Organizing Filipino Registered Nurses: A Social Movement Unionism Approach

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The Filipino Nurses Hymn

We pledge our lives to aid the sick
To help and serve all those in need
To build a better nation that is healthy and great
We'll bring relief to every place
In towns and upland terraces
In plains in hills and mountains
We shall tend all those in pain
Beneath the sun or stormy weather
We shall travel on
To heed the call that we must be there
With our tender care
We pray the Lord to guide our way to carry on our work each day
And grant us grace to serve the sick and love to help the weak.

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Glossary of Terms:

Registered Nurse—Administer general nursing care, which includes assessing, planning, ordering, giving, delegating, teaching, and supervising care to promote optimum health & independence for ill, injured and well persons.

Traveler—A

Introduction

"We owe it to [the Filipino nurses] because they have served their community and leave their country where there is a nursing shortage and hospitals are shutting down to help this country. There are deeper issues that need to be looked at...the healthcare situation in the U.S. hurts the Philippines." Chito Quijano, Organizer, California Nurses Association

Currently healthcare is the fastest growing industry in the United States. As the industry grows, the hospitals have started to decrease patient s

healthcare workers. By organizing within the healthcare sector, the labor movement could be revitalized and an organizing strategy, I identify as social movement unionism, could be established, designed in part to improve the quality of healthcare in the U.S.

During an internship with the California Nurses Association in Fall 2003, I had the opportunity to begin researching why and how Filipino RNs organize. Through this internship, I developed relationships with Filipino RNs working in hospitals in Southern California. These relationships provided insight about both the need to organize within healthcare as well as the need to organize Filipino RNs in particular. These relationships have both guided me and given me a reason beyond my interest in supporting the labor movement—namely, working with Filipinos and understanding their needs and perspectives on the nature of their work. This research is necessary because Filipinos are often mistaken for being quiet and unmotivated to organize around social justice issues. However, Filipinos could become leading advocates for broader changes within the healthcare field as well as around such social justice issues as race and gender discrimination.

This report is divided into six chapters. The first chapter discusses the history of Filipino nurses both in the Philippines and the United States. The chapter also analyzes how the U.S. colonization of the Philippines and its influence on Philippine nursing schools established the hierarchy among Filipino and American nurses that exists today. Furthermore, this chapter addresses the American use of Philippine nursing schools to recruit nurses to eliminate the nursing shortage in the U.S. and the consequences of such recruiting on Filipino RNs in the U.S. The second chapter explores activism within the Filipino community that counters the idea that Filipinos are socially and politically passive. This analysis is based on an examination of Filipino labor movements in the Philippines as well as how Filipinos organized around nurse

licensing issues in the U.S. In the third chapter I talk about the history of the U.S. labor movement and the rise and importance of the concept of social movement unionism as a strategy to organize workers. The chapter also addresses the current views about unions among the American public as well as the need to organize immigrants, women and registered nurses. The fourth chapter looks at the history of organizing in hospitals and how unionization in hospitals can improve the quality of care. In the fifth chap

Chapter One: The History of Filipino Nurses: In the Philippines and the United States

The historical impacts associated with the United States colonization of the Philippines and the development of nursing schools has created a large population of Filipinos in nursing—particularly in U.S. hospitals. According to immigration statistics, between 1965 and 1988, more than seventy thousand foreign-born nurses entered the U.S., more than half of whom were Filipino. Furthermore, among all foreign-trained nurses with temporary working visas in the U.S., seven of ten from 1985 to 1988 and three of four in 1989 were Filipinos—by 1984, the U.S. had an estimated twenty-six thousand registered nurses (RNs) who had been trained in the Philippines.² In Southern California, including Los Angeles, Orange, San Bernadino, San Diego, and Ventura counties, Asians are the largest minority group of RNs, with 67% of them Filipino.³ Due to this, they are a key part of the RN workforce for unions to try and unionize.

However, during American colonization in the Philippines, social constructs, such as an established hierarchy placing Americans on top and Filipinos on the bottom, were developed that have led to cultural problems that affect the current state of unionization today. From the early 1900s to the 1940s, the U.S. government, individuals, and philanthropic organizations sponsored Filipino nursing students to study in the U.S. Nursing served to justify the "white man's and white woman's burden" and created a cultural and racial hierarchy with Americans on top.

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independent; these women aided in the "creation of the protected environment of the hospital." ¹⁰ Concurrently, in the U.S. the hospital training schools were attempting to reform nursing to become suitable employment for young "gentle-women" with the virtues and qualities of middle-and-upper-class womanhood. In addition, nursing schools housed the young Filipino women in dormitories, which were considered a safe haven because many of the nursing students had traveled far from where they grew up or their families lived in order to have this opportunity.

Nursing students in the Philippines studied anatomy and physiology, practical nursing, material-medica, massage, and bacteriology, which were not all of the courses that American nursing students took. Unlike the Filipino nursing students, American students also took psychology in conjunction with their other courses—a difference that became an issue for Filipino nurses trying to pass U.S. licensing examinations. As a second year student, the nurses were required to participate in practical work at local area hospitals and take English grammar and colloquial English courses. In the early 1900s nursing standards rose and nursing students were expected to complete secondary school, which now entailed the completion of an entrance exam. The early 1900s also witnessed increased interest in Public Health nursing and in 1922 the University of the Philippines established its first course for training public health nurses. ¹³

Beginning in the 1880s and 1890s, nursing alumnieir other0 tor tra

"to exalt the standard of the nursing profession and other allied purposes." ¹⁴ Following its mission, the PNA created a section of the League of Nursing Education, which published standard nursing curricula, raised admission requirements to Philippine schools of nursing, and advocated a baccalaureate program in nursing; in addition, the PNA promoted public health nursing. ¹⁵ Concomitantly, the PNA registered Filipino nurses, created a central directory for private duty employment, and advocated increased salaries of nurses and a government nurses pension. They also provided financial assistance to elderly and sick nurses, and started a scholarship fund for nursing students. In 1929, the PNA joined the International Council of Nurses (ICN), which looked to raise the standards of nursing education and professional ethics amongst nurses. ¹⁶

Immigration Act of 1965

As stated earlier, from the early 1900s to 1940s the U.S. government, individuals and philanthropic organizations sponsored Filipino nursing students to study abroad through the Visitors Exchange Program. Originally, the idea behind the abroad form of study was to perpetuate the use of Americanized nursing in the Philippines by giving Filipino nurses the opportunity to receive advanced training.¹⁷ The Filipino nursing students would come to the U.S., study for a couple of years on work visas and then return to the Philippines to work. However, the Immigration Act of 1965 enabled Filipino nurses to not only study in the U.S. but also settle here permanently, which has led towards the approximately 200,000 Filipino nurses in the States today.¹⁸ Part of the reason for passing an act that made immigration easier on

¹⁴ Ibid., 60

¹⁵ Ibid.

¹⁶ Ibid., 62

¹⁷ Some hospitals exploited this program by using the "trainees" as cheap labor to supplement their work force, and these abuses contributed to the ultimate demise of this program in the late 1970s (Ong and Azores, 174).

^{18 &}quot;Census 2000 Data for the State of California."

Filipinos was because the U.S. wanted to utilize educated, trained, foreign-born nurses as a way of reducing the nursing shortage in the U.S.¹⁹ As part of the Immigration Act, the U.S. Secretary of Labor ruled that nurses could receive automatic labor certification without the prior sponsorship of an employer—allowing foreign-trained nurses to enter the U.S. as immigrants under the occupational preference quotas.²⁰ Foreign trained nurses were also now able to enter the country on temporary work (H-1) visas to fill temporary positions; by 1970, however, the immigration amendment allowed H-1 visa holders to fill permanent positions.

With no end in sight to the critical nursing shortage, Congress passed the Immc0.1182 Tw 12 0 Tm

Filipino nurses working in the Philippines did not enjoy, such as uniform allowances, health and pension plans, weekends off, paid vacations, holidays, and sick leave.

Unlike Filipino exchange nurses, who arrived in the U.S. under the sponsorship of a specific hospital, immigrant nurses often came to the U.S. without prearranged employment. As a result, they actively sought the company of nursing friends and family members who could help them with the adjustment process. Filipino nurse networks also extended into the area of employment by former exchange visitor nurses who returned to the U.S. as immigrants utilizing contacts from their exchange visitor experience. According to Catherine Ceniza Choy, in her study of Filipino nurses, *Empire of Care*, the majority of newly arrived Filipino nurse immigrants she interviewed were single at the time of immigration and few had been married in the Philippines. Among those with husbands, their husband's initial reaction to migration abroad varied. Nevertheless, the wives claimed that once they had received their immigrant visas, there

demand for health care, while further exacerbating the domestic nursing shortage. By 1967, the National League for Nursing cited a shortage of 125,000 nurses in the U.S.

The shortage of nurses both in the Philippines and in the U.S. in the 1960s allowed for Filipino entrepreneurs to open new schools of nursing in both provinces and urban areas of the Philippines. In 1950, 17 nursing schools existed in the Philippines, but by 1970 that number rose to 140, and, in 1966, the Philippine Republic Act 4704 relaxed the minimum standards for nursing school operation, making it easier for nursing schools to open up. Perla Sanchez, the president of the Association of Nursing Service Administrators of the Philippines (ANSAP) in 1968, lamented that the Philippines was losing nurses faster than the Filipino nursing schools could produce them, and further complicating this issue was the problem that those nurses who had left and returned and those who had stayed were becoming discontented and filled with frustration over the nursing shortages in the Philippines. Also, adding to the loss of nurses was the declining enrollment of nursing students by the mid-1970s; while these numbers appeared to be dropping, however, the 1989 Philippine Statistical Yearbook reported that there were more than sixty-five thousand newly registered nurses in the period from 1979 to 1988. Thus, while

ilipp9667(ilippe)Tejvlæs2a18uBsTatg3s2a76s4g2e)Triothe9P2iri(mp38iets)Triot2p0ologie885v2a95v0x169mTphe(sext)93ittle)Triot22lackg.of0 0keep F 2795 students enrolling in nursing schools but rather the large percentage of nursing students moving abroad. 32 siwlinrt4Fnts m

purpose of these service requirements was to alleviate general nursing shortages in the Philippines, specifically the urban versus rural maldistribution of nurs

Chapter Two: Activism Within the Filipino Community

As discussed in Chapter One, historically Filipinos, specifically Filipino women, have been viewed as docile, passive, and reluctant to challenge the status quo. However, in recent Philippine history, Filipinos have been organizing around issues such as corrupt dictatorships and worker's rights. While men did play a key role in both of these movements, the development of the Kilusan ng Manggagawang Kababaihan—Women's a key role in b6617 570.9599 Tm12 392

reformers.³⁷ Trade unionism in the Philippi

Around the same time, the printers, who had established their own craft union, remained at the forefront of organizing efforts until 1941. Although splintered in the immediate postwar years, the printers soon regrouped themselves and in 1949 spearheaded a national movement for a general strike. In the years immediately preceding World War II, the printers union negotiated a number of collective bargaining contracts while at the same time providing political leadership within the trade union movement. Using a two-pronged approach, the printers union looked to enhance the organizational needs of the union through expansion of membership as well as to obtain wage increases and benefits for their members. 41 Although the UIF, in the post 1950 period, became relatively weak politically, its commitment to the two-pronged approach was renewed with its alliance in 1969 with the emergent Pambansan Kilusan ng Paggawa—or National Movement of Workers—to enhance the labor movement's participation in politics. This development was indicative of what was to be the general trend of trade union action in the early 1970s. In fact, the declaration of martial law in September 1972 by Philippine President Fernando Marcos was partly meant to curb the labor movement's collective power and the gains of left-wing unionism.⁴² Between 1972 and 1974, the military authorities detained top officials of different unions, left-leaning academicians, and students.⁴³

The impact of the labor movement could be seen in terms of the growing number of workers organized in the major industrial and plantation regions of the country as well as the urban manufacturing, transportation and commercial sectors. Furthermore, government employees in both private and civil service agencies also joined workers organizations.⁴⁴

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⁴¹ Ramos, 94.

⁴² Marcos declared martial law in the Philippines in order to ensure that "what he called the 'oligarchy' and communist insurgency" could not take over the government. (Calixto V. Chikiamco, "Martial Law?," <u>The Manila Times</u>, 16 September 2003, http://www.manilatimes.net (9 April 2004).

⁴³ Ibid.

⁴⁴ Ibid, 170.

Kilusan ng Manggagawang Kababaihan—Women's Workers Movement

During the 1980s, Filipino workers actively formed alliances with community members and organized more broadly to include workers who were not only in the industrial and export processing zone sectors, but also in the service, transportation, banking, mining, and agricultural sectors as well. Alliances were formed with community organizations such as the Young Christian Workers, while unions started to speak out and organize around class consciousness connected to larger social and political issues.

Wanting to work within political and social justice frameworks, some trade unions turned towards political party activism, a form of social movement unionism defined in this context as "an effort to raise the living standards of the working class as a whole, rather than to protect individually defined interests of union members." Using this approach, the Philippine May First Movement—Kical issues. g this a

membership of 28,000, which included the Kilusan ng Manggagawang Kababaihan (KMK) or Wome

women's oppression, how women workers are oppressed, advice on how to form factory chapters, the objectives of KMK, nationalist democratic principles, trade unionism, and health and reproductive issues in order to raise consciousness among women workers.⁵⁰ KMK members also developed a program for legal and workplace reforms; KMK wanted to ensure full employment for women where work would not be denied because of gender, age, or civil status and where women would be paid equally with men, while also attempting to abolish the piece rate system and forced overtime, guarantee regular work for women, and ensure that women had full reproductive rights, which included the right to maternity leave and protection for pregnant workers. In dealing with the labor movement, KMK became part of the Women's Committee of the Labor Advisory and Consultative Council (LACC) that was established in 1988, which was formed by four different federations of unions in order to advise the Ministry of Labor and Employment on union issues. Prior to the KMK's involvement, LACC had no representation of women. The coalition obtained a commitment from congresswomen to present an extended maternity benefit bill in the Congress to increase maternity leave to four months, up from three months, but instead Congress adopted a bill that decreased maternity leave to six weeks because even though congresswomen had agreed to the bill, Congress was still very male dominated and not concerned with women's rights issues.⁵¹

Though members of the KMK were frustrated by their inability to have laws passed to their satisfaction in Congress, organizers were making improvements on a case-by-case basis, focusing primarily on individual worksites and achieving collective bargaining agreements. In one factory, for example, workers were able to convince management to establish an on-site day

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⁵⁰ West, 80.

⁵¹ Ibid, 81.

organizations in the Philippines while also reflecting their diverse and competing interests within the U.S.⁵⁶

In the late 1960s and early 1970s, the use of the Exchange Visitor Program decreased, causing occupational immigrant visas to become the major avenue of entry for Filipino nurses wishing to work in the U.S. However, as foreign professionals took advantage of available occupational immigrant visas, backlogs for these visas increased and the waiting period for a third pr

obstetric nursing and nursing of children. The National Council of State Boards of Nursing, as part of the Am

bound foreign-trained nurses and informed H-I visa nurses already in the state that their visas would be revoked if they did not pass the SBTPE.⁶¹

Unhappy with this decision, the Texas Hospital Association protested the decision by claiming that the removal of H-I visa nurses from the Texas hospital workforce would be a "catastrophic experience for Texas hospitals." ⁶² By referring to the passage of its exclusion clause, which stated that anyone could practice nursing in a Texas hospital under the direction of a physician, the Texas Hospital Association sought to convince the INS to reverse its decision.

Still upset that foreign-trained nurses were able to earn licenses when they were still failing the SBTPE, the American Nurses Association Commission on Nursing Services, in June 1974, presented a resolution at the ANA biennial convention that had two objectives: to remove the preferential status of foreign nurses with respect to the U.S. immigration policies, and to support the authority of state nurses associations to evaluate the practice of foreign-trained nurses. Unlike the Texas controversy, which focused on Texas hospitals' use of H-I visa nurses that had high failure rates on the SBTPE, the ANA Commission's resolution lumped all foreign-trained nurses together. The ANA looked to pit the interests of U.S. nurses against those of foreign-trained nurses by insisting that U.S. citizens should be given priority in U.S. nursing education, suggest 0 0 12 7847a7.41 all.16 Tm(e SBTPE, the Am)Tj12 0 ANA lo

Disgruntled with the Commission's decision, nurses and ANA leaders who disagreed with the resolution form res

utilized civil rights legislation to oppose what they considered to be a racist nursing licensure examination.⁶⁹

Still not completely happy with the capacity of these organizations to promote their missions, and feeling more and more isolated from the PNA in the Philippines, members of local PNA chapters throughout the U.S. formed, in 1979, a new U.S. national nursing organization, the National Federation of Philippine Nurses Associations in the United States. 70 The National Federation of Philippine Nurses Associations in the United States also focused on the H-I visa nurses and the CGFNS controversy.

Though the Filipino nurses did not play a large role in changing how nurse licensing in the states was regulated, they were able to stand up to racist comments and practices by the American trained nurses and organizations. In addition, in the case of the unions and the KMK, Filipino women learned that they too had a voice in political matters while also addressing gender inequalities within the workforce. Both of these examples demonstrate that contrary to Filipino stereotypes, Filipinas were not necessarily passive and docile but rather could play key roles in organizing drives, given their own organizing history in the Philippines and in the U.S.

⁶⁹ Ibid., 179.

Chapter Three: U.S. Labor History and Social Movement Unionism

A comparative perspective on labor unions reveals that the best of all worlds for the workers is coordinated bargaining at the natioectiv7

recent Gallup poll found that in 1999, 66 percent of the public approved of labor unions, a percentage that had increased by 11 points from 55 percent in 1981. In addition, that same Gallup poll discussed that we may be witnessing a revival of organized labor because there has been a growing gap between the haves and the have-nots in the U.S., which may increase the demand for unionization. Between 1967 and 1997, the degree of income inequality increased by 15 percent. However, for about this same time period, unions have increased their members' wages above those of non-union members.⁷³ In fact, a study conducted by SEIU found that RNs in highly unionized markets of Minneapolis, New York, San Francisco, and Seattle, earn 17.4 percent more than RNs in a nonunion market such as Chicago.⁷⁴ Furthermore, union members are so pleased with the

work in the service sector. As a way of accomplishing this goal, labor unions have started to look to organize laborers in industries that have not always been considered organizable such as the healthcare industry and clerical workers. Similarly, unions have begun to address issues of sexism or racism during organizing drives by developing a union contract that provides an outlet for workers to speak up when they feel they have been discriminated against.

Part of bringing the power back to citizens and union members is done by stopping unions from cutting deals with management that do not give the workers what they want but rather just guarantee that a union can gain more members. Recently, SEIU has begun to target janitors and healthcare workers, in industries that are primarily comprised of women, immigrants, and people of color. These are workers that many unions have not cared about. Part of the reason SEIU and other unions have focused their attention on these industries is because they are industries in which a union can gain control over the local labor market rather than those that are in international competition, such as garment workers. Also, these industries have demonstrated a desire to take what is known as the "low road"—downsizing, using low-wage labor, busting unions, and, in the instance of hospitals, using unqualified, lesser paid workers in place of more qualified staff. Companies do not take the low road because they are short sighted or "stupid mismanagers," but rather because the current market rewards low-road companies; an example of which is Kaiser Permanente, the huge health maintenance organization.⁷⁷

Similar to other healthcare companies forced to compete with for-profit giants, nonprofit Kaiser has closed hospitals and departments, contracted out care, cut professional staff, and shifted work to non-licensed employees (i.e., giving work that an RN should do to less qualified staff such as an LVN). During a federal investigation of Kaiser, it was found that there were

 $^{^{77}}$ Jane Slaughter, "Big Labor's Little Problem," <u>The Nation</u>, 25 October 1999, http://www.thenation.com/doc.mhtml?i=19991025& s=slaughter

severe deficiencies in the care given in hospitals in low-income areas, with one Kaiser union accusing the company of "medical redlining." Despite this anti-worker and poor quality of care record, in 1997 the AFL-CIO partnered with Kaiser; the federation would market Kaiser to unionists, and the company would give workers "input" on quality issues and remain neutral during organizing drives because AFL-CIO affiliated unions, such as SEIU, were looking to organize in the Kaiser facilities. Both the AFL-CIO and Kaiser claimed that this partnership was to show that "labor-management collaboration produces...market leading competitive performance." ⁷⁸ As part of its agreement with Kaiser, the union agreed not to participate in activities that might damage the company's reputation, such as public opposition to any closing or other service cuts. Members of the union at Kaiser, however, felt that this agreement would undermine both the quality of patient care and their ability to fight the loss of jobs; furthermore, it seemed clear to them that all the AFL-CIO was looking for was the prospect of tens of thousands of new union members. The heavy emphasis on organizing new members, which most observers typically view as positive, in this case led to a collaboration that hurt current members while ignoring the workers' concern fo

unpredictable historical waves." Social movement unionism on the other hand is "a type of unionism based on member involvement and activism." Turner and Hurd further argue that "although it is possible to build social movement unions in the

AFL and demanded union membership and recognition. The years during and following World War II brought a system of labor relations that was engaged in

services (i.e. health plans, insurance, group legal services) for the union member. ⁸⁵ Concurrently with the switch towards business unionism, the labor movement began to place a premium on stable and responsible relations with management, social respectability, insider political access, and pursuit of a middle-class lifestyle. Rather than questioning big business, unions started to accept the achievements and constraints of modern industrial capitalist society. ⁸⁶

Furthermore, due to this move towards business unionism, most labor leaders excluded Black

partnership, management promised advanced discussion of strategic business decisions and employer neutrality in union efforts to organize the remaining unorganized Kaiser workers—yet the agreement did not discuss the different cost cutting measures Kaiser was attempting (i.e. facilities closures and job cuts). Kaiser retained the right to act as it saw fit when management and the union did not agree and the AFL-CIO would promote Kaiser as a "preferred" union provider of healthcare.

for instance, during the early 1900s, "sacrificed members' larger interests to the hope for 'a share

workers, specifically RNs. In Southern California three unions—CNA, SEIU, and the United Nurses Association (UNA), a subgroup of the American Federation of State, County, and Municipal Employees (AFSCME)—have pushed towards organizing RNs in hopes that organizing in different fields of work will help rekindle the labor movement.

Organizing within hospitals is also good for the labor movement because unlike other industries, such as the garment or other manufacturing industries, hospitals do not have the luxury of capital flight. In addition, there is currently a shortage of RNs in the field because many nurses no longer want to work at the bedside but instead would prefer to go into healthcare management. These two factors give unions a prime opportunity to unionize because hospitals do not have other outlets to find replacement RNs. Concurrently, these two factors add to the sad state of healthcare today, which leads many RNs to desire unionization—and the eventual push toward

Chapter Four: Organizing in Hospitals

Unions have been present in hospitals since the early 1900s but only during the past 30 years have union organizing efforts taken off. ¹⁰¹ While independent unions were able to organize in hospitals prior to WWII, the AFL did not see its first real victory in organizing workers in the healthcare sector until 1936 when it successfully organized the engineers and institutional workers (i.e. janitors, kitchen staff, and aides) in three large San Francisco hospitals. The group that was organized included engine room, housekeeping, laundry, kitchen employees, nurses' aides, and orderlies. Soon after the AFL successfully organized those three hospitals, recognition of the benefits of unionization to workers spread and ten other hospitals were able to be organized.

of their working and professional lives." ¹⁰⁴ The association did, however, urge the acceptance of minimum wage and hour standards.

In addition to the ANA's decision to not support union organizing, unions did not originally want to organize in hospitals because hospitals are widely dispersed in thousands of communities and the workforce is further divided into numerous departments within each hospital, making organization more difficult. Further underlining the difficulties of organizing in hospitals, Federal laws originally excluded nonprofit hospital workers from collective bargaining until the passage of the Wagner Act. Without the basic right to organize, and with the strike frowned upon by the ANA, a hospital union would have little or no clout in the eyes of management. ¹⁰⁵

Although Federal law and ANA policies hindered the unions' ability to organize within hospitals, by the 1960s, unionization in healthcare started to spread and by 1978, roughly 24 percent of hospital workers had joined unions or associations to bargain with employers over working conditions and for political action. Part of this boom in unionization is also due to the rapid expansion of the healthcare industry, which made the industry fertile ground for labor organizing. Following the enactment of federal and state healthcare programs in 1965, such as Medicaid and Medicare, which expanded the number of nursing homes, healthcare grew from a \$42 billion industry to a \$212 billion industry in 1979. In addition to the rapid growth of the industry, the composition of the healthcare workforce, particularly in recent years, contributes to the drive for worker organization and collective action. Historically the healthcare industry had been comprised predominantly of women and minority workers in the bottom and middle rung

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¹⁰⁴ Ibid., 68.

¹⁰⁵ Leon J. Davis and Moe Foner, "Organization and Unionization of Health Workers in the United States: The Trade Union Perspective," in <u>Organization of Health Workers and Labor Conflict</u>, ed. Samuel Wolfe (New York: Baywood Publishing Company, Inc., 1976), 18.

¹⁰⁶ Ibid.. 45.

Today, RNs are unionizing faster than other categories of workers while simultaneously becoming more militant.¹¹²

The Unions

While many unions have chosen to organize the healthcare industry, in Southern California, the California Nurses Association and the Service Employees International Union are the two most visible forces in the field today. For the past decade, the two unions have been battling against each other for members and going as far as telling nurses to vote against the other union if that union was attempting to collect cards. However, in a press release on December 15, 2003, the two unions announced their joint cooperation agreement to confront the healthcare industry and the growing number of attacks on healthcare in the state and around the country. As part of this agreement, the two unions will begin working to:

"Ensure that California's It Cb7(:)TjETEMC422.2217 432.959/22s Ita2 0 0 12 245.89o2 245.89o

Help all hospital employees in California achieve union representation to work for affordable, quality care and fair treatment on the job.

SEIU will support campaigns by RNs to join CNA, and CNA will support campaigns by professional, licensed, certified and other health care workers to join SEIU." 114

CNA

Established in 1903, the California Nurses Association (CNA), originally called the California State Nurses Association, currently represents over 50,000 RNs in 150 different hospitals throughout California and is one of the fastest growing professional associations and unions for RNs in the country. In the past seven years CNA membership has doubled and in 2001 to 2002 alone, CNA organized 7, 200 RNs in 17 hospitals. From the beginning, CNA established itself as a professional organization that was not only a voice for RNs but also a voice for policy changes within the health care field. It endorsed the women's suffrage movement in 1908 and fought for the First Nurse Practice Bill, which created a licensing board for RNs. By 1913, technological improvements in healthcare moved patients from seeking care in their homes, to seeking care in hospitals; however, hospitals relied on unpaid students nurses to provide care, which left many graduates without employment opportunities. As labor unions across the country grew, CNA, due to its affiliation with the American Nurses

^{114 &}quot;California Nurses Association and Service Employees International Union to Work Together for Quality Health Care in California," <u>California Nurses Association</u> 15 December 2003, http://www.calnurse.org/cna/press/121503.html (14 March 2004).

¹¹⁵ California Nurses Association, www.calnurse.org (13 November 2003).

¹¹⁶ Charles Idelson, ed., <u>California Nurses Association</u>: 100 Years of RN Power, (Glendale, CA: Autumn Press, 2003), 4.

be considered a "profession" if they joined labor unions. In accordance with this belief, CNA implemented a "no strike" policy. This was demonstrated though the relationship between CNA and the California Hospital Association, where CHA claimed that they were more willing to cooperate with CNA because of their "voluntary hospital cooperation." 118

By 1943, CNA had decided to abandon its voluntary cooperation standards and move towards a collective bargaining me

By the mid-1960s, RNs decided that they needed to take more forceful action in order to improve wages and working conditions, while also addressing issues associated with understaffing and heavy workloads. Frustrated by the issues they faced, and because the nurses were not allowed to strike per ANA and CNA's

Summit Medical Center in Oakland, CA who were represented by five different unions, including CNA and SEIU. In response to the attacks, CNA RNs, along with the hospital workers represented by other unions, went on a seven-week strike in Northern California. Recognizing the strength of CNA and its collective bargaining leaders, the hospitals decided to attempt to weaken CNA while also dividing the other unions. Prior to the 1990s, staff nurses had not been involved in CNA's power structure but rather the Board of Directors was comprised of mainly nurse administrators and educators that focused more attention on organizational policy and legislative and regulatory reforms rather than workplace conditions. Many of those on the board agreed with the approach of the hospital administration that higher degrees, advanced practice, and supervision of lesser skilled staff were the most appropriate roles for RNs. 123 Realizing that change would not happen within CNA unless the staff nurses challenged the existing power structure, the staff nurses across the state began to fight back. In 1993, staff nurses won a majority on the CNA Board for the first time in CNA history; wanting to promote the interests of staff nurses and patients, the new Board adopted a patient advocacy program and CNA began to build consumer-patient coalitions. 124 In one last attempt to disassociate itself with its past problems, CNA severed all ties with the ANA and became an independent union and professional association in October 1995.

Now independent from the ANA, CNA launched an agenda to expand its challenge to unsafe hospital restructuring, increase CNA membership among non-union RNs, and achieve healthcare reforms that protected both RNs and patients. Working with Ralph Nader, CNA initiated Proposition 216, which fought HMO abuses by requiring health care businesses to make tax returns public, establish criteria written by licensed health professionals

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¹²³ Ibid., 16.

¹²⁴ www.calnurses.org.

for denying payment for care, and establish staffing standards for health care facilities. ¹²⁵ In addition, in 1999, Governor Gray Davis signed the nation's first law mandating minimum RN ratios, which went in effect January 1, 2004. ¹²⁶ Lastly, the CNA Board of Directors created a 12 Step Program to advocate for the transformation from a market based healthcare system to a quality-based healthcare system, which includes pushing for a universal healthcare system.

SEIU

The Service Employees International Union, formerly named the Building Service Employees International Union, began in the early 1920s as a craft union. Initially, SEIU claimed jurisdiction over building service and maintenance workers, while concentrating its organizing activities in New York City, in Midwest cities, and on the west coast. In San Francisco, during the 1930s, SEIU organized hospital workers that ranged from relatively unskilled hospital staff workers in maintenance, cleaning and food services to more highly trained health professionals such as nurse's aids. 127 After WWII, SEIU expanded its jurisdiction into other industries and began focusing on organizing government workers, hotel and office workers, as well as healthcare workers. Today, SEIU boasts approximately 275,000 healthcare members and represents more than 45 hospitals in California, and is currently the largest AFL-CIO affiliated union. 128 Unlike CNA, SEIU looks to organize all healthcare workers ranging from RNs to the unskilled hospital staff workers in maintenance, cleaning and food services.

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¹²⁵ "Health Care. Consumer Protection. Taxes on Corporate Restructuring. Initiativ

Although SEIU has been organizing in recent years along industrial lines, particularly in the service industries, the union's internal structure still reflects its traditional craft union origins. Most significantly, SEIU's decision making powers remain widely decentralized by giving its locals the power to make decisions on organizing, collective bargaining, and general policy. According to an internal report put out by SEIU,

> "Local Unions are the heart of our organization. They are free to elect their own officers, to adopt their own by-laws, to negotiate their own contracts, to set up their own dues structure, to conduct their own strike votes (if they choose to) and, generally, to function as an autonomous labor organization." 125

However, the locals themselves are complex entities because many are quite large and can cover many different service industries and employers. For instance, one California local has over 27,000 members, including 25,000 healthcare workers, with the remaining 2,000 workers employed at schools, offices, stores, and amusement facilities.

Worried that their decentralized approach could increase the vulnerability of healthcare workers to the onslaught of federal, state, municipal and private industry-wide health cost containment policies, SEIU has taken steps toward centralizing certain union functions. First, it has established Joint Councils in different geographic areas where several member locals are active. The Joint Councils act as a resource for leaders and members from neighboring locals to pool their financial, research, bargaining and political action resources in order to confront the issues that affect them jointly or at least affect more than one local or several bargaining units. Second, SEIU has expanded its international staff, hiring several industry specialists to coordinate research, policy and political action at the national level. 130

Through their nurses alliance, SEIU represents more than 110,000 RNs in 23 states with the idea that when united, "we have a voice in decisions about staffing, patient care, and the

¹²⁹ Schoen, 64.

¹³⁰ Ibid., 64.

recruitment and retention of nurses in our hospitals and other healthcare institu

1,000 fax messages from healthcare workers across the state to California's then governor, Pete Wilson. Kaiser Permanente, due to pressure from the Coalition of Unions at Kaiser Permanente, joined SEIU in urging Wilson to sign the bill. The joint partnership between management and unions at Kaiser marked the first time the healthcare industry, including the California Health

in the state of California about service provision, finances, and resource utilization; the database also includes information about capital acquisition, labor staffing, and the provision of medical care in each revenue unit of the hospital. The sample used came from all acute care hospitals in California. The dependent variable was the av

permeated the institution because the "evolving working class, grassroots hegemony of the RN union continued to challenge the dominant hegemony and was acknowledged by outsiders." ¹³⁷ Unionized RNs are able to successfully increase the scope of their professional practice through collective bargaining while fostering cohesiveness and commitment of union members—creating a power that establishes legitimacy during contract negotiations with management and generally enhances their image throughout the hospital. ¹³⁸

Unions Transmit Trans

Chapter Five: Issues A

92.3% of the survey respondents were female and 53.6% of them were between the ages of 40 and 60. 92.3% of the respondents were not born in the U.S. and 66.7% came to the U.S. twenty plus years ago on a visa sponsored by the hospital and 71.4% moved to the U.S. because of job opportunities. Of those nurses, 38.5% have remained at that same hospital.

For those nurses who had already gone through collective bargaining, 45.9% said that the largest gain they have achieved through organizing was better wages and benefits. Patient to staffing ratios was the second largest at 20.8%,ed

the intern who she thought relieved her pain. She did not thank her primary and associate nurses by name. She included a general thank you to "the nurses." 144

We cannot blame the patient for not knowing who really helped her through her pain. However, the patient would have known that the nurse played a larger role in her care if nurses were more willing to speak out about their jobs and how they provide for patients.

Part of the problem of nurses not wanting to communicate to the public or to try and organize around issues is that they are taught in nursing school that to call attention to themselves takes away from the care they give to their patients. A nursing professor, upset with the idea of nurses talking about their work to patients or to the general public, "beats her fists against her cg2 450.113 710.82 Tm(and)Tj10.398.2281 710.82 47.9799 Tm(or 301.6199 492.7798 Tm(tients or

make them coffee... There are still some doctors who will ask you to get stuff off the computer for them. "147 Although times have changed and not all doctors have these expectations of nurses, doctors still do not fully give credit where credit is deserved. This is demonstrated in the story of the oncology nurse.

Further complicating the MD and RN relationship, doctors often still "think they are up there and you are still on the ground," which, as one nurse put it, hinders a RNs ability to successfully or want to communicate with the doctor. The nurse further states that it is the nurses' responsibility to communicate with the doctor because if something happens to a patient, typically it is the nurse who is directly involved in taking care of the patient, not the doctor. Since the nurse is the one continually around and monitoring the patient, "if [the nurse does] not agree with the treatment [the nurse] should say something because [the nurses] are there 24 hours and [the nurse] does know what the patient needs." In order to fully care for the patients, camaraderie needs to develop between the nurse and the doctor.

Lastly, nurses need to know that they can speak up when a doctor or hospital is practicing unethical medicine. For instance, a doctor at Western Santa Ana Hospital had been performing more neurosurgeries than normal in order to bring in more revenue for the hospital and himself. The RNs, outraged by this practice, mobilized RNs around the issue, while educating the other RNs about the need for a union in order to have a strong voice against unethical practices, eventually the doctor was removed from the hospital. By banding together and voicing their concerns the nurses successfully removed a doctor that they felt practiced unethical medicine.

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¹⁴⁷ Personal Interview with nurse from Midway Hospital Medical Center, October 29, 2003, Los Angeles, CA.

¹⁴⁸ Personal Interview with nurse from Cedars Sinai Medical Center, November 20, 2003, Los Angeles, CA.

¹⁵⁰ Author's Notes, CNA Meeting With Western Santa Ana Nurses, September 24, 2004, Santa Ana, CA.

Staffing Ratios

On Saturday, October 10, 1999, Governor Gray Davis signed AB394, the Safe Staffing Bill—a law requiring hospitals to meet fixed nurse-to-patient ratios in an ef

bill. However, Governor Davis still needed to sign the bill into law and although he had shown support for the bill before, he was hesitant to do so then because he thought the staffing ratios would place a greater burden on the state budget. After a compromise was made, where Senators agreed to propose a bill to push back the implementation of the staffing ratios, Davis signed the bill and ended CNA and the RNs' five year fight for safe staffing ratios. 153

The law, which went into effect on January 1, 2004, has, as of early February 2004, improved staffing conditions in 68% of the 111 hospitals CNA surveyed, which accounts for nearly 30% of the acute care hospitals in California. According to the law, each unit would have a set safe nurse to patient ratio:

Units— (nurse:patient[s])

Intensive/Critical Care 1:2

Neo-natal ICU 1:2

Operating Room/PACU 1:2

Labor and Delivery 1:2/Antepartum 1:4

Postpartum Couplets 1:4/Women Only 1:6

Pediatrics 1:6

Emergency Room 1:4/ ICU Patients in the ER 1:2/Trauma Patients in the

ER 1:1

Step Down 1:4

Telemetry 1:5

MedSurg 1:6

¹⁵³ Ibid., 190.

¹⁵⁴ "Staffing Improved at Nearly 70% of California Hospitals: Safe Staffing Laws Off to a Good Start Says CNA," 4 February 2004, http://www.calnurse.org/cna/press/2404a.html (12 March 2004).

Other Specialty Care 1:6

Psychiatry 1:6¹⁵⁵

However, the California hospital industry is currently trying to get the State Legislature to pass an Anti-Ratio Bill.

According to my survey, staffing numbers was an important issue to RNs today. Nurses care about the staffing issue because the shortage of nurses creates a larger burden on the nurse, it also improves the quality of care given to the patient because RNs are able to give each patient the attention and care they need. Further impacting the problem is that nurses are choosing to not remain bedside nurses because the work is too hard. As one nurse commented, there are a lot of nurses that would like to work the bedside but it is too stressful a job right now; "even when you are off work you are always thinking about work because you are thinking about your patients and trying to remember if you did everything. You think you could have done better for a patient." ¹⁵⁶

the nursing assistant. If you don't have an assistant then that is still too many patients. It also depends on how sick the patients are. When they do the schedule an

work time and a half it is like you work straight time during an 8-hour day. The truth is that you are busting it working 12 hours and you should be compensated for your work...before we would get 5 weeks of paid vacation.

Although mandatory overtime affects nurses by forcing them to work longer shifts than norma

them." ¹⁶⁵ Moreover, the established hierarchy in the U.S., due to U.S. colonization of the Philippines, discussed in Chapter One, has set in place a standard that Filipino nurses should thank hospital management for giving them the opportunity to move to the U.S. as opposed to demanding the same respect that other nurses receive.

Historically Filipino nurses have come to the U.S. through sponsorship by a hospital or family member. Of the nurses interviewed, 66.7% said that they came to the U.S. on a visa

Filipino—"For instance a worker who management liked would get the full 5% raise and I would only get a 4%…I also see that the people getting raises are white. It is about the color." ¹⁶⁹

The use of language in the hospital also acts as a form of discrimination. Filipinos typically are not allowed to speak in their native language, Tagalog, while in the patient care area. Nurses understand why they cannot speak in Tagalog—because their patients cannot understand them. The nurses are also okay with only speaking Tagalog while on breaks and in the lunchroom. What they get upset about is the double standard that hospitals set because other minorities in the hospital are allowed to speak in their native language. If a nurse is talking to a patient that only speaks Spanish, then the nurse should speak Spanish to the patient. However, if a nurse is simply communicating in Spanish to another nurse while on the patient floor, then the nurse needs to speak English so that all of the nurses, other hospital staff, and patients can understand what the nurse is talking about. The problem, said one nurse, is not really that the other immigrants can speak in their own language but rather that Filipinos are upset about not having the ability to speak Tagalog while on the job but still choose to back down to the "aggressor;" historically "we have been complacent to aggressors" and that complacency "needs to stop." 170 Joining the union will help the Filipino nurses find their voice and stand up to the hospital administration. Without that voice, the nurses will not succeed in getting what they want.

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¹⁶⁹ Personal Interview with nurse0 0 12 7 ₹0.02 0 0 10.02 199.50497r5fo8 Tm(e0 0 aT/TTg/T40 0 10.02 1010.02 0 0 12 0 0 12 137.04

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In this situation the nurse did speak up but was told that she was the one that was acting irresponsible, not the hospital or the charge nurse. However, once she realized that she was going to have to fight in order to have management understand her position, she was unwilling to do so. If the nurse had had more training on the importance of her individual voice then she may have been willing to put up that fight, and if her coworkers also understood the importance of their voice, then the nurse may have had more support in putting up that fight.

Ideally, this same curriculum should be made available in foreign nursing schools, particularly Philippine nursing schools because they are developing nurses to work in other countries, primarily the U.S. These nurses need to have the same understanding of the importance of their voice for two reasons: first, Filipino nurses do often feel indebted to the hospitals that gave them the opportunity to come to the U.S. and the nurses need to understand that unless they speak up, they do run the risk of being taken advantage of; second, if quality of care is an important part of their work, which many Filipino nurses assert holds true, then they need to openly communicate with hospital administration and other coworkers about issues that may affect their ability to give their patients the best quality of care.

Organizing Filipino RNs

Although organizing Filipinos is not that much different than organizing other nurses,

past racial discrimination. However, Filipinos are still fearful to go against what an American tells them to do. In one hospital, an American nurse who was against the union was telling a group of Filipino nurses to vote against the union, which scares organizers because we fear that past issues of Filipinos not wanting to displease Americans will affect their vote. While the Filipino nurses that I spoke with did not speak directly to this issue, one nurse did comment that she feels discrimination that began during the U.S. Colonization of the Philippines still remains an issue today when nurses are dealing with their employers and coworkers.

Filipino nurse leaders and organizers have an easier time establishing a strong relationship with the other Filipino RNs because they can speak the language, Tagalog, as well as talk about the Philippines, where they grew up, where their family lives, and other related issue.9064 626.1598 Tm(Filipinc,im)Tj 0 12 9 Tm61 Tf8.4 0 Tw 7.7Tc 12 0 0 12 449.28 547.36 Tm()TjETEM

on a break she could leave her unit and go talk to the nurses in the other units, get their phone	
numb	

as quality healthcare for themselves and their dependents and a pension plan, Filipinos cannot ensure that they can provide for their family outside of putting food on the table.

By educating Filipino nurses about the discrepancies in their pay compared to the other RNs, this will provide organizers a way to mobilize the RNs around an issue. As one Filipino RN said, Filipino RNs will not participate in the union unless they really feel that somebody has done something wrong or bad that directly affects them—wages and benefits are that issue. In order to educate the nurses about the discrepancies, organizers need to provide material that highlights the differences between what a Filipino nurse earns compared to the other RNs in their unit.

Promote Social Movement Unionism

Another issue that Filipino RNs feel deeply about is quality of care. Many Filipino RNs go into nursing because they want to make a difference in people's lives. As one nurse commented, she works as a nurse because she wants to work for the betterment of all humanity. Part of organizing around quality of care issues can be addressed by utilizing social movement unionism tactics and strategies in order to mobilize nurses around a greater cause. Nursing is considered a professional field with a high standard of ethics and part of "being a professional means having a say in work conditions and quality of care. Without the union, we hardly have any say about these issues." Social movement unionism provides a framework for these nurses to speak out about issues around quality of care while also giving those nurses who are

Utilizing a rank-and-file approach to union organizing, social movement unionism seeks to include broader issues in organizing. With Filipino RNs, the broader issues include improving the quality of care but also organizing around issues of race and gender discrimination. Fifty tsurvey respo gent

as a nurse in the U.S. 182 With an already struggling economy, the Philipp

Appendix A: Survey Questions

Filipino RN Survey

Dear RN,

First, I would like to thank you in advance for completing the survey I have sent you today. I am an Urban and Environmental Policy student at Occidental College in Los Angeles, CA and am conducting research on Filipino RNs with the intent to determine why and how Filipino RNs organize into labor unions. Through research and collecting data via this survey and interviews, I will compile information to form an organizing manual for labor unions looking to organize RNs and more specifically, Filipino RNs. I would like to emphasize that these survey results and your identity will remain completely confidential unless you inform me otherwise. If you are interested in participating in an interview, or would like to find out the results from my research, I can be contacted via email at carlasaporta@yahoo.com. Once again, thank you for your participation in this study!
Sincerely,

Carla Saporta

Please Choose All That Apply for Each Answer. You Can Include More Than One Answer Per Question.

1.	Male Female
2.	Age? a: under 25 b: 25-40 c: 40-60 d: 60+
3.	Were you born in the United States? If yes, please skip to question #6. Yes No
4.	How long have you lived in the United States? a: less than 5 years b: 5-10 years c: 10-20 years d: 20+years
5.	How did you move to the U.S.?" a: Visa sponsored by the hospital b: Visa sponsored by a family member c: Came to the U.S. with a student Visa d: Came as a tourist e: Other
6.	What hospital do you currently work at?

f: Nurse to patient ratios g: Other	
14. What issues in hospital work do you for a: Discrimination b: Having a work visa	eel are related to one's ethnic status?
c: Not wanting to challenge the status	quo
d: None	
e: Other	

- 15. What kinds of discriminatory conditions (if any) do you think Filipinos face at your work?
- a: None, different from other nationalities.
- b: More vulnerable to the em

Appendix B: Interview Questions

Filipino RN Interview Questions:

- 1. Why and how did you become an RN?
- 2. What ma

- 19. If so, how would you like to address these issues?
- 20. How would you describe to me your experience in organizing your colleagues?
- 21. What tactics or strategies did you use to organize your colleagues?
- 22. Do you feel that being Filipino has played a role in how you organize? Being a woman?

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