategy, the strike, nurses achieved more than they had in nearly a decade – not coincidentally, the last time they utilized the strike.

Moreover, the rank and file rebellion and action during negotiations, framed by a gendered class consciousness, laid the groundwork for a process of change within the union. In the months that followed, the BCNU began a review of its structure and the strike. At the union's annual convention in October 1989, delegates demanded that union leaders take rank and file concerns into account during this review process. Delegates criticized a union telephone survey of member concerns as rushed and inadequate.³¹ In her speech to delegates, President Pat Savage admitted that communication was inadequate and essential services levels were too high during the strike. But she also emphasized

....BCNU's failure to educate its members adequately about some of the hard realities of collective bargaining. The most important is that you cannot get everything you want and need – even if your cause is just....we missed how far nurses' expectations might run

³⁰ "Reviewing the State of the Union: President Looks at Past Year and Immediate Future," *BCNU Reports*, November-December 1989, 7. The HEU, for example, was given a 13.1% wage increase over two years: Webb, *The Heart of Healthcare*, 88.

³¹ Valerie Casselton, "You Didn't Ask, Rank and File tells BCNU," *The Vancouver Sun*, November 1 1989, B1.

beyond the capacity of the negotiations process – and how years of anger at the terrible effects of the nursing shortage might focus on the Union, instead of the government and employers.³²

Delegates did not want more of the same. They wanted meaningful change based on rank and file input, and an acknowledgement by leadership that this was necessary. It was in this context that members elected Debra McPherson, co-leader of the dissident 1989 faction, as BCNU President in August 1990. McPherson called her election “a mandate for change from a membership who felt the time had come following the 1989 General Hospital strike.... Clearly our structure must be examined and altered to improve organization, communication, and education at the grassroots level.”³³ McPherson promised results on these issues from a Structural Review Committee. The Committee mailed a questionnaire to members entitled “Would BCNU Benefit From A New Structure?” that explained the current structure and functions of the union.³⁴ It asked members if they would prefer to move to a system of locals, and provided space for written recommendations. Unlike the previous leadership, the Committee made it clear that “the intention is to stimulate debate and ensure maximum membership involvement prior to making organizational changes, if any, to the union structure.”³⁵ Here was the acknowledgement of rank and file input and the promise of change that members wanted.

³² Valerie Casselton, “You Didn’t Ask, Rank and File tells BCNU,” *The Vancouver Sun*, November 1 1989, B1.

³³ “President’s Address, Annual Convention,” *BCNU Reports*, November-December 1990, 2.

³⁴ “Would BCNU benefit From a New Structure?,” *BCNU Reports*, November-December 1990, 7-10.

³⁵ “Role and Functions: The Changing Face of BCNU,” *BCNU Reports*, November-December 1990, 7.

The review process produced results that delegates strongly supported. Both the review committee and President McPherson recommended the establishment of a system of locals to move away from a highly centralized structure.³⁶ The union's job action program was the first to undergo structural change:

The Union's job action program is a grassroots effort which relies on stewards and other BCNU members who best know the needs of their individual health agencies. Nurses have established a local Strike Steering Committee in each bargaining unit. These local committees are supported by a network of provincial committees which report to the BCNU Council, the Union's elected governing body.³⁷

The structure of the new job action program was built from the hospital level upwards. Each hospital now had a Bargaining Unit Strike Steering Committee, which under the direction of stewards, implemented job action plans at the local level and communicated with a Regional Strike Steering Committee. The Regional Strike Committees coordinated communication and implementation of job action plans at the regional level; for example, for Lower Mainland hospitals. Cohesive union policy was maintained by a Provincial Essential Services Committee, which would oversee essential services plans, audit their implementation, and consult with other health care unions to ensure compatibility with their essential services plans. A Negotiating Strategy Implementation Committee provided a formal means of communication between the Negotiating Committee (which performed collective bargaining) and the Regional and

³⁶ *BCNU Reports*, December 1991, 10.

³⁷ *BCNU Update*, December 1991, 12.

Bargaining Unit Strike Committees. The BCNU Council, meanwhile, remained the ultimate authority in the union and established policies on all decisions relating to collective bargaining.³⁸ This reformed structure marked a concerted effort to address the communication gap and inadequate local structure that plagued the 1989 strike. Each hospital had its own administrative unit and its own Strike Steering Committee with formal communication links to provincial committees. This was a dramatic change from a central bargaining committee with informal communication links to stewards, as was the case previously.

Stewards were vital to this reformed job action plan, and were the next focus of reform. Previously stewards were volunteers; now, the BCNU decided to pay them as official employees, which delegates approved. This removed their erratic appointment and commitment and cemented their role in the union structure. The establishment of locals also provided a two-person minimum executive to deal with administrative duties so that stewards could develop deeper ties with membership and address contract and workplace concerns.³⁹ Delegates also approved a formal election process for stewards, and set a steward-to-membership ratio to replace the previous practice of erratic appointments to the position.⁴⁰

These reform efforts demonstrated a desire to strengthen trade unionism, not to abandon it. Creating an effective form of trade unionism did not come from

³⁸ *BCNU Update*, December 1991, 13.

³⁹ *BCNU Update*, December 1992, 10.

⁴⁰ Vol 13 No. 2 *BCNU Update*, April 1994. The ratio of members per bargaining unit was established as follows: 1-500 members, up to 6 stewards; 500-1000 members, up to 10 stewards; and 1000 plus members, up to 15 stewards.

leaders or a centralized collective bargaining process, but rather from the experiences of nurses themselves. It was the actual experience of popular militancy that convinced nurses of the need for grassroots action to make a decisive impact, and they engineered changes in their union structure that reflected this. Of all the negotiation tactics tried by the BCNU and its members in the 1980s, the strike – poorly organized though it was - proved the most effective. For all the turmoil of the 1989 job action and mutiny, there was a feeling among both leadership and members that nurses had finally discovered their collective power and ability to effect change via their own action.⁴¹ Nurses had done so by rallying around a gendered class consciousness and translating this into collective class-based forms of action.

Nurses had endorsed the strike and made democratic changes to the trade union model. Unionism in nursing was here to stay, and this raised a significant issue for the nursing occupation: what would the union's relationship be with the professional association, the RNABC? In the climate of change and reform that followed the strike of 1989, nurses began to ask questions about the role of the RNABC that revealed growing political and functional differences between it and the BCNU. During the job action of 1989, the RNABC had maintained a position of strict neutrality. It did not comment publicly in the media or offer any form of support, which angered rank and file nurses. Nurses found this silence unacceptable and wanted RNABC assistance with decision-making

⁴¹ "Reviewing the State of the Union: President Looks at Past Year and Immediate Future," *BCNU Reports*, November-December 1989, 9.

on patient care issues.⁴² In her study of the strike, Georgina Dingwell, herself an R.N., concluded that

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.⁴³

Indeed, concern grew over what the exact function of the RNABC was and whether it was compatible with increasingly difficult labour relations and working conditions. The RNABC also maintained neutrality on Bill 19 and the follow-up Bill 82 of March 1991, both clearly unacceptable for the BCNU. The RNABC Position Statement on Job Action did support the right for nurses to engage in collective bargaining and job action, but only “under the law.”⁴⁴ But Bills 19 and 82 sought to legally remove collective bargaining and job action, which made the RNABC position irrelevant. BCNU President McPherson called this position “not compatible with an organization that calls itself a professional association and professes to be concerned with the recruitment and retention of nurses,” and demanded that the RNABC refund nurses’ dues.⁴⁵

In the climate of structural change and reform that followed the strike of 1989, many members wanted answers on the role of the RNABC. The union

⁴² 85% of nurses wanted the RNABC to provide active support during the strike, and were angry that the RNABC was invisible. Dingwell, “An Analysis of Conflicts Experienced by Nurses During the 1989 Nurses’ Strike,” 169-171, 339. A review of newspaper sources from the time of the strike reveals no public commentary from the RNABC.

⁴³ Dingwell, “An Analysis of Conflicts Experienced by Nurses During the 1989 Nurses’ Strike,” 433.

⁴⁴ *BCNU Update*, Winter-Spring 1991, 11.

⁴⁵ *BCNU Update*, Winter-Spring 1991, 12.

arranged a presentation on this issue at the 1991 annual convention.⁴⁶ The content of this presentation, more than any other union address in the prior decade, identified the longstanding differences between professional functions and union functions in nursing. The presentation made the problematic disciplinary functions of the RNABC explicit. It reminded nurses that RNABC professional functions had not adapted and evolved on par with trade unionism in the prior decade, and actually posed a threat to nurses:

The tendency of any professional association is to view and to judge the professional employees conduct in isolation from the particular work place and context. In other words, the panel tends to look only at the conduct in question on the one hand, and the applicable standards on the other. Why is the discipline process becoming longer and more complicated?

Employers have discovered that they can complain to the Association about matters that have nothing to do with serious professional misconduct or unsafe practice and that the Association will pursue all of these complaints regardless of their seriousness or significance. The employer then sits back and lets the Association do all the work instead of dealing with employment related matters in the employment context. This strategy gets the employer off the hook in other respects. As I have pointed out, in labour arbitration the employer has some explaining to do when things go wrong in the workplace. But before disciplinary panels, professionals are treated as though their profession and their employment status are two separate concepts. That just isn't the case. When you are employed by a facility or organization, how you conduct yourself as a professional cannot be viewed in isolation from your conduct as an employee under the direction of someone else (management) and in accordance with policies and procedures set out by the facility in question.

Management or facilities never receive scrutiny in these proceedings. It is always the nurse. I repeat that it is not just the RNABC that is encountering these legal difficulties. Other professional organizations are encountering them as well.

⁴⁶ *BCNU Update*, December 1991, 10.

All the more reason to ensure a professional disciplinary process that only considers grave professional misconduct or negligence.

In summary, concepts entrenched in your professional legislation, concepts such as professional misconduct, incompetence and negligence cannot be considered only against standards of practice. They cannot be considered in a vacuum when are you both a professional and an employee employed by some third party.⁴⁷

A disciplinary process that did not take practice settings into account was a longstanding concern for rank and file nurses. The issue first arose in 1977 when the RNABC amended the Nursing Act to expand and streamline its disciplinary powers but failed to take practice settings into account. At this time, the recently formed RNABC Labour Relations Division did not have the clout to challenge this decision. But in 1984, the BCNU challenged RNABC plans for compulsory licensure and demonstrated competence. Debate and discussion between the organizations lasted for one year. Once again, proposed RNABC plans for demonstrated competence and investigative and disciplinary procedures did not incorporate workplace settings.⁴⁸ The BCNU countered that workplace settings were vital for consideration in such procedures. In addition, the union called on the RNABC to

....seek amendments to the Registered Nurses Act that would empower Association representatives to enter any publicly funded health facilities to investigate and make recommendations on

⁴⁷ "Taking a Stand - Lawyer Identifies Conflicts Between BCNU and RNABC," *BCNU Update*, December 1991, 10-11.

⁴⁸ "Position Paper on Nurse Licensure," (BCNU: 1984), 10. This was the official BCNU Council position on nurse licensure as put forth by the RNABC. Although the paper supported the idea in principle, it had a number of reservations, particularly the issue of a lack of enforcement for quality practice settings. The paper was attached to *BCNU Reports* December 1984 edition for members.

nurses reports of unsafe or inadequate patient care situations, the result of all such investigations and recommendations to be matters of public record.⁴⁹

The union encouraged the RNABC to take on a much more active role: if the Association could enforce standards for individual nurses, surely it could also enforce standards for institutional settings and consider these in disciplinary hearings. But the Association did neither in the end.⁵⁰ Some other areas of conflict occurred between the organizations before 1989, such as the debate over licensure and the BCNU decision not to back the RNABC credential goal of EPA 2000.⁵¹ But it was the strike and grassroots action of 1989 that finally threw the role of the RNABC into critical light. In this pivotal moment and its aftermath, the RNABC was invisible as a supportive organization for nurses. It was little wonder that this bred concern among nurses and the BCNU, given that the RNABC controlled a disciplinary process that still did not take into account work settings that had deteriorated enough to push nurses to strike.⁵²

⁴⁹ "An Endorsement of RNABC Plans," *BCNU Reports*, November 1985, 1.

⁵⁰ "An Endorsement of RNABC Plans," *BCNU Reports*, November 1985, 1-3

⁵¹ "It's Just a Matter of Degree," *BCNU Reports*, December 1986, 1. The union took this stance because only 9% of BCNU members held degrees; most held four-year diplomas. Also, employers arbitrarily began adding a university degree as a requirement for nursing positions that had not changed in work content; when asked why, they believed it was RNABC policy for entry-into-practice, and not reflective of actual employer needs: "It's Just a Matter of Degree," *BCNU Reports*, December 1986, 1-2.

⁵² Barbara Beardwood et al., eds., "Complaints Against Nurses: A Reflection of the New Managerialism and Consumerism in Healthcare?" *Social Science and Medicine* 48 (1999), 363-374, note that deteriorating working conditions and increased managerial control have made it increasingly difficult for nurses to meet the standards they are trained to provide; as a result, complaints against nurses have increased since the 1980s, which professional associations monitor closely. But because professional associations do not concern themselves with institutional settings, complaints are individualized and not considered in the context of workplace settings or healthcare restructuring. It is not surprising that nurses have voiced considerable concern over this arrangement, as they did in British Columbia after 1989.

Emboldened by the effectiveness of the strike and grassroots action of 1989, nurses reformed the structure of the BCNU. An explicit class consciousness was the basis for labour action and for the reform of working class institutional structure that had not kept pace with nurses' growing militancy. But the RNABC showed no comparable adaptation to nurses' class consciousness and sense of militancy. In this time of organizational reform and change for the union, nurses expressed concern over the unchanged role of their professional organization. It was unclear how the RNABC could offer nurses any protection as semi-autonomous female employees. If the RNABC only enforced a problematic disciplinary process, this left nurses vulnerable to employers and doctors who could complain if a nurse stepped beyond her traditional role, simultaneously defined by gender and class. The professional disciplinary process, as it existed, was an avenue to keep nurses in their place as women and as employees. After nurses consciously fought these very issues in 1989, it was little wonder that the role and functions of the RNABC exploded into controversy. The strike action and results of 1989 finally gave nurses and the BCNU the political clout to challenge and criticize the RNABC.

As the 1980s drew to a close, nurses' gendered class position interacted with previous union developments and the negotiations of 1989 to produce an explicit political conscience, framed by gender and class, that led to action and changes in the union. It was no accident that trade unionism in nursing had resonated due to the reforms engineered by nurses from their gendered class experiences, and the implications for the occupation were significant. A reformed

union attacked both the gendered ideology of traditional professionalism and its organization and functions. Nurses were prepared to confront not only external sources of oppression such as employers and government, but also internal weaknesses such as bureaucratic unionism and problematic professional functions. The limitations of professionalization as a strategy and form of organization, evident for over a century, came under renewed criticism as nurses found an alternate strategy and organization to be more effective: the class-based approach of grassroots, militant trade unionism.

CONCLUSION

This thesis has demonstrated the diverse workings of gendered class relations in the power struggles of the post-industrial, service-sector economy of contemporary capitalism. Class was a gendered and exploitative socioeconomic relationship that was pivotal to change in the nursing occupation. As public sector workers ultimately employed by the state, nurses were subject to the exploitation and proletarianization of the emerging white collar workforce of the 1970s. Nurses worked for the state, an institution central to capitalism, itself a socioeconomic system that depends on the exploitation of waged labour. The state itself exploited nurses as workers with its employment practices, modelled after capitalist labour relations, and its ideological, spending and taxing priorities – designed to support ventures in private profit accumulation. As nurses felt the pressures of proletarianization in the 1970s and exploitation as waged workers of the state, they began to forge new ground with strikes and new forms of labour organization. This took place in the context of a historical and ongoing internal struggle in nursing between unionism and professionalism. The formation of an independent union coincided with direct political attacks on labour by the Social Credit party, which gradually led nurses to see themselves as state workers. This evolving class consciousness did not mean a neat, parallel evolution in union organization and structure. Nurses found problems with their own union in 1986. But class consciousness continued to evolve so that by 1989, it was the ideological basis for strike action that explicitly challenged an exploitative

socioeconomic relationship. This included action by nurses against their own union officials, which led to structural reform and sharp criticism of the RNABC's professional functions that had not evolved to meet changing working conditions and nurses' view of themselves as state workers.

These diverse workings of class stand in sharp contrast to André Gorz's claims about the disappearance of class in the late 1970s, and to the subsequent arguments made by some postmodern academics. This is not to condemn postmodernism at large, which has produced a richly varied literature.¹ Rather, this thesis cautions against works that abandon class as an explanatory social and political framework in postindustrial, capitalist society. For nurses, the late 1970s marked a beginning of a period of change in organization and identity along gendered class lines. It is important to recognize that class, and class consciousness, are not reductionist or dualistic explanations of historical change, which some postmodern authors have assumed. Class is a socioeconomic relationship that exploits the majority of people in capitalist societies, the working class. This is a diverse and always changing group, but its members share a common social experience in that they sell their labour power for a wage to employers. How people handle this situation in cultural terms, however, can vary

¹ Dennis Dworkin, in *Class Struggles*, 69, traces the evolution of postmodern thought in academia and the socioeconomic conditions from which it arose, and offers a definition that acknowledges the diversity of the genre: "...a growing culture of affluence, an emerging information society, the spread of a service economy and consumer capitalism, the decline of working class militancy, the rise of new social movements, and the globalization or Americanization of the popular media....The postmodern is notoriously difficult to define, in part because it has encompassed so much: the privileging of surface over depth, the triumph of the image, identity politics, the intermingling of high and popular culture, the reign of the simulacrum and pastiche, the fragmentation of the subject and the end of metanarratives, and the decentering of the West."

greatly. Sometimes, people become explicitly aware of this exploitative relationship and will seek to change it. Once they are politically aware of this exploitative relationship, an awareness that can be called class consciousness, humans have the ability to change seemingly natural or concrete class relationships. But productive relations and being a member of the working class do not automatically produce class consciousness or change; this depends on social, cultural, and political factors that can vary greatly and interact with class in a number of ways. In this sense, this thesis agrees with other postmodern approaches that demand attention to additional social factors and struggles that lie beyond class.

For nurses, class consciousness and occupational changes were conditioned by the changing role of the capitalist state, gendered work relations, and a historic internal struggle between professionalism and unionism, and contemporary political factors. An objective class position can lead to organizational change for workers such as independent trade unionism in a particular socioeconomic context, as it did for nurses, but it is not the only factor. It is more about how this class position can interact with other developments. For nurses in the late 1970s, implicit challenges to gender roles in the workplace led to experimentation with new forms of labour strategies, which conflicted with professional functions under a single organization. Combined with effective class-based action in 1980, this then convinced nurses of the utility of an independent union. But the emergence of the BCNU did not mechanically produce a grassroots class consciousness or an effective form of trade unionism.

Leaders involved the BCNU in the wider labour movement to fight the class-based attacks of the neoliberal Social Credit government, and advocated a rejection of the inherently gendered notions of professionalism in favour of a trade union identity for nurses. They had established an important identity for nurses to rally to. But centralized collective bargaining and trade unionism, itself a product of World War II labour conflict, hit a wall in the political and economic climate of the 1980s. The shortcomings of collective bargaining and the union became apparent by 1986, and the union strengthened its opposition to anti-labour legislation with a legal boycott and published an explicit consideration of nursing as a gendered occupation. This resonated with nurses at a time when they felt vulnerable, but they also knew that the union would have to change how it fought for nurses' goals. It was up to nurses to make to make this change. Nurses acted on a growing gendered class consciousness in 1989 when they challenged employers and their own union. This grassroots consciousness and the rank and file action that followed were the products of processes of class and gender that framed the BCNU's development.

The death of class in some areas of academic discourse because of its supposed inadequacy as a form of historical analysis is thus not compatible with the story of nurses. Some works argue that class is too simple or dualistic nature to explain social experience, that it does not explain multiple identities, and that its theorists only try to identify a class structure and then why or why not this

produces class consciousness.² These assumptions were the starting point for some postmodern works that argued that the postindustrial world was too fluid and fragmented by local, unconnected factors; and that class was too rigid and simple a concept to explain this diversity.³ Yet in the case of nurses, class and its interconnectedness with gender operated as multifaceted processes that drove organizational change, framed experience, informed politics, and led to action. Class and its effects certainly vary according to historical and socioeconomic context, but to claim that class has ceased to exist in an era of global capitalism is premature. Rather, class and its effects have changed – and the challenge is to explain how and why.

This thesis has also demonstrated the importance of centralized structures of power in postindustrial capitalist economies - primarily institutional employment and the state - and how these centralized structures maintain and reproduce class and gender power inequalities. Some postmodern discourse emphasizes the multiplicity of identities and how power emanates from

² Dennis Dworkin, Class Struggles, 215-216. Geoff Eley and Keth Nield, The Future of Class in History: What's Left of the Social? (Ann Arbor: University of Michigan Press, 2007), 178 and in a theme throughout their book, criticize historical approaches that exclude class merely on the grounds that it is no longer useful as a historical category compared to postmodern approaches. They also note that such criticisms have often looked at isolated orthodox Marxist writings of the 1960s and 1970s, which are only a small sample of historical writings that have utilized class.

³ Bauman, for example, rejected class on the grounds that a binary model of class structure and its relationship with action and class consciousness was too simplistic; instead, he argued for multiple forms of status and random, autonomous power structures and social practices: Intimations of Postmodernity, 54-5. But the concept of class fully fleshed out allows and demands a much more complicated and dynamic analysis than this binary explanation. This thesis has sought to demonstrate this dynamic potential of class as an explanatory socioeconomic concept. Pakulski and Water in The Death of Class, 157, also argued that class and class conflict were too simple to explain postindustrial society, which was instead divided along multiple status lines grounded in culture. This was producing a mosaic of subcultures that ranged from gangs to religious movements.

innumerable, local positions without an overarching effect in contemporary capitalism.⁴ This does not mean that centralized locations of power cannot be found or do not exist.⁵ Discourse that focuses on the multiplicity of identities and power locations have often excluded, and have failed to explain, wider trends of inequality and power struggle.⁶ In the case of the BCNU, centralized locations of power certainly existed and were of pivotal importance. Nurses struggled against managerial structures built around class and gender in hospitals, while employers constantly shunned their demands. The oppressive legislation of the provincial government dramatically hindered the BCNU's ability to meet nurses' bargaining demands. On a number of occasions, state legislation and intervention directly backed employer efforts to keep nurses in a subordinate power position. But the union also acted as an organization for opposition to such practices, and as an outspoken representative for nurses' collective interests. This was a power confrontation at a structural level between organized labour and the state that had important consequences for how nurses thought about their work situation and how they responded. Not coincidentally, the most decisive showdown and effective form of action was the strike of 1989 that confronted employers and government head-on and did not allow them to hide

⁴ This is a key part of the analysis for works that advocate abandoning class. In The Death of Class, 155, Pakulski and Waters argue that central social divisions that might inspire organization are rapidly disappearing; social status is due to personal circumstance, and is not externally constrained by overarching power structures (such as class). In Intimations of Postmodernity, 54-5, a central tenet of Bauman's analysis is the collapse of any type of overarching social structure into autonomous, uncoordinated agents that produce an always changing social setting and social antagonisms. Although originally arguing against orthodox Marxism, Laclau and Mouffe, in Hegemony and Socialist Strategy: Towards a Radical Democratic Politics, 85, argued that economic life and class should be left behind in favour of multiple areas of social contestation that did not display any common pattern.

⁵ Eley and Nield, The Future of Class in History, 157.

⁶ Eley and Nield, The Future of Class in History, 196.

behind the bureaucratic layers of state-sponsored collective bargaining. Nurses then turned this critical energy towards their own professional association, because its strategies and functions did not address the gender and class-based challenges that nurses faced. By collectively confronting centralized locations of power - the state, the employer, the undemocratic union and the professional association – nurses produced significant changes in the nursing occupation.

The story of trade unionism in nursing thus highlights the point that political movements must recognize and confront existing power relationships such as gender and class to be effective.⁷ When nurses treated employer, state and union structures as real sources of gender and class power and inequality, they produced concrete changes in their contract conditions, organization, and political self-awareness. This is perhaps the most crucial point of this thesis: unionism in nursing resonated because it addressed issues of gender and class in a critical manner, whereas professionalism did not. This helps to explain why historically, as noted in the first chapter, professionalism struggled to achieve results for the rank and file who then turned to union strategies. The emergence and development of independent unions such as the BCNU, from 1976 to 1992, marked a new and deeper shift to class-based strategies at a time when class was thought to be of marginal importance. Nurses' struggle was a gendered class struggle that took place in the context of a changing capitalist society, and reminds us of the totalizing effects of capitalism as social reality. A critical approach to the social and economic power relationships that groups such as

⁷ Ellen Meiksins Wood made this point against “New True Socialist” theory and politics as early as 1986 in The Retreat from Class: A New True Socialism (London, 1986), 187-188.

nurses experience and struggle against is important, because it historicizes capitalism. Failure to do so means we may naturalize exploitative gender and class power relationships of the present, at a time when a critical approach to capitalist society is sorely needed. When this critical approach is adopted, as nurses have shown, the opportunities for concrete change are great.

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