

NURSING AND NATIONAL HEALTHCARE IMPLICATIONS WITH THE RISE
OF THE CALIFORNIA NURSES ASSOCIATION AND THE
NATIONAL NURSE ORGANIZING COMMITTEE

by

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**Nursing and National Healthcare Implications with the Rise
of the California Nurses Association and the
National Nurse Organizing Committee**

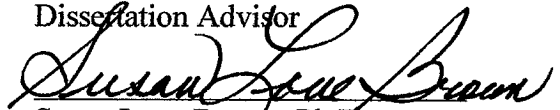
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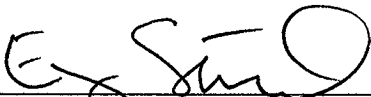
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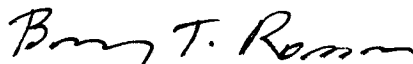
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son, Alexander, are truly special to me, and serve as a constant reminder of purpose beyond the academic. My mother, too, has been a special role model with her unwavering belief in higher education and the need to be a lifelong learner.

ABSTRACT

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In 1993, a group of unionized bedside nurses took control of their state nursing association. In 1995, they disenfranchised themselves from the American Nurses Association, which historically had billed itself as “THE” voice of the profession of nursing. This study utilizes a case study format to look at who they are, what their intentions are, and what their vision is for the future of the profession.

Twenty questions were submitted to key participants identified by the California Nurses Association (CNA). The questions were organized into three main areas: the period leading up to the disenfranchisement, the period of growth after the takeover up until the historic passage of the ratio laws and whistle blower protection, and the period after the passage of the laws wherein the association began a national movement. This movement continues to evolve, and in December, 2009, the CNA (now the National Nurses United) became the largest nursing organization in the country.

As the title of the study implies, one intention of the study is to look at the implications for the profession of nursing and the inevitable political implications for the national healthcare debate. Another purpose is to introduce this group to the academic and professional nursing communities, which until now have largely ignored them. Still another purpose is to lay out a blueprint for other state nursing associations who may wish to empower themselves, to analyze the process by which this group has grown to political prominence. No other nursing association has been able to duplicate their political success.

Finally, the study raises many crucial questions which nursing academics and nursing leaders must address if nursing is going to be able to utilize our only real political power, the power of numbers. Uniting the field, or at least growing the association to significant numerical strength, is the only way nursing can become an equal partner in the national healthcare debate.

NURSING AND NATIONAL HEALTHCARE IMPLICATIONS WITH THE RISE
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INTRODUCTION

Study Purpose

The purpose of this study is to provide a working theory-based model for nursing organizations that want to become politically empowered. The model chosen was the Janet Hagberg (1984) model based on her Real Power theory. This model has been accepted in nursing literature (Caputi, Englemann 2004-2005), and proposed as a model for individual political empowerment within an organization. The question examined here is whether the Hagberg model has a predictive capacity for political empowerment at the organizational level, for success or failure, and if so, whether this study supports the model, or whether changes in the model are necessary.

Question Purpose

The purpose in the twenty questions asked is to examine, incrementally, and in the words of the participants, the events that have challenged and enabled the emergence of this politically empowered nursing movement. This movement officially began in 1993 in California, and has included:

- a staff nurse rebellion that elected a bedside practice nursing majority to the Board of Directors of the California Nurses Association (CNA) (1993);
- the election of a complete bedside practicing nurse board and executive officer slate as well as the disenfranchisement of the CNA from the American Nurses Association (ANA) (1995);

- the introduction and passage of two state laws in California regarding maximum patient to nurse ratios and a whistle-blower protection for registered nurses (RNs) (1999);
- a successful legal defense of the ratio law after Governor Schwarzenegger and the American Hospital Association (AHA) attempted to block its enforcement (2004);
- the formulation of the National Nurse Organizing Committee (NNOC), a national arm to reach out to other states (2004); and
- the precipitous increase in CNA membership to 88,500 RNs by 2008, making it the second largest nursing organization in the country and mounting an increasing challenge to the ANA assertion that they are *the* political spokesperson for the field of nursing (<http://nursingworld.org/>).

Even the CNA is in flux, as evidenced in December 2009, when the organization integrated into the National Nurses United, a super union that rivals the ANA in membership and directly challenges the ANA position as the largest nursing organization in the U.S. (<http://nursingworld.org/>).

Chapter Outline

Chapter 1 will begin the discussion into the academic and political background of this study and its justification. What is in the literature, if anything, about this fast growing nursing association? What has research shown that would empower this one association to have enacted such potent legislation and defeat the legal challenges brought by a very popular state governor who had the backing of one of the largest national associations in healthcare, the American Hospital Association (AHA)? Finally,

what research is looking at the impact these practice changes have made in terms of patient safety and outcomes? Given the vigorous opposition to the CNA/NNOC movement within nursing leadership, it behooves us to look at *who* is conducting this research as well.

Chapter 1 also will discuss, in broad terms, collective bargaining, unionization, political action, social activism, state associations, and specialty organizations, in order to contextualize the framework of the study. The chapter will look at the significance of this study on nursing research and healthcare policy as well as research questions to which this study can attempt to contribute and the research questions that will arise from it. Finally, the chapter will discuss the concepts of organizational change and political empowerment as they apply to the present study.

Chapter 2 will present an historical contextualization, a history of nursing political activism, which began with the emergence of professional nursing following the Civil War, under the leadership of women with direct experience in several prominent social movements, including the Women's Suffrage Movement. Also presented will be the innovative healthcare delivery organizations that began under the direction of these activist professional nurses.

All of this independent innovation and practice ended, as it did for most non-physician health care practitioners, with the passage of the Medical Practice Acts by all of the states during the late 1800's up to the 1930's. Medical doctors (MDs) and their very powerful political organization, the American Medical Association (AMA), legally controlled the practice of "medicine". Currently, the political battle for the control of medicine is a vicious struggle between corporate actuaries and practicing physicians.

(According to the Bureau of Labor, employment for actuaries is expected to grow much faster than the average for all occupations. <http://www.bls.gov/oco/pdf/ocos041.pdf>) Meanwhile, their physician counterparts are turning to specialty practices, all but abandoning primary health care, and organizationally opposing the utilization of nurse practitioners to fill this emerging void at every turn. Chapter 2 also will contextualize current nursing political associations and organizations as well as provide a history of the CNA and the NNOC, including the present day status of nursing political activism and the impact, or potential impact of that status to healthcare in the United States.

Chapter 3 will propose the research design for this study, which is a qualitative case study, including the strengths and weaknesses of this research methodology for obtaining the interviews and corroborative documents.

Chapter 4 will present a summary and analysis of the responses from the CNA members who participated. Many of the background events surrounding the interview information also will be included, as well as an historical contextualization of the political events in nursing where applicable. References to the corroborative documentation submitted by the CNA will be given, where applicable, to substantiate the information provided by the responders from CNA.

Chapter 5 will include a conclusion that discusses the implications to nursing and the national healthcare arena with the ascendance of this bedside nursing organization, as well as present the implications of this study for the Hagberg theoretical model of individual political empowerment as it is applied to the organizational level, and support a model applicable to other nursing organizations who seek to politically empower themselves.

CHAPTER 1

BACKGROUND

“It was one of the first and happiest fruits of improved medical education in America, that females were excluded from practice; and this has only been effected by the united and persevering efforts of some of the most distinguished individuals of the profession”
(Boston Physician, 1820).

In their widely utilized and frequently referenced work, *Policy and Politics in Nursing and Health Care*, Mason, Leavitt, and Chaffey (2007) articulate the need for nurses to not only understand the political process and the dynamics of that process, but to be **engaged** in the political arena if they wish to become political players.

The implication is that the nursing profession *can* be a political force, but only *if* it is engaged in the political process. Mason, et al, asserts that nursing was a force during the early years of the Clinton administration. The ANA Political Action Committee (ANA-PAC) was the first health care organization to endorse Clinton during the 1991 campaign for President (p.3); it eagerly became involved in his task forces on healthcare reform that resulted in the Health Security Act, and nursing anticipated a bright future as leaders in the new healthcare system. This legislative effort to reform healthcare was defeated, however, after political pressure mounted from a new Republican Congress and a clever media campaign by the Health Insurance Association

of America mobilized public resentment. By 1997, in response to a survey conducted by the *American Journal of Nursing*, more than 7,500 nurses reported that RN positions had been reduced at their facilities and unlicensed assistants were being substituted for RN's, and more than 1/3 reported their nurse executives had been dismissed (Mason et al., 2007). This had not been professional nursing's first political defeat, nor would it be its last.

The industry restructuring efforts were not limited to corporate administrative schemes such as Total Quality Management (TQM) and the advent of Managed Care Organizations. Bedside care nurses were beginning to rebel around the country against the efforts of the facilities to replace them at the bedside with lower paid, unlicensed caregivers. Fortunately, for nurses, the public wanted them there. The entire California experience after 1993 and the New York "Every Patient Deserves an RN" campaign in the late 1990s showed the political power of a nursing-patient alliance.

During the transformative period from 1991 to 1996, covers of the staff nurse journal *Revolution: The Journal of Nurse Empowerment* (important because it was the only nationally published journal devoted to staff nurse issues) showed how many bedside nurses felt at the time. Covers of the journal showed pictures of nurses without mouths (Winter 1991); nurses appearing as little girls while daddy doctor lectured them (Spring 1992); nurses with puppet strings attached looking exhausted (Summer 1992); a skeletal hand reaching for terrified nurses surrounded by open graves (Winter 1992); a nurse restrained to an American flag with multiple caduceus thrown into the flag as if a knife thrower had thrown them (Fall 1993). The spring 1995 cover showed a nurse trapped in a bottle, her companions a spotted owl and a dodo bird. Signs above each

bottle read, extinct for the dodo, vanishing for the owl, and threatened for the nurse. The fall 1995 issue depicted a nurse chained to two waist-sized blocks of cracked granite, with the sign University Hospital on one of the blocks. The winter 1996 featured a story entitled “What are Nurses so Angry About?” with a cover of small paper nurses and a caption reading, “Where will all the Nurses go?” By the summer of 1998, the cover showed striking nurses speaking out against unsafe patient care conditions, while an editorial called for nurses to challenge the misguided healthcare reform measures that threatened the very existence of our nursing profession. This imagery, though at times dramatic, is important in understanding how many staff nurses felt, and in explaining why nurses could become inspired for change.

Nursing Literature

For its part, nursing literature is replete with instructions on how to become politically active. Political education, generally provided in a roles and policy course at the graduate level, started with the 1978 ANA Code of Ethics for nurses, which called for political action with patient care issues. Those outside of nursing as well (Winslow, 1984) noticed this shift from loyal servant to political activist in the Code of Ethics. The first national nursing organization devoted strictly to political action was the Nurses for Political Action that began in 1972, but it was consumed immediately by the ANA and re-named the Nurses Coalition for Action in Politics (N-CAP) (Donahue, 1996). N-CAP considered itself non-partisan and was organized as a not-for-profit association.

The streams in the academic literature have been relatively consistent over the last 30 years. Prior to the 1970s, however, most of the academic literature dealt with defining, or attempting to define, nursing practice (Donahue, 1996). This academic

flourish resulted in at least seven distinct philosophies of nursing, eight grand theories (a conceptual framework that describes broad perspectives for nursing practice), and 13 middle range theories (theories that function as a limited guide for a specific practice reality in nursing) (Marriner-Tomey, 1994). With the exception of the mid-level theory proposed by Madeline Leininger, which dealt with cross-cultural care, most of the philosophies and theories dealt with nursing as a one-on-one experience and not as a social responsibility. As late as 1988, Paterson and Zderad's humanistic nursing theory called for nurses to focus on the particular patient, the specific nursing interaction. No mention is made of empowering themselves or their profession within the political process of the facilities in which they practice or the national health care debate.

This dominant focus on an almost spiritual relationship with an individual patient, coupled with an apolitical organizational agenda, the nursing administration affiliation with the American Hospital Association (AHA), and *moral* image of the nurse, appears to have delayed nursing's affiliation with the civil right's movement of the 1950s and 1960s and, strangely given the almost 100 percent female membership of the nursing profession at the time, the feminist movement of the 1960s. As late as 1985, Chinn and Wheeler were examining the issue of feminism and nursing and asking if nursing can afford to remain aloof from the feminist issues. Nor did this issue escape the attention of nurses in other countries. In 1985, *The Canadian Nurse* published an article entitled "Women, nursing and feminism: An interview with Alice J. Baumgart, RN, PhD." So while this period of time from the 1930s until the 1960s may have been vital in terms of introspection and theoretical development, nevertheless it was the dark ages for nursing political activism. Professional nursing organizations and nursing

leadership, instead of helping to lead these movements and become a major social force as it had done during the late 1800s and early 1900s, instead chose to remain closely affiliated with the conservative administrative systems and vigorously maintain the almost militaristic and very paternalistic relationship with medicine.

Advanced Practice

A major political event did occur in nursing between 1965 and 1967, but it centered on practice, not social activism. A group of Colorado nurses, with assistance from some visionary physicians, developed the first Advanced Practice Nurses (APNs), also commonly referred to as Nurse Practitioners (NPs). These (pediatric) nurse specialists trained to function independently from direct physician observation. Their focus was on a more holistic approach to health care with a strong emphasis on education and prevention.

Nursing graduate schools, which previously had focused on administration, theory, and education, immediately took to the new clinical specialty degree. Training soon included specialization within a broader family track and offered 13 specializations: acute care nursing, adult nursing, psychiatric nursing, community health nursing, geriatric nursing, family nursing, home health nursing, neonatal nursing, occupational health nursing, oncology nursing, rural health nursing, women's health nursing, and of course, pediatric nursing. According to the American Academy of Nurse Practitioners (AANP), there were approximately 120,000 practicing NPs in 2007, with 6,000 graduates from 325 colleges and universities added each year. The goals of the AANP include complete independent practice and full prescriptive authority for nurse practitioners in all 50 states, and thus the political conflict with medicine.

The nursing vision for this advanced practice nurse was someone who would help open the doors of access to primary health services, reaching out to rural, immigrant, poor, and other populations through innovative and imaginative delivery systems that included neighborhood clinics, home care, and public health education. This would be a return to the roots of nursing, but exclude the management of complex disease processes and surgery, which would remain the domain of medicine. From its inception, however, the state medical associations and the AMA vigorously opposed the idea of independent practice and prescriptive authority, and have opposed this effort in all 50 states. It was not until 1998 that NPs received the right to bill Medicare directly and to receive DEA numbers, thus allowing them to prescribe narcotics. Today, 48 states (but not Florida) allow prescriptive authority to NPs, but almost all include some limitations. Only eight states allow full prescriptive authority, while most require some form of protocol arrangement with a physician.

Since 1965, it had taken nursing 33 years to gain political victory at the federal level, which allowed independent billing to Medicare and the right to secure a DEA number, only to realize STATES regulate nursing practice. It had not been a complete victory either, since the opposition had managed to mandate *collaboration* with a physician in the agreement. This opened up the door to a state's interpretation of collaboration, and state medical associations jumped at this rhetorical weakness. This author was at the 1998 ANA convention when the announcement came, and it did not take long to realize the potential implications of mandated collaboration. In some states, such as Pennsylvania in 1998, the state medical association was the ONLY political opposition NPs faced, and they lost (Mason et al., 2007).

This has been a long, drawn out political battle between nursing and medicine in virtually every state. Gaining increasing popularity is the Doctorate of Nursing Practice (DNP), a response to the challenge from organized medicine that if you want to play doctor, you need to have a doctorate. It is unclear, however, how these new nurse doctors will fit into the healthcare delivery system. Will they be allowed admission privileges to hospitals? Will they have unfettered prescriptive authority? A resolution in the house of delegates of the AMA (2008) included one to prohibit these practitioners from being called doctor within the hospitals.

Organized nursing had been unable to get medicine to share the vision of opening the doors of primary care access, and even today, as physicians increasingly abandon primary care (Moore & Showstack, 2003), they continue to oppose any infringement on what they perceive as their right to dominate medical care. Organized medicine has a long track-record of political involvement, dating back to the late 1800s and early 1900s (Malmsheimer, 1988) and media manipulation of their professional image (Turow, 1989). Nursing political power, which is based solely on the membership in its professional organizations, is weak and ineffective (ANA membership is only 6% of the total nursing population) when it comes to major issues to which medicine is opposed, and the continued monopoly on health care is a vital issue to organized medicine.

The remaining streams in mainstream nursing political literature relate to coalition building, for example the 1986 Tri-council of Nursing, which consisted of the ANA, the American Organization of Nurse Executives, the American Association of Colleges of Nursing, and the National League of Nursing (Hitchcock, p.438). Also

prominently mentioned in the literature are political and business networking (particularly prominent in nursing administrative journals), structural components in the political process, and the process involved in forming a grass roots public health movement. These political cookbooks fail to deal with very significant issues such as the role of money in the process, the significance of targeting key committee members and sub-committee members, or the significance of majority and minority party roles. While most books call for the utilization of nursing's large (2.7 million) potential political power, few discuss or investigate *why* so many nurses refuse to join. This critical self-reflection simply does not exist in nursing literature. Hence, it was no surprise when Milstead (1999) revealed the results of Laumanns' 1991 study that no nursing organizations were considered to be major players in the health policy arena. Today, any study would yield similar results, with one possible exception.

The coalition building and networking streams are prominent particularly in the nursing administration literature. Journals such as the *Nursing Administration Quarterly*, *Nursing Administrator*, *Journal of Nursing Management*, and the *British Journal of Nursing Administration* are replete with articles on the political process. In the *Nursing Administration Quarterly*, Peters (2002) likens the nurse administrator's role in the health policy process to teaching the elephant to dance. In clear alignment with the AHA, Storfjell, Omoike, and Ohlson (2008) report in the *Journal of Nursing Administration* that the now politically charged issue of patient safety and improved patient outcomes can be achieved if we simply reduce the amount of what they term "non-value-added" time spent by nurses in delivering care. This is essentially a throwback to the time-management studies of the 1950s and the scientific management

school of Frederick Taylor. Douglas McGregor's Theory X management approach is very evident in administration journals. Topics such as bed-hiding (where nurses supposedly delay the entry of discharged patients into the tracking system to avoid getting new admissions) and the reduction of incremental overtime are hot administrative issues.

Foreign Perspective

Across the Atlantic, British administrators also note the strange absence of nursing from the political process. Hewison (2007), in the *Journal of Nursing Management*, states that the "lack of involvement of nurses in the policy process is an issue of concern which has resulted in calls for nurses to become more active..." but concedes that "what is often less clear is precisely how this can be done" (p. 693). She goes on to present a template for nurse managers. In the same journal, Davies (2004) discusses political leadership and the politics of nursing and concludes that joint initiatives with service users and not advocacy positions will best serve nursing's political interests, and that nursing leadership is not at fault but rather that nursing "operates in a position of both cultural and structural disadvantage" (p. 235). The article is essentially a feminist critique of the government's patriarchal attitude towards nursing, nurses, and nursing leadership. The article also may be a partial response to the increasing number of articles in British, Australian, New Zealand, and Canadian journals, which challenge nursing leadership as politically inept and, in many cases, diametrically opposed to what the writers perceive as the interests of clinical nurses.

Boswell, Cannon, and Miller (2005), also from Great Britain, note that "nursing apathy toward participation in the political process is pandemic" (p. 5). They go on to

posit multiple reasons for this apathy, which include “heavy workloads, powerlessness, sex issues, oppressive images, understaffing, management inapproachability, fear of infringement on family time, anxiety with public speaking, and fear of retaliation” (p. 5). These authors contend that involvement in the political process is a responsibility for nurses, but that they need to overcome their barriers by teaming up with others, by making curriculum changes to educate nurses about the policy process, and by educating others about the role of the nurse. Heavy workloads, powerlessness, understaffing, management inapproachability, and fear of retaliation are issues that have been and continue to be adressed directly by the California movement.

Political Power

In the United Sates, Mason et al. (2007), drawing from multiple authors, present to nurses their ideas on the sources of political power. This book is widely utilized in nursing programs around the country, regarded as an authoritative health policy textbook in nursing, and so this power classification merits some discussion here. Both coercive power and reward power, as presented by Mason et al, seem untenable for nursing since it lacks the unification to actualize any type of coercive political presence, except, of course, for the issue of horizontal violence which has received widespread coverage since the 1980s. When it comes to health care, legitimate (or positional) power has belonged to medicine since the early 20th century. Policy leaders simply do not see nurses as authorities on any health care issues except those directly pertaining to nursing issues, such as the nursing shortage. Though rated the most trusted profession in polls of the American public, nursing is strangely absent from the media debates and public discussion on health care.

Mason et al.'s expert power is a potential source of authority for nursing, but even nurses in the academic world argue about what nursing knowledge is and how it is distinct from medicine. No clear teleology for nursing has been widely accepted, and those proposed, such as caring and health education, are vague at best. Nursing administration has been counting on referent power (emanating from the association with powerful people or organizations) and connection power (arising from occasional extensive connections with powerful people or associations). Information power, particularly within nursing, is subject to the interests of the healthcare industry. *Nursing Spectrum* and *Advance*, the magazines geared to most working nurses, depend heavily on advertising from the health care industry, and preface the occasional article that deals with sensitive issues with a disclaimer from the publishers to distance themselves from the controversial opinions.

Other nursing political instruction texts do not even reference a section relating to political power. In *Health Policy & Politics: A Nurse's Guide* (Milstead, 1999), the words collective bargaining, unionization, power, political power, and political parties are not even referenced in the index. The same is true in *Legal, Ethical, and Political Issues in Nursing 2nd Ed.* (Aiken and Catalano, 2004). Neither book mentions the California movement or its success in passing such unique legislation. Of note here is that California nurses already had been able to exert influence back in 1975 when the state legislated 2:1 critical care ratios. Neither author felt compelled to discuss this activist state's political successes.

In *Leadership Roles and Management Functions in Nursing 6th Ed.* (Marquis & Huston, 2009), the CNA and NNOC never are mentioned in Chapter 22, which

discusses the history and current status of collective bargaining and unionization for nurses. Only the CNA is mentioned in Chapter 17, Staffing Needs and Scheduling Policies, and then only because the issue of staffing ratios is discussed. No mention of the NNOC is in this text, although it is noted that some states do have staffing ratio legislation pending. The irony in this book is that both authors, Bessie L. Marquis and Carol J. Huston, are professors of nursing in California. In her book, *Professional Issues in Nursing: Challenges & Opportunities* (2006), Carol J. Huston does discuss the CNA in Chapter 10, Mandatory Staffing Ratios: Are They Working? The discussion seems rather premature for a 2006 book, however, given that the ratio laws had barely taken effect due to the attempted obstruction and delay of their enforcement by the new governor of California with the backing of the AHA. The author does cite the ongoing battle between the CNA and the CHA to control any studies relating to how effective staffing ratios are. While the author does discuss moves towards similar ratio legislation in other states, no mention is made of the NNOC.

Interdisciplinary Literature

Of equal significance to nursing is the absence of nursing from many books discussing health care from other disciplines, particularly health administration and public administration. In *Understanding Health Care Reform* (1994) by Theodore R. Marmor (professor of public policy at Yale), *Health Care Politics and Policy in America* (1995) by Kant Patel and Mark E. Rushefsky (both from political science), and *Health Policy Making in The United States 2nd Ed.* (1998) by Beaufort B. Longest (Health Services Administration), the word nursing is not even referenced in the index. These books are all widely used in a variety of educational programs related to health

policy and administration. By the 4th Edition of the Beaufort book (2006), the issues of nursing homes, the Nurse Reinvestment Act, and the Nurse Training Act are included, and the ANA's participation in the 2003 National Hospital Quality Alliance is discussed.

Significant evidence of political invisibility comes from *Delivering Health Care in America: A Systems Approach 3rd Ed.* (2004) by Leiyu Shi (Department of Health Policy and Management, John's Hopkins School of Public Health) and co-author Douglas A. Singh (Health Care Management, School of Public and Environmental Affairs), who, in their excellent discussion of healthcare facility power, fail to mention nursing at all. Nursing's political invisibility appears at both the national and the organizational levels, leaving the state level as the only real venue for serious nursing political activism. Perhaps this partially helps explain the success of the CNA/NNOC in California in regulating the practice environment.

The message to nurses is simple: writing about foot ulcers is professional; writing about unionization and labor issues is not. All of these factors reinforce the conclusions of Jaqueline Goodman-Draper in *Healthcare's Forgotten Majority: Nursing and Their Frayed White Collars* (1995), essentially a labor analysis of nursing. In the book, nursing leadership is described as closely aligning with the white-collar values and abandoning the blue-collar priorities of the nursing workforce. This distancing of administrative nurses (nurse executives is the term being used increasingly) from the direct concerns (at least in terms of staffing issues, pay, and labor disputes) of bedside nurses is hardly new. In 1903, Lavinia Lloyd Dock (1858-1956)

warned nurse leaders against subjecting nursing to the paternalistic over-sight of hospital administrators and physicians. According to Ashley (1975):

Nursing leaders ignored all her warnings and in the second decade of the century actually became nonvoting members of the American Hospital Association.

They worked with physicians and administrators on joint committees, expecting their oppressors to help them solve nursing problems. They sought approval from men, not liberation. As a result, from the first decade of the century onward, physicians and hospital administrators have remained in positions of dominance and control over nursing and health care. (Donahue, p. 1466)

The ramifications of this decision in 1903 remain in full force today: the American Organization of Nurse Executives (AONE) is a registered chapter of the American Hospital Association. In 2008, the AONE launched a letter writing campaign to Congress to oppose the reversal of the Kentucky River Decision, a decision formalized in 2006 by the National Labor Relations Board, with full approval of the Republican Congress and Republican President George Bush and based on a 1997 case in which the NLRB originally had backed the workers. After the U.S. 6th Court of Appeals reversed the decision in favor of the employers, the case was sent to the U.S. Supreme Court. The Court's decision was strongly supported by the AHA, but it took the Bush-appointed NLRB to formalize the decision. In opposition to the legislation, and supportive of Congress's RESPECT Act to reverse the decision, were the American Nurses Association (ANA) and its labor arm, the United American Nurse (UAN), as well as the CNA/NNOC. The legislation now is in both chambers but has not been

resolved since the elections in November 2008. The ruling impacts almost eight million nurses and could exclude them from any and all unionization efforts.

One needs only to examine the political donations and connections of hospital associations to the Bush-Cheney administration to see why the strict party line vote (3-2) occurred at the NLRB, despite the clear attempt by the Republican majority to violate the original intent of the NLRB, according to the two dissenting voters. Of the 46 members of the team, 30 were hired lobbyists or representatives from the pharmaceutical, insurance, and hospital associations, including:

- Daniel T. Boston, Assistant Vice President of Legislation and Public Affairs for the Federation of American Hospitals, which spent 1.6 million on lobbying expenditures in 1999 and gave \$5,000 directly to George W. Bush;
- Julie James, a consultant for Health Policy Alternatives (a lobbying firm for the AHA and the Federation of American Health Systems, now known as the Federation of American Hospitals), which gave \$220,000 in 1998 and \$660,000 in 1999 to Republican causes;
- Michael Place, CEO and President of Catholic Health Association, who contributed \$25,000 to the Bush inauguration and \$970,000 in lobbying dollars between 1997 and 1999 to the Republicans;
- Mary Taylor, an in-house lobbyist for the AHA. AHA contributed over \$1.5M during the 2000 election cycle, and lobbying expenditures of \$10.52M in 1998 and \$12.48M in 1999; and
- Thomas Scully, President and CEO of the Federation of American Hospitals (FHA), who personally donated to both the Republican Party and to the

Bush Presidential Recount Fund. The FHA PAC also contributed directly to President Bush. Scully hosted several Republican fundraisers.

(www.bushcheneytransition.com, www.opensecrets.org,
www.inauguration-2001.com)

The future role of nursing just may hinge on the next Congressional election in 2010 and the Presidential election in 2012, with the inevitable interpretations or even repeal of the just passed health care legislation.

Study Questions

This study attempts to situate itself in the context of these ongoing academic, social, and political discussions. The significant research question is- what happened in California in 1993 that enabled this one nursing group to reverse years of dwindling organizational membership and become the second largest nursing organization in the country? How have they managed to overcome decades of nursing social apathy not only to enact powerful new state laws to protect their practice, but also to engage the organization publicly and politically as a major proponent of national health care? Why are nursing academics not investigating vigorously the reasons why 94% of the nursing workforce fails to support their national organization, given what we know about political power? Does the political impotence of nursing reflect the political fracture in the field between administrative, academic, and practicing nurses? What implications are there from this study for nursing organizations, and what can nursing organizations who desire to become more politically empowered learn?

Background Definitions (Unions, Collective Bargaining, and Organizational Effectiveness)

“The nurse participates in establishing, maintaining, and improving healthcare environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action” (2001 ANA Code of Ethics #6, p. 11)

The philosophical volatility within nursing regarding unionization, collective bargaining, and organizational (political) effectiveness warrants some clarification of these terms. A professional organization’s Code of Ethics is a social contract that attempts to detail the responsibilities of the profession to itself and to the community it serves. According to Rainey (2003), an authority in organizational theory, “writers on organization theory and management have argued for a long time over how best to define organization, and have reached little consensus” (p.18). Many of the terms needing interpretation, such as professional organization, professional responsibility, organizational membership, collective bargaining, unionization, and social activism, carry with them both positive and negative connotations, and so are subject to perspective interpretation. The purpose of this section will be to present definitions of these terms as they apply to this study.

While unable to provide a definitive definition of an organization, Rainey nevertheless talks about certain characteristics that organizations should share. These include:

- Groups of people who work together to pursue a goal;
- They obtain resources from their environment and transform them with tasks;

- They apply technologies to help them achieve their goals;
- They organize their activities;
- Their leaders develop strategies to achieve their goals;
- They develop structures to provide stability and division of responsibilities;
- They create rules and processes to help coordinate the various responsibilities and actions; and
- They formalize power relationships to assist with decision-making, conflict resolution, evaluation, communication, and to deal with innovation and change. (Rainey, 2003)

The responses in this study detail how the CNA fulfilled all of these essentials.

Linda Shinn (Mason et al., 2007) describes some of the contemporary factors that are influencing nursing organizations, including the industry progression from a product-driven to a customer-driven focus, competition in the marketplace, demands for improved service, the need for more efficient and effective operation, and members who want a more tangible return for their money than just altruism (p .601). Other factors include the growing Internet community, generational considerations, less focus on credentials and more on skills, and a desire for individual service. Most of these are recent phenomena, however, and nursing organizations have been suffering in terms of membership for several decades, preceding any specific generational or technological issues. According to the ANA, the purpose of nursing associations is in “articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy” (Code of Ethics, ANA Publications, p. 24).

Member benefits, according to Shinn, include information, political advocacy, collective bargaining, and workplace advocacy. The ANA includes a unionization arm known as the United American Nurse, which represents roughly 1/3 of the estimated 350,000 unionized nurses in the United States (p. 604). These numbers seem inflated or at least incongruent with ANA statistics. Total ANA membership is only 152,500, so by this figure, 115,000, or 71% of ANA members are UAN nurses. The Constitution of the UAN mandated that the UAN “shall be affiliated with the American Nurses Association (ANA) in accordance with the Autonomy and Affiliation Agreement between the UAN and ANA” (UAN Constitution, p. 26). Another perspective involves the “inheritance” of the 97,000 unionized nurses in 2003 when the Federal Election Commission ratified this agreement. Under the agreement, all unionized nurses directly represented by their state ANA affiliate organizations became UAN nurses. Since 2003, the UAN has only increased by 18,000 nurses. The UAN claims only 20 state affiliations at this time, including:

- Alabama
- Missouri
- Alaska
- Nevada
- Colorado
- North Carolina
- District of Columbia
- Kentucky
- Florida

- Utah
- Georgia
- Virgin Islands
- West Virginia
- Hawaii
- Wyoming
- Illinois
- Iowa
- Kansas
- Michigan
- Minnesota

The only major states on the list are Illinois and Michigan. Other major nursing union representatives include the *Teamsters*, the *SEIU*, and of course, the *CNA/NNOC*.

Professional organizations (also known as professional associations), in contrast to non-governmental organizations (NGOs) for example, have the additional mandate of “control of professional activity and advancement of professional interests in the wider society” (AAN). These associations have varying degrees of internal cohesion, political influence, and social or media presence. According to *Fortune* magazine, both the American Medical Association (which ranks 12th) and American Hospital Association (which ranks 13th and which now ranks 5th) are among the top 25 most effective lobbying organizations in the country (*Hospital Purchasing News*, 2001). Also included in the top 25 are the pharmaceutical industry and the insurance industry. Once

again, we have a complete absence of any nursing influence, and apparently a disproportionate political presence by some members of the health care community.

Organizational effectiveness, though frequently a topic of consideration for organizational theory professors, is all but absent in nursing academic literature. The heavy reliance of nursing departments on facilities for clinical affiliation, and thus on nursing administrative support for the affiliation, may partially explain this lack of critical self-reflection. This issue should be one of particular concern for nursing academics, though they may have considered the reasons obvious. In terms of the ANA, for example, the political empowerment impact with the loss of almost 90,000 members since 1995 warranted an intense investigation. As discussed earlier, the CNA/NNOC appears to be addressing the major concerns of working nurses, which explains its growth, while the ANA is not. Passed legislation would be another measure of organizational effectiveness. Again, the CNA/NNOC is the only nursing group credited with having passed bedside nurse protection legislation dealing with specific ratios (both in 1975 and in 1999).

The Nurse Alliance of SEIU, the union for RN's under the SEIU umbrella, claims a membership of 84,000 nurses in 23 states. The SEIU and the CNA/NNOC have been very aggressively opposed to each other for some time now, and CNA leaders went so far as to have a restraining order placed against SEIU personnel. Both claim union raiding, and the recent Ohio controversy regarding a scheduled union vote was particularly hostile. The CNA/NNOC claims that SEIU staff are badgering CNA/NNOC members at home in an attempt to undermine the staffing legislation by collaborating with them in a staffing survey. Included in this conspiracy to undermine

the legislation are the University of California at San Francisco (UCSF) and the American Organization of Nurse Executives (AONE) group California Nursing Outcomes Coalition (CALNOC), who recently have published a highly questionable (at least academically) report to show insignificant improvements in patient safety indicators from the improved staffing. According to the CNA, the SEIU: is opposing the staffing law in California because it wants Licensed Vocational Nurses (LVNs) included in the RN ratios that exist; has backed out in Florida in supporting the ratio law there; has not endorsed the ratio law currently proposed in Massachusetts; and works out agreements with hospital administrations that oppose the interests of working nurses.

The allegations by the CNA/NNOC against the SEIU International are supported by the Dearborn, Michigan police, who evicted some 800 SEIU staff and union members from a violent attempt to disrupt a banquet appearance by Executive Director Rose Ann DeMoro and other female CNA leaders at a Michigan event. The first two buses to show up at the event had male nurses and staff, attempting to intimidate the largely female attendees. As the crashers pushed, punched, and shoved in an effort to enter the facility to confront Ms. DeMoro, the police were called in.

Collective bargaining is the process, unions are the agents. Nurses find themselves with a varied assortment of unions, as previously indicated, and the UAN is the most recent addition, existing only since 2003. The NNOC was established in 2004 from the CNA, which itself is only 15 years old in its current activist state. The Teamsters have a long and proud history of union activism (corruption charges aside), but a sporadic relationship with nurses. The recent battle at the Northern Michigan

Hospital in Petosky, Michigan, where nurses rejected the Teamsters as their bargaining agent, and which centered around a 2-year strike (the longest nursing strike in U.S. history), demonstrates how unionized nurses are beginning to seek out other possibilities (*Detroit Free Press*, March 2008). The SEIU International represents many workers, not just RNs, and frequently is accused of working against the interests of RNs due to its support for other healthcare workers such as LPNs and LVNs, who though licensed as nurses, have limited responsibilities compared to RN's. In response to this, SEIU created the Nurse Alliance to strengthen their "(RN) nurses working for (RN) nurses" claim.

Unions, historically, have had both positive and negative connotations in the United States, and this is true particularly within the nursing community. The nursing administrative branch is generally opposed to any unionization, a position endorsed by the AHA. Some in nursing oppose the use of unions for what they perceive as a violation of professional stature. Others do not endorse this perception of nursing as a "profession" however, including the eminent sociologist Dr. Amatai Etzioni, who in 1969 edited a book entitled *The Semi-Professions and Their Organization: Teachers, Nurses, and Social Workers* (Etzioni, 1969). Given the results of the limited number of national nursing surveys available, nurses appear to be having a hard time accepting their status as "above-it-all" professionals as well as the lack of power in controlling their practice environments. Results in the ANA-sponsored 2004 survey of 76,000 RNs revealed:

- High satisfaction with their RN peers, their professional identity, and developmental opportunities;

- Only moderate satisfaction with nursing administration, nursing management, interactions with physicians, and their own level of autonomy; and
- Low levels of satisfaction with their decision-making power, tasks, and pay.

Unfortunately, the potential wealth of information that researchers could harvest from facility nursing (employee) satisfaction surveys is proprietary to the facilities and unavailable for analysis by impartial researchers. Strangely, the ANA also refuses to mandate and reveal nurse satisfaction results from its MAGNET facilities, a designation given to hospitals that are committed to retaining RNs and providing them with a healthy work environment. A study just released (2010) on Magnet certification by the University of Maryland revealed no significant improvement in terms of the working conditions for nurses at Magnet certified facilities.

The CNA/NNOC is committed fully to social activism in its support for universal access to healthcare for all Americans, and unlike any other nursing organization, is investing in media to present this position. The 2008 CNA commercial featuring former Vice President Dick Cheney demonstrates how this organization is attempting to be both politically active and socially present in its commitment to social reform. In the commercial, Vice President Cheney is entering a healthcare facility for expedited care related to his heart condition. The political question raised by the commercial: Why isn't this level of care available to all Americans? Bill Moyer also has done a PBS spot on the CNA and its call for universal health care for all Americans. Such media presencing is extremely rare for other nursing organizations, including the ANA. By these moves, the CNA/NNOC has advanced itself, and the bedside nurses it

represents, from just another labor organization for nurses into a national voice in the healthcare debate. This return to the roots of nursing's social activist history appears to be connecting well with practicing nurses.

Assumptions

There are several assumptions inherent in transitioning nursing into a social change agent. The apparent assumption from those actively involved in the process is that we could begin to address the tremendous inequalities that exist in the American health care system, inequalities that should not be present in a healthcare system that spends roughly 2.7 trillion dollars per year for a population of 300 million. Another assumption is that the intentions of the leaders of this movement (CNA/NNOC) are consistent with the desires and values of the bedside nurses they purport to represent. An underlying assumption, given the failure of nurses to support their professional associations, is that there truly is a fracture in the field, with administrative nurses supporting their AHA agenda, academic nurses failing to examine critically the root causes, and bedside nurses largely underrepresented in the internal and external political arena. Finally, there is the assumption that nurses, if politically united and politically active, could change the existing healthcare structure.

In 2000, the World Health Organization (WHO), the public health arm of the United Nations, released a study that ranked the nations of the world using five measures:

1. overall level of health or life expectancy,
2. health fairness or life expectancy as measured across various populations within a country,

3. responsiveness or how well people rated performance of their health care systems,
4. fairness in responsiveness among different groups in the same country, and
5. fairness in financing among different groups, which looked at what proportion of income is devoted to health care.

In this study, the United States ranked 37th. The European systems generally are performing best and, according to analysts, the United States ranking largely reflects a large inequality in the distribution of health care resources. Since 2000, the current health care system's response to this study has been lackluster at best.

In 1999, the Institute of Medicine (IOM), a division of the National Academy of Science, released a report that has had profound effects on the American health care system. The study concluded that each year anywhere between 45,000 to 90,000 Americans in American health care facilities were dying from preventable errors. A follow-up report was entitled *Keeping Patients Safe: Transforming the Work Environment of Nurses*. In this report, the IOM made several recommendations, including the need to determine safe staffing levels for nurses within different types of nursing units. It appears the CNA was well ahead of this curve, having passed their mandated safe staffing levels four years prior to the report. To date, the ANA has refused to endorse mandated staffing levels, opting to continue its course of advancing the nebulous safe staffing initiative which began in 1993. In 2006, a study reported in the journal *Critical Care Nurse* noted some improvement as reported in an online survey of 4,346 critical care nurses, but also concluded that there remained pressing

challenges for both the nurses and the nurse leaders (Ulrich, Lavendero, Hart, Woods, Leggett, & Taylor, 2007).

In 2007, *The Center for American Progress*, a not-for-profit and non-partisan think tank, released its own study of health care; the results reveal a healthcare system that is broken. While noting that (many) Americans have the best health care, the best trained doctors, and the most sophisticated technology in the world, they concluded that the U.S. does not have the best system. Results of the study conclude that:

- 44.8 million Americans lack health insurance (15.3% of the population),
- Another 16 million are under-insured,
- 18,000 Americans die prematurely from lack of health care services,
- 23% of families report spending less on other basic needs due to healthcare expenditures,
- America ranks #1 in healthcare spending (over 2 trillion dollars),
- Health care costs increased by 7.4% in 2005,
- America ranks 31st in life expectancy,
- America ranks 28th in infant mortality,
- Health care costs are the #1 reason for bankruptcy,
- America spends 6 times more on administrative costs than other developed nations,
- America spends 75% of its health care dollars on (largely preventable) chronic diseases,
- America spends only 1 to 3% on prevention, and

- America would save 1 trillion dollars in health care expenditures if the nation's obesity level in 2007 returned to the 1980 level.

All of these studies point to a health care system that is disproportionately expensive compared to the results achieved. In a retrospective study published in *The New England Journal of Medicine*, the authors concluded that from 1969 to 1999, administrative workers in the U.S. health care system increased from 18.2% to 27.3% and administrative costs increased to 31% of health care expenditures (Woolhandler, 2003). Executive compensation in health care has mirrored the trend in society, and now stands at around \$15.6 million per year for a CEO (Vanderkam, 2008). Health Maintenance Organization (HMO) median salary for CEOs was \$298,475 (not-for-profit) and \$312,060 (for-profit) per year, excluding bonuses (Walker, 2007). As noted earlier, Jeb Bush receives \$450,000 per year as a member of Tenet Health's Board of Directors. According to *USA Today* author Julie Appleby (2004), executives at the six largest non-profit, tax exempt hospital systems make more than \$1.2 million a year (*USA Today*, 2004), without including benefits that can include loan forgiveness (one system gave out \$5.1 million to eight executives).

The IRS and Congress increasingly are under public pressure to look into these compensation packages, particularly in the not-for-profit sector. Walker goes on to discuss a *Chronicle of Philanthropy* report that stated that five hospital executives were the most highly paid executives in the non-profit world. Given the disparities and financial concerns in the U.S health care system, this is bordering on the obscene; the IOM report cited earlier concluded with a call for a nationalized system, a position endorsed by the CNA/NNOC.

The second assumption relates to the intentions and values of the CNA/NNOC leadership during the process of empowerment, and constitutes the focus of this study. How and why did the CNA/NNOC come into being? What are the intentions of the CNA in its move towards a national union for nurses? What are the intentions of this group as it actively seeks to restructure the healthcare environment for nurses and patients? What impact do the CNA leaders see in terms of health care administration, health care services, and patient safety? What is their strategy for re-invigorating and re-energizing nursing as a social and political force? What are their visions for the future of healthcare? What mechanisms do they intend to put in place to ensure that this movement does not become the victim of hubris or inertia? Finally, what political strategies do they envision to expand their influence and reach the vast majority of nurses who have denied their committed support to any organization in nursing?

The third assumption deals with the apparent fracture, both politically as well as socially, in nursing. This fracture politically has divided the nursing field and prevented nursing from exerting its ONLY major political power, the power of numbers. It has alienated the bedside practitioner from the administrator, the bedside practitioner from the academic, and the academic from the administrator. It has prevented nursing from assuming its rightful place as a major leader in the healthcare debate.

It took more than six years to pass needle safety acts in most states, essentially a political no-brainer. Nursing has an impotent political system when it comes to opposing the interests of the healthcare industry, and legislatures are responsive to the big money that these health care players bring to the table. State and national legislatures continue to enact only incremental changes, mainly related to

reimbursement issues. Organized medicine, with its strong political presence and social prestige, has continued to thwart the move of NPs towards independent practice in primary care. The healthcare industry continues to siphon off community health care resources in favor of increasing corporate profits, and paying out exorbitant administrative salaries, bonuses, and shareholder profits. Healthcare facilities continue to subject nurses to mandatory overtime, inter-departmental floating, and high patient care ratios, and offer them little sympathy or support when dealing with abusive physicians and patients.

Clinical nurses have been systematically relegated to blue-collar status, while nursing administration has aligned itself with white-collar priorities. The most extensive study of this is Jaqueline Goodman-Drapers labor study of nursing, *Health Care's Forgotten Majority: Nurses and their Frayed White Collars*, published in 1995. This class structure reveals itself in the various nursing groups' interpretation of professionalism:

1. Nurses in the low class position (primarily staff nurses) (84%) reshaped professionalism into an ideology that connotes work control.
2. Nurses in the medium class (the director level) (76%) incorporate both work control as well as popular individualism based on meritocracy into their vision of professionalism.
3. Nurses in the high class position (senior administrative and academic nurses) interpret professionalism as synonymous with capitalist individualism, by:
 - improving their own human capital through credentialism and compliant behaviors (in concert with the goals of management), and

- gaining monopoly control over the education and marketing of the occupation.

Interestingly, nursing is one of the very few healthcare professions that cease to practice its trade when assuming administrative roles. The Chief of Surgery at medical facilities still practices medicine and performs surgery, but it seems that when a nurse gets a title, he or she abandons bedside nursing as fast as they can. This only serves to reinforce the perception on the part of those still practicing that bedside nursing practice is blue collar work and that the nursing *other* exists.

Regarding their employees, many nurse administrators readily have bought into McGregors' Theory X, a view strongly supported by many hospital administrations. In this view, staff nurses essentially are lazy, passive, resistant to change and responsibility, and indifferent to organizational needs. With no strong incentive to improve performance, a frequently changing mid-level administrative team, and intermittent clinical support personnel at best, there can be little wonder why staff nurses perceive changing administration demands as temporary and useless.

An additional illustration of the divide can be seen in Zammuto and Krakower's Competing Values Framework (1991), a study of organizational culture. In this model, academic nursing is firmly in the quadrant emphasizing production, pursuit of goals and objectives, task and goal accomplishment, and competition and achievement, with rewards based on achievement. Nurse administrators, however, are entrenched just as firmly in their quadrant of formalization and structure, rule enforcement, rules and policy orientation, and stability, with a reward system based on rank. The problem is that the practitioners of clinical nursing are not in either quadrant. They stand, in fact,

opposed to each other. Bedside nurses place importance on personal relationships and desire warmth and caring, loyalty and tradition, cohesion and positive morale, and, above all, equity.

Academic nursing has distanced itself from both the practice of bedside nursing and the administration of nursing practice. Few schools incorporate, or seek out, the priorities and concerns of nursing administrators. Even fewer schools do follow-up surveys to assess the clinical environment into which their students will enter. This lack of institutional awareness has escalated in recent years as the corporate nature of healthcare delivery has increased dramatically. In competitive systems, information (such as institutional employee surveys) is very proprietary, and the surveying of employees by outside agencies (including academic institutions) is difficult at best. The major focus of academic nursing has been, and remains, the criteria for passing the National Council Licensure Examination (NCLEX) exam, with its focus on the individual patient, representative pathologies, medications, delegation, and prevention/education. In entrenched curricula, there is a lack of education on the expectations for graduate nurses by the healthcare systems, the congruence of those expectations with nursing history and nursing philosophy, nor frank and open discussions on the rationales for political empowerment by nursing organizations. Many student nurses do belong to and support the student nursing association; however, once employed, the vast majority quit within the first year or so as a result (perhaps) of negative peer feedback.

Many academic institutions only tacitly support the ANA and representative state association, although there are some who require membership as a condition of

employment. Even the advanced degree environment has failed to foster the increased radicalism, critical self-reflection, and leadership skills necessary to unite the field and move a political agenda forward. This is not to negate the influence of some nursing centers, such as the Health Policy Institute at George Mason University in Fairfax, Virginia, or the work done by several other research centers in state university systems. In essence, the attempt to educate (politically) the individual nurse fails to deal with the issue of the systems into which they will return, or the political realities in the legislative process. One reason for this may be that many nurses, both inside and outside of academia, regard the MSN primarily as a tool for self-advancement, not field strength.

There appear to be two main obstacles to the emergence of true nursing leaders:

1. Nursing administrators are hired, and fired, by facility administrators. Thus, in spite of the increasing rhetoric advocating shared governance plans, the concept of a truly independent practice arena virtually is inconceivable at the staff level of healthcare facilities. So too, the political power of this dominant labor body is stymied, subjugated to the business priorities as detailed in administrative vision plans and organizational change strategies. Perhaps most important is the inability of this nurse leader to visualize healthcare in a broader sense of community, county, and state/nation, or even in a more longitudinal sense regarding public education and prevention. Working as an employee in a highly competitive (self inflicted as it may be) market, these other appointed nurse leaders are poorly positioned to advance

any global nursing agenda, for fear of the appearance of being involved in labor issues, or at least running opposite to the administrative value system.

2. There is no definitive medium for bringing together these fractured nursing interests for a frank and open discussion about the political and philosophical priorities of nursing. Bedside nurses pitifully support state nursing associations, which could and should serve as a platform for this dialectic. For example, the FNA can claim only 5,200 members in a state with 178,000 nurses, many of those obligated under current labor agreements. With this lack of support, the associations are simply unable to serve as the rallying point for hard discussion, even though they can protect the individual nurse from retaliation by unsympathetic employers. What results is almost exactly what has relegated academic nursing to the point of practice irrelevance; namely, that each specialty becomes self-absorbed, systematically imitating its community values, images, and fads.

To be fair, one bedside nursing leader did emerge in the 1990s, Laura Gasparis Vonfrolio, who published *Revolution*, and who was the key organizer in the Million Nurse March on Washington, D.C. in 1995. She opened up a dialogue with nurses during her CEU presentations on advanced clinical practice, drawing on her nationally recognized expertise in critical care nursing. Though achieving the Ph.D. credential, she continued to practice clinical bedside nursing. She openly discusses the administrative opposition she has faced, including a memo sent to hospital personnel after her graduation, instructing them that she could not be addressed as doctor in the facility. Her memoirs or biography, should they ever be written, would be a welcome

addition to nursing leadership studies and the history of political activism. During a seminar in Key West, Florida, this author had the opportunity to talk with Dr. Vonfrolio, and one could sense her frustration with what can only be described as the fear on the part of the average nurse to get involved with, and exert effort for, any organization that potentially could antagonize their administrative superiors. One need only visit *allnurse.com*, a popular blog site for nurses, to read personal accounts of how nurses are persecuted for discussing taboo subjects or for appearing to be a politically active nurse.

The final assumption can only be indirectly supported- that an organized and politically empowered nursing field would exert a beneficial effect on the healthcare system, and consequently improve America's health. The domination of medicine has been complete since the early period of the 20th century, and the administrative structure in health care facilities has been imposed, not organically grown. That said, since the 1970s, there has been a tremendous amount of nursing research dealing with health services to rural, immigrant, and impoverished populations. We also have, as a model, the work done by nursing leaders prior to the imposition of medical and administrative restraints in the 20th century. In terms of advanced clinical practice, nursing has a 43-year trackrecord on the safety and efficacy of advanced practice nurses, even with their varying degrees of restrictions and politically imposed limitations.

During the latter third of the 20th century, a significant amount of nursing research dealt with health education and prevention strategies primarily targeted to vulnerable populations. From inner cities to isolated rural communities, nursing researchers sought to empower women (primarily), and thus families, to live healthy

lives. This focus remains the commitment of our underfinanced and politically impoverished public health system. The vast majority of these often innovative and certainly non-traditional delivery systems could not meet the primary litmus test for administrative approval, however. They did not generate significant profits, if any, and the health care benefits would not materialize for years, or in some cases, decades. Acute intervention was the golden calf, not prevention and educational empowerment. The quasi-independent nature of this rural and urban practice was interpreted as a threat by the AMA, which actively campaigned to control and create a financial reimbursement system that was to their benefit. Independent nursing practice was a threat to their insured enclaves, so they reasoned.

This research mirrors the efforts of the original pioneers in nursing, and the conclusions are similar. Community-based health centers, tele-health networks, non-competitive and collaborative delivery systems, periodic primary health assessments, and environmental health education would yield significant benefits to otherwise underserved minorities, but they will not generate the profits required to attract the attention of an increasingly corporate model. The Henry Street Settlement model, first actualized by Lillian Wald (1867-1940), opened in 1893 and was a true community-based, inter-disciplinary resource for the Lower East Side of New York (Donahue, 1996). Given Wald's impact on health policy and social activism, her efforts and achievements are discussed in greater detail in Chapter 2. Suffice it to say, her model for the delivery of health services was the direct antithesis of what eventually evolved in the United States – a system that prioritizes institutional bound care, allopathic high-tech intervention, pharmaceutical control, and an insurance driven payment system.

Wald's contribution to a vision for professional nursing does deserve mention here, since its application would allow some insight into how nursing directly could influence health policy and health care. Prior to entering the Women's Medical College in New York, she practiced as a nurse for one year, working in the New York Juvenile Asylum. While attending the medical college, she was assigned to the Lower East Side of New York. It was during a visit to a tenement family that she had an epiphany. In 1915, she recalled:

That morning's experience was a baptism of fire. Deserted were the laboratories and the academic work of the college. I never returned to them.... To my inexperience, it seemed certain that conditions such as these were allowed because people did not *know*, and for me there was a challenge to know and tell. . . . if people knew things - and "things" meant everything implied in the condition of this family- such horrors would cease to exist, and I rejoiced that I had a training in the care of the sick that in itself would give me an organic relationship to the neighborhood in which this awakening had come. (Donahue, 1996, p. 305)

The systems created by Wald and others such as Mary Breckinridge, who founded the Frontier Nursing Service to deliver health services such as midwifery to rural Appalachian families in Kentucky, envisioned a community needs driven, multi-disciplinary system that delivered visiting nursing services, clinic care, and educational empowerment to disadvantaged families. Wald's "challenge to know and tell" could form the basis of a social contract with an independent profession of nursing, and elevate nursing to a prominent position in the national healthcare debate.

The clinical model of the advanced practice nurse presents another vision. While physicians see the APN as a threat to their dominance, the role of the APN is much more oriented towards education, prevention, and collaboration. Given the primary care void being created with fewer and fewer medical students opting for general practitioner status, the continued subjugation of this group of professionals is socially illogical, even more so when one considers the 40+ years of research documenting that APNs deliver safe and effective care, with equal or better patient compliance. State governments are not responding to the evidence; they are enforcing the political desires of an interest group. As the CNA/NNOC introduces its safe staffing legislation in the other state legislatures, it is making the argument for reasoned policy with respect to the hospital industry. It takes resources, however, to launch a sustained public presence, and few nursing organizations have the leadership, the money, or the will to emerge as independent activists on the public stage.

Thus, one can begin to envision how an engaged nursing workforce could impact health policy and health care. In the U.S., there are approximately 2.9 million RN's, all potential organizational members and voters. Empowered nursing organizations would have the resources to maintain a presence on the public stage. Community-based, multi-disciplinary delivery systems would augment, and reduce the dependence on, high-cost and high-tech interventional centers. Non-competitive, indeed cooperative, delivery systems would emerge, focused on community as well as individual health. The social contract would allow nursing to become the monitoring system for public health, with a duty to "know and tell." Unfettered by medicine's political stranglehold, nursing could develop its APNs to fulfill their ethical obligations,

opening up cost effective and affordable health care services to most, if not all, Americans. Nursing would not be the antagonist to medicine, but part of a comprehensive health care system that balances social and individual responsibility, community-based needs, cost, and culturally sensitive care. Ultimately, nursing could advance to administrative control over the development of true regional health care systems.

Significance to Nursing and Healthcare

The emergence of the CNA/NNOC movement and its significance to nursing cannot be overstated. Practicing nurses have witnessed the political impotence of their professional organizations to protect them from a variety of administrative abuses for decades. Abuses include: mandatory overtime, floating to units for which they are untrained or have no desire to work, non-competitive pay scales, retention schemes that do not reflect the difficulty of the job or the realities of the economy, and rigid administrative oversight in which they have little, if any, voice. Is it any wonder that the country faces a nursing shortage, with national projections reaching as high as 20% by the end of 2010? National nurse surveys reveal that as many as 30% of practicing nurses actively are seeking work outside of nursing. These fractures in the field have not served any particular interests in nursing, certainly not those of the practitioners, though there has been some gain in terms of administrative prestige and pay grades for administrative nurses.

With the exception of SEIU's Alliance for Nurses, the CNA/NNOC is the *only* political nursing organization increasing in presence and sheer numbers. It is the only organization to do so and remain grounded completely in bedside nursing priorities,

even as it advances its universal healthcare vision. It is certainly the only nursing organization to advance its cause with media presence and a nursing agenda for public safety and healthcare restructuring. The Johnson & Johnson television spots that have aired over the past decade certainly attempt to portray the courage and dedication of America's nurses, but the CNA/NNOC challenges both nursing and America to create a healthcare system for everyone, not just those who can afford it.

As the CNA/NNOC expands, it will face the same challenges faced by any organization that advances in social and political power. Span of control issues, maintaining its focus, and avoiding the pitfall of hubris are universal human traps in all successful organizations. This organization, as well as nursing in general, will face its challenges as the movement progresses. This study will examine the path taken by the CNA/NNOC, look at its leadership structure and organizational design, and attempt to present its case to nursing academics for review. The CNA experience will present a blueprint for those nursing organizations and associations that are looking to become more politically empowered. Most importantly, it may help bedside nurses realize that political inertia and systemic domination are not "inevitable" consequences for nursing.

In terms of society as a whole, the nursing model for health care would contribute to lowering costs, provide health services and education to vulnerable populations, and expand access to primary health care. It would reorient the systems away from competitive for-profit units and foster the growth of true community-based health care systems. Nursing, in terms of historical philosophy and its code of ethics, is committed fully to achieving these results. In terms of healthcare administration, the *chimeraic* structure currently in place would see the goat head (nursing) evolve into

the leadership role its founders envisioned. Nursing stands ready to assume this role, but not until some force in nursing emerges to lead the charge. The CNA/NNOC may be such a leader.

Research Questions

The political emergence of the CNA/NNOC raises, or should raise, multiple research questions for nursing academics, but it also can stimulate the interest of political scientists, sociologists, and anthropologists. The intent of this study is to look at:

- When both the CNA and NNOC began,
- Where and why the movement started,
- Why the leaders felt this organization was necessary,
- Who were, and are, its leaders,
- What their goals for the organization are,
- What impact they foresee from their movement for the healthcare of the nation.

A number of other research questions also arise:

- Why do so many nurses feel this movement is necessary?
- Why has membership in the ANA been so low for so long?
- Why has the AONE taken such a vested interest in opposing major nursing workforce issues such as staffing ratios, and politically opposing most nursing labor disputes, even those supported by the ANA?
- What information could be obtained if researchers surveyed nursing graduates?

- *Is the field of nursing politically, socially, and/or spiritually fractured?*
- *How do bedside care nurses view current nursing leadership locally? At the state level? At the national level?*
- *What tactical strategies worked when nurses were successful in affecting health policy? What strategies did not work?*
- *What will be the impact on professional nursing with the increasing state nursing association disenfranchisements from the ANA, given its billing as *the* national voice for professional nurses?*
- *Where is the critical reflection on nursing organizations and leadership by nursing academics?*
- *To assist with unifying the field, what can nursing learn from political science, sociology, social psychology, and anthropology? Can the field be unified into a coherent political voice?*
- *What level of support would a nursing organization need to become a real political (financial) player at the national level? How much do the “competing” players contribute to a particular issue?*
- *What political impact on nursing has the affiliation of the AONE with the AHA had?*
- *What would be the structure of a nursing-administered and nursing-grounded health care system?*
- *Why do teachers, who also are predominantly female, support their national organization (NEA) at a rate of more than 10 times that of nurses?*

- What role should nursing curricula play in preparing nurses for the political world in which they will most certainly practice?
- How does the structure of the state government affect the success rate of nursing legislation? Is there a “party” preference in terms of nursing issues?
- If surveyed, how many nursing leaders could the average staff nurse identify?
- Where is the greatest demand and return-on-investment for an increase in staffing levels?
- What do practicing nurses, from a variety of states and systems, feel are safe staffing levels?
- How could or should the Medicare system play a role in establishing safe staffing levels, especially in view of the recent dramatic interventions regarding non-payment for secondary issues?

These, and many more questions, remain unanswered.

Application to Theory

This study examines the evolution of political empowerment in an open systems organization. The historical development of political power by the CNA is examined using the Janet Hagberg (1984) Real Power Model within the context of the W. Warner Burke- George H. Litwin (1992) open systems Change Model Theory. Since its inception, organizational theory has attempted to look at a variety of external and internal forces that impact and can alter organizations. Almost all “management and organizational theory (today) is concerned with performance and **effectiveness**”

(Rainey, p.128), and thus applicable to this study. Organizational sociopolitical empowerment models, however, are scarce.

A brief introduction to the Burke-Litwin open systems Change Model theory is warranted, but the reader is referred to Burke's 2008 book *Organization Change: Theory and Practice* for a more detailed presentation. Burke outlines a general consensus in organizational theory that organizational change is both a potentially empowering managerial tool as well as an inevitable political consequence for some organizations, given the social and political currents which dominate the public domain. In the Burke-Litwin model, organizational change can come from any level in the organization, and leaders of the change can come from any unit within the structure. They go on to note, however, that "if the organization change is large in scale and transformational in nature, requiring significant change in mission, strategy, and culture, then leadership must come from the top of the organization, from executives, particularly the chief executive". (p.25)

Open systems, according to Burke and Litwin, display 10 distinguishing characteristics (pp. 51-54):

1. They draw their energy from the outside to ensure their survival.
2. They demonstrate throughput of information gathered from the employees and fed back to management.
3. They use the information to take appropriate actions based on the feedback.
4. Actions and events control the organizational identity, not structures or policies. Social structures do, however, establish the organizations boundaries.

5. Organizations take more energy from their environment than they expend, avoiding negative entropy.
6. Since there is frequently a very large amount of information involved, organizations code the information they deem most appropriate and important in order to consider possibilities for their response.
7. Organizations need to grow and expand their sphere of influence or else risk failure. An organization as a steady state is an illusion.
8. As organizations evolve, differentiation and elaboration are vital to avoid entropy.
9. Shared norms and values remain, however, vital to ensure that too much differentiation does not occur.
10. Open organizations recognize the need for equifinality, the fact that specific goals can be attained by various routes and methods.

This open systems framework is apparent in the transformation of the CNA under the direction of Rose Ann DeMoro. It is readily apparent as well in the transformation of the American Medical Association in the early 20th century, as detailed in the magnum opus *The Social Transformation of American Medicine* (1949) by Paul Starr, and the AMA is certainly a success story in terms of organizational effectiveness and political empowerment. The ANA, however, lost touch with the direct communication between its leadership and the work unit (the bedside nurse), did not and does not respond appropriately to the concerns and priorities identified by the work units, and so has been unable or unwilling to set these concerns as an organizational priority. The result for

the ANA of neglecting this vital component of the Burke-Litwin model has been a state of negative entropy for more than three decades.

The theoretical model of interest for this study in terms of political empowerment is the Janet Hagberg (1984) Real Power Model of personal political empowerment in an organization. In this model, Hagberg identifies six stages of power, which are both sequential and cumulative. The six stages are:

1. Powerlessness,
2. Power by association,
3. Power by achievement,
4. Power by reflection,
5. Power by purpose, and
6. Power by wisdom.

The first three stages of this model deal with issues like resource control, goal attainment, people management, causing events, achieving cultural success, and making it profitable in terms of making a living (viability and growth). The second half of the model addresses such concerns as the discovery of meaning, the exploration of the self, the creation of long term effects, the connectedness to self or community, and then, once again, making a living at it.

In further explaining the Real Power model, Hagberg notes that:

- These stages are arranged in a developmental order;
- Each stage is distinct;

- People (and organizations) can be in different stages at different times, but there IS something of a “home stage”, a stage we tend to stay in or go back to;
- The movement must be sequential, from stage 1 to stage 6;
- “Power” is different at each stage;
- Each stage has a positive and negative aspect to it, and developmental struggles that are unique;
- Gender is a strong determinant as to which stage one identifies with;
- While age and experience are important, they do not necessarily move you from one stage to another; and
- The external 1-3 stage are dramatically different from the internal 4-6 stages.

A theory discussion section will follow the data analysis/interpretation and conclusion sections. Does the application of the Hagberg model explain the historical rise of the AMA and the newly empowered CNA, and does it explain as well the failure on the part of the ANA. Is it valid as a model for nursing *organizations* to gain political empowerment?

CHAPTER 2

REVIEW OF THE LITERATURE

History of Nursing Political Activism

In the United States, the early years of professional nursing, which developed out of the American Civil War, were rife with political engagement. Understanding this history is necessary to understanding the ethical and philosophical roots of professional nursing in the United States. The significant year for the emerging profession was 1861. On June 3rd, 1861, President Lincoln established the United States Sanitary Commission, charged with the oversight of the Union Army medical facilities and personnel. A branch of this Commission was the Women's Central Association for Relief located in New York City. Organized by the first woman physician, Dr. Elizabeth Blackwell, the association is considered by some as the forerunner of the American Red Cross. Both of these organizations began organizing and training nurses.

Also in 1861, on June 10th, Dorothea Dix (1802-1887) was appointed Superintendent of the Female Nurses of the Union Army. Though not a nurse herself, she brought strong administrative skills with her, having worked for 20 years to reform the nation's mental health facilities. Criteria to serve as a Union Army nurse included being between 35 to 50 years old (with matronly and plain looking women preferred) and well-educated; as well, those with a serious disposition would receive preference

(Donahue, 1996, pp. 252-253). These first professional military nurses received 40 cents per day as well as subsistence.

Many other women rose up to prominence during and after the Civil War. Mary Livermore (1820-1905) was a nurse for the Sanitary Commission; after the war, she went on to prominent positions in the women's suffrage movement and the women's education movement. Clara Barton's efforts during the war led eventually to the formation of the American Red Cross in 1881, and she served as its first president when the organization became official in 1882. It is a little known fact that Clara Barton also served in the Franco-Prussian War (1870) (Donahue, 1996, p.256).

Louisa May Alcott (1832-1888), perhaps best known as an American author, also served as a nurse during the Civil War; and her first famous work, *Hospital Sketches*, was published in 1863. Walt Whitman served as a union army nurse, although he opposed having women employed for such services (Donahue, p. 261). Ardent feminist Sojourner Truth (1797-1881), with fellow strong-minded African-American women like Harriet Tubman (1820-1913) and Susie King (1848-1912), laid the foundation for respect and admiration from physicians and administrators alike for the mostly volunteer nursing services.

It was not until 1873 that the first formal Nightingale School of Nursing opened, largely due to the efforts of the American Medical Society (Donahue, 1996, p. 264). Nursing education was under the direction of the practicing physicians in each hospital. During 1873, Bellevue Training School, the Connecticut Training School, and the Boston Training School all opened. Formal nursing education had begun, but independent control over the curriculum would not come for several years. In 1885,

Clara Weeks Shaw published the first nursing text, *A Textbook of Nursing for the Use of Training Schools, Families, and Private Students* (Donahue, 1996 p. 294). During the 1890s, the American Society of Superintendents of Training Schools of Nursing was formed (1893), as well as the Nurses' Associated Alumnae of the United States and Canada (1896), and the International Council of Nurses (1899) (Donahue, 1996, p. 295).

In 1900, the *American Journal of Nursing* began publication, and by 1903, the first Nurse Practice Acts were passed in North Carolina, New Jersey, New York, and Virginia. Mary Adelaide Nutting (1858-1948) is credited with being the first professor of Nursing, appointed in 1907 to the faculty of Teachers College (Donahue, 1996, p.296). In 1879, there were 11 training schools; by 1900, that number had reached 432 schools. These "diploma" schools laid the foundation for most nursing education until the community college explosion that followed the Second World War. The 4-year university based baccalaureate programs, starting with Ms. Nutting's appointment as professor, have grown steadily since the end of WWII. According to the U.S. Department of Labor Statistics (2010), as of 2006, there are 709 BSN programs and 850 ADN programs in the U.S., but only 70 diploma programs. Independent Colleges of Nursing are the norm, with the curricula completely removed from medical association dominance. The same independence does apply to the work environment however.

Nursing and Politics - The Early Years

There is a great deal of consensus among scholars about the origins of professional nursing. It appears that the Crimean War, the Civil War, and the Spanish American War played instrumental roles in public demand for an educated nursing

workforce, both in the U.S. and England. British and U.S. militaries were among the first organizations to promote formal nursing education and to institutionalize the role of professional nursing. The large number of wounded soldiers from these wars overwhelmed the private, charity, and public hospitals, and poor care was the standard of care until the governments took action.

Another factor was the global influenza epidemic of 1889-1893, which focused much public attention on healthcare and the immigrant issue, and which caused an estimated one million deaths. This number paled in comparison to the estimated 20 to 50 million deaths from the influenza epidemic of 1918-1919. The rapid spread and high mortality from these epidemics would empower the expansion of the Public Health Act of 1798, which had the primary focus of providing health services to veterans of maritime service, and in 1912, the National Organization for Public Health Nursing was established (Donahue, p.327).

The reader is referred to the book *Nursing and Social Change*, by Monica Baly (1994) for detailed information on the influence of the reform movements on professional nursing, and the leading role played by nursing in these movements. In the book, Baly details the empowerment of the abolitionist movement from the mid-1700s to the Civil War period. Many of the leaders of the movement were women, especially educated women from the Quaker faith and from affluent families in the New England states. Women would emerge as key leaders not only in the abolitionist movement, but in the temperance movement, in the movement for increased scrutiny of hospitals for the sick and mentally ill, in the movement to improve the treatment and living conditions of immigrant populations, and of course, in the women's movement for

social and political equality. The women who would emerge as nursing leaders after the Civil War had gained their political experience in one or more of the social reform movements. Dorothea Lynde Dix, for example, appointed Superintendent of the Female Nurses of the Union Army in 1861, was famous for her crusades to reform insane asylums (Donahue, p.252).

The late 1800s and early 1900s witnessed a great deal of social and political activism on the part of professional nursing, and can provide a window into the vision these activists had for the role of nursing in health care. One vision entailed the integration of visiting nursing services into the public health system, a model first attempted in England and which had been used by faith based groups in the U.S. for some time. Another vision is embodied in the work of Lillian Wald, who co-founded (with a fellow nurse) the Henry Street Settlement House in 1893, and would go on to become perhaps America's most visionary nursing pioneer.

Both developments are more significant when one considers they were without obligatory medical oversight (in other words, truly independent nursing systems), and both focused heavily on education, prevention, and empowerment, primarily for the poor and the immigrant communities. Wald's famous challenge to herself to "know and tell" (an apt mission for nursing even today) could have been achieved with this triumvirate of community based interdisciplinary services, community delivered primary nursing services, and the Public Health mechanism for reporting. Political developments would radically alter these plans as (m)edical (d)ocor's increasingly dominated the political, and thus legal, control over health care.

Until the expansion of the hospital system in the 20th century, the majority of nursing services had been home-based care; hospitals, managed and run by religious orders, were considered death houses. Other specialty hospitals, such as those dedicated to the care of patients with consumption (usually tuberculosis) and leprosy, also existed. Organized visiting nurse services, loosely modeled on the “Queen’s nurses” in England, would spread rapidly to the U.S., South Africa, New Zealand, and Canada. By 1890 in the U.S., there were 21 organizations providing mostly independent home-based nursing services, with nurses generally referred to as “instructive nurses” (Donahue, 1996, pp. 299-300). Health education was an integral part of their mission.

Lillian Wald would incorporate visiting nursing into her Henry Street Settlement House, insisting on their commitment to serve both the rich and the poor, *and* their independence from medical control. In 1912, she became the first president of the National Organization for Public Health Nursing (Donahue, 1996, p. 307). Many authors credit the dramatic improvement in life expectancy witnessed in the 20th century not only to the consolidation of medical providers and technology explosion, but to the implementation of public health measures as well. A listing of Wald’s accomplishments show a woman deeply committed both to nursing and social/political action:

- (1893) Armed visiting tuberculosis nurses with sputum cups and disinfectants. While in retrospect this may seem relatively minor, Louis Pasteur’s germ research had become prominent in 1862, Robert Koch’s

work on Anthrax in 1878, and gloves were worn in surgery for the first time in 1890 at Johns Hopkins (Donahue, 1996, p. 294).

- (1895) Created neighborhood playgrounds by adjoining backyards.
- (1897 to 1909) Investigated a variety of social issues including unemployment, dispossessed tenants, New York midwives, children with physical defects being kept out of school, child labor, labor and construction camps in New York, and working conditions for girls in department stores, factories, and canneries.
- (1899) Began a public health nursing association with Teachers' College, Columbia University, and Mary Adelaide Nutting.
- (1902) Initiated public school nursing in America.
- (1905) Served on the mayor's Pushcart Commission, which regulated the pushcart industry on the streets of New York.
- (1908) Served on the State Immigration Commission.
- (1909) Henry Street Settlement nurses began providing nursing service to policyholders of the Metropolitan Life Insurance Company.
- (1912) Credited with the idea for The United States Children's Bureau, which later was created as part of the Department of Commerce and Labor by an Act of Congress.
- (1912) Established the Rural Nursing Service for the American Red Cross.
- (1912) First President of the National Organization for Public Health Nursing. (Donahue, 1996, p. 307)

Her accolades and awards included a Doctor of Laws degree, awarded by Mount Holyoke College in 1912; the medal of the National Institute of Social Sciences, awarded in 1913; the Certificate of Distinguished Service to the City of New York, awarded in 1937; and being named to the Hall of Fame for Great Americans in 1971. She died in 1940 at the age of 73 (Donahue, 1996, p. 307). How she politically managed these accomplishments is an area rich for nursing research.

Nursing and Politics – Recent History

As organized medicine began its domination and legal control of healthcare, the introspective and subservient years of nursing followed. Great advances were resulting from the technological, pharmaceutical, chemical, biological, and physics research that was going on. Surgeons gained increased expertise in trauma-related care from World War II, the Korean War, and the Vietnam conflict, and applied this training in automobile accidents, which were accounting for 55,000 deaths a year in the United States by the 1970s. Following World War II, the United States began a vigorous program of hospital construction, assisting physicians in their desire to consolidate the practice and distribution of health services. With the development of increasingly sophisticated monitoring and life support technology in the 1960s, critical care units became a reality. Title IXX of The Social Security Act passed in 1968, creating the Medicare and subsequent Medicaid systems, although the physicians politically were astute to preserve their independent status with the passage of Medicare Part B that paid for their services. Units devoted to trauma care began in the 1970's, with a nationally affiliated trauma system being developed by the 1980s. Some unintended consequences included the rapidly expanding cost of health care, an increasing desire on the part of

medical doctors to specialize and thus not enter primary care services, and the ever-increasing cost of health insurance, generally employer provided. These unintended consequences form the quintessential American problem for healthcare.

The financial realities of this system of high-cost, acute care, allopathic medicine are enormous and continue to escalate, with the exception of a brief period during the 1990s when managed care organizations proliferated rapidly and increasing costs were constrained. Major corporations like GM have petitioned the government for relief for years now, something small businesses owners have done for decades. The uninsured now stand at around 46 million, and health care costs are the major reason for bankruptcies in the U.S. It can take weeks to schedule an appointment with a primary care provider, and the 9 to 5 office schedule forces an increasing number of people to utilize high-cost emergency rooms, which in turn creates delays and overcrowding. Hospitals have been forced by law to screen every patient, regardless of their ability to pay, who present themselves to the emergency room, and these costs increasingly are being passed on to those with insurance.

Hospitals now are in the untenable position of having to balance:

- the fear of being sued;
- low reimbursement rates from many insurance groups;
- a disgruntled and increasingly union-minded nursing workforce;
- public and political pressure to decrease the error rate;
- political pressure to increase oversight;
- reduced coverage or non-payment by Medicare for a variety of hospital-acquired secondary complications; and

- a political party whose ongoing policy platform calls for a universal health care payment system.

All of these events provide nursing with an opportunity to present to the American public its case for a restructuring of a true system grounded in nursing. Unfortunately, the fractured field of nursing is not in any position to do so.

Though it presented a visionary Code of Ethics and Social Policy Statement in the late 1970s, the ANA had committed a serious political blunder in 1968 when it called for the entrance requirement for nursing to be limited to nurses with a baccalaureate degree. It was not so much the call for the BSN as an entrance requirement that created the blunder, as it was the idea that associate degree nurses and diploma nurses were technical nurses, and thus not true professionals. This rhetorical error cost the ANA much needed support from working nurses, and the 40 years since have seen limited implementation of this desired change. It amounted to another fracture line in a field already politically disadvantaged as compared to the power brokers in healthcare.

The political ramifications of the BSN entry requirement continue today. Nurse educator groups continue to insist on this requirement, while many politicians see it as illogical given the current and projected nursing shortage predictions. Other factors which negatively impact this include the limited number of university programs, the low percentage of advanced degree nurses and impending nursing faculty shortage estimates, the large number of nurses expected to retire in the coming years, and the predicted explosion in the demand for nurses as baby boomers retire. These reasons do not include the political pressure to increase, not reduce, access to educational

opportunities for advancement provided by the community college system. While on-line programs for RNs to earn their BSN have seen a significant increase over the last decade, generic-based BSN programs continue to reject large numbers of qualified applicants due to a lack of faculty and the limited number of clinical sites available for training.

Nursing educational organizations are ignoring calls to “back-burner” the BSN entry requirement and are continuing to advocate for it. If blogging sites such as allnurses.com are any indication, practicing nurses have varied positions, with arguments for and against the requirement passionately presented. Many in favor see it as the path to true professionalism, and point out the benefits achieved by physical therapy after it mandated BS entry. Many opposed are infuriated with being characterized as technicians when their clinical skills are as competent as those with a BSN. Hospital systems offer little, if any, pay difference for the BSN title, although there is some movement to require the BSN for management positions. Even so, executives who fill senior nursing positions value the Masters of Business Administration (MBA) degree more highly than the Masters of Science in Nursing (MSN). The Veterans Administration (VA) system, which has required the BSN since the 1990s, also bases pay grades on educational level, in stark contrast to most health care facilities and systems. Only two states have mandated BSN entry, and neither have a sizable nursing workforce (North Dakota has 6,000 nurses and Minnesota has 60,214 as reported by the U.S. Department of Health and Human Services in 2004. This same report estimates there are 2.9 million nurses in the U.S.). Currently, there is legislation proposed to institute a BSN requirement in New York (with 2.2 million nurses), but the

SEIU, which represents 17,000 of these nurses, “firmly rejects any bill that would limit entry into or maintenance of practice to the BSN...” (SEIU, n.d.). More battle lines being drawn.

There is a recent history of collective nursing activism both inside and outside of the U.S., and even outside of union direction. In 1997, the New York State Nurses Association launched a public media campaign entitled “Every patient deserves a nurse” in response to the replacement of bedside nurses with non-nurses. The campaign included bumper stickers, billboards, and the utilization of other public media. Patients admitted to New York City hospitals were directed to ask if an RN would care for them. Public support mounted and the industry backed down under this pressure. Though these nurses had mounted a successful campaign, no national effort to protest industry re-structuring emerged.

On June 26th, 1999, 17,000 nurses in Quebec walked off the job, demanding a new contract with the government and by July 2nd, the National Assembly passed two laws ordering an end to the strike. The public support that the nurses received on the picket lines in Montreal was not to support their political goals, however (Whitton, 1999). The demands of the Quebec nurses never took hold across Canada, and the nursing political cohesion seen during the strike remained confined to Quebec.

The Massachusetts Nursing Association also has been very aggressive in its political activism, strongly supporting a universal health care package for the citizens of Massachusetts, and recently proposing state legislation to mandate staffing levels. With the assistance of the CNA/NNOC, Ohio has introduced legislation that would mandate staffing ratios. The movement for unionization in health care has been extremely

difficult in non-union states, and in Texas, only in 2010 did the CNA/NNOC have its first union vote win in Houston. CNA/NNOC is working to introduce the Texas Hospital Patient Protection Act of 2009 that will establish statewide set ratios, protect nurse whistleblowers, and protect the historic position of RNs as patient advocates. Maine is a state where the NNOC has made some inroads, and the Maine State Nurses Association (MSNA/NNOC) has developed community education programs explaining why patient concerns are important to patient safety. On August 9, 2008, nurses in Cook County (Illinois) rode NNOC floats during the Bud Billiken back-to-school parade, the nation's largest African-American parade. At the CNA/NNOC information booth, school age children received school supplies collected by the nurses and placed in CNA/NNOC bags.

Such is the current state of nursing activism. The CNA/NNOC is gaining ground in a methodical and apparently well thought out strategic plan. At the start of 2008, the organization began meetings in Florida, and by September, holding formal training sessions around the state. According to the CNA/NNOC representative at one meeting, the response from their mailings has been higher than when they first started in Texas. Despite the recent marketing of their 1993 Safe Staffing Initiative, the ANA efforts fall far short of mandating RN staffing ratios, calling once again on nurse administrators to ensure safe staffing. These administrators, however, have little if any control over their staffing ratios. If they are members of the AONE, they are opposed diametrically both to mandated levels *and* nursing organizations with workplace advocacy affiliations.

If one accepts the definition of insanity as doing the same thing over and over again and expecting different results, then entrenched nursing leadership over the last 40 years could be classified as paranoid schizophrenic. By all evidence, it appears that these bedside nursing organizations are beginning to collect the membership numbers in order to become significant players not only in their state governments, but nationally as well. The CNA, with its national expansion via the NNOC, is showing increased signs of becoming the dominant nursing organization within the next two to three years.

Assuming even a modest presence in Florida over the next year or so, the CNA/NNOC could easily take over the Florida Nurses Association (FNA) by infusing members into the FNA and voting in their own NNOC affiliated officers. In the 2000 FNA election, for example, only 2,400 members voted, thus showing the organization's vulnerability to a takeover. With 190,000 nurses and an openly hostile nursing administrative history, Florida, in spite of its Right-to-Work status, would provide a rich reservoir of both unionization activity and membership for the CNA/NNOC. The UAN, with its increasing insistence on fixed ratios and union radicalism, is distancing itself farther and farther from the mainstream ANA. Despite this, however, the UAN is not showing enough of an increase in numbers since its inception to demonstrate true growth. The most recent ANA convention saw the dissolution of the UAN ANA affiliation agreement, with the UAN now in a position to affiliate with any group and technically re-create itself as an independent organization. It did this, in fact, at the end of 2009 by affiliating with the NNU.

Political Nursing Associations and Organizations

In 2002, the president of the American Association of Critical-Care Nurses (AACN), during a talk to a group of nurses in Florida in which some questions related to staffing ratios in critical care units were raised, informed the audience that the AACN was *not* a political organization and would not advocate politically for fixed ratios. This statement was, of course, preposterous, given the mission statement and vision of the AACN:

Mission: Patients and their families rely on nurse's at the most vulnerable times of their lives. Acute and critical care nurses rely on AACN for expert knowledge and the influence to fulfill their promise to patients and their families. AACN drives excellence because nothing less is acceptable.

Vision: AACN is dedicated to creating a healthcare system driven by the needs of patients and families where acute and critical care nurses make their optimal contribution.

At best, the mission statement is vague, but the vision statement calls for a politically engaged organization actively participating in state and national political discussions. One might argue, however, that the mission statement is also a call for political engagement, since it mandates a drive to excellence and influence in the clinical arena, which is a domain largely controlled by private hospitals, and corporate chains.

The proposed position by many nursing associations and organizations of political neutrality is a major impediment to the profession of nursing both in accessing and in sustaining a presence in the national debate on healthcare reform. Malone, Chaffee, and Wachter (Mason et al., 2007) discuss additional barriers preventing

nursing from becoming a political force, including a lack of focus (politically) on core issues and the free rider problem. These authors contend that nursing organizations suffer from having disparate political positions on core issues as they relate to multiple educational levels, increasing specialization, and the fragmented image of nursing. Many unions with open shop agreements face the free rider problem, where a limited number of members pay dues and perform the work required to extract benefits. In an open shop, however, all in the profession gain, so there is less incentive to become a member. The authors further report that the ANA responded to this challenge in 2000 with the creation of the Futures Task Force. In an attempt to create a unique political niche for nursing, the task force identified five core issues: appropriate staffing, workplace health and safety, patient safety and advocacy, workplace rights, and continued competency.

In 1999, the Institute of Medicine (IOM) issued a report describing the tremendous impact of medical errors on the health care system and preventable deaths of between 45,000 and 90,000 Americans each year. This report has been instrumental in bringing about reforms within the current administrative environment as well as the clinical practice arena. The response from the industry has been a call for a climate of safety, although once again, each facility continues to define what it considers safety issues. Systemically, this has not included a call for stricter staffing ratios. There is increasing pressure to focus on evidence-based practice in the clinical practice environment, in nursing and in medicine. Since the core missions of specialty organizations involve setting professional certifications and standards of practice, these organizations should be empowered by this move. However, they remain outside of

decision-making circles, and therefore are unable to mandate reforms or regulate practice environments. There has been, and continues to be, a disregard for the studies documenting safety improvements resulting from improved staffing ratios. Perhaps the mandate for evidence-based practice does not apply to the administrative teams that actually control the practice environments.

While the AACN purports to represent the 500,000 nurses who work in a critical care environment, their membership figures are not readily available. The ANA, for example, projects itself to be *the* voice for the 2.7 million nurses in the United States, but actual membership figures are around 152,000, or less than 6% of nurses.

According to its web site, the AONE represents around 5,000 administrative nurses. The American Academy of Nursing (AAN), an invitation-only honor society within the ANA, has approximately 1,000 members. The National League for Nursing (NLN), which emerged as the major force in nursing education in 1952, offers faculty development programs, networking opportunities, testing and assessment, nursing research grants, and public policy initiatives to its 20,000 individual and 1,100 institutional members. The American Association of Colleges of Nursing (the other AACN), which represents about 600 nursing programs, is the national voice for America's baccalaureate and higher degree nursing education programs. AACN's educational, research, governmental advocacy, data collection, publication, and other programs work to: establish quality standards for bachelor's and graduate degree nursing education; to assist deans and directors with implementing those standards; to influence the nursing profession with improving health care; and to promote public

support of baccalaureate and graduate education, research, and practice in nursing. The relationship between the NLN and the AACN is unclear.

The vast majority of the remaining 100 or so national nursing organizations are specialty associations, with small membership numbers and focused priorities. These groups represent a variety of specialties, including oncology nurses, rehabilitation nurses, nurse anesthetists, nurse mid-wives, pediatric nurses, legal nurse consultants, psychiatric nurses, African-American nurses, male nurses, etc. While these organizations are important to specific fields within nursing, their ability to contribute both financially and politically to a national movement are limited. With so many small specialty organizations in nursing, coalitions are the only possible means of orchestrating a national presence. Even with coalitions, however, the number of nurses who would mobilize for a political effort is small, and more importantly, the money raised to support a national effort is significantly less than any competing forces.

There are very few nursing organizations with a political focus, and of those, none are considered effective. For its part, the AONE is merely a political puppet of the AHA, functioning as a nursing control mechanism by helping the AHA control the nursing labor force. It has opposed, and continues to oppose, major workplace reforms that practicing nurses consider vital. For example, the AONE opposes any collective bargaining that is independent from administrative oversight. It contributes openly to the dissemination of propaganda that opposes the staffing ratio issue, and is waging a campaign using pseudo-academic studies to discredit the ratio law in California. At the same time, however, it has deluded itself into thinking that through its referent and connective power it has positioned nursing as a major player in the national healthcare

debate. After health care reform initiated under President Clinton and opposed by AONE was defeated, nursing resumed its position of political obscurity, with the exception of the movement by the CNA/NNOC and some state associations to pursue a vigorous campaign to address single payer health insurance and bedside nursing issues. Only the California group initiated a national campaign.

For its part, although the ANA has had a political presence since the 1970s, it has not been effective in changing public perception of nursing as a subservient semi-profession to that of a true political visionary. There has been no actualization of the bold ANA position statements of the 1970's. The ANA is consulted readily by Congress and others on issues directly related to nursing, such as nursing shortages or the advanced practice debate, but it is rarely, if ever, consulted on the more central issues of healthcare restructuring or healthcare financing. With its low membership, the organization is not in a financial position to compete with the lobbying efforts of such notables as the American Hospital Association, the American Medical Association, and the pharmaceutical industry (Big-Pharma), or with the numerous peripheral corporate interests that dominate the political discussion with their enormous contributions to both House and Senate members.

All of this helps explain the polarization of the healthcare into two camps. On the one hand, we have the liberal position of universal healthcare for all citizens, financed by a national healthcare insurance system much like Medicare. This is the position advocated by the CNA/NNOC, the Massachusetts's Nursing Association, most trade unions, and others. The opposing conservative position believes that the free-market will evolve to handle the issues of access, equity, cost, and distribution once

there is no government interference. Given the increasing impact of healthcare costs on the GDP, personal bankruptcies, and corporate profits, this latter position may become modified or even become politically untenable, particularly in light of the current chaos in the financial sector, and many consider a lack of oversight as a major contributor to the collapse. There is a crisis in healthcare, a crisis forewarned by the Assistant Director of the U.S. Government Accountability Office (GAO) in his description of the looming Medicare and healthcare crisis as the elephant-in-the-room during the Congressional debates on Social Security reform in 2004.

So where is nursing positioned within the growing political polarization? After the conservative takeover of the House of Representatives in 1994, and with the subsequent defeat of the Clinton health care restructuring initiatives, nursing organizations favoring some form of national healthcare have found themselves in the political minority, opposed by those who favor deregulation and the free market. As is now known, the K Street group, whose regular customers included the AHA, big-Pharma, and other healthcare industry heavy weights, were increasingly controlling political lobbying. Nursing (sic) once again found itself in the position of reacting to events rather than initiating a political agenda of its own. Hospital systems increasingly looked at their nursing staffs as overhead instead of active participants in increasing profits. Ignoring the growing body of work showing increased profits are associated with better patient outcomes, the industry models of employer-employee, management-only reward for performance, and micromanagement of staffing levels dominates many health care facilities. These issues are readily apparent in the results of the limited number of national nursing surveys done to date.

In 2004, the ANA conducted a national survey of nurses. This sampling of 76,000 RNs has provided some insight into the working world of nurses from around the country. The survey revealed some interesting information. RNs “as a total group reported being highly satisfied in regards to interactions with other RN’s, their professional status, and professional development opportunities,” but only moderate satisfaction with “all other aspects of the respondents’ jobs, including nursing management, nursing administration, interactions with doctors, and their own level of autonomy” (*ANA Nursing World*, 2005). Not surprisingly, job satisfaction varied depending on the area of practice, with maternal-newborn and pediatric nurses reporting the highest satisfaction, and emergency room, medical-surgical, and step-down RNs the lowest. The information provided by this survey supports discussions on nursing blog sites that while RNs love their work, they do not like the administrative decisions regarding their caseload, pay, human resource allocation, and institutional power. Furthermore, they do not trust that their own management systems can remedy the situation.

Summary

The success of the CNA/NNOC movement *may* be attributable to the fact that the focus of the ratio initiatives and the union agreements achieved under their direction deal directly, *and in specifics*, with the core issues revealed in the national surveys. The refusal of the ANA to support the California ratio laws on a national level has continued to isolate the ANA both from its own labor arm (the UAN) and from a large portion of its actual and potential membership. The ANA’s Safe Staffing Campaign simply does not go far enough and continues to leave the decisions in the hands of facility

administrators. To paraphrase James Madison, experience has taught (bedside) nurses the need for auxiliary precautions.

The upcoming Congressional election of 2010, and the Presidential election in 2012, will determine, to a large degree, the history of nursing for years to come. A Republican victory will continue the anti-labor initiatives that have been politically motivated over the last 14 years, and which date back to the Reagan administration. The AONE and the increasingly isolated but historically significant ANA soon may find themselves the most politically effective nursing organizations, since both speak with a muted voice when it comes to the problems. Why the AACN, since its inception in 1969, has not initiated a national movement to implement the critical care ratio laws that California has had since 1975 is anyone's guess. Of course, we must remember that the AACN is not a political organization. Labor groups increasingly will find the regulations from the NLRB changing, more responsive to the industry agenda.

The election of Senator Obama to the Presidency in November 2008 created a Democrat led Executive Branch. Combined with a Democrat majority in Congress, it should have opened the door for nursing to actualize both a more vital and a more directive role in the shaping of national health care policy. While the restructuring of the healthcare financial system initially may be delayed due to the current economic crisis and political stonewalling, it eventually must be addressed because it impacts directly both personal and corporate income. Almost nothing was said in the national healthcare debate of 2009 about what must be considered the *inevitable* restructuring of the delivery system, given the tremendous disparity between what the American healthcare system was designed to do and what it is in fact being mandated to do. This

political discussion needs to begin soon, providing a potential political opportunity for a visionary and growing nursing group, who has political experience and knows how to recruit and mobilize public support, to emerge as a national nursing leader.

As Medicare increasingly focuses on patient safety and patient outcomes, another potential ally for nursing is emerging. One can well imagine that an empowered Medicare may soon acknowledge the increasing body of research supporting the ratios and begin to mandate set ratios according to the California initiative. These ratios are time tested, from their initial political victory, the extensive time under review by the California Department of Health, and its survival of the assault by the AHA/Governor of California. If evidence based practice becomes a systemic mandate, regulations involving standardized documentation, patient identification, and pharmaceutical distribution systems, as well as interdisciplinary communication protocols, will follow shortly afterwards.

Medicare also is central to another nursing issue, one that may open the door to a part of the very restructuring that is so desperately required. That issue involves the removal from Title VIII of The Social Security Act of the insistence for collaboration for Nurse Practitioners. The following changes are recommended:

1. That the term “physician” be replaced with the term “primary care provider” (PCP) throughout the entire document of Title XVIII with the following exceptions:
 - a. When the term physician refers to any specialty service, such as those services performed by surgeons, not identified with primary

care services, or where law requires that only a physician perform the procedures.

- b. In section 1848 [42 U.S.C. 1395w-4], where the payment schedule for services is based on physician reimbursement. This remains the benchmark for establishing Medicare reimbursement for practitioners. Nurse practitioner reimbursement already is established in P.L. 105-33, Section 4511 Subchapter B as 85% of physician billed services. No changes to this are proposed.
2. The term primary care provider (PCP), as defined in this amendment, shall include all primary care practitioners independently capable of billing Medicare for services rendered. These include medical doctors, doctors of osteopathic medicine, naturalopaths, nurse practitioners, and other practitioners so defined to legally practice independent primary care treatments.
3. Nurse practitioner shall refer to those advanced practice nurses who possess at least a Masters degree and have national certification from an acceptable national accrediting agency.

The passage of these amendments would have a profound effect of giving millions of Americans access to primary care services. Urban areas, in particular, could benefit from a Lillian Wald model of interdisciplinary community based health services. Nursing models for the delivery of health services to rural areas also date back to the 1800s. There is a wealth of nursing research, largely ignored by the profit-oriented healthcare systems, dealing with the prevention of illness, medical, nutrition, and

hygiene education, and the delivery of direct health services to rural communities.

Pregnancy issues, including prenatal care, were an integral part of the early nursing sociopolitical movement, and should become so again. This issue has the best chance of igniting the switch under the politically active national nursing movement, but to date is not being addressed by the CNA.

The following news story published by *U.S. News and World Report* details an awareness of the problems, and an indictment of our current delivery model:

Byline: Michelle Andrews

Dying before your time is bad enough. Dying from something like heart disease, diabetes, treatable cancer, or a bacterial infection that never should have killed you is worse. Yet a new study finds that the United States ranks last among industrialized countries when it comes to such preventable deaths and that our performance actually got worse instead of better over a five-year period.

The study examined preventable deaths before age 75 in 19 industrialized countries in 2002-2003 and compared them with preventable deaths five years earlier. Death was considered preventable in the study if it should not have occurred with timely and effective healthcare. (*U.S. News and World Report*, 2008)

These statistics, given the 2+ TRILLION dollars spent annually on healthcare in the United States, constitute a gross failure on the part of the health care system. If a fully loaded 747 jet airliner were crashing on a daily basis in the U.S., which is roughly the equivalent of the 90,000 ceiling of preventable deaths in American Hospitals as estimated by the Institute of Medicine Report cited earlier, how long would it take before public pressure mandated congressional investigation and action? Where is the

public outrage? Once again, we see a political opportunity for an engaged and supported nursing organization to mount a public pressure campaign to support the nursing alternative vision for restructuring the healthcare delivery model, if only there was one. Nursing, with the sole exception of the CNA, has been both unwilling and unable to take on either the free-market dominated mess we have, or even come close to matching the political influence which the industry can bring to bear on vital issues. In California, the CNA took on both at the same time . . . and won.

CHAPTER 3

RESEARCH METHODS

Research Design

The research design in this study is straightforward. Twenty three of the past and current CNA leaders were sent email questionnaires, consenting to the study with their responses. The research questions investigate why the CNA was chosen as the vehicle for this nursing movement, how and why strategic moves within the CNA occurred, how the CNA was able to motivate both peer support and public support for their legislative actions, what political developments led to the formation of the NNOC. It also asks for their vision of the future role of the CNA/NNOC within the broader context of the profession of nursing.

The resolute position for a national health care initiative (a single payer system) advocated by the CNA/NNOC changes their primary orientation as a nursing labor organization into one of a nationally organized political advocacy group. Similarly, their increasing membership and potential growth surpassing that of the ANA may soon place them in the position of being the dominant national political voice for nursing as a profession. This empowerment could alter radically both the state and national policy debates. This study is essential for nurses who wish to learn more about unionization, the history of the most politically successful nursing organization for at least the past 30 years, or who wish their organizations to become politically empowered.

This study also will serve nursing academia, which, for all practical purposes, has ignored this movement. It may provide nursing professors with a tool for educating future nurses on one model for achieving political empowerment, and potentially could open up academic debate about what nursing leadership means and what a nursing led healthcare system would look like. Academics from other specialties such as political science, organizational studies, gender studies, sociology, and even industrial psychology, may learn from examining an emerging political presence into one of the most serious policy debates the United States will have in the next few years. Finally, this study may encourage the nursing profession to examine critically its political structure, its strategies for political actualization, and the pressing need for a more engaged nursing profession in the public domain and in the health policy debate.

Methodology

This study is a case study of a sub-culture within a sub-culture. There also is a comparative quality to the study, both in terms of the historical perspective of the CNA/NNOC's ties to nursing's activist roots and in terms of the CNA/NNOC's radical, but successful, departure from the nursing establishment. In particular, the CNA/NNOC growth pattern is compared to the growth patterns of other nursing organizations.

Robert K. Yin, in the preface to his 2003 book *Case Study Research: Design and Methods*, notes that the case study has been, and continues to be, categorized as a weak methodology among social science researchers. He goes on to suggest that researchers who utilize case studies are regarded by their peers as having downgraded their academic disciplines. He provides a warning to researchers who are anticipating

the use of, or already using, the case study methodology: “Do case studies, but do them with the understanding that your methods will be challenged from rational (and irrational) perspectives, and that the insights resulting from your case studies may be underappreciated” (Yin, 2003, p. xiii).

In spite of this positioning, Yin notes the case study methodology continues to be used extensively in the social sciences, from active research by distinguished academics to research at the thesis and dissertation levels. He also cites the increasing use of case studies by “practice-oriented fields such as urban planning, public administration, public policy, management science, social work, and education” (p. xiii). According to Yin, the case study method is becoming the preferred method of the U.S. Federal Government. The nursing community of researchers has used qualitative research, including case study, for a long time, although not without some controversy.

In his book, Yin proposes that the stereotype of the case study methodology is inaccurate, and that its strengths and weaknesses have been misunderstood. He essentially disentangles case study as a research tool from (a) the case study as a teaching tool, (b) ethnographies and participant-observation, and (c) qualitative methods, providing the case study methodology with a renewed and vigorous sense of appropriateness within the research methodology world.

Bergen and White (*Journal of Advanced Nursing*, 2000), while noting that the case study has become an acceptable research vehicle in many disciplines, nevertheless caution that researchers need to provide four main areas of clarification:

1. The definition of what is meant by *case* in the study. What is the context for the phenomena being studied, the limits to what constitutes the case, what

control the author has over defining the case, and the unit-analysis being utilized in the study.

2. What tactics are used for external validity? They suggest Yin's concept of replication logic, which involves generalizing to theory rather than empirical data.
3. The use of method triangulation (i.e., using multiple types of data collection) for construct validity.
4. The relationship of the case study to theory construction, through the prior development of propositions.

It is the author's belief that all four criteria are evident in this study. First, there is little doubt that the CNA, in and of itself, and with or without the NNOC expansion, would constitute a case for the study of how a nursing organization can impact health policy at the state level. Second, the results of this study basically can *only* be applied to theory since there is no actual political nursing organization that can claim outright ownership of the voice of professional nursing. Third, interview data will be verified horizontally by comparison to other interviewees, as well as to historical records and documented actions. Finally, this study may lead to the development of a more comprehensive nursing theory that not only maintains the almost sacred trust between the client and the nurse, but also includes an obligation to the public to fulfill Lillian Wald's vision of a profession that *knows and tells*.

This study also may fall under the rubric of *critical reflexivity*, which Donna Freshwater (*Nursing Times Research*, 2001) described as a political and ethical methodology for applied nursing research. Freshwater acknowledges that the split

between research knowledge and practice knowledge, long the practice of traditional interpretations of research in nursing, simply does not make sense. For example, until the summer of 2006, this author was, for the most part, a practicing ER nurse at the staff level. Combining the roles of graduate nurse, researcher, and triage nurse allowed for a rather close examination not only of nursing concerns, but of social concerns as well. This unique perspective needs to be developed; however, the proprietary control of employees by agencies does not allow for independent research. The protection offered by the organizational level may well afford nursing a means for beginning to “know,” while the empowered organization also can become the means to “tell.”

Part of the significance of this study may be to open up among nursing scholars a critical self-reflection, what Peter M. Senge (*The Fifth Discipline*, 2006) considers one of the five essentials for a learning organization, the Mental Models. The “discipline of working with mental models starts with turning the mirror inward; learning to unearth our internal pictures of the world to bring them to the surface and hold them rigorously to scrutiny” (p.8). If nursing is to repair the damage done by its fracturing, it must begin with this discussion. Our only real political power comes with our large numbers, not only within specific medical facilities but also in our society as a whole.

Methods

Where possible, an email-based interview was the preferred method for this study, however some respondents preferred taping the responses. Twenty questions were developed to explore the critical issues for this study. In some instances, it was necessary to use email communication as the only means to reach key participants. All participants were informed of the purpose of the questions, the intended use, and all

consented to the study with their participation. Fortunately, the majority of the original members of the CNA movement still are accessible and active. Firsthand accounts are preferred, but secondhand accounts may be included. It is anticipated that having information provided by multiple participants, representing multiple roles within the organization at the time, will provide a broader context for the responses and avoid simple organizational mythology. Email responses were encouraged for a written record trail, while taped responses were transcribed.

Where possible, the interview data was validated with historical documents, such as meeting minutes or committee reports. Certain events and outcomes are a matter of historical record, however, not theoretical constructs. Another method for validation came from the comparative analysis of the group, one to each other. It was anticipated that, at some point, a saturation point would be reached on some of the questions. Since raw numbers are compared more easily to each other, the comparative data on the various nursing organizations needs little validation, unless we are to dispute the organizations' own statistics. In the appendix, written transcripts of the recorded interviews are available to provide the reader with no doubt as to the "speaker's" intent.

The intent of this study is not to present the views of every nursing interest regarding this movement; that task is left to others.

Question Selection

The twenty questions asked can be classified broadly as falling into three main historical periods. The first period is the time leading up to the disenfranchisement of the CNA from the ANA. The second period is the time after the disenfranchisement up to the time the CNA began the national movement with the formation of the NNOC.

Last, but not least, is the time from the NNOC creation to the present time, which now includes, but which did not at the time of the study, the formation of the NNU. Each of these periods had unique obstacles to overcome and strategies to employ. At each challenge, the CNA was able to emerge victorious. The CNA presents a blueprint for political success for other groups of nurses, particularly bedside care nurses, who wish to join in this struggle, and who may feel alienated in their respective organizations.

Another goal of the study was to provide an introduction to the CNA, allowing other nurses to meet the CNA leadership, both historically and presently. Who are these people who are leading the fastest growing political presence in the field of nursing, both within the context of state practice as well as nationally? What are their intentions, what are their backgrounds, what are their stories? These responses to the questions will provide at least some insight into these issues, particularly given the pernicious mythology of the CNA as just a union; pernicious at least to those nurses who see unionization as beneath nursing.

Questions 1 through 4 deal with the period leading up to the disenfranchisement from the ANA. Question 1 establishes the credibility of the respondents, presenting their respective enlistment dates and their positions within the organization. Question 2 deals with the origin of the idea to split off from the ANA. Question 3 looks at why these “rebels” chose to maintain an identity as CNA nurses, as opposed to starting a new group, thus avoiding a battle with the entrenched power of the ANA. Question 4 discusses the strategies for the disenfranchisement from the ANA, a blueprint for the political takeover of an organization.

In terms of theory, questions 2 to 4 also depict the emergence of an open systems organization. The new CNA reestablished the throughput of information from the work unit to the leadership, and practicing bedside nurses remain in the leadership positions. CNA leadership then used the information to take appropriate actions, and action and events controlled the organizational identity as opposed to policies and structures. They began the process of coding the information, educating members on the key issues and strategies. There was a re-definition of the shared norms and values, recognizing and embracing equifinality. Here to we see the movement away from an attempt to gain power by association (Hagberg Step 2), which had long mired the ANA, and a movement towards power by purpose (Hagberg Step 5)

Question 5 begins the look at the period after the split from the ANA. How did they grow the organization within California? As noted earlier, membership numbers for the majority of nursing organizations are pitiful. If money is political power, which it is, then nursing organizations MUST look at membership as a measure of political power, field relevancy, and organizational effectiveness. Question 7 asks the respondents to reflect on the financial picture during the early days, and the means used to make-do during times of limited resources, which is a common situation with most nursing organizations. Question 6 explores how these leaders could begin a process of passing state laws while simultaneously having to build back membership numbers and fight off a variety of personal and legal attacks from the now disenfranchised ANA stalwarts. Question 8 looks at political tactics used to enact the ratio laws while question 9 asks about the obstacles taken on by the CNA. Question 10 solicits CNA

respondent views on how other state associations could enact similar legislation in their states.

Questions 6 to 10 further demonstrate to movement towards an open systems model. The CNA began to draw its energy from the outside, forming alliances with a variety of supportive organizations (though not necessarily major ones), as well as directly from the public. They moved away from the negative entropy which dominated the ANA controlled organization, and continued to use events and actions to identify themselves, solidify their norms and values, and they began to grow their sphere of influence. This was a move from Step 5 of the Hagberg model to Step 3, power by achievement. As the organization increased its membership through additional contracts, it began to have success within the legislative process, leading up to the passage and signing of the ration bill.

Question 11 deals with the CNA response to a vigorous fight against the ratio law mounted by an extremely popular governor, backed by what some political observers feel is the biggest and most financially influential lobbying group in healthcare, the AHA. There is no doubt that the ratio law, since its inception, had been very unpopular with the AHA. While many nursing associations have trouble overcoming even one major player, such as overcoming the AMA opposition to NP practice, the CNA had the “Governator,” the AHA, the AONE, and the ANA-California group positioned against it in a heated legal battle. Even after what some observers note is an extraordinary period of administrative review that lasted four years! In the responses, we witness the CNA executing a brilliant legal strategy that eventually resulted in an upset victory. There are lessons here for many of the nursing issues,

including advanced practice issues such as prescriptive authority and independent practice. This was a true David and Goliath legal battle waged using a full spectrum of legal maneuvers and public spectacles. With the open systems organization firmly entrenched, the CNA gained true power of achievement, and the ratio law was fully enacted.

Questions 12, 13, 14, and 15 deal with the original need for the NNOC, the creation of the NNOC, and the ongoing evolution of the NNOC. Why did the CNA feel the need to reach out in a structured, organized way to nurses around the country? What is their motivation? Is this a union organizing strategy, or a tapping into the pent up frustration of nurses? How can a group of union-minded California nurses persuade other nurses, who generally are typically apolitical and almost fearful to join up, to take on their facilities and state legislatures, and enact similar legislation? This was a period of rapid growth for the CNA, expanding their sphere of influence and opening up more energy from the outside. They began to associate with other nursing organizations around the country as they moved into other states, at least with those who shared their norms and values (Power of Association). They achieved true power by wisdom as they became an invaluable and authoritative political voice to the California legislature.

Question 16 deals with the vision CNA members have for the “localization” of the CNA/NNOC (now the NNU) along the political spectrum we know as nursing. How do CNA members anticipate their emerging role as THE leader and spokesperson (at least politically) for the bedside nurse? What impact do the respondents envision the emergence of their organization will have on the existing political powers within nursing, the ANA and the AONE? Question 17 looks at the other force in nursing, the

academics. As far as the respondents are aware, what has been the response of this community to the increasing political power and representational authority of the CNA/NNOC? Question 18 asks the respondents to present how nursing administrators have responded to the CNA and the NNOC, particularly through their main organization, the AONE.

Question 19 attempts to present the views of the respondents on how nurses around the country can best support the efforts of the CNA. If, as is anticipated, the goals and values of the CNA are tapping into the previously ignored core issues of bedside nurses, then a large number of nurses should be willing to support the efforts of the CNA, even if direct unionization is unlikely at their facilities. What can bedside nurses do to assist this organization in its efforts? Finally, question 20 asks the respondents for their views on how a politically empowered CNA/NNOC will impact national health care policy. The CNA/NNOC is ALREADY a major political force in healthcare, but only in California. In recent years, this has been steadily increasing outside of California with the affiliations of Maine, Pennsylvania, and Massachusetts. How do the respondents see this increasing national presence impacting the national healthcare debate and healthcare policy in the U.S. in general?

CHAPTER 4

INTERVIEWS

Participant Selection

As noted previously, the participants of the email questionnaire were selected from past and present leaders of the CNA/NNOC, as supplied by the CNA itself. Since the respondents had the option of anonymity, no specific respondent names are included in the study. Table 1 shows the list of names, based on the known 2007 – 2009 leadership.

Table 1

Past and Present Leaders of CNA/NNOC

OFFICERS	
Council of Presidents:	
Deborah Burger, RN	Kaiser Santa Rosa, Diabetes Educator (1999)
Geri Jenkins, RN	UC San Diego, Step-Down ICU (1999)
Malinda Markowitz, RN	Good Samaritan, San Jose Surgical/Oncology (1999)
Zenel Triunfo-Cortez, RN	Kaiser South San Francisco, PACU (1993)
Treasurer:	
Martha Kuhl RN	Childrens Hospital Oakland, Hematology/Oncology (1993)
Secretary:	
Jan Rodolfo RN	Alta Bates Summit Medical Center, Oncology (2005)
Board of Directors:	
Region 1:	
Veronica Rocha RN	San Gabriel Valley Medical Center, Health Education (2007)
Region 2:	
Janice Webb RN	UC San Diego (2005)

OFFICERS	
Region 3:	
Sherri Stoddard RN	Sierra Vista Medical Center San Luis Obispo, Labor & Delivery (2001)
Region 4:	
Carol Koelle RN	St. Bernadine Medical Center, Telemetry/DOU (2007)
Region 5a:	
Christina Swift RN	Kaiser Fresno, Medical Surgical (2007)
Region 5b:	
Bonnie Martin RNP	Kaiser Stockton, Geriatric Medicine (2003)
Region 6a:	
Kathy Daniel RN	UCLA, Home Health (1995)
Region 6b:	
Debbie Cuaresma RN	St. Vincent Medical Center Los Angeles, Cardiac Surgical (2007)
Region 7:	
Margie Keenan RN	Long Beach Memorial Medical Center, CCU (2002)
Region 8a:	
David Welch RN	Enloe Medical Center Chico, Cardiac Rehab (2003)
Region 8b:	
Elizabeth Pataki RN	Mercy General, Cardiac Surgical (2003)
Region 8c:	
Cathy Kennedy RN	Kaiser Sacramento, NICU (2006)
Region 9a:	
Lauri Hoagland RN	Kaiser Napa, Medicine Clinic (2005)
Region 9b:	
Martha Kaufman RN	Kaiser Vallejo, Health Education (2006)
Region 9c:	
Trande Phillips RN	Kaiser Walnut Creek, Pediatrics (1993)
Region 9d:	
Kathy Donahue RN	St. Joseph Hospital Eureka, ICU/CCU (2005)
Region 10a:	
John Trites RN	Good Samaritan San Jose, Psychiatry (2007)
Region 10b:	
Greg Miller RN	Kaiser Santa Clara, Medical Surgical (1993)
Region 10c:	
Lorna Grundeman RN	Dominican Hospital Santa Cruz, ICU (2007)

OFFICERS	
Region 11a:	
Robert Marth Jr. RN	Kaiser Hayward, Critical Care (1995)
Region 11b:	
Alicia Torres RN	Alta Bates Summit Medical Center, Oncology (2007)
Region 11c:	
Michelle Gutierrez-Vo RN	Kaiser Fremont, Medicine (2006)
Region 12a:	
Allen Fitzpatrick RN	St. Mary's Medical Center, MICU (1995)
Region 12b:	
Genel Morgan RN	Mills-Peninsula, CCU (1998)
Region 12c:	
Diane Koorsones RN	Kaiser South San Francisco, Medical Surgical (2005)
Region 12d:	
Maureen Dugan RN	UC San Francisco, Medical Surgical (2005)
Region 13:	
Brenda Langford RN	Oak Forest Hospital of Cook County, Cook County Bureau of Health Services, Illinois; Telemetry (2007)
Region 14:	
Maureen Caristi RN	Eastern Maine Medical Center Bangor, Respiratory (2006); Maine State Nurses Association/CNA/NNOC
PASNAP:	
Patricia Eakin RN	Temple University Hospital Philadelphia Pennsylvania, ER (2008)
Executive Director, CNA/NNOC:	
Rose Ann DeMoro	
Other:	
Lucia Hwang	Editor <i>Registered Nurse</i> The CNA/NNOC Journal of Patient Advocacy (CNA)
Hedy Dumpel, RN JD	Chief Director of Nursing Practice and Patient Advocacy (CNA)

Summary and Analysis of Interview Data

“The power of story is never stronger than when it lives on the breath of those from whom it came” (Gayle Ross, Cherokee storyteller).

Question 1. When did your association with the California Nurses

Association begin, and what was your level of involvement at the time? Fourteen of the members started working with CNA before the time of the staff nurse rebellion and before the disaffiliation from the ANA. Only one of the respondents started after these events (in 1997) and the impetus for increased involvement with CNA was, in this case, a direct response to the restructuring efforts at the facility that employed them. Four of the respondents started their affiliation with CNA during the period immediately preceding the staff nurse rebellion (1992 - 1993), but none of these respondents were nurses.

This validation of the respondents as actual participants is critical to this study. While not all respondents were in leadership positions from the beginning, some were, and the big picture perspective provides for a better understanding of this organization. Thus, respondents had varying degrees of depth to their responses to any particular question depending on their level of engagement at the time. Interestingly, the majority of the respondents did not begin their association with the CNA as hardcore unionists. In fact, most joined as a mere consequence of their employment, and then entrained into their activist positions by mentors or direct employment experiences such as the restructuring efforts of the industry, a strike at their facility, or the shared vision for a national healthcare system.

Another reason why the first hand accounts are so valuable is that they provide multiple perspectives on the events and avoid the mere repetition of organizational mythology. By soliciting the information from actual participants, a depth is provided that can allow other nursing organizations to see themselves in their current political

state, not just present an idealized vision. What were the issues that the CNA were addressing that inspired this level of commitment from so many nurses, nurses who historically do not belong to or support their professional organizations? Why was this organization able to tap into a vision on the part of bedside nurses?

Question 2. When did the original idea for the disenfranchisement of the CNA from the ANA begin taking off, and why? As several of the respondents noted, the disaffiliation from the ANA was not the major event that occurred in the CNA. According to the respondents, the disaffiliation was more of an inevitable consequence as the nursing union portion of the CNA grappled with what it perceived to be the lack of respect and interference by the ANA-dominated Board and executive committee of the CNA. The firing of the E&GW personnel in December of 1992 was the final straw in a long battle between these groups. The subsequent campaign with the direct care slate, which ended up becoming the majority of the Board of Directors in June of 1993, paved the way for the reforms that direct care nurses felt were long overdue. As many of the respondents noted, they had long tried to work with both the CNA and the ANA.

One of the respondents noted that these issues had begun as far back as 1911. The CNA began in 1903, and the reader is reminded that this was the same year the ANA convention was held that affiliated the ANA, and later the AONE, with the AHA. Many of nursing's top leaders opposed this affiliation, but it was carried out in spite of their objections to the subjugation of nursing to the hospital industry. Several key events from the history of CNA support this assertion. In 1937, the *Pacific Journal of Nursing*, a publication from CSNA, supported the idea of unionization for nurses in direct opposition to the ANA position that opposed unionization. In 1938, California nurses

established the first economic security package for nurses, which called for voluntary implementation from the hospitals. In 1943, however, the CNA abandoned the concept of voluntary compliance, and by 1946 the first contracts were enacted. However, these contracts still adopted the ANA position of “no strike.”

In both 1952 and 1955, nurses staged mass resignations at facilities in California since the ANA prohibited striking as a labor tactic. There again were mass resignations by nurses in 1966, but by 1969, the California nurses had had enough and staged the first strikes in the Bay Area, directly opposing the no strike policy of the ANA. In 1974, there was a 21-day strike at 42 northern California hospitals, setting the stage for true collective action by an increasingly organized nursing workforce. In 1975, CNA accomplished what no nursing group has accomplished, even to this day: legislative action that established a 2:1 ratio in the critical care units.

Not every action was successful. In 1982 there was an unsuccessful 90-day strike for comparable pay with male professionals, an action actually supported by the women’s movement, which the reader may recall had largely ignored nurses for most of the 1960s and 1970s. In 1983, the University of California Medical Center nurses joined the CNA, an action involving 4,420 RNs; this was one of the biggest collective actions ever for nurses. In 1986, a 2-year contract was bargained for the nurses of the UC system. The friction between the increasingly organized direct care nurses and the ANA-oriented administrative and academic leadership was becoming palpable. The 1975 Sierra Vista decision had forced the separation of these groups, but the dominance of the organization by the ANA-oriented leadership, and their control of the purse strings, was leading to an inevitable clash.

In 1988, there was a 4-week strike by 2,200 RNs in San Francisco, which resulted in a 21% pay increase for the nurses. Finally, the situation reached a crisis in 1992, and there was a strike for the right to strike in support of each other by 1,700 RNs (and other healthcare workers) that lasted seven weeks at Summit Medical Center in Oakland. This strike received a lot of media attention, resulting in a big win for the union nurses and a headline in the Oakland Tribune that read “UNION POWER.” Both the healthcare industry and the ANA-dominated CNA felt threatened. Over the course of 1992, CNA, under the influence of its labor arm, introduced the first legislation for nurse-to-patient ratios on all units, and held the first workshops on the restructuring initiatives advocated by the industry.

Finally, in December of 1992, the ANA-dominated executives, under the direction of both the ANA and the CHA/AHA according to some, fired the collective bargaining director Rose Ann DeMoro and 12 other E&GW staff in an attempt to stem this rebellion. Also suspended, in 1993, were Kit Costello, Kay McVay, Martha Kuhl, and Marilynne Kenefick, the top four elected officers of the E&GW Congress. In March of 1993, however, a court injunction was issued that reinstated this entire group. This injunction came just in time for the CNA election campaign that resulted in the staff nurse takeover of the Board by an 8 to 7 majority at the House of Delegate (HOD) meeting in June. Many attribute these firings and suspensions, and the subsequent organizing work by the union nurses, as the impetus for both the take-over as well as the disaffiliation.

Three days after the HOD meeting, regions 3, 4, 5, 8, 9, 10, and 12 retained lawyers in an attempt to secede from CNA; they issued illegal severance packages as

well. As the reader will note from the numerous supportive documents listed in the appendices, the new CNA was plagued for several years with legal issues in the attempt to recover property, invalidate costly and illegal contracts, and prevent the secession of several regions. In each case, the new CNA won. Finally, two years after the staff nurse rebellion and the takeover (or take back, as some refer to it) of the CNA, the CNA disaffiliated from the ANA. Of the 20,000 or so nurses in CNA at the time of the disaffiliation, 12,500 went with the new CNA, while 8,000 chose to join the ANA-California, set up by the ANA after it had lost its bid to keep the CNA designation.

Question 3. Why not form “another” association? Why use the CNA?

Overwhelmingly, the answer here was consistent. The CNA was THEIR organization to start with. By even the most conservative estimates, direct care nurses constituted over 90% of the organization, with some respondents placing it at 98%. Union dues were supporting the association, and the facility contracts were with CNA. Finally, after noting the historical information in the previous section, one can see the historic alliance of CNA with the interests of the direct care RNs. Some respondents did note that the idea of forming another organization was discussed, albeit briefly. Finally, the case went to arbitration where the decision was made that the election results were valid, in spite of the unusual activities with the accountant, and the fact that the ANA did not own the nomenclature. The elections in 1995 sealed the deal for the new CNA.

Question 4. Can you discuss the events leading up to the disenfranchisement from a strategic perspective? As one respondent noted, “. . .we were handed an historic opportunity. . . ,” a sentiment that readily is apparent in almost all of the responses. It was the confluence of many events, including the firings and

suspensions, that led to the rebellion in the CNA. Other events, some external to nursing, included:

- the restructuring attempts on the part of the hospital industry;
- the increased organizing momentum of the union;
- the increasing lines of communication between the organizations leadership and bedside RNs; the increasing corporate takeover of the healthcare industry; and
- the increasing sense that the ANA had accepted the industry assault on direct care nurses and was supporting these restructuring efforts.

All of these factors contributed to the awakening and a realization by the staff nurses that change was necessary. The hiring of Rose Ann De Moro, (the General), with her ability to select, mentor, and inspire leadership figures also provided for the perfect storm situation.

It is evident from the responses that it was this perfect storm scenario that resulted in the disaffiliation, not a tactical battle over time. Contributing factors included the Staff Nurse Action Project (SNAP) meetings in the late 1980s, which were the first times that the Kaiser nurses had even gotten together, and the gradual awareness that the ANA-dominated organization would not allow the staff nurses to participate as peers. Following the SNAP meetings, nurses attempted to attend Board meetings, only to meet stiff resistance. They could not serve on the PACs, or even the Practice Committees, in their own organization! As one respondent noted, “The staff nurses were assumed to be less intelligent and less capable of being able to make decisions and to understand the process.” In 1989, they lost, by three votes, the

opportunity to get one staff nurse on the Board of CNA. This was a big motivator for the staff nurses according to the respondents, who were able in the next election (1991), to get one staff nurse on the Board. That staff nurse, however, was banned from some board meetings, and essentially was treated by the rest of the Board and the Executive committee like an unwelcome houseguest.

Some respondents note that there was a tremendous amount of staff nurse education and planning meetings to discuss the organization structure and the direction it should move. Virtually everyone, however, credits the leadership of Rose Ann DeMoro and Martha Kuhl with providing the inspiration to move the organization along, and more importantly, the belief that they actually could accomplish these changes. Other major contributors include the emergence of the communications director, who receives numerous kudos in the responses for his use of the media, and finally, the legal counsel retained by the new CNA, whose use of innovative and controversial, but very effective, tactics allowed the organization to gain the legal victories that it so desperately needed. The papers in the appendices that document the legal updates to the CNA particularly are interesting to read, and provide a great deal of insight into the numerous legal battle fronts. Many respondents credit the legal firm's ability to coordinate these diverse and complicated legal strategies as being nothing less than brilliant.

Question 5. What was the strategic plan for growing the association within California? It is in response to this question that we see real strategy emerging on the part of CNA. Even as they battled on the legal fronts, the CNA leadership stayed focused on the drivers for growth. They increased organization efforts to unionize

facilities. In 1994, CNA established the Agenda for Healthcare Reform that called for a single payer system, something which, in spite of the legislative setback in 2009, they continue to advocate. They launched the national “Patient Watch” program about the dangers of hospital restructuring. They sued Alta Bates Medical Center (in Berkeley, California) for its restructuring initiatives that were displacing RNs with unlicensed assistive personnel (UAPs), forcing Alta Bates to rescind several elements of the plan. CNA also co-chaired Proposition 186 in California, which was an effort to establish single payer in California. This proposition lost, with the hospital industry spending 10:1 to defeat it.

In 1995, CNA achieved its formal independence from ANA. They continued to accelerate their work to take on industry restructuring and formed many new alliances with patient and consumer groups to advocate for single payer. In 1995, they also won their first legal battles to reinstate regions that had attempted to secede, starting with region 12.

In 1996, they formed an alliance with Ralph Nader and other consumer groups to sponsor Proposition 216, the first such initiative to call for sweeping HMO and hospital reform. While this initiative lost, most of the provisions later would become law. CNA sponsored improvements in the Nurse Practice Act Title 22, establishing protections for the floating of RNs to other units within a facility, and requiring that patients be assessed by an RN every shift. Also in 1996, 1,700 RNs at Mercy Healthcare Systems (Sacramento, California) joined the CNA.

In 1977, 7,500 RNs staged a series of short strikes at 47 Kaiser facilities in California to challenge RN layoffs. All of these efforts had media exposure, resulting in

an increasing number of RNs in California becoming aware of the CNA; but an increasing awareness that this was a new, invigorated, and most importantly, staff nurse led, organization.

In 1998, CNA initiated the move into southern California, with RNs at St. Vincent's Medical Center (Los Angeles) joining CNA. The reader may recall that the old CNA not only had neglected the facilities in southern California, but also had actually abandoned them to other unions during their tenure. CNA also reached an agreement with Kaiser, settling their dispute, and established Quality Liaisons, with CNA selected as patient care monitors.

The year 1999 saw the first major legislative victories, a result of not only tremendous grassroots political activism, but also of large CNA sponsored nursing rallies in the capital while the legislature was in session. Legislators not only received visits from RNs, but there was a massive letter writing campaign that resulted in over 14,000 letters being sent in support of AB 394, which called for minimum RN to patient ratios. Other legislation that was passed included whistle blower protection for healthcare workers and legal protection for the title of nurse. These victories received widespread media coverage, not only in California but also nationally.

CNA had recognized the concerns of direct care nurses, addressed them head-on, and consummated political victories no other nursing organization had ever achieved. To date, no other nursing group has managed to overcome the political obstacles and establish a ratio law. Many states have them proposed, but none have achieved the political victory. CNA had been patient, building the organization from the ground up, one facility at a time, and then focusing on the larger groups as they

could. They had stayed true to the demands of direct care RNs from around the state, keeping patient advocacy as a central theme, not just a rhetorical construct. They fought for issues that California nurses felt were vital – ratios, pay and good contracts, benefits like retirement (something many nurses do not have), floating protection, mandatory overtime, and industry restructuring. The CNA leadership provided true leadership for direct care nurses, not just a club for the self-advancement of academics and administrators. They removed the affiliation between the AHA and the CNA leadership.

CNA has emerged from this process as the ONLY nursing group significantly growing in numbers. By the mid-2000s, they had grown to over 80,000 members, and were going national. As it stands now, after the HOD meeting in December 2009 where the new “super union” was approved, CNA rivals the ANA for membership figures and can legitimately claim ownership of the title THE direct care RN organization. In merging with the UAN, for example, they now can claim ownership of all the previous ANA labor groups in the states, including LURK, the labor arm of the Florida Nurses Association (FNA). Though pitifully small now at 5,200, the FNA potentially represents almost 200,000 nurses in the state of Florida. The new group, called the National Nurses United (NNU) has the potential to ignite a national RN movement. Even so, it is largely ignored by academic nurses, and continues to be seen as a threat by nurses in administrative positions, particularly those nurses affiliated with the AONE. President Obama, as he institutes health care reform, now has a choice to make when he summons nurses to the Oval Office to discuss reforms. What nursing group is he inviting? The ANA is crumbling. Since Mr. Obama already hears from the AHA

(probably more than he should), listening to the AONE only would be redundant. Will this new national labor based organization emerge, at last, as a politically active voice for nursing? To date, President Obama has not consulted with the CNA.

Question 6. When did you feel you had enough momentum to begin the policy initiatives? The majority of respondents feel it was the staff nurse rebellion and the take-over of the Board of Directors in 1993 that allowed for the policy initiatives to gain traction within the CNA rank and file. Some note the historical context, citing, for example, the fact that the CNA had sponsored legislation as far back as 1905. One respondent recalled the 1975 ICU staffing ratio legislation, although no one seems to recall how that was done or even who was involved. Many credit a type of awakening after the 8 to 7 majority was elected, almost an immediate awareness that they did have political power, that they could shed the oppressed group thinking that had dominated them for so long. The ratio initiative was introduced in 1996, very soon after the disaffiliation from ANA, and finally was passed and signed into law on October 10, 1999. It had, by most accounts, been a long battle and, of course, they still had to deal with a lengthy public policy period while the actual ratios were set, followed by the legal battles with Governor Schwarzenegger and the CHA. It was 2005 before the phasing in of the ratios began.

Question 7. Money always is the elephant in the room. What was the financial status of the CNA and how were the resources allocated under the strategic plan? Not amazingly, many of the rank and file members were unaware of the financial status of the organization. Many were practicing as bedside care nurses, and involved in their facility labor teams, as well as going out to talk to and organize

other nurses in California. The respondents who were well aware of the internal operations recall a time of great poverty for the organization. They did note the huge savings when the per capita payment to ANA stopped, but also remember eating box lunches and begging members to stay with them.

It appears the ANA oriented leadership had seen the change coming, and of course, they had the transition period after the election. Friendly regions had been identified, resources transferred to them, properties acquired in them, and bonuses paid to many leaders, undeservedly, and at times, illegally. The reader is referred to some of the legal documents and legal briefings in the appendixes that highlight those events. Region 12, for example, had two very large houses, and Region 10 also had purchased property. The CNA leadership had leased a mansion in San Francisco, dubbed the “Crystal Palace,” a long-term bad lease, and had stocked the mansion with expensive artwork and a \$3,000 conference table. After the transition, leases had to be broken, contracts re-examined, and legal cases brought forward. Once again the new CNA leadership showed that it could multitask, take on the financial issues, pass a dues increase, and remain focused on the issues of bedside nurses (Even if they did have to barter for their legal representation by buying their lawyer a sailboat!).

Compounding all of this was the attempt by many regions to break away from CNA, which resulted in another layer of legal issues as well as the bleeding of membership as nurses withdrew from CNA, many citing as their reason the hiring of a non-nurse as leader. In all, the organization lost around 8,000 members after the staff nurse rebellion and the disaffiliation from ANA. The ANA, of course, also had lost some 20,000 members, so they came in almost immediately and set up ANA-California

to welcome some of the nurses back into their fold. They also launched a vigorous campaign, both before the election in 1993 and up to the disaffiliation, to discredit the new leadership. The legal vigilance and vision of the CNA legal staff readily is apparent. The innovative strategies and the sheer number of cases that they won is remarkable. Many respondents credited this multifaceted and methodical legal onslaught as a major factor in why the organization not only survived, but also thrived.

In terms of the allocation of resources, prior to the take-over, E&GW had received the amount of money that the executive council had decided it deserved, since the executive council controlled the budget. One respondent wrote:

There was a lot of money being devoted to ‘nursing practice’ and ‘government relations.’ And the problem is not with the 2 titles per se, it was with the content of what their agenda was. So in government relations, say, it was much more about, and this is nothing against nurse practitioners, it was much more about getting them prescriptive authority. That was important to some members. California still does not have that, but at the time, it was a huge legislative effort. So instead of focusing on protecting labor law, worker’s rights in general and regulatory rights for RN’s, specific to RN’s practicing at the bedside, they were doing all these kinds of things.

This had been one of the major concerns of the union nurses, and they were upset that they received only about 50% of the money when they paid 95% of the dues. The union members did manage to campaign successfully to get a dues increase passed in the early 90s, but had to come back after the disaffiliation to ask for another one. Many felt that the leadership had abandoned the interests of the bedside nurse in favor

of advanced practice, a logical step if one blindly accepted the industry plans for restructuring. The new CNA would choose to confront those efforts just as the E&GW and the union nurses had been confronting it since the late 1980s.

Question 8. What specific political tactics were used during the legislative process for staffing ratios and minimum pay? The respondents identified a wide variety of tactics, which include involving the patients, families, the public, and the communities; public education on the benefits of the proposed legislation; political announcements; letters to the editor, being visible in the press and in Sacramento; and rallying large numbers of nurses (even nurses CNA did not represent!) for key events. Of particular importance is their reporting that they took the fight into the home districts of representatives. This was no longer the softball politics of the ANA based organization, which preferred not to endorse any particular party and which supposedly gave what little it did contribute to political campaigns in an even and balanced fashion. This was hardball politics, and the new CNA was ready.

They used their RN members in visiting representatives, in letter writing campaigns, in testifying before panels and in hearings, and with phone calls to legislators, making sure to follow up on the visits. They openly engaged the public, a public who historically places a great deal of trust in nursing, to support their efforts. They educated the public, the nursing profession, and their own membership on the need for reform and the protection of the law for RNs. “Nurses in the streets, and nurses in the offices,” as one respondent put it. They recognized the financial imbalance between the industry and themselves. They took the fight to the public domain, and won. As another respondent noted: “We at one point actually invaded the

Capital in contravention of every law that existed in the State of California and managed to get away with it – sort of because of who we were, who we are.” This was a combination of good old-fashioned hardball politics, street theatre, public engagement, and media utilization that led to the success.

Question 9. What political obstacles did you encounter with the California Legislature, and how were they overcome? One of the more interesting responses notes that the obstacles CNA faced in the California legislature during the process to achieve ratio legislation were the same obstacles seen in the legislative efforts by the Obama administration in passing the healthcare legislation. The Republicans were seen as an obstacle to passage of the ratio law, and perhaps are even more of an obstacle now because they seem so determined to have President Obama and the Democrats fail. They have shown tremendous party unity in this opposition. During the ratio efforts, however, one respondent commented on how surprised they sometimes were with who was supporting the legislation, finding that many legislators had wives, friends, and other family members who were nurses, and many had immediate family members in the hospitals as patients. Some could understand the ratios and the message from CNA nurses on how necessary they were.

Still, the conservative and largely Republican areas in southern and central California were and staunchly are opposed to government interference in the corporate system and the free market, and when combined with the tremendous amount of money given to the political process by the healthcare industry, it amounted to a very formidable opposition to any reform effort. As one respondent noted, “They had 100 lobbyists and we had one.” This same pattern is evident across the country, particularly

in states like Florida, where profits from healthcare are high. The poorly empowered ANA based nursing organizations are severely outgunned in their efforts to sit at the decision-making tables, in spite of the rhetorical support political leaders give to them. Of course, the ANA message also is watered down and non-specific, which allows for even this façade of public support. As the reader has seen, the CNA message deals with quite a few specifics and is anything but watered down.

Overcoming this stiff political opposition took some 13 years, and called for a multitude of tactics, an unwavering message, and very dedicated members. Perhaps if this story had been told previously, the current administration could have learned from this experience and dealt more successfully with the reform efforts. Some respondents recall the hardball politics, how they picked off individual legislators, published their PAC money and endorsements, essentially tying them to the special interests and exposing them in their own home districts. Another respondent recalls a particular effort in the East Bay Area against Wilma Chan, a legislator who was on a key committee and refused to support the ratio initiative. They sent 500 nurses to her office in what amounted to an intense confrontation. CNA actively looked for events like this, and not for a compromise position. They had specific demands. As another respondent notes: “We weren’t at the table to debate. You know, the notion that a social movement, a fact I try to emphasize here, that a social movement would reject its fundamental principles, its objectives, in order to make some kind of political compromise, is a joke.”

While party seems to be more of a factor now in this political healthcare debate, at least one respondent reminds us that the ratio bill was a Democratic bill, sponsored

by a Democrat, passed by a Democratic legislature, and signed into law by a Democratic governor. Republicans opposed the legislation, forced the compromises and the review period, and it was a Republican governor who attempted to block them, at least partially, from being enacted. If the CNA not been so effective in translating this ratio argument into an argument for patient care and patient safety, if they not had the brilliant legal team they had, if they not been so effective at forming alliances with patients, if they not been so effective at working in the public domain, and if they not had the visionary leadership and committed membership they had, the entire event might have faded into obscurity. The union nurses would still be fighting solitary battles against individual facilities and an increasingly bold and uncontrolled healthcare industry.

Question 10. What advice would you give other state associations who want ratio laws and/or minimum salaries for RN's in their states? Once again, there is tremendous solidarity in the responses to this question. Organizing the nurses in their state was, and is the top priority. Numbers do matter! There must be some degree of a power base. After organizing, education of the members is a *must* according to the respondents. Members needed to have a more sophisticated understanding of financing and the political process and recognize that they are a political force with which to be reckoned. Public visibility is a key to success if the CNA model is to be replicated by other nursing organizations. “There has to be an element of activism and an element of being out in the street.” Phone calls and letter writing are not enough!

For the majority of nursing associations still mired in the maternal back world of the ANA, the advice is simple – Get Out. The logic is simple: if the ANA tactics like

the Safe Staffing Campaign which was launched in 1993 or the MAGNET recognition program had worked, then no staffing legislation would have been necessary. The same can be said for TQM, QSEN, TIGER, and all the rest of the management quality improvement schemes that administrations have attempted to impose on healthcare institutions. They do not work when the nurses, who are expected to implement these strategies, are overworked. One need only read the IOM report from 1999 and the Hearst report just issued in 2009, which showed very little improvement over the last decade. These institutional and industry responses simply have not worked, period.

Stay independent. “What we don’t do is to put ourselves in the service of anyone else.” At times, CNA has found itself in conflict with other labor groups as it pursued its single focus on RN issues. While they work with other organizations, they appear careful not to entangle themselves. This mirrors the original advice from Thomas Paine in *Common Sense* and George Washington in his farewell address to the newly formed United States: “Have trade with all nations but treaties with none.” While CNA was eager to work with individual legislators, they were careful to avoid entanglements, even with the Democratic Party that had sponsored, passed, and signed the ratio bill into law. “We never allow ourselves to get co-opted by that.” That said, there are natural allies for this effort, namely patients and the public, groups that are very concerned with safety and care. “I remember, for example, the Gray Panthers were at our rallies a lot. They’re senior citizens and they’re concerned about healthcare. A lot of them have been in the hospital or their friends or family members have.” Nurses need to remind the legislators that they comprise 1 out of 44 voters in this country, and then make it apparent they intend to vote.

Join us! The CNA offers itself as a model for how to succeed, and the NNOC as a vehicle for action. They say learn from us and our experiences, and walk that walk as evidenced by their eagerness to participate in this study. Look at what we did! Organize the nurses, educate the nurses, educate the public, and then play hardball politics just like everyone else is doing. Take the gloves off, stay focused on the message, and determined in the expectations. Do not compromise and expect to win. Take advantage of the political opportunities that inevitably present themselves during any campaign. Finally, recognize that this is an important campaign, not just for nurses, but also for the very philosophical core of nursing, our ability to advocate for our patients and to provide safe care. The obstacles to success are tremendous, and the effort to win must be equally as vigorous. They caution that you have to be in it for the long haul. There will be setbacks.

Question 11. When did you realize Governor Schwarzenegger was opposing the ratio law, who was the driving force behind the court case, and how did you gain the legal victory? It is clear from the responses that CNA very much was aware that Schwarzenegger would attack the ratio law immediately, or very soon after, taking office. Some historical context may help. California had elected Gray Davis in 1998, and at the time he signed the ratio bill into law, in 1999, he was very popular. This was the height of the dot.com boom, and California was enjoying the fruit from the Simi Valley technological explosion. By 2001, however, California was going from the 8th strongest economy in the world to a debtor state. The energy crisis, with soaring heating and utility bills, coupled with Governor Davis' perceived weak crisis management, contributed to a political storm that in 2003 caused his recall and a new

election. Suddenly, a host of candidates emerged, from ex-porn stars to Arianna Huffington, from business tycoons to ex-baseball commissioners. The recall election became the butt of late night comics and a political amusement around the world. Late in the game, Arnold Schwarzenegger entered the race: personable with tremendous name recognition, well financed, boasting he was going to come in and take on the special interests in Sacramento, and married to a Kennedy, Maria Shriver. Here was the marquis personality the Republicans needed, with a slightly liberal social policy and a persona so well recognized that he almost appeared to transcend political party. He won the election. What was not well known or presented to the public was where his financial backing came from and the strong affiliation he had with some corporate interests.

CNA braced itself for the inevitable confrontation, and that came when the “Governator” issued emergency proclamations putting a hold on the ratio implementation in some areas such as emergency rooms and rural facilities. CNA was ready and took them to court. “This guy, just like the Bush’s or so many other of these big bank, corporate politicians, they just don’t give a shit. They’re not strategists, they just don’t give a shit. They just plunder, which was kind of fortunate, because when they did their emergency regulations, their shit wasn’t together.” CNA knew who was behind the efforts, they had just spent 13 years battling with them, and the arguments used as a basis for the emergency executive proclamations were the same arguments used in the long battle for ratios. “What we did was to sue him; we took him to court and each time we won and I think we sued him 3 times, and we won each time, because he had always overstepped his bounds. He went over and beyond his powers in order to

fight the ratios.” “No one is entitled to do this (healthcare) business here. Basically, they think they are. But you know the judge didn’t decide that the executive branch had exceeded its authority and power and not obeyed the legislative branch. It presented again, the objective issue of the day, which is the same issue today and why we need single payer. These hospitals’ staffing practices are the product of an insurance profit risk assessment by the direct provider, the hospital, and they are instituting practices to get a piece of the premium dollar. The staffing has nothing to do with patient care.” The hospital industry claimed they didn’t know that the ratio law meant *at all times*, even during lunch and breaks, and that the law had unintended consequences. “They said they did not know any of this. And the judge went - Well, here’s your testimony during those hearings saying that you couldn’t possibly cover these nurses during meal and breaks, so you did know this. You’ve had 4 years to plan for this.”

CNA was flexing its new political power, and the affiliations and the organizing it had spent 13 years developing paid off. “It was only our power, the CNA, our legal department, and the honesty of what we were doing and why we voted for ratios, and why we needed them. We explained that to the public.”

Perhaps the most colorful story to emerge from this legal engagement was the public confrontation with Schwarzenegger himself. Schwarzenegger, at the height of his popularity, publicly took on the CNA at a women’s conference in San Diego. He called the CNA protesters special interests, and told the crowd they were upset only because he was “kicking their butts.” By one account, the media could not get out of the convention center fast enough to interview the CNA members protesting outside. As one respondent recalls, the Republicans and Schwarzenegger could not “grasp the

idea that a woman, since we are predominantly a women's organization, would be able to have the kind of power that they perceive us to have. I think what we did to Arnold, when he tried to hold the ratios hostage, scared them. We were in the streets, we had billboards, we had trucks and buses with billboards on them. We drove to Eureka, to Crescent City. We drove all over the state of California, down into the Imperial Valley. We'd find out where he was going to be, and we'd be there. We would be in front of him. He went to a baseball game back east, a Red Sox game; we were there. He went to a rock concert, and the star of the concert came out and welcomed the CNA. I mean, it was just fantastic!"

According to another respondent, "I mean we had planes with banners flying over where he was. We were in the streets. When we went to the capital, we marched from the convention center and there were a whole bunch of unions and other organizations all protesting his propositions. We came walking down the street, doing our chants and all that, and it was like the seas parted. Everyone stopped, and started clapping and cheering for the nurses. We were recognized for having the guts to take him on." "We pushed harder, and so wherever he went, we followed him and we also took it to court and I think we just kept adding the pressure. Wherever he was we made noise. We were an irritant in the media."

There was one other factor that contributed to this new political and social power, the CNA never had lost sight of the organizing efforts, never been distracted by the fame, or compromised in its essential core responsibilities as a union for RNs. In 2000, CNA took over the publication of the journal *Revolution*, providing a mechanism for national distribution. This journal had gained some popularity with bedside nurses

nationally, thanks to the efforts of Laura Gasparis Vonfrolio, the publisher, who herself enjoyed some national recognition as an emerging nurse leader – at least for the direct care nurses. They also were participating in a rudimentary national organization for nurses, meeting in Baltimore with direct care nurses from Massachusetts, Pennsylvania, Arizona, New York, and Missouri.

In 2001, CNA signed a labor pact with Catholic Healthcare West, the largest Catholic chain in the Western U.S., and they won elections at nine CW hospitals during the year. In 2002, CNA negotiated pension/retirement improvements for over 30,000 RNs working at Kaiser, the UC system, Sutter Health, HCA and others. RNs at Long Beach Memorial, the 2nd largest private hospital in the west, signed their first CNA contract. Also in 2002, RNs at Cedar’s Sinai Medical Center, the largest private facility in the west, joined CNA.

In 2003, the year of the recall election, CNA filed for elections at 19 Tenet Healthcare facilities. Tenet RNs set up statewide CNA councils at 24 Tenet facilities. This same Tenet Corporation would soon hire Jeb Bush, the ex-governor of Florida, for \$450,000 a year to be on the Board of Directors. CNA membership now exceeded 50,000. In 2004, while battling Schwarzenegger over the assault on the ratio law, CNA also was assisting with the tsunami relief efforts, moving into the international arena even as it was moving into the national political arena. All of these developments were contributing to the social and political empowerment of the CNA.

It was 2005 before opposition to the ratio laws would be dropped. CNA spearheaded a campaign that defeated Governor Schwarzenegger’s efforts to eliminate the Board of Nursing and 88 other boards and commissions. CNA, and the newly

formed NNOC, enjoyed their first election victory outside of California, with 1,8000 RNs from Cook County in Chicago joining NNOC. This was the year of Katrina, and CNA had responded to the crisis by sending in 300 volunteers to assist with the relief efforts. Many of those volunteers came back with a renewed commitment to restructuring the healthcare delivery system. Another significant development was the 2005 decision by CNA to affiliate with the AFL-CIO, giving them a larger union presence on the national stage. After the CNA, in conjunction with teachers and firefighters, defeated Governor Schwarzenegger and his “reform” initiatives, the ratio laws were re-invigorated and implementation begun. The once popular governor had seen his image and his ratings reduced drastically.

Question 12. When did the concept of a National Nurse Organizing Committee begin? The general consensus of the respondents is that the NNOC officially began in 2004, but many respondents can remember discussions about single payer and a national organization (at least a national organization for direct care nurses) as far back as 1986, and certainly after the staff nurse rebellion of 1993. At first, resources were very strained for the new CNA, and the legal obstacles appeared daunting.

By the 2000s, the picture had changed dramatically. After the ratio bill was signed into law, nurses from around the country increasingly were calling on CNA to help them, help them pass the laws California had succeeded in passing. Though the first initiative to form a national union had not been successful, CNA had managed to assist Massachusetts’ nurses and Maine’s nurses in pulling out of ANA. They also were working very closely with PASNAP, the Pennsylvania nursing association.

Crucial to understanding the NNOC is the awareness that this group is not just about ratio laws. The ratio bills are an organizing tactic, and a very successful one. But the NNOC also is concerned with whistle-blower protection, salaries, floating, and the contracts signed, contracts that many consider to be the best in nursing. There is the social aspect too, with NNOC strongly favoring a single payer system. Whether this will fly nationally with nurses is yet to be seen. Certainly, the new “super union,” formed in December 2009, will maintain this advocacy for a single payer insurance system, in spite of the recent political setbacks.

In 2006, the Maine State Nurses Association and the Kentucky Nurses Professional Organization joined CNA/NNOC. In California, Governor Schwarzenegger vetoed the single payer initiative, but by this time, California was in the throes of a major recession. It is in 2006 that CNA/NNOC formed its national disaster relief organization RNRN (most recently activated following the Haitian earthquake in 2010), where they were able to offer the assistance of 1,500 RNs, if needed. Why the government refused to immediately mobilize these experienced nurses is a mystery.

In 2007, CNA/NNOC would lead protests in Cook County Chicago against proposed cuts in essential health services. CNA/NNOC was granted full charter and a seat on the AFL-CIO Executive Board, with Executive Director Rose Ann DeMoro named a national V.P. of the AFL-CIO. The AFL-CIO also adopted a single payer platform during 2007. A multistate labor pact was signed with Tenet, representing 6,500 RNs. St. Mary’s RNs voted to join CNA/NNOC, becoming the first CNA/NNOC facility in Nevada. In 2008, PASNAP would join CNA/NNOC, and the membership

would exceed 80,000. Cypress Fairbanks Medical Center would become the first hospital in Texas to unionize, and they unionized under the banner of CNA/NNOC.

Question 13. What was, and is, the strategic plan for the NNOC? Has it changed in the last four years? The respondents believe that the strategic plan for the NNOC essentially has remained unchanged since its formal inception in 2004. It was created to serve as a vehicle for organizing nurses nationally, with the goal of “ratios in all states, protection of the RN scope of practice, whistle-blower protection, protect the patient advocacy role, and, according to some, to unionize every hospital in the country for RN’s. The NNOC was a response to increasing requests from nurses all around the country for assistance from the CNA, mostly in terms of the ratio laws. The strategic plan, however, incorporates the notion of being a social movement as well, advocating for a single payer system, national standards of RN protection, and an increasing political capability to influence legislation.

The plan was to work with other organizations where possible, and they have done so very effectively with groups like the Maine State Nurses Association, the Massachusetts Nurses Association, and PASNAP. Although the relationship with SEIU was hostile at first, the recent agreement and the formation of the National Nurse Union has forged a new alliance and hostilities have ended. The new group also unites with the UAN, and the platform for this new super union includes the CNA/NNOC vision for a single payer system. At 150,000+ members, the new NNU now rivals the ANA as an equal, and legitimately can claim to speak for the direct care nurses. Once again, we see the commitment to keeping a cohesive and collaborative open systems organization led by practicing RNs and adhering to democratic principles.

Another component of the strategic plan was to organize at new facilities. So far, they have had isolated success, even in states like Texas that are very hostile to unionization. Along with Texas, several states, including Pennsylvania, Illinois, Nevada, and Ohio, now have these isolated CNA/NNOC facilities. Maintaining the success in these facilities will be a challenge for the new NNU, as they are under almost constant assault from anti-union forces both from within and outside of nursing. The nursing blog sites such as allnurses.com are good exemplars of just how hostile this discussion can get, with both the union nurses and the anti-union nurses confronting each other in very polarized positions. The hostile opposition to unions on the part of some nurses simply is baffling, since the arguments are emotional, not factual. As noted earlier, the opposition to unionization from academic nurses, themselves often unionized, is disingenuous at best.

The last strategy was working with regional nursing groups, regardless of their union status, on a variety of nursing issues as well as on some of the political issues. There has been a very clear recognition on the part of the CNA/NNOC leadership that size does matter politically, and that if there ever is going to be a chance for realizing the social goals of the organization, then the organization has to have the political power to influence the debate. Since nursing cannot compete, at least not yet, with the money given to the political system by the medical industry, it must be patient and wait for the membership to achieve a critical mass. What we have seen, however, is that the CNA/NNOC leadership has been extremely effective with the grassroots street-theatre action, and that the few TV commercials that they have produced have been very potent. The leadership appears to recognize that a media presence is a vital component

to becoming a political force in the U.S., substantiating the comment by legendary reporter Daniel Schorr, who once observed, “If you don't exist in the media, for all practical purposes, you don't exist.”

If anything, the commitment to the idea of a national nurses union has grown over the past 6 years. The actions taken at the HOD in December 2009 are evidence that all the CNA/NNOC members endorse this vision for this national union. Perhaps the greatest influence on this commitment came after the CNA/NNOC responded to New Orleans in the aftermath of the August 2005 hurricane Katrina. As one respondent notes:

They saw not only the physical devastation, the physical horror that was there, but when they got into the hospitals, or the tents, or the Astrodome to provide the care, they were talking to people who had never even seen a doctor or a nurse practitioner. They knew they had some kind of family history, like hypertension, or diabetes, a history of something. To see those people suffering unnecessarily, because they couldn't afford care, or because it wasn't available for them, just opened their eyes to how bad it is in our country. All these people living in hovels, with most nurses working in not-for-profit or for-profit facilities where insurance is the norm.

These were not the leadership nurses according to this respondent; they simply were bedside care nurses who went down to help as part of the RNRN disaster response network. The 1,500 experienced nurses potentially mobilized to assist in the Haitian earthquake relief effort in 2010 illustrate what an effective, socially focused group of empowered nurses can accomplish. Were they politically and financially empowered,

they also would have been able to orchestrate this assistance directly after the quake, perhaps as part of the governmental emergency response network, and not have to wait around for financial sponsorship before being able to help.

One factor not brought up in the responses is the increasing void in the national political debate created with the fracturing of the ANA. This very well may contribute to the soon-to-come dominance by the new NNU. Last year, 2009, witnessed the most extensive political debate on healthcare restructuring that the U.S. has had since the early 1990s. At that time, of course, the CNA was just the CNA, a constituent member of the ANA. Unfortunately, the full potential of the healthcare reform initiative has been lost politically, and the chances for meaningful reform have faded into obscurity, especially since the Democrats lost their super majority in the Senate in December, 2009. Had the NNU existed in December 2008, they well might have been a major player in the 2009 debate. The ANA role was useless.

While the ANA boasted of the invitation to the White House to meet with President Obama, for all practical purposes they were invisible in all the major news stories. In fact, the Health Care Summit that had been scheduled by the ANA for June 2009, a summit that was to release a White Paper on health care reform, was cancelled for lack of attendance. The New Orleans summit would have been a timely event for both the ANA and for New Orleans, a city that desperately needs to return to some form of normalcy. No White Paper, no media coverage, not even the capacity to perhaps re-group and stage the event in Washington D.C., home of the ANA (actually a suburb in Maryland), and certainly no media presencing at a key time in the 2009 debate. An emerging, empowered nursing group, grounded in political activism like the

CNA/NNOC, well may be able to mobilize a coherent nursing vision for healthcare restructuring and muster the street support to make true reform politically viable. This vision, being presented by the CNA/NNOC (now the NNU), is a radical change from the mere ANA rhetoric (no action) that has been, up to this point anyway, the most recognized nursing position.

Question 14. What kind of response has there been from bedside nurses around the country to the NNOC? One interesting note is that the favorable response to the NNOC by bedside nurses from around the country, which most of the respondents describe as tremendous, primarily has come from nurses in urban areas. One reason for this may be that rural nurses have many fewer facilities to choose from; thus, being fired for organizing behaviors in a rural community carries a much higher personal price than in urban areas, with their large number of facilities. This fact can not be overlooked, particularly by a union-based organization transitioning into a national nursing association. It almost mandates an effort to work at a regional level, getting control over the state nursing association and then working the changes in the laws through the state legislatures. A facility-by-facility battle plan would be too costly, in terms of money and in terms of time, though some facility administrations probably necessitate a union. The political debate will not stand still and wait for nursing to empower itself, and the next time the opportunity presents itself, nursing needs to be ready, financially and politically. Of course, a truly empowered nursing organization, with say 300,000+ nurses as members, may be able to launch the political debate with only minimal assistance from some previously formed consumer alliances, coupled with public demand.

The respondents note how impressed they have been with the response to the NNOC. One respondent does note the concerns, on the part of some nurses, that there will be a loss of autonomy with a national organization. But the general impression is that nurses around the country are interested in what the CNA/NNOC have done and continue to do, and are requesting not only ratio law assistance, but assistance with all kinds of legislative efforts. Again, the central issues revolve around bedside nursing issues like floating, mandatory overtime, wages, competencies, and the ability to have input into administrative decisions. These are all issues bedside nurses have identified as central for decades, and which largely have been ignored, or at least addressed only rhetorically by the ANA.

The message from the CNA/NNOC has been consistent: When you are by yourself, it is hard to do anything. Collectively, we can make a difference. This is a message that resonates well with bedside nurses, as does the rejection of the mandatory BSN for professional status position strongly advocated by the ANA leadership since the 1960s. The tactic used by the CNA/NNOC, namely holding group meetings after focused flyers are distributed in certain areas, has been a slow but effective one. The ability of the CNANNOC to have bedside nurses talk to bedside nurses is a strong asset, and hopefully will not be lost as the organization grows and becomes both more empowered but also, inevitably, more bureaucratic and global in its focus. The increased size of the organization will allow more resources to be devoted to increasingly larger organizing campaigns, with potentially an explosive growth in membership beyond the already impressive numbers. A membership percentage equivalent to the National Education Association, somewhere around 80%, would mean

the NNU would represent 2.2 million nurses, and it would thrust the organization into not just *a* political force in healthcare but *the* political force in healthcare. Still, the opposition to this is well-financed, very determined, and very well connected politically, both inside and outside of nursing. Whether or not these internal divisions in nursing have been damaged irreparably has yet to be determined, and will probably not be brought to a conclusion until the inevitable collapse or at least re-invention of the ANA.

There is another consideration. While the CNA/NNOC, and now the NNU, advocate for a single payer system as part of their core message, we really do not know if nurses around the country actually support this. The CNA/NNOC has considered this a matter of education, implying that if the nurses knew the facts, they would opt for a single payer system. CNA/NNOC itself has bought into the argument that the only two options are either a free market system or a government controlled system. Advocating for a single payer system does not equate with offering a design for the new healthcare system, a nursing model. If nurses split along the lines that the public shows in general, than this insistence on a platform of single payer itself may become a negative for the union. Certainly, the organization must be open to having a forum devoted to this topic. There are other models!

Question 15. What media utilization strategies are in place within the CNA/NNOC, and what do you anticipate is the need for media presencing? The media strategies, which along with the brilliance of the legal strategies, are cited by every respondent as being a central element in the success of the movement, and as a key component of the political successes, are described by most as innovative, focused,

and creative. After CNA disaffiliated from the ANA, and as noted previously in the responses to question 7, for all practical purposes, the organization was broke. The central questions for the now staff nurse led CNA, in the face of this poverty and the restructuring efforts underway by the industry were: “How do you confront a trillion dollar industry? How do you confront these hospitals and the HMOs, the drug companies, with the billions of dollars of resources they have, and the choke-hold they have on the legislative process?” An additional concern for the fledgling organization was how to do all this with the loss of 8,000 members, the defectors to the new ANA-California, and the loss of even that revenue.

The solution was using multi-media, particularly low-tech media such as billboards, op ed letters in newspapers, email, mailings, radio talk shows; media that cost little but also that are designed for smaller audiences. In the U.S., TV and major radio stations are the big media players, with TV dominating all other media. Of course, as one respondent notes, “They cost a fortune.” Several respondents speak to how strategic the media utilization has been, and how the Board of Directors, which approves all of these media efforts, have remained focused on the patient care issue and are open to a variety of media formats.

Newspapers have been a major source of coverage, and particularly receptive to the street theatre or “guerilla media” as one respondent calls it. The coffin marches, the bus tours, the large numbers of scrub wearing nurses who would show up at a march, or the big billboards, what one respondent describes as “keeping nurses on the ground and in front of patient care concerns.” CNA realized that nursing was the most trusted profession in the country according to the polls, and they reasoned that if nurses

delivered the message, and that message had to do with patient safety, then the combination might be enough to confront the trillion dollar industry and the billion dollar lobbyists. Evidently this strategy was successful.

They now have been covered by a vast array of print media, including newspapers from as far away as China, Spain, and France. They have taken out ads in the *New York Times* and the *Los Angeles Times*. They have fostered relationships with reporters, issued press releases, and been opportunistic about using what media is available. Op Ed pieces were aggressively used, particularly in the smaller media markets, and one might assume in a rather targeted fashion towards opponents to the CNA legislative efforts. One respondent remembers an ad in *Roll Call*, but cannot remember the substance of the ad; this may refer to the congressional newspaper *Role Call*. The nursing journals appear to have been much less receptive to CNA/NNOC ads. One respondent recalls, “. . . we tried to run an ad in *Nurse Week* and they refused to run it.”

Apparently, the trade journals are affiliated too closely with the industry, and too dependent on the advertising dollars to run controversial ads or stories. This author too has had major disclaimer statements when controversial topics are the subject matter, and many articles are just rejected outright. One respondent notes that, “These publications tend to be anti-union, and that is certainly reflected in their copy, in their coverage, and in their editorial content.” Interestingly, the *American Journal of Nursing* (AJN) does receive some kudos after breaking away from ANA control, and there are hopes it will continue to demonstrate the move towards independence.

The CNA has made several efforts to use the much more expensive television media. While CNA always has had success with getting TV coverage for their street theatre and large marches, the proactive utilization of media is new to nursing. The first efforts involved working with others, such as the United Auto Workers or the United Steel Workers during the Patient Watch Campaign for ratio legislation, and involved a patient pushing their call light at night and the caption: Who will be there for you? Someone vaguely recalls another TV ad regarding the replacement of RNs with nursing assistants. One respondent recalls how a newspaper intern in Oakland, who was actually a Master's prepared nurse, brought the reporters and cameras to the CNA strike lines over several days, and how the striking bedside nurses evolved from silent strikers to "grab the mike" protesters.

The CNA still was predominantly a reactive media player, and live events covered only sporadically. Perhaps the biggest break for CNA came when Governor Schwarzenegger issued his now famous "kick their butts" comments at the women's convention in San Diego. This had media, with a capital M, written all over it. The plot line of David vs Goliath is a favorite of U.S. media, and here was this little nursing organization actually chastised by the Governor (who at the time was hugely popular), on top of having international star name recognition. The result, according to one of the respondents, was that "we were in the newspaper (and television) . . . an average of 3 or 4 times a day, across the country!" Other issues also were in the media, but the CNA was in the media "more than SEIU by about 3 times as much." If he had just taken a breath, notes one respondent, "we might not be where we are today, really."

The proactive use of media, particularly of television, has been a recent phenomena for CNA and the NNOC. In 2008, we saw the Sarah Palin ad during the Presidential race. In this ad, “we had him (John McCain) disappearing like he was being sucked down this black hole, and then Sarah Palin coming out, and she sort of looks attractive at first, but then it starts listing all the take aways that she had.” The respondent notes that you can’t have nurses everywhere, and when you start organizing nationally, you have to be able to get out the message. Another television ad was the 2008-2009 one depicting Vice-President Dick Cheney being rushed into a medical center after one of his frequent heart related events, and the question being asked: Why EVERY American wasn’t entitled to this kind of health care. Still, the ad was limited to a few markets in California. However, unlike the infamous Harry and Louise ads of the insurance companies during the 1990s Clinton healthcare debate, which also were aired in very few markets, it never was picked up by the national media and itself become a story.

In 2009, CNA took out the first national ad and ran it on the TV show *Hawthorne*, one of two shows that featured a nurse in the leading role. In general, the media has “portrayed nurses as well, looking for Mr. Goodbar types, pretty poorly.” Of course, even in *Hawthorne*, they had to make the nurse a nurse manager, which is particularly amusing to the bedside nurses when they have the manager, this CNO, actually working. “EVERY bedside nurse knows this never happens.” The feeling was that this would be a very good way to reach people, people “that might not otherwise be aware of our organization or some of the activities we do.” The general consensus among the CNA respondents is that the ad was a good one.

Nursing in general, but not the CNA specifically, has benefited from the Robert Wood Johnson Foundation “feel good” ads that have run nationally for several years. In these ads, the nurses are depicted holding patients hands, etc., and the viewer is left with the sense of nursing as a noble and caring profession, which actually is quite true. The ads are an attempt to address the nursing shortage by showing nursing within the affective domain. None of these ads present a nurse taking care of ten patients, or show screaming physicians, short staffing issues, violent patients, angry family members, or incompetent administrators. There is no political message in the ads, no commentary on the healthcare system, no disappointment in the political process for reform. There are no angry nurses on picket lines, no administrative nurses ranting about how bad unions are for nursing. There is only nursing being what nursing should be, the deliverers of high quality patient care.

With the emergence of a national media strategy over the past year, and the formation of the NNU, revenues may become sufficient to have a sustained media presence in the national media. One can envision the potential success in the careful blending of the affective nursing commercials with the political message of the newly empowered union. It potentially would serve as a potent recruitment tool for the NNU, entraining more and more nurses, even if only anonymously, and opening up major membership drives among even rurally located nurses. The state law initiatives transcend the rural/urban issue.

Today, the CNA/NNOC, and now the NNU is present in all the contemporary media, from YouTube, to blogging, and to their web sites. As one respondent notes, “You know, ten years ago, Huffington Post didn’t exist. Now we have staff writing

articles and opinion pieces. The electronic media is very important.” The media have reported on their ability to mobilize nurses with the RNRN disaster network, most recently a potential response of 1,500 nurses for the Haitian earthquake relief effort. This kind of response easily could be tied into a government-funded and logistically-capable national and international emergency relief team, further advancing the group’s political presencing. It would require this kind of legislative backing since this author personally has witnessed the unwillingness of corporate healthcare to respond to a disaster (even though it was only on the other side of the state) with even a minimal team or equipment. Profit systems are just that, for profit. The perceived competition, albeit self-created on the part of the industry, prevents the lateral flexibility needed for disaster relief.

Question 16. Given the increasing breakup of the ANA, and the historic alienation of the AONE from the interests of the bedside nurse, what role do you anticipate the CNA/NNOC will have in the profession of nursing? The respondents clearly have a sense of the historic nature of what they are doing. They see the CNA/NNOC as filling a longstanding void in nursing, a political voice for the direct care nurse. Their goal is a simple one: “To be the front-most authority for healthcare decisions, and to be the leader for RNs across the nation. To set (practice) standards, laws, regulations. . . .” They clearly see themselves as the only ones capable of or interested in mobilizing nurses to oppose the restructuring efforts of the industry as it seeks to reduce personnel costs, replace RNs at the bedside, de-skill nursing in general, and divert care away from preventative efforts to expensive, high-tech interventions. They clearly see a day when the CNA/NNOC will replace the ANA as the voice of

nursing, and the convergence in December clearly gives them the right to be called the voice of the bedside nurse. How this eventually will coalesce with the interests of nurse educators has yet to be seen, and to expect some degree of priority re-assessment on the part of nurse administrators seems an even more remote possibility. Whether these groups finally will diverge and form their own organizations is still not clear. Both the educators and the managers may well stay on course with the ANA, continuing to claim they represent nursing.

A common sentiment is that nurses finally will gain control of their practice under an empowered CNA/NNOC. “This is about me being able to work as a professional. . .”, about being able to say, “I can only do this much work. . . .” They see their new role the same as the old role, “a response to the searing contradiction of this continuing hospital and employer abandonment forced by the insurance method of financing.” They see the ANA and the AMA as aligned too closely with the hospital industry, and note how the ANA historically has not attacked particular politicians. “Let’s make nice with everyone,” they say. “Well, that doesn’t work. In your family it might work, but in the dark alley of politics, it doesn’t.” They see themselves as finally outing the ANA for what it is, an arm of the industry with a need to control the labor force.

They see themselves as turning the political world on its head. Of being an organization that will apply the successful techniques used for the state fight into a national strategy for reforming the entire healthcare system. “I think California is a great example of what we can do. . . .” No small goal to be sure. They also have been unable to enact any kind of single payer in California, so there have been limitations

placed on their political success. As with the ratio law, however, the leadership team is well aware of the persistence that is required to achieve success, and in this case, they are up against more than a few hospitals, or even just the AHA. The insurance companies have proven themselves a formidable political opponent, and they take no prisoners. Their ability to mobilize large numbers of lobbyists, aggressive media campaigns, and enormous amounts of capital are legendary. Many of the figures are presented in the Institute For Health & Social-Economic Policy (IHSP) report entitled: *Market Based Health Care: Big Money, Politics, and the Unraveling of U.S. Civil Democracy*, released June 22, 2007. This report details just how daunting the task of politically taking on the health industry is, and whether the same tactics will work nationally as they did in California has yet to be shown.

Perhaps the two most challenging problems faced by CNA/NNOC, and now the NNU, will be to hold onto the sense of social mission that was very evident in the CNA core, and to deal with the inevitable diffusion of the most passionate bedside nurses as the organization spreads itself thinner and thinner. Particularly as the inevitable bureaucracy creeps in, and as the newer members, who may or may not have had to fight for their rights, begin to dominate the membership. What happens, for instance, if the new membership does not endorse single payer? Along with the tactics of union militancy, which need to be appropriate to the situation and the opposition, so too the union verbiage needs to be mainstreamed to become closer to the academic unions and farther away from the coal miners. What worked for the heavily unionized northern California area, and other urban areas around the country, now needs to be palatable to the average nurse. “Where is our Thomas Paine, our Common Cause?”

Question 17. Has there been a response from the academic community to the CNA or CNA/NNOC movement, and what explains this? “Well, there hasn’t been a direct, explicit reaction, well until now with you.” This seems to be the general consensus in the responses, that the entire CNA staff nurse movement, and the subsequent NNOC national movement, largely has been ignored by academic nurses. Here is a nursing group that disaffiliated from the ANA, had multiple state laws enacted to protect bedside nursing, and has grown into a national organization currently representing as many or more nurses than the ANA; and academic nurses are ignoring it. “I’ll go to my deathbed strangulated on the whole ‘house slave’ ‘field slave’ thing. It keeps me going. It’s like the industry is saying, ‘How dare they stop singing and look around them.’ ” It seems like academia is more interested in the rigors of scholarship, going to libraries, reading, writing, whereas the CNA experience is more of an experience.” “But I know nurses in New York, Ph.D.s, who HATE CNA, I mean they hate CNA irrationally.”

Part of the problem seems to be the sense of detachment towards nursing academics in general felt by bedside nurses. Some have heard from students about the lectures they get at school, lectures that ask them whether they should be union, or professional. “It’s kind of annoying. I don’t know why they do that. Maybe they believe it.” The anti-union sentiment among academics is both frustrating and confounding to many of the respondents. Airline pilots, physicians, government workers, and teachers all are unionized, as are many of the academics themselves. This staunch opposition to all things union when it comes to nursing appears more visceral (or political) than rational.

Another factor may be the opposition of the CNA/NNOC to mandatory BSN entry requirements, a position long endorsed by the ANA and nurse educators. With the exception of the VA system, however, nurses are not paid more for higher degrees. Not only are they not rewarded financially, but also, many of the corporate centered executives who are in favor of the MBA corrupt the value of the MSN degree, particularly for executive levels in administration. Nursing academics need to consider the entire spectrum of graduate nursing education, if potential graduate students will be abandoning nursing for more lucrative credentials. Of course, the BSN entry requirement also feeds the interests of the university professors, who would have an endless supply of students given the fact that the 4-year university system is completely incapable of meeting the projected demand for nurses in the next 10 years. One solution has been to offer the BSN degree from a re-envisioned community college system. There is some degree of self-interest here on the part of at least some academics. The compromise position of mandating a time after licensure for the completion of the BSN may be the eventual compromise that works and allows the two sides to talk to each other.

“I think a lot of them, particularly in the BSN programs, try to convince nurses that real nursing isn’t at the bedside in hospitals, it’s things like case management, nurse educators, nurse executives, the sort of work where you’re not going to get your hands dirty.” Some respondents have seen some cracks in the academic armor, particularly with associate degree faculty who are inviting the CNA representatives into the classrooms to educate the students on labor related issues. Nursing students “find out quickly once they’re in the working world that it wasn’t like what they learned in

school, and that their nurse manager may or may not be their friend depending on how things are going.”

This sentiment, that nursing academics have lost touch with bedside nursing and thus let the field of nursing down, is common among the respondents. Students, they feel, are ill prepared to begin their practice, and the academics “are not holding to the standards they should be holding to.” “There are academics that are reaching out to us, but there are also people who just don’t like us, are prejudiced, and yet who call themselves academics.” One respondent wrote very eloquently:

One of the reasons I was so thrilled about you contacting us is I thought, wow, someone who really understands bedside nursing and academia is interested in us. We need to do this! This work needs to get out on a national level, to be spoken about, looked at, real research being done, because up to now it’s just been, “Oh, you’re just a union.” It’s not just about being a union. We are professionals and we do care, and we want to see nursing continue. We want the people in charge of nursing, including the academics, to have the same dedication to bedside nursing that we do. For the old CNA people, it was all about resume building, it wasn’t about caring for people. We need to get back to caring for people.

Is this an appeal for consensus? Would the CNA/NNOC, and now the NNU, be amenable to a re-unification in the field of nursing, at least in terms of the academics for now? Is such an agreement possible among the academics? What would their role be in the organization, given the insistence on bedside practice for Board membership? Would the bedside nurses welcome the academics to join them, or is this perception of

the field of the academics as a nursing ritual, essentially useless after graduation, dominant? These are all questions the NNU will confront as it moves towards becoming the premiere nursing association in the U.S. “We’ve got to do a better job of educating nurses. Faculty salaries are not comparable between nursing and other professions. They’d have more nurses if they really wanted more.”

Question 18. What has been the response to the CNA/NNOC from the AONE or nursing administrations in general? In general, the respondents recognize that AONE and nursing administrators are hostile to the CNA/NNOC and its primary political agenda, staffing ratios for bedside nurses. “Depending on the organization, it varies from open hostility to more subtle but still intense opposition.” It indeed is puzzling to hear the outright hostile rhetoric against unionization on the part of this organization and its members. This schism in the political interests of nursing readily is apparent on several issues. One example is the potential reversal of the Kentucky River Decision by the U.S. Supreme Court.

AONE actually has lobbied its members to write their Congressmen in opposition to this reversal, which remains in limbo in the U.S. Senate. (This author received such a request by email, and when the AONE was queried what the position of the ANA was, they did not know. The response from the AONE was that they were sure the labor arm of the ANA supported the reversal. In fact, the ANA openly has supported the reversal of this decision.) This story begins in 1995, with the Supreme Court rejecting the long-standing patient care exception to the supervisory exemption. Up until 1995, the NLRB had had a blanket exception for RNs, and it was assumed the general course of their duties involved the supervision of others in the provision of

patient care. This case was critically important to nursing unions since the ruling set limits on who was eligible to unionize. “Scalia wrote the decision saying that, sorry RNs, your interest is the same as the employers, the delivery of patient care. Bad decision, a theoretical decision knocking out a rule.” This also ran in direct opposition to legal amendments from 1974, “which say the reason we have to include RNs . . . for the patient care.” “So, there were a series of NLRB decisions, up to the Kentucky River, when the Supreme Court considered it again.” This is an important distinction for this respondent, that we recognize the interest of the nurse is the patient, not the delivery system for patient care. “If any NLRB case had tried to trap us, I would have sued the NLRB.”

One does need to recognize that many of the CNA/NNOC leaders remain hardcore union people. They are firmly convinced that employers, and thus management, are anti-union and opposed to the unions philosophically as well as in fact. One respondent recalls “passing out flyers in 1948 for Helen Gahagen Douglas (who some allege had an ongoing affair with Lyndon Johnson) who was running for Congress (2nd of three terms she would serve in the U.S. House of Representatives) against Richard Nixon...” This respondent also talks about the benefits received because of unions, benefits such as “the weekend,” healthcare coverage, retirement. All of these “benefits” now are standard practice in most businesses. “The problem is everyone thinks of a union as Hoffa with a scar and tattoos, and the mob. That’s not what unions are all about. I’m very proud of this union. There are a lot of unions that do fantastic work.”

One respondent recognizes that, at least in their facility, the management team realizes “they have to get along with us.” Even so, hostile reactions from managers towards the ratios still arise from time to time. This respondent also has seen the open hostility from nurse managers in a hospital in Las Vegas owned by Columbia HCA. “The administrative response is really hostile because they realize it’s all about power. If we represent the nurses there, the nurses are going to have more power. If they’re unrepresented, they’ll have more power. It’s all about who’s got power with them.”

“Every once in a while we run across someone who’s not (hostile), but that’s very much the exception.” This respondent notes the connectivity of the people between the ANA California, AONE in California, and the purportedly independent research team CALNOC, which for several years now has been issuing studies of the impact of the ratio law. “They’re a lot of the same people. . . .” The respondent looks back to the breakup, noting that there was “a lot of very acrimonious rhetoric that we got from A1 (AONE is frequently referred to by the CNA/NNOC respondents as A1) and the new ANA-C people because they felt like we had stolen their organization here in California. And in fact I guess, like the sense that Robin Hood was a thief, we had certainly taken it from them. Whether it was theirs to begin with is another question.”

This CALNOC assault on the ratio law appears to be a political tactic in preparation for the upcoming legislative review of the ratio law in 2010 and 2011, an attempt to influence the review by pointing to multiple studies that demonstrate little or no impact from the mandated ratios on patient safety or patient outcomes in general. “Our CNA research team looked at ‘these studies’ and refuted everything because all their quality indicators really had nothing to do with nursing whatsoever. Those things

were not in our control, yet they used them as the rationale for why ratios don't work, which was horse shit.”

Question 19. If they are so inclined, what can nurses do to assist the CNA/NNOC in its efforts? The easiest and least painful thing the nurses could do to support the CNA/NNOC in its efforts across the country is to join the organization (\$30/year). Many respondents also are aware of duties the nurses have to protect themselves, educate themselves, and become a part of the larger social battle for a single payer system. As noted earlier, it is unclear whether the CNA/NNOC, and now the NNU, will exclude or dissuade membership to those opposed to a single payer system, a central platform issue of the new super union.

For its part, the CNA/NNOC is very aware of its need to provide continuing education for its members not only about bedside practice issues but also about organizational and systemic structures, administrative power, and political activism. The CNA/NNOC leadership is convinced that if nurses are educated about, among other things, the “healthcare system as compared to the systems in Canada or many of the European countries,” they will “understand the pitfalls of the current health care system, (and) be willing to step forward and stand up for the people who can't do it for themselves.” This constant, ongoing educational responsibility on the part of the organization is evident throughout the responses, and is a successful tactic used extensively during the post-rebellion days. Following is a list of the suggestions from the CNA/NNOC members for the staff nurses, or for that matter, for nurses anywhere who want to assist the CNA/NNOC effort:

- Get more involved, become more knowledgeable.

- Join the CNA/NNOC at \$30 per year.
- Stick together.
- Write letters.
- Come to events.
- Visit legislators.
- Educate each other.
- Speak at public events.
- Go online to nursing web sites to promote nursing unity, network with CNA members.
- Join the RNRN disaster relief team of the CNA/NNOC.
- Organize in the facility, the state association.
- Run for public office.
- Become a nursing rep at their facility.
- If necessary, pull out of their state association.
- Respond positively and militantly in organizing their place of employment.
- Even if you belong to another organization, you can still support us as well.
- Look to the CNA as a model of success.
- Support single payer efforts.
- Advocate for ratio efforts in their state.
- Be “on the steps of the capital” when needed.
- Get involved in committees and panels in their facilities devoted to quality improvement.

- Inform their co-workers.

Question 20. What influence could a politically empowered nursing profession have on the national healthcare debate? To a person, every one of the respondents clearly sees the impact a politically organized nursing workforce would have on the national healthcare debate. Massive, enormous, huge, and unbelievable are terms frequently used in the responses to describe this potential impact. While many see this as nursing's chance to influence the debate, some recognize an organized nursing force as potentially being able to control the direction of the reform effort. They recognize nursing as the most trusted profession in the U.S., and the political imagery of this well-respected, well-trusted group of professionals up against corporate interests is a potent one. They recognize that the recent financial meltdown has placed great public doubt as to the intentions of corporations and the need to control them.

Some see this as an opportunity to institute national standards of nurse protection, and through this, patient protection. By protecting the nurse with ratios and whistle-blower statutes, they reason that they will be improving patient safety. So far, over 100 studies have supported this association. One would think the recent moves by Medicare, wherein certain hospital acquired conditions are no longer reimbursed, would empower this kind of staffing concern; but, once again, we see the industry willing to engage in every mode of administrative re-organization except the increase in RN staffing. Even the AHRQ data, which clearly showed no profit loss from increased staffing, seems ignored. Perhaps if the financial conditions are made to be SO intolerant, Americans finally may see an industry relenting. This move to work within and through Medicare is a noteworthy one, particularly since it establishes national

standards and avoids the state-by-state bouts. This could be a very potent tool in the hands of an empowered nursing organization.

They feel that they, and not the ANA, should be representing the interests of nursing at the summit meetings with President Obama. “They do not represent our ends. They do not represent the patients. Yet they speak as the voice of nursing?” They recognize that the lack of organizational strength has kept them from establishing a national presence in the public domain, primarily because the funding needed to maintain a national media campaign is tremendous. Considering how effective they have been with a shoestring budget, one can only imagine their effectiveness when the campaign becomes not only focused, but endowed.

“I think nurses speaking out about what is wrong with the current system...and having an idea HOW to fix it would actually influence the debate.” This indeed is a return to the Lillian Wald vision of a profession of nursing “knowing and telling,” of acting independently to advocate for patients, and of addressing the social conditions that are influencing our collective health. So far, the solutions presented by CNA/NNOC for a solution include only a single payer mandate. They then assume that the entire system will re-structure along this decision, although there is no guarantee that other systemic changes also will occur. How, for instance, will a single payer system mandate the need to move from a system based on acute intervention to one focused on prevention and screening? How will single payer address the imbalance between primary care services and specialty care? How will the CNA/NNOC support ARNPs, or will they? Many questions have yet to be answered, including what constitutes basic care? Single payer is a solution for the payment issue, but not for the

cost issue, and the chasm between payment and provision will remain. He who pays the piper frequently begins to call the tunes.

One respondent addresses the self-worth issue, noting, “It makes everything so much better if you feel like you have a say in the world. To me it does anyway.” They are addressing the historical nursing perceptions of political impotency, both within the practice facilities as well as within the public domain. The ANA position has been long on rhetoric but short on action. The CNA/NNOC has been long on action but with a muffled voice, at least outside of California. That appears to be ending, and as the NNOC continues to expand into states like Florida and Texas, the recent merger indeed may bring about a strong national voice for this organization.

Also mentioned is the responsibility of the nurses themselves to get involved politically. “I meet some nurses, not many, but some nurses who don’t even vote! They’re not even registered to vote! Like spending a few hours every 4 years is asking too much.” “Voter fatigue! That one really pisses me off.” “Who’s getting fatigued? They’re getting fatigued about voting once every 4 years for President? What are they getting fatigued about? If they’re fatigued listening to all the media, maybe they need to turn off the TV and read, or get involved somewhere. Go to a town hall meeting and discuss the issues with your fellow citizens. Just voting is the bare minimum!”

CHAPTER 5

IMPLICATIONS OF THIS STUDY

Conclusion

“In the FAA’s most recent federal budget, one of its stated goals is to reduce from airplane crashes in the United States by 80 percent by 2007. This is a goal of an organization that: 1) is accountable to the public for achieving it, in partnership with the industry and others in aviation; and 2) has the authority to require the airline industry to take actions to achieve the goal. There is no game plan yet to prevent deaths and serious injuries from medical errors. Without it, they’ll keep coming - another million deaths a decade” (Gibson & Singh, 2003 p. 240).

This study discusses the impact on both the profession of nursing and the national healthcare system with the rising political power of the California Nurses Association and the National Nurse Organizing Committee. Effective December 2009, that now changes to mean the National Nurses United, an empowered super union composed of the Maine State Nurses Association, the Massachusetts State Nursing Association, the Pennsylvania Nurses Association, the California Nurses Association, the United American Nurse, and most of the SEIU nurses. In addition to Massachusetts and the CNA core, the new organization now represents nurses across Michigan, Minnesota, and in VA facilities nationally. This organization is now 150,000+ strong and rivals the American Nurses Association as *the voice of nursing*.

Delegates at the December conference in Arizona elected a new three-member NNU Council of Presidents, made up of RNs Karen Higgins of Massachusetts, Jean Ross of Minnesota, and Deborah Burger of California. Martha Kuhl, RN (from California) was elected secretary-treasurer, and a number of board members from the constituent associations were named vice-presidents. Most importantly, Rose Ann DeMoro, who has served as the CNA executive director since the staff nurse rebellion in 1993, was named executive director of NNU. Along with Rose Ann DeMoro's other accomplishments with the CNA/NNOC, she:

- is a nationally prominent voice in labor;
- has been named among the 100 most powerful people in healthcare by the industry publication *Modern Healthcare* for nine consecutive years;
- was cited among the 'Most Influential Women in America' by MSN, and among 'America's Best and Brightest' by *Esquire Magazine (Registered Nurse, November/December 2009)*;
- has a demonstrated track record of leading nurses to a political end, not just a rhetorical façade;
- has extensive experience taking on entrenched power and overwhelmingly better financed industries; and
- has brought the CNA/NNOC to the very brink of dominance as THE political force in nursing.

She is keenly aware of the need for public presencing, public participation, and the need to keep the public focused on the safety issues at hand. She, and the people who work with her at CNA/NNOC, are resolutely determined to see their organization

succeed, to see the direct care nurse empowered to protect patients, at their facilities, in their states, and in their country.

The murkier waters are those surrounding the issue of a single payer system. While this is a platform for the newly formed NNU, it remains to be seen how nurses across the country will respond if this is made a critical issue for membership. The organizational view that education will lead nurses to see single payer as the only possible solution presupposes a lot. If nurses respond as the American public has responded over the past year, it well may take a LOT of education to accomplish this. Of course, a single payer system does nothing to address the issues of non-competitive facilities, staffing, quality, distribution of services, high drug prices, or a host of other systemic failures in the U.S. healthcare non-system. While intelligent people can argue numbers all day long, the public perception appears to be that healthcare reform is good as long as it does not cost anything more. The irrational argument that it increases governmental control over healthcare nevertheless is a politically significant one, since it is used by some groups (in the media), to create instant opposition in the public to certain policies. When projected costs are presented, the public also seems to balk.

The Republican Party oppositionist stance is contributing to this morass, and the fact that they failed to initiate any meaningful reforms during their tenure, and that their new plan is nothing more than a re-hashing of previously proposed and politically defeated gestures, is disconcerting to those who see healthcare reform as a critical national priority. True Libertarians, of course, are opposed to anything that runs against outright free market control, but they represent a very small number of citizens. Politically, the Tea Party'ers are much more dangerous, as they appear able to tap into

anti-big government people, and provide a forum for the more racist segment of American society, thus potentially representing a significant voting block that also opposes the socialization of healthcare. If education is indeed the key, than the new NNU better hire a large number of teachers!

2010-2012 promises to be a very interesting period, particularly when it comes to healthcare reform, since both the Senate and the House have passed the healthcare bill and President Obama has signed it into law. Unfortunately for the reformers, the election in Massachusetts has thrown the U.S. Senate into chaos, and a vigorous empowerment of the passed healthcare reform now seems a distant dream as the administration pivots to address the continuing unemployment situation in the country. Never mind that the corporations are the primary reason unemployment is so bad, having shipped so many jobs overseas and moved the industrial base for the U.S. offshore. The continued inability of labor organizations to address these issues has been one reason for the imbalance of political power over the past three decades.

What role the newly formed NNU will play in the interpretation of the healthcare bill has yet to be determined. Will we see the politically, socially, and media astute professionals who have managed win after win in California, or will we see the emergence of a more conservative and ever composing organization that feels its way onto the national stage? Will the hardball politics learned in California be applied to the national arena? Will the street theatre that was so effective work at the national level, or will it drive people away, including nurses? Will we see a rejection of compromise positions regarding a single payer system, or will we see political acceptance of whatever emerges from the bowels of Congress? Will the CNA media and legal teams,

which have shown nothing but brilliance over the past 17 years, be traded in for a national team, or will they translate their accomplishments to the national stage? If past history is any lesson, do not expect this organization to play anything less than political hardball, and expect them to come out swinging very soon. And that means via the media.

The impact on nursing is more absolute and strangely, while not acknowledged by most nursing academics or nurse administrators, it already has happened. The impact goes far beyond the simple numerical calculation of membership, and represents a new hope for the re-emergence of a socially active profession of nursing, a profession dedicated to the Lillian Wald challenge to know and tell. A nursing profession grounded not on a false sense of what it means to be a professional, and certainly not on the rationales given by others as to what that term means. The CNA/NNOC movement has generated, or at least should generate, a discussion about what the core essence of nursing is. Are nurse's administrators and recorders of healthcare, or are we direct care practitioners and true partners in healthcare? Are we patient advocates, with all the social responsibility that that entails, or are we industry representatives who also try to be concerned about patient safety? Many nurses are asking themselves: Is this CNA/NNOC for real, or is it just another mirage like the ones we have had from our nursing leaders and their organizations for decades?

At some point, this organization will need to transcend the image of just a labor organization and announce its birth as THE political organization for nursing. It is not enough for nursing just to be empowered, it must be overwhelmingly dominant. The numbers in nursing are impressive as a field, but the money spent by the opponents of

reform also are formidable, and cannot be underestimated. Spending millions on a national media campaign only to have it unravel from a few well-placed ads right before a vote is a lesson nursing needs to have learned from the past. In 2009, a year when healthcare was hotly debated, the industry spent over \$4.4 BILLION dollars on lobbying. Nursing simply cannot compete with this. The new organization must learn from the California experience, and listen to the only leaders who ever have been successful. Nursing must use this experience as a guide to local, regional, and national empowerment, and a template for what can and does work politically.

The challenges facing the new organization are daunting. They must continue to expand, reaching out to individual nurses, groups of nurses, regional groups of nurses, and other associations of nurses. What the AACN will do also is unknown at this time, and whether the critical care nursing association can or will emerge as the natural leader they are, may go a long way to further expansion of the NNU, in fact positioning the NNU as the dominant voice in nursing. Other, smaller nursing groups need to be recruited, and recruited actively. These include the cancer nurses, the pediatric nurses, the home health nurses, the public health nurses, and many more. Though small, their numbers can add up quickly, and the association of so many specialties adds political credence to the message. Ultimately, this is the most challenging task of the NNU: how to broaden the membership without diluting the message. At what point does the growth of the association create a critical mass where the old messages and messengers become muted by a louder din? Will the union language of Franklin Street play on Main Street?

The hope is that the reader will get a sense of the commitment from the members of this organization, and with that, a renewed interest in the ongoing struggle for nursing. This struggle has been taking place since 1903, when executive “wannabes” were seduced by the possibility of power and prestige in the emerging healthcare delivery system. That power and prestige never has materialized, but the imagery within this group is strong. This is a battle for the very heart and soul of nursing, a profession envisaged to be one of social and political activism, of independently creating and refining health delivery systems to every citizen, regardless of socioeconomic status. Lastly, this is a battle that, for the last few decades at least, was waged by a relatively small number of visionary nurses, not out of a sense of personal aggrandizement or resume padding, but out of a deep commitment to patient advocacy and quality nursing care. These are bedside, direct care nurses. They are not blinded by degrees, by power, by prestige, or by income. They are fiercely determined to wage this battle, and are resolutely convinced that other nurses will join them once the cause is explained. They are battle hardened from years of taking on the opposition forces in California. They will not give up anytime soon.

Implications for Theory

Powerlessness in an organization is too often attributed by members to external constraints (the other) or historical demands/limitations (the way it’s always been). Yet, waiting for others to bestow, i.e., give away power, is a fool’s errand, like waiting for Godot. The evolution and political empowerment of the CNA demonstrates how purpose, commitment, and achievement can take power instead of waiting for it to be given. However, it raises questions about 1) the necessity of including every one of

Hagberg's six steps, 2) the necessity of the steps always occurring in the sequential requirement of the model, and 3) are the requirements cited by Hagberg applicable when the model is utilized at the organizational level. This appears reasonable and defensible in light of the Burke-Litwin proposition that activities and events control the organization, not structure or policies. One major theoretical implication of this study, then, is that the development of organizational power in an open systems environment may adhere to traditional constraints/models, but is not determined by them.

Well supported in this study is the Burke-Litwin theory regarding the value of an open systems model for organizational change. Both the CNA and the AMA adopted this organizational structure, and both are significantly empowered because of it. For nursing in particular, the necessity of having a clear focus on the issues of the work unit (the bedside RN's in this case) seems irrefutable. Bedside nurses comprise a large majority of the nurses, and their support is vital. By not addressing these concerns, the ANA is quickly losing its relevance as a national voice for nursing, and membership numbers are telling this to the ANA. Whether they listen or not is yet to be seen, but so far they have not listened. The Burke-Litwin open systems model was consistent in predicting the success of the CNA and AMA, and the failure of the ANA.

At first glance, the two major themes that emerged out of this study (organizational change and political empowerment) may appear indistinguishable. It would make logical sense to assume that political empowerment (of a previously unempowered organization) would require and follow organizational change, but that may not always be the case. Take for example, the nurse practitioner issue. Here is a group very focused on the work unit, the autonomy and independent prescriptive

authority of the individual practitioner. They appear to be a prime example of an open systems organizational model. Yet, though they won the national battle in terms of direct Medicare reimbursement and DEA clearance to prescribe, they have become politically bogged down in many states, battling with state medical associations. The evidence to support them is overwhelming, the political will is strong, and yet the empowerment is simply not there. One clear reason may be that there are simply not enough Nurse Practitioner's to make a political difference, and thus they cannot overtake the influence (in prestige or money) of medicine in the political process.

Political empowerment must be distinct from whether organizational change occurs or not. Too many groups have political power and not all are open systems. As a result, it is theoretically possible to provide a model for political empowerment based on this study of the California nurses. The model applied in this analysis is the model based on the Hagberg Real Power theory. A discussion follows on how this model applies to other nursing organizations as they seek political empowerment.

As noted in the introduction, the development of organizational power in an open systems environment may adhere to traditional constraints/models, but they do not determine them. Several myths surround the issue of political empowerment, warranting some discussion. Some believe that money is the sole determinant in achieving political power, and much of human history supports this. The CNA/NNOC, however, did not have money (at least money to burn) and yet became and are quite successful and empowered, at least at the state level. The ANA had much more in terms of resources, and yet were unable to acquire any real power beyond rhetorical power. Others believe that gender is the key determinant, and yet the ANA and the

CNA/NNOC are both overwhelmingly women. The National Education Association is also predominantly female, and this organization is very politically empowered. Lastly, some believe that the game is too rigged for meaningful reform, that powerful special interests control the political agenda and have bought the legislators. The CNA experience shows this is not true. Using street theatre, low-tech media, and innovative legal strategies enabled this small group of determined nurses to confront and defeat both the big money of the AHA and the attempt at political coercion by a very popular governor. This study debunks all of these myths.

The study question is, then: Is the Hagberg model, a model designed for personal political empowerment within organizations, also applicable to the organizations themselves? If it does apply, and supported in this study, then nursing organizations (who may already be familiar with it) may begin to use the model for political empowerment. If it is not applicable, is the model completely irrelevant, or does the study support some variation to it?

As the reader may recall from chapter one, the Hagberg model consists of six sequential stages:

1. Powerlessness,
2. Power by association,
3. Power by achievement,
4. Power by reflection,
5. Power by purpose, and
6. Power by wisdom.

The AMA, the ANA, and the CNA/NNOC all were powerless at one point, although it has been more than a hundred years for the AMA. The ANA has been politically powerless since its inception for anything beyond strictly nursing issues, and limited further to those nursing issues that did not interfere with facility or medical interests. The CNA (pre 1995) as a member of the ANA was included with this powerlessness, even though they did manage to enact ICU ratios in 1975, and had a history of activism. Both the ANA and the AMA followed the traditional path to political empowerment. The CNA deviated from this path after 1995.

The ANA faltered at stage two of the Hagberg model, power by association. Physicians, according to Starr, historically situated in the urban areas of the eastern U.S. for some time, enjoyed their association with the wealthy class found there. The power by association was already in place when the scientific discoveries, which catapulted this group into medical supremacy in the late 1800's, became available. They readily capitalized on this and easily transitioned into stage three, the power of achievement. The ANA, however, in spite of the prominence of leaders experienced in social activism, could not move out of stage two. While individual nurses did demonstrate tremendous innovation in designing true community based health care systems, the organizational affiliation in 1903 relegated the field of nursing to a subservient position. The affiliation with hospital management was not enough, or never designed, to move them into stage three. The CNA/NNOC evidently bypassed both of these stages.

With the power of achievement growing almost daily for the MD physicians, they quickly moved into, and completed, stages four, five and six. In the early 20th century, organized medicine absorbed those groups that were also popular with the rich

and famous, adopted an open systems model for their professional organization, and took control of both their education and their legal supremacy. The ANA remains mired in stage two.

The post-1995 CNA appears to have moved directly to stage four, the power of purpose. While there was a period of reflection leading up to the staff nurse rebellion, the organization itself was not involved. The union, however, did provide a mechanism for the nurses to communicate with each other, and a sense of purpose emerged out of those associations. By taking over all the positions in the CNA, especially the executive layers, these nurses empowered the organization to focus its entire resources on this purpose. It was only four years until the ratio legislation became law.

A period of reflection did follow the take-over, and the organization faced enormous challenges during the first few years. Teleological and tactical strategies were developed, ratified, and implemented, often on a shoestring budget. Threats came from all directions, including from within nursing itself. The strength in their power of purpose held it all together, and these nurses, who were tasting empowerment for the first time, would not let anything stop them.

From stage four, the CNA moved into stage three, power by achievement, which culminated in the passage and signing of the ratio laws. The achievements at first were modest, consisting mostly of isolated union contracts in primarily northern California hospitals. Soon, larger and larger systems were under contract, and the achievements became significant. Hospitals, and hospital systems were becoming CNA facilities, and this soon spread to southern California, an area long neglected by the pre-1995 CNA.

Nurses responded to these achievements from all over California, and the CNA grew to over 65,000 members by the end of the century.

The power of wisdom, stage six, was the final stage for the CNA. The early political failures educated the CNA leadership, and they quickly adopted the strategies of political hardball. The lessons these nurses learned in the hostile take-over of the CNA made them quick studies in the state political arena. Long gone were the days of coming hat-in-hand to the political decision making tables. The CNA actively engaged and confronted legislators who opposed the ratio law, in their home districts, and even in their offices. They mobilized public opinion to support them, and they used whatever media they could find to get their message out into the public domain. They opportunistically took advantage of every event to gain both media exposure, public sympathy, and support. More important, they actively created events to attract the media. This is really the first time that a nursing organization has implemented a strategy of proactive media utilization, since even the media utilization in New York was reactive, not proactive. The message from CNA was always clear and concise: Safe patient care depends on safe staffing levels for RN's. Later on, the media messages would also engage the issue of a single payer system, but the original messages were consistent.

The most problematic stage for an organization seeking to become politically empowered in a non-traditional way is stage two, the power of association. With the exception of the public, CNA steadfastly refused to enter into agreements or committed relationships with other groups, including the Democratic Party (which compared to the Republican Party, more often than not supported their efforts). There

was, however, a brief affiliation with the AFL-CIO, but this was well after the organization had become influential. This non-affiliation strategy proved very successful for the CNA. Now, we see the move towards a national association, the NNU, and one can assume national affiliations via the NNU will become more of a strategic necessity. As was noted earlier, the AMA had already been in stage two when the scientific discoveries of the late 1800's allowed them to move their position forward into stage three, the power from achievement. The ANA, in the 1903 affiliation with the hospital administration, moved into stage two, but it would never emerge from this level, nor achieve the influence many assumed that affiliation would bring.

The Hagberg model for political empowerment also included nine conditions or qualifications. A discussion follows on whether those conditions must be satisfied when the model is adapted to organizational political empowerment. The nine requirements are:

1. These stages are arranged in a developmental order;
2. Each stage is distinct;
3. People (and organizations) can be in different stages at different times, but there IS something of a home stage, a stage we tend to stay in or go back to;
4. The movement must be sequential, from stage 1 to stage 6;
5. Power is different at each stage;
6. Each stage has a positive and negative aspect to it, and developmental struggles that are unique;
7. Gender is a strong determinant as to which stage one identifies with

8. While age and experience are important, they do not necessarily move you from one stage to another; and
9. The external 1-3 stages are dramatically different from the internal 4-6 stages.

This study does not support the idea that the stages are necessarily developmental, requirement one according to Hagberg. CNA moved directly from stage one into stage 5, backtracked into stage 3, and then moved forward again into stage 4. Stage 6 evolved after some major achievements had been accomplished. This sequencing may apply to any organization unable to follow the traditional pathway, from whatever cause.

Each stage does appear to be distinct in this study. There was an obvious movement from one stage to another, sometimes conscious and strategically planned by the CNA. Each of the 6 stages are evident in the responses, as the course of this movement is relayed.

The third requirement is that, while organizations can and do move into and out of the six stages, there is a home stage that they tend to go back to. It appears the CNA has never left their home stage. Their sense of purpose dominated all activities, and continues to dominate them. The AMA has also never strayed far from their power by association with the wealthy and powerful, a relationship which accelerated after the 1960's, perhaps due to the increase in physician specialization. The ANA appears never to have found a home stage, unable to advance to a sense of purpose strong enough to attract their much needed work unit support, and mired in what appears to be a futile attempt to achieve political power via their affiliation with the AHA.

This study also does not support requirement 4, the need for sequential movement through the stages. While the more traditional history of the AMA supports this requirement, the study of the CNA clearly shows that alternative pathways are available. In a comparison with the NP political empowerment experience, it does appear that numbers are important. Both organizations focus on the concerns of the practitioner, but the NP situation is hampered by a relatively small support base.

Power does appear to be different at each level. With each progression, the CNA had more and more political power, enhancing both internal and external power. The power of purpose increased membership, the power of reflection gave them coordination in their efforts, the power of achievement allowed them to gain more notoriety, increase membership dramatically, and move into the national arena, while the power of wisdom has now made them an indispensable consultant to the California Legislature.

To date, the CNA has not really experienced a downside to their progression towards political empowerment, requirement 6. The respondents remain optimistic and clearly focused on their goals. This clear focus, combined with their conscious decision to avoid structural affiliations may help explain why. While the developmental struggles at each stage do appear to have been unique, it appears that the leadership team at CNA was more than up to the task of keeping the organization cohesive. One of the criticisms from inside nursing is that Rose Ann De Moro is not herself a nurse, but readers might remember that Dorothea Dix, credited with having a very strong influence in the early development of nursing during and after the Civil War, was also

not a nurse. This criticism of CNA seems superfluous and petty given the long list of accomplishments under her leadership.

The issue of gender being a determinant of the stage the organization identifies with is inconclusive in this study. The AMA, mostly male, appears to have resided itself in stage 6, power by wisdom, but they have never gone too far from their stage 2 affiliation with the rich and powerful. Some studies suggest that the majority of medical students now enter training for the goal of monetary gain, not serving to poor and sick. There has been no mass physician outrage regarding the production and manufacturing of cigarettes, or environmental pollution, or even poverty and poor housing. Once the physicians moved their practice from the house to the office, they essentially abandoned their commitment to social issues, perhaps not to antagonize the power by association. The CNA (mostly women) and the ANA (mostly women) present contrasting experiences, so support for the influence of gender as a determinant of the stage is not available from this study.

Age and experience are not supported in this study as a requirement for political empowerment, and are irrelevant to the movement from one stage to another. It took the CNA only four years to pass the ratio laws in California once they reorganized themselves, and the ANA has been in existence for more than 100 years. Both the ANA and the AMA have been around for a long time, but differ sharply in their political empowerment. CNA has not had to confront the AMA directly, since the staff nurse issues are irrelevant to most physicians, except those who own medical facilities. Advanced practice for nurses has caused severe friction between the AMA and nursing organizations, but the CNA has remained outside of that fray. Whether the AMA

supports the CNA in their efforts is unclear, but the AMA has moved to the right politically since the 1970's, perhaps as a response to the managed care explosion and perhaps a consequence of their self-identity with wealth, and so the sociopolitical agendas of these two organizations are almost polar.

There is no support in this study for the last requirement, that the internal stages (1-3) and the external stages (4-6) are dramatically different. All of the stages are internal in the CNA experience. This is clearly a result of leadership and the work units keeping so completely on task as to their purpose. The fact that the leadership of the CNA, up to the President level (but not the Executive Director), has as a requirement that they BE a work unit (bedside nurse) is a major reason why this organization works. Their refusal to affiliate has also reduced the chances that their message and purpose would be watered-down by compromises or re-directed under the influence of another organizational agenda.

The Hagberg Model for Organizational Political Empowerment

What emerges from this study is a variation of the Hagberg model applicable to nursing organizations that desire to achieve political empowerment. Only further testing of this model will allow researchers to determine if this variation applies to organizations outside of nursing, whether it applies to any disempowered organization, and if it is effective with an organization unable to mobilize a large support base.

The first challenge for a nursing organization seeking political empowerment will be to establish a system for nurse-to-nurse communication, because only then will a cohesive purpose be revealed. In California, the unions played this important role, but that is not to say that only a union can provide this. This is particularly true given

today's media technology, technology that did not exist during the time of the staff nurse rebellion. Traditional nurse-to-nurse media are simply too controlled by either nursing academics (the peer reviewed journals) or the healthcare industry (Spectrum, Advance, etc.), and both have their own agendas distinct from those of the nurse work unit.

Once a means of communication is established, enough support can be garnered to move into the reflection stage. During this stage, the nurses need to decide on a tactical plan for their empowerment. One alternative would be to create a new nursing organization, but due to the small numbers associated with the existing ANA state chapters, it makes logical sense to take over those state nursing associations and re-direct them in purpose. Why re-invent the wheel? Once taken over (or taken back as the California nurses see it), a decision will have to be made regarding whether or not to say affiliated with the ANA. The advantage in staying with the ANA is unknown, but it may prevent the loss of many nurses such as happened in California. The advantage in leaving the ANA (after the take-over) is in having an organization, and an organizational message, clearly focused on the purpose. The disadvantage in starting a new organization includes having to invest in infrastructure, and a loss of name recognition. Any organizational take-over, however, must be complete and include the executive levels, a position supported in the Burke-Litwin open systems theory of organizational effectiveness.

Once integration of the organizational purpose occurs, distribution of the message becomes reality, and membership numbers are increasing, then and only then can the organization begin to implement the political strategy supported by its members.

This must include both proactive and reactive media presencing, although the media method need not be expensive or the venue complicated. Members must be engaged in this process, however, and willing to support the efforts of the organization, be they writing letters to legislators or marching in the street to protest. The organization must also learn the rules of hardball politics. Members must be willing to confront legislators who oppose the changes, and support those who do. They must be willing to learn who the key legislative players are, and understand the committee structures in their respective states. Data must be collected, analyzed, and integrated into the political strategies. This does not mean, however, that the organization must do everything alone. Public support, patient support, and both individual relationships as well as social networks can broaden the support for the political goal. If the goals of the organization are compatible with those of the CNA, a simple NNOC affiliation may bring needed advice, political strategy consultations, and membership in the NNU, which in turn strengthens their political empowerment.

Achievements, be they small or large, need celebration, and setbacks need to be learning experiences. Small achievements can include membership milestones, successful media events, positive media exposure, or even the mere introduction of a bill in the state assembly. Larger achievements include the doubling of membership, massive rallies, the moving of a bill out of subcommittee, and, hopefully, the passage of a bill and the signing by the governor. If the study of the CNA shows anything, it shows an organization that was patient but persistent, fiercely determined but realistic, and which learned from their failures.

The power of wisdom will come once large achievements begin to be realized and the public and the legislature recognize and accept the purity of the cause (as in the case of the staffing ratio law in California). Nursing organizations, and nursing in general, must keep the focus on the provision of safe patient care, and avoid the trappings of hubris or self-interest commonly associated with success. The advantage nursing organizations have include public recognition as the most trusted profession, and the fact that protecting the bedside nurse is the best way to protect safe patient care.

APPENDIXES

APPENDIX A

INTERVIEW QUESTIONS

1. When did your association with the California Nurses Association begin, and what was your level of involvement at the time?
2. When did the original idea for the disenfranchisement of the CNA from the ANA begin taking off, and why?
3. Why not form another association? Why use the CNA?
4. Can you discuss the events leading up to the disenfranchisement from a strategic perspective?
5. What was the strategic plan for growing the association within California?
6. When did you feel you had enough momentum to begin the policy initiatives?
7. Money is always the elephant in the room. What was the financial status of the CNA and how were the resources allocated under the strategic plan?
8. What specific political tactics were used during the legislative process for staffing ratios and minimum pay?
9. What political obstacles did you encounter with the California Legislature, and how were they overcome?
10. What advice would you give other state associations who want ratio laws and/or minimum salaries for RN's in their states?
11. When did you realize that Governor Schwarzenegger was opposing the ratio law, who was the driving force behind the court case, and how did you gain the legal victory?
12. When did the concept of a National Nurse Organizing Committee begin?

13. What was, and is, the strategic plan for the NNOC? Has it changed in the last four years?
14. What kind of response has there been from bedside nurses around the country to the NNOC?
15. What media utilization strategies are in place within the CNA/NNOC, and what do you anticipate is the need for media presencing?
16. Given the increasing breakup of the ANA, and the historic alienation of the AONE from the interests of the bedside nurse, what role do you anticipate the CNA/NNOC will have in the profession of nursing?
17. Has there been a response from the academic community to the CNA or CNA/NNOC movement, and what explains this?
18. What has been the response to the CNA/NNOC from the AONE or nursing administrations in general?
19. If they are so inclined, what can nurses do to assist the CNA/NNOC in its efforts?
20. What influence could a politically empowered nursing profession have on the national healthcare debate?

APPENDIX B

INTERVIEW DATA

1. When did your association with the California Nurses Association begin, and what was your level of involvement at the time?

The following table breaks down the respondent year of entry and the reason given for joining the CNA.

Year Of Joining	Reason For Joining
1969	As new grad at Mills-Peninsula Hospital.
1974	Various levels of involvement, started off as a general staff nurse just belonging to CAN.
1979	Employment at Good Samaritan Hospital, a closed shop.
1982	Moved from Sacramento to San Francisco- Took Kaiser job. Not happy at non-union hospital.
1982	Employed at closed shop hospital, but did not get active until 1988. Saw a difference from non-union hospital in central California.
1982	New RN at Children’s Hospital in Oakland.
1982	Moved from Chicago to California - Hospital was a closed shop.
1985	Employed at Kaiser Santa Rosa.
1986	Took job at University of California San Francisco Hospital.
1991	Hired by CAN - Was a Longshoreman’s union representative, but had worked with some healthcare groups they represented.
1992	Labor representative hired by CEGW.
1992	Represented “other” unions, but liked CNA and got consulted mid 1992 after the Summit strikes but before the firings. Worked out legal challenge to terminations of CEGW management employees, resulting in a legal injunction against the CNA for interference with the CEGW.
1992	Hired to work on “Dues” campaign, became Communications Director.
1992	I was hired as a secretary for the organization in which capacity I am still working.
1997	Joined with unionization effort at Mercy General in Sacramento, became an organizer due to re-design efforts at hospital.

In all, 10 of the respondents (all of the RN’s) maintained general membership and did not become active in the CNA until a catalyst such as a strike or other crisis at their facility. Three were labor representatives, including attorneys, who became

admirers of the CNA organization, the “cause,” and the leadership. One was a project manager who later would become the communications director. One was a secretary. Currently, all of the nurses are representatives of the CNA at their respective facilities, may or may not hold an office with CNA, and many travel around the country assisting other state nursing associations or groups of interested nurses with their efforts to organize.

The respondents clearly are direct participants of the events discussed, relaying first hand information as opposed to organizational mythology. While not every respondent was an authority on every topic, their combined accounts of the events provide for a rich participatory history analysis of the time and events.

2. When did the original idea for the disenfranchisement of the CNA from the ANA begin taking off, and why? Responses have been edited for clarity and continuity.

That was the thing, there was no choice. We learned that management people, management RN's could not represent the bedside nurses: they could not speak on our behalf. Started in the 1980's and early 1990's. We knew we had to take over and that's when we started organizing bedside nurses to speak for bedside nurses.

All those years that we had been under them we tried to work with them. It's just that this group of people, these groups of RNs have a different mindset. They work for the hospital industry. They run the hospitals. It's a big conflict of interests if they're speaking on behalf of our employers and yet they want to speak on behalf of the employees. They dominated the organization (CNA). They set policies, and they set standards, and the policies were, of course, in favor of the hospital industry, not in favor of the RN employees, the bedside nurses.

Finally we gained the momentum, we went to our House of Delegates (which happens every 2 years) and we had this motion to remove ourselves and disengaged from the ANA.

I was not with the CNA at that time, but it was in 1992 after many staff members of the organization then associated with the ANA (CEGW) were fired. At that time the staff nurses had little power, the nurses were not allowed to choose their own staff representatives and often a lawyer did the negotiations, not the staff nurses.

I believe the original idea for disenfranchisement from the ANA began in about 1992 and the reason it was supported was because the bedside RNs in CNA did not see ANA advocating for them or their patients.

In 1992, because managed care was touted as the solution for controlling cost by the healthcare industry, and the CNA Board dominated by the nursing elite told the staff nurses to get on board with the new model of clinical restructuring, although the hospitals had unsafe staffing, excessive patient loads, and high acuity patients.

This then caused the staff RNs (90% of the membership) to elect in 1993 (at the convention) a majority to the Board of Directors, then in 1995, by a vote of 92%, at the House of Delegates to become an independent organization, severing ties with ANA. The change was needed because of the differences between the membership and the elite in how the organization should be run, and the governing principles behind what was important, and the focus of where/how the organization would grow.

I remember that happening in the late 1980s, early 1990s, but my involvement with CNA was not much because of my children. But it started around the late 1980s and the 90s and it was more that the staff nurses really didn't have a voice within the then CNA which had a strong ANA influence. There was the firing of Rose Ann DeMoro and several of the staff. It was at that point that the staff nurses really wanted to take over. They wanted a voice.

I am not sure exactly when the idea of disenfranchisement of the CNA from the ANA began. I know in the early 1990s nurses were becoming progressively more unhappy with the tone of the organization reflecting managers' and academics' priorities and not frontline nurses. The majority of members were not represented by the elite group in power who did nothing to support bedside nurses. At the time there were great changes going on with HMO's and hospital restructuring and in the clinic I worked in they were trying to eliminate the RNs.

Probably in 1911 you know, as I think is reflected in the history book of the CNA. There was a history of conflict between the interests of bedside nurses and the nurse-managers/nurse-executives who continue to dominate the ANA. They have been ossified for 100 years and the people who ran CNA up until 1992 were very much a part of that mentality. Literally there were debates that went on in the Progressive era between bedside nurses and the management of CNA over issues related to the interest and needs of Director RN's having to do with work place conditions, powers, pay, and the ability to advocate for patients.

Then you can follow that pattern up through the 1920s and 1930s, and as you probably know, there were huge debates within the 1930s in particular related to what was happening in the depression. All those generalist nurses were losing their jobs - like 60% of nurses lost their jobs in the depression. They were seeing all around them working people joining unions, and more and more bedside nurses knew they had to do that to protect themselves and their families as well. The ANA was

torn apart, almost destroyed over the whole issue of unionization.

Historically, the leading proponents of unionization were in California. California nurses were the first ones to unionize. California nurses got the first union contracts in 1946. California nurses were the ones who led the first mass protests in the 1960's leading to the mass resignations at Eden Hospital and the eventual repeal in California of the "no strike" pledge which the ANA had issued. It was taking off long before I was here.

It was the mid-1990s. By that time I was more active in the organization in my region, and we were talking about it. The point was it (CNA) was getting too far away from the bedside nurse and the rank and file nurse and going more administrative. More supervisory nurses were running the ANA and we wanted to change that direction for us.

I'm not sure I can answer this question. It had to be probably earlier than 1992. This is a little bit not a direct answer to your question but it's background that might be useful. What I remember is that in 1992 there was a strike at a hospital in Oakland, CA that is called Summit Medical Center. The strike involved not only nurses who were members of the CNA, but I think all the other labor unions representing employees there. There was the office of professional employees union who represented the clericals and business office people, what was known then as the Service Employees International Union Local 250 who represented a lot of the ancillary healthcare workers, and the IOW who had the x-ray techs and I think had the food service employees. Maybe even the Engineers and Scientists of California.

Anyway, it was a big strike. Interestingly, all of the union contracts had expired and the employer was taking a pretty tough line. This was pretty early in the days of HMO's and there were cutbacks all over the place. What I recall the nurses complaining about at the time (I did not represent the nurses) was that their work was being de-skilled and across the industry, employers were trying to reassign RN duties to lesser skilled employees. It was a problem, and the lesser skilled employees didn't necessarily want that responsibility anyway. I can't even remember the reason for that strike, or what the economic proposals of the employer were, but I do remember that it was a hard fought strike and it got a lot of national attention and a lot of press and it upset hospital management very much because it was ultimately a very successful strike. All of the unions got a contract and it was a resounding success.

Everyone honored each other's strike lines, and they really shut the place down. Like I said, it was a pretty big hospital, and this strike upset hospital management a lot, that these uppity unions had the audacity to take them on and shut them down. At this time, the CNA was operated under the ANA model of two houses - one a professional organization and the other the CEGW.

So, the Executive Director of the CNA, apparently at the behest of management (and it probably went right up to the CA Hospital Association), decided that they better stop this move that was afoot to empower bedside nurses, whose function was to fund the organization with their dues but not run it. She then made a decision to terminate everyone employed in a management position in the CEGW, in other

words the decision makers of the organization who were not covered by a staff collective bargaining agreement. She, with phone calls and then hand delivered letters on a Sunday morning (December 20th, 1992) fired the Director of CEGW and the key management employees of the Congress.

The ANA sent in replacements to take their place. The fired leadership wanted to challenge this decision, so I and an attorney I worked for brought an action in US District Court in CA to challenge, seeking injunctive relief to reinstate to their elected positions, the staff nurses who had been removed and also the staff, the employees of the Congress.

I can't answer that accurately. Probably in a lot of peoples hearts around the 1990s. It was apparent to me in the House of Delegates, and I remember Martha Coles speaking about it in particular. I didn't even know who she was, but I think she was with the CEGW. It was kind of evident sitting in the back, she was a counter weight to the rest of the bench. You could see they were trying to organize; they were bringing up new bylaws, all kinds of things that had just been slapped down by the Board which was extremely hostile to anything. They used parliamentary procedure against them and that was extremely evident as well.

It gave me a sense of what was going on in this organization, and I got very curious about Martha Cole and Al Bartel and I can't remember the names of the other players who were attempting to bring some kind of staff nurse control or at least influence into the organization at that time.

Well, there was a lot of internal activity going on inside CNA when I started in 1991. The CNA Executive Board at that time was nominated almost exclusively by educators and managers. CNA was a professional organization with a collective bargaining arm. The Board had, if I recall, 15 members including the officers, the president, etc., but only one of those was a staff nurse. The Board had control of the budget. There was a separate governing body for the collective bargaining arm which was called the Congress of Economic and General Welfare Commission (EGWC) which WAS made up of staff nurses. This was the result of an NLRB case and NLRB decision called the Sierra Vista decision where a number of years earlier (1975) the CNA had attempted to organize nurses at a small hospital in central, coastal California called Sierra Vista. The company went to the NLRB Board and challenged CNA's right to do that claiming that CNA was a management dominated organization, not a union. This explains why the ANA model had a bifurcated structure.

So there was this tension that existed there because the Board was prohibited from interfering in the activities of the EGWC because the Board was management dominated, yet the Board had control over the budget. There was a lot of internal conflict going on at CNA. CNA was affiliated with the ANA and the Board was very close to the ANA. I don't remember specifically, but I believe that one of the CNA Board members was also a Board member of the ANA. A couple of particular events occurred. At the 1991 CNA House of Delegates, during the biannual convention, the collective bargaining nurses brought forward a bylaw amendment to increase the

monthly dues by a relatively substantial amount. I don't remember what they started out with but the number that sticks in my mind is \$28 a month. It was quite controversial. The additional monies were earmarked for collective bargaining and organizing which is what made it controversial because it was, in essence, taking away some of the budget authority from the CNA Board.

That bylaw amendment passed, but because it involved dues, it had to be ratified by all members and a campaign was started for a vote in early 1992, around February or March. At the same time, there was a huge controversy developing around a hospital here in Oakland. When I was hired in 1991, my initial assignment was to bargain the renewal contracts for CNA at Providence Hospital and Merit Hospital, which at the time were located across the street from one another on what's called Pill Hill here in Oakland. We were able to do that, and got good settlements in the early summer of '91, sometime in July, possibly early August. Providence settled first, Merit settled second. They were not affiliated- they were competitors. One week following the ratification of Merit, the second hospital, the hospitals announced a merger, and clearly it had been in the works for some time. I then began as the CNA rep for both hospitals, meeting and working with the representatives of the other unions involved.

The 2 hospitals had an interesting history. They had both been part of the associated hospitals of the East Bay. It was an employer group comprising 6 or 8 hospitals at that time, or just before that time. The associated hospital group had bargained as a single bargaining group with CNA and with other unions. There was a substantial history, probably a 25 or 30 year history of that. In the mid-1980's, the association broke up and each hospital started bargaining separately. Merit Hospital was the first hospital to break away from the association around 1985 or 1986, and was able to negotiate with the unions a "no sympathy" strike provision in the contracts. The other hospitals negotiated their respective contracts but didn't push for that. So when these 2 hospitals merged in the summer of 1991, the employees at Providence Hospital had sympathy strikes and Merit did not. Additionally, because of the previous six year period, Providence and other hospitals had bargained 2 year contracts (1985, 87,89,91) whereas Merit had bargained 3 year contracts (1985, 88, 91). So when we came into the 1991 bargaining, the nurses at Merit Hospital and some of the other employees as well were behind in standards as compared to Providence and some of the other area hospitals.

And so in the lead-up to the actual merger (the merger was announced in August 1991 but not consummated), and in meeting with the other unions, we took the approach, unusual approach at that time, that effective with the date of the merger, which was going to be the following spring, all the contracts would be voided. Typically in a merger situation, unions fight to have the contracts carry over and be recognized. But we had this sympathy strike issue as well as some other things, but primarily the sympathy strike issue, that we really wanted to address and so we figured out this strategy whereby we declared the contracts void as of the date of the merger. So we had a process of bargaining new contracts. We did it as a coalition leading up to the merger date.

Well, this coalition with other unions and especially around the issue of sympathy strike rights, drove the leadership at CNA nuts. We wound up striking Summit

hospitals, 6 unions, collectively. The strike lasted 7 ½ weeks; we won. We mobilized community resources; we mobilized politicians. We had all kinds of stuff going on. One CNA Board member was actually a Vice President at Merit Hospital. We saw her once the first week of the strike, and then we never saw her again. No other members of the Board of CNA ever showed up at the picket line or at any rallies or events. The collective bargaining unit was fully engaged, however. We won that strike in July 1992, but following that the tension continued to mount until December, when the CNA Board launched essentially an internal coup and the executive director fired 13 staff. It was all of the management, collective bargaining staff, and probationary collective bargaining reps. I was not fired because I was a labor rep, was represented by the staff union, and I was not on probation at the time. The four officers (elected officers) of EGWC were removed from office by the Board. This really brought things to a head, and a legal fight ensued which resulted in the fired employees and removed officers being reinstated by the Federal Courts in March of 1993.

As it turns out, the timing could not have been worse for the Board of CNA. The biannual election process had just started, so the December firings coincided with the period of signing up candidates, mobilizing towards the elections, and the folks just reinstated came back in time to help mobilize with the votes counted in May or June. The staff nurse slate won an 8 to 7 majority on the Board, but of course there's a lame duck period. They don't take office until after the convention in September, so it was a three or four month period. Once the convention was held, the staff nurse majority put into place what is now the staff structure at CNA, just on a smaller scale. So here we were, trying to run a union now and still under substantial internal turmoil because it was only an 8 to 7 majority and of the 8 not all 8 were absolutely solid so we had to keep people in.

At the same time, '93 to '94, we were facing massive attempts to restructure on the part of the industry. They were instituting- it was mislabeled at that point as patient-focused care. It essentially involved deskilling, replacing RN's with nurse's aides, techs, whatever, increased use of LVN's as we call them here (LPN's in other places). And so we were fighting the industry on that. Two major fights broke out with a hospital here in Berkeley, and then Kaiser of Northern California, both of whom were trying to implement elaborate systems.

We found we were paying significant per capitas to the ANA at the same time, and the ANA was supporting restructuring. SO this is '93, '94, and into '95. It became pretty clear to most people that, to most CNA members at that point, that belonging to ANA was completely an issue of are we getting our monies worth. It was actually and demonstrably counter-productive. We were paying the ANA, I don't remember what it was at that time, a million dollars a year, 2 million dollars a year, whatever it was, to support the industry fight against us. SO, in 1995, at the biannual House of Delegates, bylaws amendments were put forward to disaffiliate from the ANA. I think that's the short answer to your question.

I would say in the early 1990s. I'd been on the Economic and General Welfare Commission for a while. After I'd gotten involved in association governance and got

myself elected to the EGW commission. CNA had a sort of dual structure of a Board of Directors who could be anyone: supervisory nurse, nurse educator, nurse manager, and then they had the EGW commission that was to set policy for the collective bargaining arm of CNA. I'd been involved in that for a while and we'd been attempting to actually get the association to pay attention to the concerns of bedside nurses, who were the bulk of the members. That lasted throughout the 1980s, into the 1990s, and we had gotten a little more active and were attending Board meetings and as part of that we started going to ANA to see if we could influence them as staff nurses as well.

We attended a couple of conventions in the early 1990s and it looked like they were just not going to pay attention to our issues and we started to look at it structurally to see if we could change ANA. Was it even worth it to stay with ANA? We were giving them a million and a half dollars at the time that seems small to me now in terms of our current growth and budget but at the time it was a huge portion of our budget. We were giving them all this money and we weren't getting much back, they were actively opposing us on really critical issues, one of which was our struggle for ratios. We had a ratio law passed in 1975 for critical care units, but not anywhere else. I was a pediatric nurse at the time, and we weren't getting anywhere with our struggle for ratios and then the ANA was actively opposing us at every turn. We first started taking over the organization, we ran for office, we took over our Board of Directors, I was elected Treasurer. We had a slim majority, 8 to 7 and we started thinking about how to direct the organization for real since we had access to the money. We decided to mount a campaign for disenfranchisement.

I think it began taking off the minute we won that election. The CNA election, and in particular the period right before the election, was crucial to what happened. After the December firings, we needed to move to get the case into Federal Court, and we brought in the employees themselves to claim THEY were the union. We got the judgments in our favor, but for a period of time it was a revolution in the streets. But you know, while the injunctions were unique, novel, and probably essential, the major factor was really the organizing by the staff nurses themselves. It was the little victories that allowed the organization to take off...and to win that election.

Speaking of that election, it was as crooked as it could be. The guy hired BY THE BOARD to do the election was an accountant for the industry. We had to go to extraordinary lengths, including getting sued for defaming him with the Accountancy Board. It was a very open warfare time, but we got through that and won the election. I mean, the ANA was the Board of the CNA, so there was no point in time where it started, it was a point where there was a focus on doing it and getting out. What happened in 1975 was not a function of healthcare financing, it was just a function of blatant disregard for even the appearance of insulation, and so we had the Sierra Vista decision by the NLRB. Members had historically not been informed as to their rights. Nomination committees were set up to control applications for office.

They had to run a campaign to get one staff nurse on the Board at CNA, and then the Board ruled that she had a conflict of interests in going to Board meetings. They wouldn't call on her, they wouldn't allow her to speak. She was elected and then

closed out of meetings. After the Summit strike in July of 1992 and before they all got nailed in December, there were campaigns being thought of and put together to run for the Board. The networking and coalition building being done was incredible, and in the aftermath of the events of 1992, it became imperative for staff nurses to win- and every staff nurse felt it.

So again, there wasn't a point in time. The original idea had been there since day one since the objective conflicts at the workplace incinerated by the financing change, since the employer, hospital management, CNA Board, interests misaligned with the interests of staff nurses. So that's a process. It became clear when everyone was fired and suspended and then during the warfare period, ANA came in heavy and notoriously and very visibly against the staff nurse movement. So it was a process that got deeper over time.

It still took two years, and it shouldn't have taken that long. It wasn't from a lack of organizing. There were five or six regions of the CNA that were separately incorporated, formed in the waning moments of the last CNA years, that were real holdouts and strongly affiliated with the pro ANA forces. Many little corrupt power bases, and they started coming at us, suing to separate. We were in litigation all over the place, and they were putting out materials that were really slanderous, and of course backed by the ANA. It was a counter insurgency after the war scenario. The strategy clearly came from the ANA. There were power bases, money, and groupings of members, and it was a hard fight.

You know, you're going to find on dates and things I'm not a very good historian. I would just say for myself, what I noticed in 1988 was we actually were on strike for one month and it seemed that our union wasn't really quite comfortable with the fact we were on strike. There was a collective bargaining arm of the union which was kind of over here and to be in that group you had to be a working nurse, you worked at the bedside, you had to be a nurse that worked in a hospital or clinic somewhere. And then the rest of the organization dealt with issues like nursing education, and nursing practice which were important, but it tended to be dominated by nurse educators and by nurses who I think were more interested in advancing their careers as individuals than taking care of the majority of the members - and I think 95% of the members were working nurses.

And so it became apparent that here we were on strike in San Francisco, and it was a large strike of 2,500 nurses and seven or eight hospitals, and the head of the collective bargaining program would come to our rallies, but the director of the union didn't come. The head of nursing practice never came, even though there were some significant issues involved here. I know others felt the same way during their respective strikes, no support from their organizations leaders. I remember one convention I went to and on one side of me was the Director of nurses from the University of California, and on the other side a nurse educator. They were very pleasant, but it became very apparent to me that my interests and concerns were not the same as theirs.

There had been some discontent among the members of CNA staff nurses around the time that I was hired, '92, that there was not a governing board of directors that had the best interests of the staff nurses in mind when there was either governance, collective bargaining, government relations, political activities or lack of political activities. So my recollection is the early '90s that that disappointment really coalesced. I would also say that a spark for that growing together was a group of staff that were hired on and sort of became more confident in their abilities, political abilities at that time.

I was secretary to a department called the economic and general welfare (E&GW) which technically no longer exists but has sort of transformed and evolved into a department today, collective bargaining, which includes acute care because now CAN has grown so now collective bargaining has a UC division, a Kaiser division, acute care, public sector. But at that time it was a smaller program, because we were a smaller organization. I wasn't hired specifically for a person but more for a program.

I hope you like stories, because this is a good one. I became a member in '74, but it was more on the periphery, no more activity than the general staff nurse who would belong to CNA. Later, probably in the later '70s, I ended up being on a bargaining team for Kaiser, and was involved in the decertification of the CNA led by some of the bargaining team who wanted to go to SEIU. So I ended up on a bargaining team as a novice, not really knowing exactly what I was going to be doing there. And, from this experience, I started getting involved a little bit into the professional performance committee because that was newly bargained in the bargaining session.

I couldn't tell you what the structure of this committee was, or how the leadership was elected or anything. The I was involved in a second bargaining session where it looked like we were going to go to strike, maybe in the early to mid '80's, 1984, somewhere around there. I ended up getting even more involved in Region 12 on their nursing/government relations group, but still not understanding the whole structure. In 1984, I think, I was introduced (given a phone call) from Kay McVay, and she wanted me to come to their Economic and General Welfare Commission meeting, just to see what it was like. There was a woman that was on the E&GW from my area that was not always attending and how I could be the alternate.

So I told Kay I'd consider that, but in the meantime she had me go to this meeting for a politician to lobby on behalf of the certified nurse assistant legislation. I don't remember how I even got roped into going to that office. By the time of I went to the E&GW meeting I was starting to get really interested in it, Kay mentored me along, and I decided to find out what was going to happen, I called the other woman (that had been the main person), and she said that she really wasn't interested any more, and so if I wanted to do it I could. So I did!

During that time, there was a lot of turmoil within the organization. We had just fended off decertification, there was legislation around "care partners" for registered nurses, and so lots of turmoil outside the organization as well. Within the organization, there was more interest in controlling where our dues went, how it was spent, and the purpose of the organization itself- who did it really represent. So

during that time, and I'm sorry the blocks of time (late '80s, early '90s) seem to have melded together, there were nursing groups that were trying to get control of the organization. Because I was still sort of not familiar with the whole organization in itself, I wasn't really part of those efforts, though I did attend some of the meetings.

I was involved in the dues increase campaign for CNA, because we were struggling to meet the needs of nurses with enough labor reps and with enough organization to have some kind of power at the bargaining table. What happened was, during the time we were organizing for the dues increase, the good old girls (how I refer to the ones that used CNA as a means to an end, using it to build their resumes so they could say they were President of the organization or that they were somehow involved with nursing practice or whatever, and ended up going back to their job as an administrator or manager or supervisor or educator or whatever), decided to give away bargaining units. They saw the need for a dues increase too, because they WERE giving away bargaining units that we had. We had many bargaining units in southern California that they gave away, and some in northern California. They said we couldn't POSSIBLY service them as if southern California was a different state!

Looking back at it, it makes sense now because all they wanted to do was to keep enough of an organization and enough nurses belonging to pay the dues so that they could have their meetings and have some influence through ANA, but not TOO much that they would have to be collecting dues and actually having to service their members. They also didn't want to empower the staff nurses in the organization because these leaders were also managers at hospitals. I think what really opened up a lot of nurses eyes was, you would be sitting at the bargaining table and right across from you was the president or the secretary or the treasurer or the regional board member of your organization, you're union, arguing against our position with the employer - it was almost like abuse, nurse abuse. And once that started happening, nurses really did start questioning things.

So these groups started pressuring CNA to do more and to stay out of management. During that time you have the Sierra Vista decision come down, the one that said that you couldn't have supervisors who are statutory supervisors in charge of the bargaining arm of the professional association. And that happened in Canada too. They solved the problem in Canada differently then how they solved it here. SO during this time there were all these things happening that fed on each other to empower the staff nurse to take charge of their organization. The problem was, these managers still controlled the dues. They gave us what's often referred to as "an allowance" and we were supposed to make do with what we got and to just take it! Even though we had no one on the CNA finance committee, no one on the CNA Board because "staff nurses" could not possibly run their organization or understand the inner workings of how an association would be run and how to spend the dues (even though we're trusted to save people's lives).

I really think it came to a head in the late 80's, early 90's in that dues campaign. The "good old girls" used us to talk to the nurses to vote for the dues increase. And I think it was naïve on our part to believe them, that they would follow through on their promises. They said yes, we would improve the labor rep situation that was pretty dire at that point, that we would have more money for organizing nurses in our

state, that we would start a Kaiser division. So we started this effort and put our credibility on the lines. We campaigned in our facilities and with the nurses that we knew, to vote for the increase. And this increase was substantial at the time because we weren't making the money we are now. We were probably making \$10/hr and I can't remember what the dues were. But it was a substantial increase at the time.

The dues increase passed, and when we went to them to hold them accountable to their promises they said that the points that they had agreed on were *merely goals* over time and that they would *gradually* be implemented and that *eventually* the labor reps would be phased in. The one thing that they did do, under some pressure, was to create the Kaiser division and they hired Jim Ryder. Other things that they did were outrageous and outlandish. They moved us from Mission Street, 18th and Mission, to San Francisco on Market Street, in one of the top 2 floors of this building called "The Palace" and furnished it lavishly with extravagant expensive rented plants and new furniture. You can see the table they bought, that they had contracted to buy, in our library. It's a simple table, a single piece of rain forest mahogany, but at the time it cost \$3,000 and this was 20 years ago. It was outrageous! It was for the good old girls, for Barbara Nichol's office.

We had NO money to spend but they were spending the dues increase that the staff nurses had voted in to get more labor reps, on new furniture and extravagant accessories to an office. They hired secretaries so they could keep track of the rabble, to keep track of everything, so that they didn't have to deal with us. But that one piece of furniture showed how arrogant they were. So we continued to pressure them to follow through with their commitments, and we started really relating to Jim. He understood where we wanted to go, and we ended up being stronger as a result of that. We formed the Kaiser division. We had the JVC, the Kaiser nurses met, and it was easier to communicate about all the things that we were trying to accomplish that were being thwarted.

Around that time, Rose Ann had been working in southern California, as the southern CA union director, and she got hired as the E&GW director. That was when she got involved in the Summit strike. These were a few hospitals that were striking for the right to be able to honor someone else's picket line. All during that time, we were still trying to do organizing, and in fact there was one woman who was hired during that time to organized Ralph K Davies. And we had a great shot at it. But she was directed to NOT win the election. They didn't want to lose by a lot because they wanted it to look like we were real close, but she was told, we don't want you to win that election by the executive director. So this was really a sick relationship/ It was toxic in many ways.

I didn't find out about this until she was getting ready to retire because we were talking about the old CNA and how the good old girls ran the organization, so I found all this out last year. Since, we've moved on, but it was really bizarre. It was one of those things where you look at it and you think, imagine what we could've been doing if they had not been in charge at all! So during that time I became a regional president, and Kay became vice president, and then president of CNA, and during that time I became treasurer and then vice president and then president myself. And then we formed the Council of Presidents. I know it's a long backdrop to this

question, but there it is.

So you have these little ripples coming through and you have these pieces of awareness that are going through. There were other nurses who were not happy with ANA because not only were they experiencing it in their own organization, but this attitude was happening in ANA. And ANA had taken several positions that really didn't address the needs of the bedside nurse or the direct care nurse. They were not necessarily opposed to restructuring and substituting nursing assistants and other lesser educated or lesser skilled workers in place of nurses. In fact, they said look, restructuring is the train going down the tracks and if you're not on the train you'll get run over and so you better get with it. And I kept saying, well what about just blowing up the tracks? And it was like I had said you're hair is on fire or something. And they said, well, wouldn't you be HAPPY just not being at the bedside and not having to provide direct care? You can carry around a clipboard and you can supervise all these people. I told them I didn't go into nursing to be a supervisor.

They had the most bizarre arguments for why you wouldn't need nurses anymore. They talked about technology; they talked about all those wonderful drugs; they talked about all of this stuff. So I asked them, how is it you won't need more nurses when there's a shorter hospital stay, the ones in the hospital are sicker and really need someone who can integrate all of the medications, treatments, orders, and procedures that are done on these sicker and sicker patients? Not to mention keeping track of all the med errors that doctors write, the errors in general, the procedural errors, all of that. You can't have someone from Burger King come in and track all these medications and their interactions and all that. So they never really had a good answer to anything, except, that's why you'll be the supervisor.

This whole dissatisfaction with what was happening on the state level started to play out on the national level, and then people like Kay and Martha were forming organizations and forming groups that were trying to work within ANA to get it to change. Once they saw that they couldn't change CNA without changing the leadership, they realized they couldn't change ANA without changing the leadership. But the ANA was even more stacked against you because it was even a more bizarre, almost bipolar organization. They had the states that had collective bargaining and the states that did not have collective bargaining, in fact rabid anti-union states. SO there was never any way that you would be able to affect that change. What the ANA did try to do was to form this little club, a substandard club, for staff nurses to play in that would sort of satisfy their demand for some control of ANA and some participation, It was a council for working nurses that were in collective bargaining, it was a way to placate them and keep them under control and keep them from disturbing the big girls. And THEY were all the meanwhile banging their heads trying to effectuate some kind of real change at ANA! I remember going one last time, to the ANA convention in Washington DC, which was our last convention, to see if there was any redeeming value or anything we could do...there wasn't.

The one thing that told me they were beyond redemption was this big plenary session where they were talking about how the nursing profession was going to end as we knew it and how we had to come up with a plan to address this immediately. These were whitewater times, and we were going down the whitewater in a canoe,

and how we're really going to have to take the bull by the horns and really move on it or we're going to be gone. So they went through this whole subcommittee thing, and went on and on about the need for immediate action, and I'm thinking, all right!, maybe we can do something here. After all this discussion about restructuring, and this is a time when the industry was refusing to let nurses identify themselves, they would not let you wear your cap, or your nursing school pin, in fact there was nothing to identify you from any other of the worker bees out there (you know, so the patient could be talking to a housekeeper, a dietician, or a lab tech and they might think they were talking to a nurse), all of this to hide the fact that there were hardly any nurses anymore because they were getting rid of them, they came up with a plan. Their plan was- they were going to study it for 2 more years and bring back recommendations to the next house. I was like - ok, so your house is on fire, let's study the effects of water and other chemicals on a fire before we put out the fire. It was crazy!

So I knew this was not working, and if we couldn't change it, then we had to do our own thing. SO that's when a huge portion of our leadership really did start moving to get out of ANA, because we saw what CNA had done to hold us back and we were sending something like \$1,000,000 a year, or more, to an organization that was beating us on the head. It would be like the beaten wife giving her whole check over to her husband while he's still sending her off to the hospital. That was when we finally got rid of the good old girls in CNA and we decided to get out of ANA. And there were other states that were coming to the same conclusions, but they were still signing up for the next nurse abuse class at the time, trying to make it work, because that's what nurses do, they try to make it work, make it better. It's our culture.

It's like the old egg trick though - once you see how it's done, you know how to do it. Once you see it work in one organization, it's easy to see it as working in another. It was interesting though, during our house involving the disaffiliation, because nurses kept saying, we have to have a national voice. Who's going to be the national voice??? So we are! We don't need ANA, even if they are out there already. When we went into the house we were pretty confident, we thought we had the 2/3 needed. We were really working it. We really, really learned parliamentary procedure because that had been used against us before, We really had our strategy about mikes and how you work the room and all that kind of stuff and how you get around parliamentary roadblocks and stuff. We practice it, we got it. We went to the house and there were some people that were still waffling, they were still on the fence. And that was when ANA's president at the time, Virginia, came in. She was not invited to come because we felt this was an issue that WE needed to deal with. We did not want her or ANA coming in.

Well, there were the good old girls that were still on the side of the other good old girls (even though they were gone), who insisted that she speak. So there was a debate on whether we should allow her to speak and the vote was telling, it was about half and half so we allowed her 5 minutes to speak. I thought, not bad for someone that was uninvited, have her take her best shot. She was PERFECT! She fed right into the whole thing because she immediately began to berate everyone there for only giving her 5 minutes and what an insult it was. Then she called all of our newly elected leadership liars to their face in front of the House of Delegates, who really

respected them! They had been elected. And then she said she couldn't possibly speak in 5 minutes because she had a southern accent and that she needed more time. She used up her 5 minutes and we said, "Thank you." We sent her on her way, thinking thank you, YOU WERE PERFECT! After this, the people who had been sitting on the fence went WAY over to our side. It only proved our point that they had no respect for us, and it made a huge difference in our moving forward.

What was even more fantastic, I don't know if you know this, but we put together the money that we were going to keep from not sending it to ANA, and we put together a mission statement about what we were going to do with that money. We thought it would take a few years to get this all done, so we put together a five-year plan. We actually did it all in two to three years. We pulled it all off. We pulled out the mission statement for the next House and when we all looked at it, it was additional proof that we had really been hindered and held back by the old guard.

3. Why not form another association? Why use the CNA?

Well I think because CNA has been known throughout the state and everybody knows that if you're in California, you need to belong to the Nurse's Association that's in California and I think it just makes sense to keep the name California Nurses Association. Even if we go out of state, they still call us CNA. Even if we have members in say, Nevada, they still say, "Yeah, we belong to CNA."

Our history goes back to 1903; CNA always was more staff nurse driven and assertive so that drive and legacy were valuable; the problem was not the nurses or the original organization, it was the ANA.

I was not part of the grassroots movement to leave the ANA, but I was at the House of Delegates where we voted to leave. I believe we wanted to keep control of CNA and make it what it could be, not form another association.

The simple answer is that we are not an association - which is defined as the act of **associating** or the state of being associated, an organized body, a society. Rather, we are a union- the act of **uniting** or the state of being **united**. The organization is made up of direct care RN's who are **united** in their goals and purposes of advocating/protecting the rights of the patient we serve, protecting the professional practice of the RN, and obtaining the goal of Single Payer.

The CNA was an established organization for RN's. We were just beginning to see the value in growing our union. We wanted an organization with a core RN identity, Our growing activism came out of our identities as nurses.

Because that was our organization! It is our organization and there was no reason to change.

Well really it was our organization and so why should we wait? I think that it was the CNA and the nurses who were in control at that time really didn't – it felt as though the staff nurse wasn't heard. So there were a lot of educators at that time, there were a lot of managers, administrators that ran the CNA and there was a very limited voice for the staff nurse. So really we felt that it was our union and we needed to take control and really be a staff nurse.

Well, I can't speak for the nurses, but the CNA was **their** organization. Bedside nurses were 90% of the membership here and yet were shut out of all the policy arms. It was CNA that had the contracts with their hospitals. It was the organization they paid dues to. Why shouldn't they control it?

Well I think there might have been a decision made to form another organization if the lawsuit hadn't been successful. But it was. The preliminary injunction (Appendix D) that was issued by the court in March of 1993 basically ordered the reinstatement to office for the members who had held office, and also reinstated the employees who had been terminated. The election was in April.

So it was very open and it was discussed in the lawsuit that the staff nurses, who were trying to gain a bigger voice in the organization and were affiliated with the congress, clearly understood that they would not get a fair election without the intervention of the court and so a lot of ground rules were debated in the course of that litigation and the injunction addressed some of what CNA was required to do in order to give the staff nurses a fair election. The reform slate, the staff nurses, won.

As far as the organization (CNA) is concerned, it was there and in place and it had at the time 20,000 members or so with a revenue stream in place and office leases in place. What was apparent to me at the time was there was this overwhelming sentiment on the part of the nurses who were members of the organization, that they wanted a real, genuine collective bargaining program and they wanted a real, genuine voice for staff nurses and they were tired of the nurse managers who were running CNA, keeping them down. There was this sense, that if they could just get a fair election and take over the organization, that they would just pick up the ball and run with it.

The contracts were with CNA, and they didn't want to give them up. The old CNA would fire the executive director of the congress every 2 years just to keep the staff nurses off balance.

That's a very good question. I don't really have a good response to that. It never occurred to me to start another association. **This** was our association. I was aware that 95% of the dues paying members were direct care RNs. It was patently obvious that the direction, the money, the philosophical underpinnings of the association were not geared to direct-care RNs. So I think it was just a sense that, this is our organization but it's actually not representative, so let's fix this rather than start a new one.

The CNA had a long history at that time. We had been I believe the first nurses' organization to collectively bargain on behalf of nurses, at least in the private sector. There may have been some public sector somewhere else, I'm not sure. But, it was right after WW2, nurses right here in this area organized and demanded recognition and got recognition from many of these same hospitals we've had run ins with.

So here we were, in the mid-90s and we've got a 50-year history of collective bargaining, contracts that were mature contracts at that point. In the Bay area, we represented 80% of the nurses, but overall a pretty small percentage of nurses in California. So here was this organization that was in place, and in which 90% or more of the members were staff nurses. They weren't represented on the Board, but they were the members. So looking at it, it made all the sense in the world to seize the organization, for the nurses to take what was already theirs. Starting something from scratch at that point never was seriously considered as an option. It would have been extremely cumbersome and cost intensive.

I think nurses all over the country were and are struggling with this because the ANA and many professional and state nursing associations have been opposed to collective bargaining - historically. It wasn't until the 1940s and early 50s that many state nursing associations started doing collective bargaining, and they essentially had to get ANA to do it. Bedside nursing issues were not being addressed, and yet we were the bulk of the dues paying members.

I had a friend who was involved in this and he did charts where all the money came from, and 95 to 97% of all the income that CNA was getting came from collective bargaining members, not from those who just wanted to belong to their professional organization. Yet a much smaller portion of the budget was going to staff nurse issues and patient care issues. If you are a nurse, you know the number one issue staff nurses have is the ability to provide good patient care. So I think nurses all over the country were kind of looking at these dual structures, EGW commissions, Boards of Directors, and all of their associations.

Some nurses were choosing to get out of their organization and go to other unions. Some nurses were forming their own little independents. Some nurses were making bylaws changes and I know I discussed this with nurses around the country who were in contact with us, frequently at ANA sponsored events! We had all been talking about the different methods people were taking and hearing about unions, rating nursing associations, and trying to figure out what we could do. And it looked to us that the best way was to introduce a series of bylaws proposals that changed the bylaws to give more power to the EGW commission. We were running for office, and started to announce we were running for the Board as a group of staff nurses to redirect the association and suddenly the firings. They feared we were attempting to take the nurses to another union- we weren't. We were essentially bound on taking over the CNA. Another impetus was the nurse managers and nurse educators were attempting, remember there were restructuring efforts going on and people were getting laid off (at my hospital the laid off 20% of the acute-care RN's and replaced us one for one with nurses' aides), to move nursing away from the bedside, the idea we were going to be case managers with other people doing our work. We didn't like

that idea.

So we needed to sort of oppose that idea and that idea was coming from this other group of people. SO we thought we needed to control our own work place and our own profession. The way to do that was to take over the association rather than to get out of it or go to another union and be a part of some other group of healthcare workers.

The reason for using CNA was we had 95% of the members were staff nurses so it didn't seem logical that we should go anywhere. I mean, we were the majority. So it was really just a question of us becoming organized and expressing what our beliefs and goals were, and once this reached the other staff nurses, it made sense. Why would anyone leave an organization if you were a 95% majority, and it may have been even higher.

Because the CNA is the union, and 95% of the association members were staff nurses. They're not going to take our union away.

I think because there was passion, and a group of people who were educated and had vision. Why not tap into that energy and move a progressive nursing group forward. That's my sense.

Well I think it was really that even though we were held back by the good old girls, there were ties to the CNA name, the California Nurses Association. We had fought for whistle-protection and we had fought for ICU ratios. We had fought against the certified nursing assistants replacing nurses. We had had contract fights. There were many nurses that had fought for sort of comparable worth. We had all of these milestone events happen under CNA, and we had loyalty to that organization even though we felt that the good old girls that were in charge, weren't doing it justice.

It was still our history and we felt that ANA didn't deserve to keep that history. It was ours! If they wanted to form another organization, OK, they could make their own history. The CNA history belonged to us because the good old girls didn't wage the fights, we did. They did suggest that, however, and we said, "Why should we give up that? You go find your own history."

4. Can you discuss the events leading up to the disenfranchisement from a strategic perspective?

We, and really at that point it wasn't really we, were handed an historic opportunity with this overreaching firing/suspension that was such a defining moment and it really is interesting. When we came in on these injunctions and took over some of the offices, they started running all these political campaigns against us and they were pretty sophisticated. But we found out information- for one thing the democratic party was fully aligned against us. The democratic party! Coming out with plans and strategies and everything. They got money from CNA in the San Francisco area.

The burdens that were placed on and the obstacles that were erected to this

burgeoning movement were incredible. Yes we had the injunctions, but so what? Getting members to vote and vote correctly was amazing. The organization at its core was built on this experience. I don't know how long it would have taken to go the normal route of election, but this was really an incendiary moment when everything was piled on- big odds, big players. The initial group here learned their experience on that. That's why they're tough forever, really. You know how people ask us why we take on these giant multi-national corporations? We have to. But that experience has a lot to do with it, and my generation emerged out of the maternal bonding generation we had had with employers.

What had been happening was that the hospital industry was trying to lay off RN's, RN's who worked at the bedside, thinking that one RN with maybe four nursing assistants could do the job with the RN being the primary caregiver, doing the thinking part, and having nursing assistants do all the tasks. They thought they could get away with that. But as you know, being a registered nurse, you need to see the whole picture of what the patient is about. You cannot do your assessment if you do not see the skin of your patient, you do not listen to how the patient speaks or if you cannot see how the patient walks. You cannot just be at the desk doing the thinking and doing the not-so-hands-on work and do a good assessment. And so we thought, at least I thought, that if these are the people thinking this, then they are wrong. This started a lot of grumbling, and it became clear to us that these ANA types were really just working for hospital management, and did not care what happened to the patients.

I would say this was in the late 1980's up to the mid 1990's. They came out and said that in order for you to become an RN, the entry level should be a BSN, nothing less than a BSN. As for me, myself, I don't have a BSN. I graduated from a national school that was affiliated with a hospital where we got a lot of clinical vs the theory. I think they were trying to steer clear of that by recommending the BSN.

Bedside nurses were held in low esteem by ANA (and still are) and those few who were on the Board were trying to leave direct nursing behind and "move up and way" into administration or education. Nursing IS direct care either in an institutional setting or in providing educational or public health care. Who takes care of the patient if the working nurse leaves the profession because she/he is not supported and honored? Thus the disenfranchisement and the need to return CNA to the direct care nurses.

Don't know.

It was the perfect storm of events that lead to the majority taking control from the elite minority. The elite leaders bought into the hospital industry plans of restructuring, downplaying/replacing RNs, they devalued the skills and compassion of the RNs for their patients, didn't understand the unique bond between bedside nurses and their patients, and didn't realize the importance of the bedside nurse in the therapeutic recovery of patients.

The elite leaders along with their power also controlled membership dues/monies, and used the money to help push their agenda instead of what the majority membership wanted. The direct-care (bedside) RNs felt the leaders of the organization were not listening to their needs or patient care concerns. There was a difference in visions and goals between the groups. The leaders and members were not united. The staff RNs elected a majority to the CNA Board of Directors for the first time using a platform promoting patient advocacy, while challenging unsafe hospital conditions.

My understanding is the decision to fire Rose Ann DeMoro and many of the staff under her riled up the other nurse leaders and prompted them to act more assertively than they might have without that impetus. It increased the urgency for change and sparked emotion in the staff nurse leadership.

I really can't discuss this. I wasn't involved at that level and I don't know where the seeds were planted to do that, other than the ANA was not listening to CNA and paying attention to what our concerns were. I can't really quite remember any example of that.

Well my knowledge on this is very limited because I was kind of in the background just kind of watching. I didn't really get heavily involved with CNA back then but my understanding is that once a few of the people, Rose Ann D. and such were fired, strategically they began to start campaigning on how to get the "rank and file" to really agree with taking over and taking control of the organization through campaigning and then it was at the House of Delegates, I can't remember the year, when the delegates wanted to take charge.

Well, the key event is actually not the disaffiliation from the ANA; the key event is the staff nurse revolting. The disaffiliation from the ANA which happened in '95 is almost a footnote to the staff nurse takeover in this organization. The firings were a key element in that, but it was also precipitated by a whole series of events that happened, including: the corporatization of medical care, the fact that the health-care/hospital environment really changed in the late '80s, early '90s. There was a huge strike in San Francisco by nurses in the late 1980s. There was a strike at Children's Hospital in 1989 I think. And then in 1992 there was a big strike right down the street here in Oakland, some medical center. This strike was precipitated by the corporatization of medical care.

You had these three separate, long standing hospitals which merged into 1 and then decided to erode contract agreements that healthcare workers and nurses had won prior to that, and the nurses and the other unionized healthcare workers came together and did a seven week strike that was very successful and could probably be a textbook case study. You could almost write a whole book on that strike itself. That was a model of grassroots nurse activism that is rarely seen, given everything that was done in that strike.

There were a lot of things that came out of that strike, one of which is that it

horrified the leadership at CNA, It horrified as much, if not more, the hospital industry. Concurrent with this was a lot of pressure between the rank and file nurses and the CNA nurses to develop a more aggressive response to what they saw happening in their hospitals as a result of the corporatization of medical care. You had all these corporate consultants who had been brought into the hospitals, people who had written all the cookie-cutter blueprints for cutting the manufacturing base in this country in the 1980s and were now looking around for the next pot-of-gold. They looked around and saw how they could make a lot of money by cutting patient services and replacing RN's with unlicensed staff or lesser licensed staff and began implementing all those cookie-cutting schemes. The response of the management and leadership of the ANA and CNA was to be complicit in it, fully complicit in it, and even thought it was horrifying for bedside nurses to stand up for patient interests and safety.

Their first alliance was to their country club and their fellow corporate CEO's. And that goes back to a point I know you write about, the affiliation between the AONE and the AHA back in (1903?). That created a bond that is still there. If you look at the top leadership of ANA today, who are the people that are the decision makers? They are people that are nurse executives, corporate vice presidents, directors of nursing, and nurse educators. They are still there. Yes, the nurse educators whose allegiances are with the nurse executives.

I actually went to a conference in Philadelphia in '93 or '94 with a leader of the then CNA. We went to this conference that was run on the restructuring of healthcare. It was run by the corporate consultants and probably co-sponsored by the ANA in which they talked about how healthcare was changing and the way it was changing. They were restructuring healthcare delivery and the nurses had to accommodate to the change because that was what was required of them as a profession. You know there are people, nurses, who don't think the proper role of nurses is touching patients. They think the proper role of nurses is professional advancement. We used to talk about this whole analysis of power vs. prestige elitism thing.

The point is, what does it mean if your fundamental alliance is with corporate management and not with your fellow nurses or with patients? That's where the orientation of CNA was up until 1993. And what they saw was a lot of ferment in the ranks that boiled over in the summer strike, the use of very militant tactics by the nurses, in concert with other healthcare professionals. A lot of direct care nurses wanted a real strong response to protect their careers, their jobs, their patients, their livelihood, their ability to continue to deliver care and not be replaced by unlicensed people and robots. CNA leadership did everything to protect their privileged status and their little power. They had set up an apartheid system for the collective bargaining arm of CNA, which was 90% of the membership. The collective bargaining unit was a tiny arm of the organization called the Economic and General Welfare commission. It had its own elective body, the congress and structure it was forced to have by law, but they had no real power in the organization. They were given policy over collective bargaining but they had no control of their own resources, they had no control over legislative priorities or policies, and no control

over the political direction of the organization. It was a real apartheid state in the organization, and there was a rebellion against that.

So on the one hand you have a nurses rebellion saying, "We're going to create our own structures that allow us to have a voice in our own governance and control our own resources," and the management at CNA was getting increasingly fearful of the direction they saw the ferment going, and of course being in collusion with the hospital industry, increasingly fearful of the unity between the CNA collective bargaining and other healthcare workers unions. And when they found out the staff nurses were running a slate against them for the Board, well that was the final straw. They tried to cut that off by firing Rose and 12 other staff, 13 people total, thinking they could eliminate that. It didn't work because it was illegal, but also because the barn door had been opened, and there was too much ferment in the ranks.

There was an unshakeable bond between Rose Ann and the staff nurse leadership and you had a brilliant general running the program- Rose Ann DeMoro. They then suspended the top leaders of the congress like Kay McVay and Martha. We developed this legal strategy that worked, and the court threw out the firings and the suspensions. We ran a group for the Board. They won that election and changed the direction of the organization.

What happened was that first, the independents got together and formed an ad hoc group called SNAP, staff nurse action project. We got a telephone call from nurses after a really bad contract with Kaiser, where some things were put in that didn't need to be in there. We were asked if we would meet with them, and we did meet at the Association building here in Oakland. It was the first time that the Kaiser nurses came together. We didn't even have a staff person, it was just us. We had Kaiser nurses from San Jose to Sacramento. First time we all got together.

We began to meet, and we began to go and knock on the door to get into the CNA meetings. None of us were allowed to serve on a PAC. None of us could even serve on the practice committee! The staff nurses were assumed to be less intelligent and less capable of being able to make decisions and to understand the process. That's what started getting us all riled up.

It must have been '89. We lost by 5 votes of getting 1 seat on the Board of CNA. That was the best thing that ever happened to us. It brought us all together, because we thought at the time that it was the worst thing that could have happened. It made us much stronger. We wanted to organize, and they jettisoned, they being the old CNA, they jettisoned the entire southern Kaiser group and actually gave them to another union.

I already talked about some of the events leading up to the disenfranchisement, but there's probably a lot more history and a lot more sort of frustrating events that occurred, but that would be before my time.

I can remember meeting down at the Hyatt in San Jose. We had asked for \$150,000 to go down to Southern California to do an organizing campaign because we felt that CNA needed to grow. We only had 17,000/16,000 staff RN's but we were controlled by the southern group who controlled the money. Well, they voted us down. They would not give the organizing committee the money but they set up their own

organizing committee to organize category 2 management. They picked up seven people for \$150,000.

I think this had been going on for a while, that is my sense. I remember a kind of discontent within the association. It was just administratively, an overall sense of, "Oh well, it's just CNA and they're a bunch of nurse educators." This is from your regular Jill and Joe staff nurses. That wasn't fomenting any revolution though in the majority of people who felt they should just pay dues to some kind of professional association. As far as strategy, it was very loose initially. I spoke with Martha C. at a meeting and asked her questions. I met Rose Ann DeMoro, which certainly made me sit up literally. She was installed as the head of the UC bargaining team on the ENGW side of CNA at the time.

She was hired in '86, so all the stars were aligned. She came to a UC meeting . I was used to going to the meetings but being severely under-impressed. She stood up and spoke, about healthcare, about staff nurses. It was diametrically opposed to everything I've ever heard before coming out of CNA. I was a back of the meeting kind of guy. Soon as the meeting was over, I dashed downstairs and introduced myself to Rose Ann and said- I like what you're saying, let's talk some more. And of course she was keen on that. Martha and Rose Ann soon emerged as true leaders, a coming together.

Their strategic plan was basically, tell the truth. Build it and they will come. I know this is an over simplification, but we sat down, we did draw up a 10-year plan, securing the future. There was definitely a consensus about who were our allies, and our allies were our patients. This was a sense that ran through everyone, that we had a moral obligation to empower patient advocacy. So our natural alignment was with the public, plus we needed to organize more hospitals. I'm not sure that is a comprehensive answer.

I think I already have answered this question, pretty much. It was basically over the issues of restructuring and staff nurse control vs. management control. Those were the strategic questions.

Planning! There was a lot of stuff we were going to do in a short series of years. We started meeting when we took over, we started meeting with both the EGW commission and the Board of Directors. We started meeting together to sort of prevent or get rid of that dual structure, but we hadn't done it officially via the bylaws. We were thinking of doing that.

We were also thinking about getting out of ANA and we were trying to figure out, could we do it. How radical was that! Was it too radical- did people care? Do nurses even understand their own structures of their union? I remember when I first got involved, it seemed like our structure was incredible. What's this commission, what's this board, where's the money? Who's doing what, and what are the staff doing? There are separate departments, like in many big organizations. Yet for me, government relations, nursing practice, and collective bargaining all meet together at my patients' bedside. SO we started talking. At first we thought we couldn't get out

of ANA, that nurses wanted to be in a professional association and disaffiliation would make us look more unprofessional. I personally did not have any of those concerns but we felt many nurses did. So we started out trying to figure out, could we get out of ANA? Could we get out of it structurally? What would it take? We looked at their bylaws and our bylaws. Would we have to do a bylaws proposal? Would we have to go to ANA? Do we have to do it at our House? We had to seriously just sort of look at some of these issues.

And then we decided what we would do, that we could do it with a bylaws change and a vote of our members, our delegate members at our House of Delegates. We began a campaign of our members. We went to one more ANA House of Delegates, which time-wise was good for us. We attempted one last time, as delegates, as staff nurse delegates, and CNA delegates, to talk to other nurses at the national level. And then they did 2 really anti-staff nurse things. They proposed BSN entry into practice that is VERY unpopular with many staff nurses. It was not CNA's position. They also proposed vague ratios one more time and they actually came out with some kind of paper so we were able to use that information from the convention we had been to, to bring it back and show our members, our co-workers and the people who were going to become delegates that we weren't able to affect these changes within ANA. We were giving them a million and a half dollars, whatever it was at that time (I use that line a lot because actually I was the treasurer at that time).

We were paying all these dues and yet they were doing things stuff that was probably going to harm us and hinder our ability to care for our patients. So we did a campaign. I went around the state, mostly Northern California at the time, driving up to Sacramento, Vallejo. We drove around the Bay area to different facilities and talked. We went to the hospital down the street and talked. We talked to our fellow nurses about why we thought this was the right move. SO, we had to have staff nurses elected as delegates. Then we had to make sure all the staff nurses understood our proposal and would vote yes. We had people assigned to different areas. We talked to many, many delegates. We had to line up the vote for people who wanted change, and we were pretty confident we had the vote when we went into the House of Delegates. And we did. We had sent out mailings, issued papers, we raised our own money, we did donations because there wasn't a lot of money around at the time. We paid our dues. We used personal money, we campaigned. We did walk-throughs, in fact all sorts of things that we would have done for our own elections, we did for the campaign to get out of the ANA.

And boy did the ANA respond. They did a bunch of mailings, they said we couldn't do it, that it would destroy the house of nursing. We were not professionals. We were just unionists. We didn't care about our patients. All kinds of anti-union things, well just short of anti-union, they weren't that stupid, but they rally alleged that the nurses who were in the campaign were bad, unprofessional people. Funny how we all still cared for patients while the President did not!

Well from a strategic perspective, what we had to do was every two years we'd have a House of Delegates and so what it meant was/were that people had to get organized and put forth bylaws, proposals that would make that change possible. Then we as

staff nurses had to make sure that the right slate of candidates was elected so we could actually make the change happen. But to back up a little, two years before that, in 1993, we had a hotly contested election where it was basically a slate of staff nurses running against a slate of nurse educators and nurse administrators. So I think the first step was when those individuals got elected and took control of the Board of Directors, preventing amendments from being blocked or undermined. I think the strategy was really just getting staff nurses involved, getting staff nurses organized, electing a slate of staff nurses back in '93. Then, when '95 came around, making sure the same people who were elected to go to the House of Delegates would vote the way we hoped they would.

It was really interesting. When the vote actually came up, some of us wondered how it would go and my guess is there were probably 200 people at the house of delegates who were voting, and only 8 people voted against getting out of ANA. This in spite of a great emotional appeal on the part of ANA leaders. It turned out people were ready. It was a pretty powerful moment

I'm trying to think about it, thinking about the elements of the disenfranchisement, but I don't know if there was a specific strategy.

There were some staff terminations, some staff firings, within my group, And then there was a Federal lawsuit. But as for a strategy, it was underlined by change, a real need for change. I think that drove the internal changes, internal strategy, a vacuum of leadership. There wasn't a lot of political will on behalf of the nurses in California. There wasn't a lot of dignity given to the average staff nurse, the average working person, and so to change that, there was some movement.

Interestingly, I wasn't fired. At the time I was a part of the SPCA that was the internal staff union, and most of the people, maybe all, were management, professional positions. Bargaining unit staff, at least at the clerical level, weren't terminated.

It was eye-opening. It happened right around Christmas time and I remember getting a call at home and at first I didn't believe it because it was just really out of left field. But after a while, when the news sunk in, I understood because there was a group of people who were entrenched in their leadership position and felt threatened by the oncoming change and they had to take what seemed to me really radical action to stop that because I think it was sort of organic to where the current staff would be moving too. They were politically aware, politically active as well. I mean, at my clerical level I was typing up contracts, doing leadership lists, doing meeting minutes. I would hear and have conversations, it was very exciting.

5. What was the strategic plan for growing the association within California?

If you mean the plan after the bedside nurses took over CNA, I believe the plan was to improve staffing (push for ratios) and fight for control of our own nursing practice.

After direct care nurses took control of the organization, CNA began an education

<p>drive to expose the dangers inherent in the restructuring programs. Staff were hired who believed in the capacity of nurses to run their own organization, and with a brilliant and dedicated group of staff and nurse leaders, CNA left ANA in 1995.</p>
<p>To build a core of registered nurses who are passionate about their patients and their practice- and then expand out from facility to facility uniting the nurses - from Northern California to Southern California.</p>
<p>The big win CNA managed with Kaiser in 1998 really led to growing the association across California in addition to the ratio fight. We needed nurse power across the state to get ratios, nurses were excited to hear about the contracts CNA nurses were getting and there were well-organized Sacramento rallies to bring all the people together.</p>
<p>The plan was to organize more nurses to belong to CNA because we thought, I thought and we thought that having a union that would do collective bargaining that would protect you is the best way to go. Because a lot of the time if you do not have a union, or you are up there by yourselves, they tend- you get intimidated by the hospital and the managers. And if you belong to one organization, one union, then you have a voice.</p>
<p>After the break-up? Before the break-up we were mostly northern California. After the break-up we filtered into southern California, central California. It was just a matter of feeling out and growing our numbers in areas that were unrepresented.</p>
<p>Really to get more hospitals and nurses organized, more hospitals that were unionized. What surprised me the most was there weren't really that many unionized hospitals in southern California. It was mainly concentrated in northern California. The strategy was organizing, organizing nurses within California.</p>
<p>After we took over. The strategic plan was to basically tell the truth. Build it and they will come. I know that's an oversimplification, but we sat down, we drew up a ten-year plan, securing the future. It was quite apparent, but I can't remember the originators of the slogans or put it into more succinct language, but there was definitely a consensus about who were our allies. And our allies were our patients. That was a sense that I think ran through everybody.</p> <p>We have a moral obligation to patient advocacy. So our natural alignment is with the public. So we did that, and organized more hospitals, just general box standards union organizing. I'm not sure that's a comprehensive answer.</p>
<p>The first thing we had to do was to consolidate our base. Following the staff nurse take-over of power and actually before the disaffiliation with ANA, we were immediately attacked by AFSCME, the American Federation of State and County Municipal Employees, who hired away about seven or eight CNA staff and started decertification campaigns at probably 15 hospitals in the Bay area, all the hospitals</p>

whose contracts were expired. They had expired sometime during that summer and were still under bargaining. So we had to settle that fight first.

We won that. Then we began to consolidate our base. We had always had a very small, tiny actually, organizing department under CNA. Historically, up until the late '70s, early '80s, CNA had represented a number of hospitals in southern California, but the Board at that time decided (10 years before I started working here) it was too much trouble and had essentially given those hospitals to AFSCME. At the time I started, we had 1 organizer who worked in northern California and every once in a while, we'd organized a small hospital somewhere. SO that was the situation leading up to probably 1995.

We started organizing, once we had consolidated our base and we were no longer sending scads of money off to the ANA, we were able to devote some more resources to organizing. So we started doing that and taking more aggressive steps than we had been able to do up to that. At that time, we also had our legislative battles going on in the legislature in California. Because nursing is highly regulated, the practice of nursing on the one hand and also hospital nursing, we saw it as absolutely essential that we maintained that component of the work.

We were always doing something in Sacramento.- we were introducing early versions of the ratio bill, making demands on the legislature and regulatory agencies to strengthen patient protections in hospital regulations. We were doing that stuff and making sure we had the publicity, that we had a communications apparatus both to mobilize our own members in support of that and also to mobilize the public to the extent we could. We also started upgrading the organization. We had been able to organize some hospitals, in retrospect it was still just a handful of hospitals, due I'm sure to the lowness of the surrounding terrain. But it looked good. We started a strategic campaign around organizing the Catholic Healthcare West nurses primarily in southern California. We already represented a bunch of them in the north, not all though. The springboard for that was really the organization of the Mercy Hospital system in Sacramento, which was a 4 or 5 hospital system that had been non-union forever, part of Catholic Healthcare West. We were able to organize them, I think it was '97. When we put that together, that sort of became the springboard for the southern California, CHW organizing. SO it was a combination of a sort of incremental but substantial increase in the kind of organizing beyond that and continuing and expanding our legislative work.

We had sponsored a couple of statewide initiatives. One was on healthcare and one was on clean money elections. I think going through that process of having the petition written, the wording approved by the Secretary of State, and titled. Having the petitions produced and signature gathering, and getting it on the ballot, that gave the organization confidence that they could participate in the political process. The fact that neither initiative won, I don't think that takes away that those were issues we believed in and that we fought the hard fight. We didn't win but at least we fought. I think with the organizing wins that we've had year in and year out, organizing victories that have made the organization larger and the collective stronger, I think that underscores our political strength. We just have more people now.

One facility at a time. One system at a time. Don't forget this is happening when the industry was shaking out. This time, in '92, '93, '94 there were still a lot of community hospitals around here. None anymore. There's Kaiser, and another system. So all of the consolidation and everything was pushed by managed care financing. Capitation was happening. In order to fight that, you had to organize.

At Alta Bates Medical Center, for example, they came in with all their new patient-focused care. I remember suing Alta Bates. You staff by acuity, right? SO the day before they implement this, they took the census and acuity of the patients on the med-surg unit, for example. The next day they implemented it- 40% reduction in RN staff through some kind of black box science, and all their gimmicky words like, seamless care. Well, now major war was declared.

And out of all that came a view of organizing, and the nurse's role. And it started a long, 10-year battle to get ratios. Well, now you're a staff nurse in Florida, and sitting there observing this. One thing leads to another, and now you start developing a strategic plan.

This was also the time Kaiser was going to close Oakland, and we filed a red lining case. I mean who ever heard of filing a red-lining case against a big corporation like Kaiser? We won. But it was all really for the patients. This was also an organizing tool for nurses. The nurses knew these problems were systemic. If you take the concept of individual responsibility, and that goes up against systemic practice, the only way to succeed is with collective action. When there are systemic, unsafe staffing practices that you have posed the remedy to, and that management has refused or undercut by unfair labor practices like unilateral implementation, which is the case everywhere with unsafe staffing, then you have a duty as a patient advocate to take action within your reasonable means to stop that attack on patients. You have a lawful right to strike. Do it! This patient advocacy, this defines CNA. It's a labor organization, yes; a professional association, yes, but bringing those things together and making it meaningful for the people at home, it's a social movement. If you don't view it as a social movement, you'll be frustrated to death because it's so difficult.

The disaffiliation was one small part of the plan, but it was the staff nurse rebellion that was the key element. Most of the changes that happened, happened before the disaffiliation. The disaffiliation was a part of the process afterwards. The key thing was the entirely new orientation. People need to watch the history video. You should watch the history video. I think it's online.

The ideological change happening in the organization was the patient advocacy program. So that meant an aggressive challenge to healthcare restructuring; it meant promoting programs in collective bargaining and legislative activity to put the interest of the patient ahead of the interest of the healthcare industry. It meant constant education, mobilization of the members, endless workshops, working with the nurses and other members. It meant developing alliances with consumer groups and with other healthcare workers and being very assertive about defending the rights of nurses and patients.

So we put all that stuff together and CNA went from what, 17,000 in '92 to 86,000

members today. As of December, we'll be at 150,000.

Organizing, earnest organizing. Organizing, organizing, organizing. You have to organize. You have to bring in new ideas and new blood if you're going to be successful.

That was our mantra. When we took over we lost members because the old CNA all resigned. They didn't want anything to do with us, so we went from 20,000 to 17,000. We're now at 85,000 or 86,000 because we actually went down into southern California and we organized. We went to City of Hope. We went to St. Vincent's. Those were the hospitals that really needed organizing and that's what we did. And then more, I mean a lot more obviously. It's been fairly exponential growth.

Organizing, organizing, organizing, organizing. Now it took us a little bit from the time we got out of ANA, and got the money back. I had forgotten about this, but we handed out, as part of our convincing the staff nurses that this was the right thing to do (get out of ANA) a brochure with our platform. Some people said, sure, they'll get the money back and then put it in their own pockets. Some wanted the dues lowered. So we won the day on that one, and we said, no, we'll put the money back and use it for reaching our goals, like the legislative agenda we had.

So one of the strategies was to start a legislative agenda. The other prong was to organize nurses who weren't represented by CNA yet. So we had this two-pronged approach.

Well from a strategic perspective, what we had to do was every two years we'd have a House of Delegates and so what it meant was/were that people had to get organized and put forth by-laws, proposals that would make that change possible to go into effect. And then we as staff nurses had to make sure that the right slate of candidates was elected so we could actually make the change happen. But let's back up a bit.

Two years before that, in '93, it was a pretty hotly contested election where it was basically a slate of staff nurses running against a slate of nurse educators and nurse administrators. So I think '93 was really the first step when those members got elected and they had control of the Board of Directors. It made it possible to bring forth the changes and not have them blocked or undermined. I think the strategy was just getting staff nurses involved, getting staff nurses organized, electing a slate of staff nurses back in '93, and then when '95 came, to make sure the same people were re-elected, or at least people who had the same ideas. We had to make sure that the people who got elected to go to the House of Delegates would vote the way we hoped they would.

It was really interesting when the vote actually came up. There were probably around 200 people in the House of Delegates who were voting as I recall. Only about 8 people voted against getting out of ANA. It was just kind of an overwhelming

feeling for us, when the vote came. Even nurses who weren't quite sure they were ready for that sort of change voted for it. Turns out they WERE ready. It was a pretty powerful moment.

The strategic plan took a while to fall into place. I think in '95 we we're probably happy that we were going to be controlling our own destiny and that we weren't going to be giving ANA any dues money basically, and we felt our ideas as staff nurses weren't the same as the people who controlled the ANA. They were very different. So I think for a few years we needed to really work on firming up our base with our nurses in the hospitals that we already represented. Then it became apparent that we were looking at the state of California, and we seemed to represent a large number of Bay area nurses, but we didn't represent a lot of nurses anywhere else.

I work for Catholic Healthcare West, which is a pretty big corporation with 30 or 40 hospitals. I think we represented around 12 or 13 in '95. But there were nurses up in Sacramento who worked for Catholic Healthcare West who were interested in becoming organized. We still at that time didn't have a very large organizing department, it was mainly two people. We had some good issues up in Sacramento with all the hospital corporations involved with restructuring, taking RNs away from the bedside and the nurses up there realized that their interests that would be better represented by representatives that were part of the CNA. SO we got those nurses organized, which I think was really key. And then we started looking at southern California, and I think the plan became quite clear, it made sense. We had Catholic HC West nurses organized at a couple of hospitals, three in the Bay area, one down in Santa Cruz, five up in Sacramento and it just made sense we should organize nurses in southern California, it was the next logical step.

It was really interesting what happened down there because I think it exceeded anybody's expectations. I remember going down there when we had the first meeting at St. Vincent's (it's not a Catholic HC West hospital anymore), we went down there and we met with 40 or 50 nurses who were very excited about becoming part of CNA. They saw the advantages in terms of patient care and in terms of their own working lives. We were in the middle of our contract talks but talking with them. We were giving them some pretty concrete examples of how we can make a lot of improvements. So that hospital got organized and it was kind of like a wildfire because the nurses at that hospital were really excited about what they'd done and so then they wanted to go to other hospitals and help. Then there were other hospitals in southern California, including central coast, about eight Catholic HC West hospitals. They got organized and in the meantime nurses at other hospitals in southern California were wondering what was going on and how the nursing world's fairly connected in terms of people knowing each other. So it just kind of spread to other hospitals and so then I think the plan and the strategy became very apparent. We should just try to organize every hospital in southern California and every hospital in the state of California.

6. When did you feel you had enough momentum to begin the policy initiatives?

I think probably around the time of the organizing. It became apparent we had a pretty strong base in northern California, and we started developing a base in southern California. There were some real concerns about nurse to patient ratios with the corporatization of healthcare and healthcare becoming more and more a big business. Obviously, there were huge profits to be made. I think we saw the need at that point, even though we had strong contracts, that we needed to make sure, now that we had the strong bases, that all patients and all nurses had the same ratios, and all nurses had the same working conditions, to give and get the same care they all deserve.

I think that our developing a strong base in southern California was incredibly important. Otherwise, it would have just looked like a Bay area, San Francisco group because that's what we were. So we could see where nurses on medical/surgical floors were having 10 patients. These patients who were in the hospital were sicker. They weren't keeping you in the hospital more than a day a lot of times if you had your appendix out. SO things were changing. We saw the need. We saw we had the momentum. Even then it took a few years.

Once the bedside nurses gained control of the leadership positions and had Rose Ann as executive Director our planning began.

The nurses, realizing that they were the last line of defense for patients against the hospital and healthcare industry, began to do political education and worked to organize nurses throughout California and also fight for reform as nursing staffing was being cut to the bone and nurses were leaving because they could not provide safe professional care. Redesign was what pushed even the apolitical nurses in our hospital to organize.

CNA-sponsored legislation was noted in 1905 that resulted in the first RN licensure, and we have actively been sponsoring bills and legislation since then. The organization came more in the spotlight when the then popular "movie star" Governor, who unfortunately is still Governor, decided that the ratios were not important, and we were just a "special interest group;" that he could just kick our butts and roll back the ratios.

I am not sure when we began the policy initiatives. Rose Ann DeMoro always had foresight- important union and political connections and we had staff in Sacramento following legislation and regulatory concerns for nurses. From start to finish getting the ratios was a big effort over many years.

I think once I myself and together, I would speak on behalf of my colleagues in my facility, we felt we were liberated when we pulled away from ANA because we did not have to fear facing your manager or your supervisor who was your union president that should have been speaking on your behalf. So we, I thought that that

<p>was the best time to start building and working on the policy of what CNA has established.</p>
<p>I guess once we did leave ANA ('95). Once we got our feet solid on that, and changed the direction of our leadership here and got rid of those supervisory and administrative people who had been running our organization, then we were able to see what was needed in our communities and for our patients and get more political.</p>
<p>If you mean the legislative issues, staffing ratios, those kinds of things, that really started to take hold around the mid 90s. What we were up against! I was back in Sacramento at the time. I came back in 1987 and then I became more involved in CNA. We were seeing a real deterioration of nursing care and then the fragmentation was almost like they were deskilling. They were bringing back the aides, the LVN's to see how they could whittle away at what the registered nurses did. So I want to say we really started looking at protecting the RN license, patient safety. We were looking at staffing ratios, those things around the late 1980's and early 1990's, and it took a while to get Senators involved and starting to write some legislation. We've had our "ups" and "downs".</p>
<p>Well, when we took over the organization in '93, the House of Delegates in '93. We got the 8-7 majority. That night was the starting point, because it was touch and go whether our majority could rise above the oppressed group thinking, which they did around 3 in the morning. I gave Martha C. a lift home that night. I would say really immediately once that barrier was broken.</p> <p>Once the majority of the Board realized they had the power. Stepped over the line, then we had the confidence that we could do everything. We had experienced people who'd run organizations, who understood how to run organizations and we knew it, we just felt it, and we all understood. Anybody who was a major part of this understood we would fight in the public arena via the media, we'd fight in the facility level and we'd fight in the regulatory and policy level. So it just felt like an inherent confidence that we then formalized into a plan. I thought people had a very sophisticated sense of the political process.</p>
<p>I think I answered this already, right after we took over.</p>
<p>These initiatives came pretty soon, with the first one in '96 and the next one in early 2001 or 2002. We got right into it, losing some initiatives but we just kept at it.</p>
<p>Staffing ratios. Well, in terms of the CNA, the ratios campaign was a strategy, an organizing strategy to get staff nurses to start thinking about and fighting for their conditions in terms of their missions, and why they didn't fulfill them. It wasn't like, hey, everybody, let's go do this. We almost got an acuity system in place in '92, and the industry went along with it, to set acuities. Well, do you know how many different kinds of matrixes there are, and that they can use? And no one knows HOW they come up with their decisions, because their the ones that set it, the CFO's. It was</p>

really an impossible situation, and they themselves are the ones that created the atmosphere for us to decide to go after ratios. There were some good acuity systems out there, real, and transparent, but the industry put them into their little black box, they bastardized it. Nurses know when they have too many patients, so it became an obvious organizing thing. It's not that we ever intended to lose, but as an organizing tool it provided a very clear framework for staff nurses to understand the evil that was upon them and to articulate a response.

Nurses at CNA worked for 12 years to get ratios.

Well, that wasn't my decision. I mean, when did they feel they had enough momentum? It started right away. They were doing stuff immediately. Upon staff nurses taking majority of the Board of Directors and selecting Rose Ann to be the Executive Director, they were doing stuff immediately. From that point on, they were doing patient watch programs, they were doing classes, they stepped up organizing, they were doing conferences with other healthcare workers...they were doing everything right away.

We started working on our ratio bill while we were still with ANA. We got ratios in '75 for the ICU's. I don't know HOW that came about, but thank god it did. In '92, we were trying to get a ratio bill, it took like 12 years to finally get the ratio bill signed into law. We started the policy stuff right away after the takeover too. It took a while for the new CNA to be accepted in Sacramento, because of all the negative information that was disseminated to the legislators and to their staff by the former CNA people, who said things like: "You can't deal with them.", "They don't know what they're doing, blah, blah, blah."

Well we started talking about what was really happening in healthcare and how things were really going downhill and how we needed to do something about "care", and we had to do something about "education". All of a sudden it seemed to change and we framed everything in advocating for patients, which was well received politically. The old CNA played by "rules", and if they gave to this person no matter what their political leaning was, they gave to the other as well. We stopped all that. You were either on board, or you were not. We were always told, "You can't do that!" And we told them, "If you don't support the ratios, we're not going to support you."

I think too that managed care was really taking off in the early '90s, and I think nurses were horrified with the patient loads, which were absolutely impossible. There was a definite decision made to shift the focus, in terms of organizing, to permit bedside nurses to really act and speak as patient advocates as opposed to being tools for management's bottom line. And that got a lot of legs because no one really addressed this under the old regime. The nurses told horror stories, over and over again, of their inability to care for people. You could see that all nurses wanted to do was to give good care to their patients.

The ratio bill was signed into law on October 10, 1999. It was a very long effort. The public comment period probably set a record on the implementation of a regulation. I think they were finally finalized in 2004, or 2005. Arnie came into office in 2004, and he tried to stop them at the end of 2004.

Actually, here are two things. One, I think all along that for many staff nurses like me, who had been involved , we had been involved in these teeny little changes, right, over time between '82, and '93 when we took office. Between that period of time we were doing a bunch of little things and everybody thought we were going to change it. What blew up even this compromised structure was them firing the staff and removing officers and essentially trying to arrest the sort of compromises we had been willing to make; to say there's no more compromise, you guys are gone.

I think that alerted the staff nurses, and it shocked me how many nurses around the state got involved after that. I received a lot of phone calls from people I didn't know at the time, nurses who called me up because my phone number was put out there. Some have now been my friends for years. My number was put out there as part of the leadership that had been removed. Turns out these nurses had really liked the direction we'd been taking the association, it shocked me how many. What was even more shocking is that they were calling me to get involved in the "taking back the association" campaign and to move forward. That's when I understood that this was a special movement and that there would be a lot of stuff we could do in moving forward.

7. Money is always the elephant-in-the-room. What was the financial status of the CNA and how were the resources allocated under the strategic plan?

Initially CNA was nearly indigent as the ANA affiliation was so expensive and did not benefit the direct care nurse. We turned the corner when we were able to demonstrate the value of being collectively organized both professionally and financially and a dues increase measure passed. That provided greater financial stability and the ability to increase our outreach in California and then in other states as their nurses also wanted to organize and take control of their profession.

Don't know.

Then as now, our strength goes from the members, their passion, and their willingness to advocate for their patients, not dollars. The organization is of course, financially sound, but there has never been big money to place into the political arena, and resources are always used to obtain the maximum good with the least amount of money.

I was not on the Board or following the financial status of CNA until 2005. I don't know how the resources were allocated before then.

Ok. When we broke off ANA I thought we were almost bankrupt because the management, the people that run the organization, pay themselves. Even the officers of the region pay themselves. They even had an office where nobody knows to and hardly any members ever visited or used the facilities. And I know for a fact that they bought expensive paintings to put in the office; they paid themselves to go on a

cruise to reward themselves. And these are people that should be, that have a fiduciary duty of making sure that our union dues were well spent. But they used it to pay themselves. And so, when we broke off, I think we didn't have anything, we didn't have any money because our union dues were not used wisely.

Money's always the key issue, but I think the real advantage we had was that the allocation of funds included a couple of staff workers in Sacramento, and they were already up there. The other allocations of funds really involved transporting members up to rallies in Sacramento, but we already had a structure in place and the nurses knew that the issue was important. We didn't have to spend any money convincing our own members that these were important issues because nurses have been able to see that their working conditions were deteriorating. We didn't have a lot of money, but we had a lot of commitment. A lot of us put in a lot of hours. There wasn't a financial compensation for people like myself, or Kay, or Martha. It was more the commitment of the members and in their belief in what we were doing.

We could see it every day almost. We see it still when we meet nurses who come in from other states and they see the difference. I worked with a nurse yesterday, she's been out of school for two years, from Pennsylvania. She's looking for a job here and having a hard time finding a job because there's not a nursing shortage here anymore. Part of the reason for that is that the working conditions have improved. Nurses feel like they can do a good job now. It just reaffirmed everything we've done. We work in ICU, and she says we have two patients max here, but she had three and sometimes four back home in PA. She said she was happy making her agency traveling pay of \$22/hour, which for here is very low. It almost seems like slave labor to make \$22/hour.

I think that this took a couple of Houses of Delegates before we recognized we were making strides in organizing nurses. That was evident when we started really making an impact in southern California where we were organizing nurses. So the numbers were slowly starting to increase, but the dues structure hadn't changed at the time, so it was a small amount of money that nurses were required to pay. At the House, we looked at changing that by increasing the amount of dues we were asking nurses to pay because salaries had also increased significantly because of what the CNA had done over the years.

It took two Houses to convince the rank and file that this is what we needed to do. It was our success in organizing a lot of hospitals in southern California as well as bringing some nurses on board up here in northern California, that we convinced everyone that it was the right thing to do and when we did that, it was amazing how much more money we had, and that put a lot more into our organization that was helpful in continuing to organize nurses within California, getting the staff that we needed.

The resources were pretty shabby at the time. I may be exaggerating, but there was a bit of financial irresponsibility, not corruption maybe, just not looking to the future and short-term thinking, on the part of the CNA prior to us. A great example is they

had a very swell office in San Francisco, on a badly negotiated long term lease, a 12-year lease. Expensive fancy table, art work, all that kind of nonsense, bourgeois stuff. Ideologically, we were opposed to that. I don't know the dollar for dollar stuff, but organizing was what we needed.

That was inherent. I can't remember detailed conversations about that, but instinctively we knew that was what we needed to do. We needed to grow the organization. So money was spent on that. Staff resources were still a bit thin on the ground, so that came under: Let's just work our balls off, just in terms of getting the press. It was very transient, a gorilla movement. We weren't going out spending lots of money on hiring lots of staff. We just worked with what we had.

I'm the wrong person to answer that question because I'm not intimately involved with budgeting and what have you. I don't know who else is responding to this, but I hope Martha C. is on the list. She'd been the treasurer of CNA for a while. She would be a good person to ask, and of course Rose Ann knows everything!

I know there was money that was directed towards organizing. I know that that was to grow the union, that was the priority. As far as the actual dollar amounts, I personally don't know. I believe they are in board reports, finance committee reports, but in my position, I don't know the details.

What resources? They bought me a sailboat, bartering with me. No, there wasn't a lot of money. It took a lot of time to consolidate the association. The region thing was a big distraction. There was this core of ANA people that really wanted to get out of their association with CNA, they were just ANA'ers. Some of the leaders went with a whole pull out campaign, which was another whole area of distraction, but at least they cleared out. Some people on the old CNA Board saw this coming, and actually took funds out and into lock boxes in "friendly" districts. That was the nature of things.

We stopped paying ANA a per cap, pretty much right away, and then came up with a 10 million dollar demand letter. They were so shell-shocked over the first litigation that they didn't know quite what to do, so we kept on not paying dues. We actually saved 3 or 4 million dollars that way. But there was an awful lot of shenanigans and it was a continuous resistance.

There was the mahogany table in the SF office. They had rented a mansion in SF, and we had to come up with a strategy for breaking that lease. We called it the Crystal Palace. We were eating out of box lunches then! It was expensive to do, but we had to break that lease. There were other financial issues, they had bought houses here and there, in friendly regions. Region 12 had two houses, very large houses. Region 10. There was a lot of litigation, and that's where the money went. They had a huge counterinsurgency thing going on. We had to take care of all of this, plus deliver for our nurses.

Well the biggest drawback on money, and this is where the ANA affiliation comes in, the biggest drawback was all the money being wasted by being sent per capita to the

ANA. That was as much a reason for leaving the ANA as anything. I don't remember how much it was. I'm sure it was quite a bit. AND the understanding that that money should be used to advance the interests of nurses and patients, not buy a second yacht for VTB and all the people in the ANA. You know what I mean.

What resources? They were limited, and it was tough. To be honest, our treasury was depleted by the people who had been here before we took over. When they realized that they were out, they took all the money into the regions. Like region 12 had all the houses. They had two houses they owned, and other things. We didn't have any money, and our senior staff went without pay for a period of time. All of us chipped in, going to meetings where ever we were needed. We did what we had to do. We used our own sick time, our own vacation time. Staff nurses were running their own organization for the first time, and doing it essentially on a volunteer basis.

Yeah. Prior to the breakup, 95 to 97% of the dues were paid by collective bargaining members and about 50% of the budget was devoted to the E&GW arm of the association. There was a lot of money being devoted to "nursing practice" and "government relations." And the problem is not with the 2 titles per se, it was with the content of what their agenda was. So in government relations, say, it was much more about, and this is nothing against nurse practitioners, it was much more about getting them prescriptive authority. That was important to some members. California still does not have that, but at the time, it was a huge legislative effort. So instead of focusing on protecting labor law, worker's rights in general and regulatory rights for RN's, specific to RN's practicing at the bedside, they were doing all these kinds of things.

I remember them telling me that restructuring is coming, and we all said yeah, yeah, yeah. And then, all of a sudden, it sort of swooped through California with all the mergers, the acquisitions, the firings. Certain nurses within the association were saying it was a good thing. They were promoting case management as the way to go in nursing. It's not a bad way to do some kinds of nursing, but it doesn't work at the bedside. They were promoting the idea of "being a professional." You should manage other people as opposed to doing the work yourself. Somehow changing a baby's diaper would be beneath me as a pediatric nurse. Well, how are you ever going to assess the kid's skin integrity if you can't see it, you know?

Well, we were doing all these kinds of things, devoting a lot of money to these areas, and we were actually doing pretty well financially but we did do a dues increase to get more money into the E&GW. We lost a lot of members between the disaffiliation with ANA and the job layoffs. New grads coming out of school couldn't find work, just like now. In fact, some of the new grads took positions as nurses aides because that was the only work they could find at the time.

And then, when we took over we lost another group of nurses. I remember receiving hundreds of those letters saying, "I'm resigning my membership, Rose Ann is not a nurse." Like, OK, why? So we lost some who believed their own rhetoric that we were not professional. And they created their own group, the northern CNA, the Northern California Association of Nurses (NCAN), Some of the labor reps left us,

and they raided six or seven hospitals in northern California, the same time we were having this dues fight. I guess it wasn't really a dues fight, we were deciding if we were going to be able to collect those dues. We were fearful of losing membership.

And I do remember having some touch-and-go finance committee meetings that I chaired as treasurer, where we were begging people saying, we're going to make it! It's really tight, but we are going to make it! You know we had some real difficult financial times there for a couple of years. So we did another dues increase, and we won that, which is kind of amazing when you think about it.

8. What specific political tactics were used during the legislative process for staffing ratios and minimum pay?

Political tactics included multiple rallies by the RN's, lobbying legislators by the RN's and going to the public with our message.

We used "old fashioned" tactics and took to the streets, took part in rallies, spoke at meetings and hearings, lobbied legislators and spoke to the public directly or with flyers and on the radio.

Minimum pay (pay rates) is one of the central elements of a comprehensive program intended to reverse years of inequities in pay for nurses as compared to other professionals. The battles for decent wages are fought during contract negotiations with facilities. The rates are used to make nurses aware of what is possible. Political tactics used during the process: involved the public, the patients, the families, and the communities. Outline how/when the law would benefit the people at large, pressure to the representatives from voting members in their area. Political announcements, bulletins, rallies, letters to the editor (in local communities), keeping abreast of current action in Sacramento, being visible, when needed, and rallying support for important events.

Nursing salaries in California are good because the hospital industry has created a difficult work environment driving nurses out of the profession, we have good oversight of laws and regulation around nursing work that has prevented encroachment and deskilling in hospitals and clinics and then we were able to get ratios - a perfect storm.

For the ratios, we lobbied our elected officials. We did legislative visits. We attended hearings and also we educated our members so that every member went to their elected officials. SO its not just the leadership of CNA per se but every member was given the task to go back to their elected officials to talk to them and put pressure on them to look into the ratio legislation. We also did phone calls; we did letter writing not only to the elected officials but to the editors. We, whenever or wherever it was available, we put ourselves in the media. We involved ourselves with radio programs and anywhere there was an opportunity we inserted ourselves. We also included the

public, our patients.

Getting the rank and file out and demonstrating and getting hooked up with our local politicians, moving forward from there. The really grassroots stuff.

I think RNs are very well respected within the communities so we really pretty much went to our state capital and met with our legislators and really spoke out about our concerns. We did a lot of leafleting around hospitals where care was really deteriorating. And we really put pressure on the governor at the time, Gray Davis, and then assembly person (now Senator) Sheila Cule. So she was the one that actually wrote the bill. It didn't pass the first time; It came back. It was a lot of pressure and just kind of really getting them to understand what it is that we do every day, and how having ratios would make a difference.

We had Title 22, ratios of 1:1 and at most 1:2 in the critical care areas (1975), and it made a difference to saving lives. I actually talked to a reporter in Florida where they still don't have ratios in the ICU's and its unbelievable. This was about an intensive care nursery and they could care for 3 babies, 2 on a ventilator. That's unheard of here in California. The most you can have here in an ICU is 2, and if they're really ill, 1. SO we felt that we needed to expand that to the med/surg floors, to maternal/child health areas, the ER. It made a difference.

I don't remember legislation on minimum pay. In terms of staffing ratios, we just felt it was a right and just cause. We felt if we publicized it, if we could describe to the California population what conditions were like currently in hospitals and the danger that posed to them and their loved ones, then we would get them on our side, which we did through the patient watch campaign. I wasn't the originator of the idea, but I thought that campaign was a stroke of genius.

We got advertisements in lots of newspapers and other avenues of communication asking the public to let us know their experiences in hospitals. We received thousands of replies so it became my full-time job going through these. Some were bona fide and some were not. Occasionally we'd have a story of somebody who had had a death and they wanted to blame someone, so my job was to vet these. Could we honestly correlate these stories to cutbacks, short staffing? It was a bit of a catchall campaign.

It wasn't massively scientific; it was anecdotal, but we got enough to track trends of short staffing. There were a lot of stories about short staffing, denial of care, premature discharge from a facility, money favor, etc. I think we were very successful in publicizing that. Some gorilla stuff, some not gorilla stuff. We worked with a public media group in San Francisco. We did a lot of non-profit drawings. We did a lot of work with them in the patient watch campaign and it was a stellar campaign in that we really brought a spotlight onto managed care. We got stories in every major newspaper across the country, not just California; ABC news, Nightline. We really did a stellar job on that.

We targeted legislators as well, in their home districts. We used media in their home districts, and nurses that lived there. I knew we were doing all that, but I was

very focused on my job. My job was to keep churning it out basically and then I passed it on to Communications. In Communications, we obviously had a lot of discussion with Jim, the lawyer about our liability in all this. We asked patients to speak; we asked them to tell their story and we asked them not to mention their particular facility. We said they could be liable. Many of them just ignored our advice and went ahead anyway.

Sometimes they'd identify the insurance company or facility. We didn't think that was terribly necessary. We just thought the very fact that there was a patient development was enough, but then we wanted people to understand that this was a whole system, a deliberate system of denying you care. As far as I know, nobody ever did get sued.

We used a combination of things. We used a letter writing campaign, we would get 10,000 or 20,000 letters, a massive campaign, from nurses on a particular issue, and then around key issues or at key times we would mobilize demonstrations in Sacramento at the legislature, especially around the ratio fight. We had several large demonstrations up there ranging from probably 1,000 to 2,500/3,000 nurses up in Sacramento at the legislature. We did legislative visits both in the districts as well as in the Capital itself. We at one point actually invaded the Capital in contravention of every law that existed in the State of California and managed to get away with it sort of because of who we were, who we are. So its that kind of traditional lobbying, membership mobilization, and militant demonstrations that we used.

The CNA filed a lawsuit and we won. SO even though we had ratios in place, they were still under attack. There were demos that included going to Sacramento, having thousands of working nurses in scrubs with placards demanding ratios, going into the capital building, meeting with legislators. It was clearly a visible campaign.

And I believe that part of CNA's continuing political campaign outside of California, is to achieve ratios in other states. And so those same kind of demonstrations, the letter writing, capital visits, and continuing education for the nurses, will be done.

Nurses in the streets, and nurses in the offices. Very grass roots, voters, nurses, voters, nurses. That's the only thing you can do. You know we can't fight these people with money. The CA Hospital association, I call it a cartel, are an interesting structure, and mutual benefit corporation. So all these hospitals are actually part of one cartel. They have tons of money and from time to time they can be very sophisticated. Well, they bought Swarz and pretty much the first thing he did was to issue those emergency regulations.

Anyway, there's all kinds of things that have happened that have been challenges politically, internally, and externally. But what's developed is an understanding of what this is, this work, and how we relate to the outside world, our social movement. You can't really compromise, because of the way the industry has developed. It has to do with the alienation from the work. It's frontline for you guys (nurses), it's not like an auto assembly line. The work is what you do. This crashing contradiction of

financing is really the reason we have to have single payer- you can't spin your way out of it.

Nurses in the streets, and nurses in the offices.

First, as you know, the ICU ratios were adopted in the mid '70s, in 1975 I think. And actually, you can go back to the late '60s when there was a policy adopted in CNA supporting ratios. SO actually the first paper I've seen dates back to the late '60s talking about the need for ratios. But I believe the first bill of hospital-wide ratios was introduced in '92. This was part of the program, another arm, but part of the program was healthcare reform from the outset. But there was a bill in '92, it didn't get very far, then it got re-introduced a couple of times. Then there was an initiative we did in '96 called Proposition 216, with Ralph Nader and with another consumer group in LA called Impromptu 16. It was the patient protection act or something like that. And the initiative was framed in a way to take on all the abuses that are characteristic of HMO's. It had 12 major components of it, one of which was ratios because the gutting of bedside care in hospitals, and the restructuring of hospital care, was a contributor to poor conditions in hospitals and the HMO's were very complicit with this.

Ratios were not the best-known part of this initiative, but it was an important part. The HMO's outspent us like 10:1 on this and won of course. There was also a spoiler initiative out there that contributed to the problem. Most of the provisions of that initiative have since become law. All these things were happening, like the right to a second opinion, outlawing bonuses to physicians who deny care, etc., etc. Something like 10 out of the 12 provisions of that initiative subsequently became laws after a democratic governor was elected and a lot of the reforms got passed.

In '98, we actually passed ratios for the first time thru the entire legislature, and Pete Wilson vetoed it, but in the course of that campaign, we had done a really excellent job in mobilizing all the nurses in the state and building a lot of the infrastructure we needed with patient alliances to do a campaign for ratios in the next year when Gray Davis was in office, and in '99, there were thousands of nurses and patients putting pressure to pass the ratio law. On the day of the final vote in the Senate, we had 2,000 nurses on the steps of the capital, while Kaiser was on the inside walking the halls and pounding on peoples' doors, trying to get the legislators to oppose it. It passed, and much to everyone's surprise, Governor Davis signed it.

The hospital industry sold it to them because that's when, in our meetings with the legislators, they would tell us about what happened to their mom, or what happened to their daughter or their son. And we would relate to them why these things were happening, and what we could do to begin fixing it. We were also lobbying the Board of Registered Nurses on these things because we felt at the time that this was putting patients in jeopardy. I remember in '99, before it was signed into law, that my husband was admitted to a premiere hospital on the peninsula. They put him on the telemetry floor where the banks of monitors were located on a floor above where he was. None of the RN's could look at the monitors, AND they had 18 patients! How do you take care of 18 patients? I testified before the legislature about this.

The legislature finally got the picture because they too were experiencing the same thing. We were constantly there, talking, writing letters, calling. We sent so many faxes to Gov. Davis that we got phone calls asking us to please stop it. Please give us an hours rest! The phones were ringing, we had the nurses calling. This was the most important thing, because they recognized that the nurses were concerned for their patients.

I don't remember a minimum pay thing. I know what we did do, we worked hard on getting ratios. We had started out asking for the ratios. I remember going to testify at the Department of Health Services, around ratios, in the '80's. They said the hospital association had convinced the DHS that ratios were inflexible so we're going to staff by patient acuity. So we said, OK, staff by individual patient acuity, as opposed to the "average" which is how they wanted to do it. Some days you had good staffing, and some days you had horrible staffing. And so we really managed to do that campaign and we won that, but it was really clear that the employer was able to manipulate that idea and say that an aide was equal to a nurse in those acuity staffing systems- so we started struggling for ratios. And we did struggle with ratios, all through the '90s.

We did it with contract campaigns. We did it with letter writing. We did letter writing to newspapers about bad staffing and horrible patient outcomes or near misses. We did letter writing to legislators. We did a bunch of demonstrations in the capital where thousands of nurses showed up to get ratios. Then, when they were under attack, after we got them, well I remember one time where we filled a room with a thousand nurses, some rooms with hundreds of nurses, one big room with a thousand nurses to testify on the need for ratios. Nurses were willing, even nurses who we didn't represent were willing to turn up and testify to why there should be a maximum number of patients per nurse.

9. What political obstacles did you encounter with the California Legislature, and how were they overcome?

I remember quite a few. I think we had a tremendous problem with our Republican legislators and we still do. There is little cooperation at all, because they don't seem to understand that you need to care for people, not just care for the money. And they can't grasp the idea that a woman, since we are predominantly a women's organization, would be able to have the kind of power that they perceive us to have. I think what we did to Arnold, when he tried to hold the ratios hostage, scared them.

We were in the streets, we had billboards, we had trucks and buses with billboards on them. We drove to Eureka, to Crescent City. We drove all over the state of California, down into the Imperial Valley. We'd find out where he was going to be, and we'd be there. We would be in front of him. He went to a baseball game back east, a Red Sox game, we were there. He went to a rock concert, and the star of the concert came out and welcomed the CNA. I mean, it was just fantastic!

Here's some history- The ratios bill passed. It took a period of years before the

regulations were finalized and set to take effect. Then there was a recall election in California and the democratic governor at the time, Governor Davis, who actually signed the bill, got recalled. Schwarz got his momentum from his star power, and connections to big money. Within weeks of his being sworn in, maybe within 2 weeks, he met with the CHA and they presented him with a written request that he issue emergency regulations to halt the implementation of at least certain facets of the ratios law. It was pretty amazing! He issued the emergency regulations, said it was basically a mistake. Didn't give us any advance notice that was politically pretty unusual. There was another big legal challenge over that, and he lost.

I mean we had planes with banners flying over where he was. We were in the streets. When we went to the capital, we marched from the convention center and there were a whole bunch of unions and other organizations all protesting his propositions. We came walking down the street, doing our chants and all that, and it was like the seas parted. Everyone stopped, and started clapping and cheering for the nurses. We were recognized for having the guts to take him on.

When Schwarz had come into office, he had this incredible Teflon, and he made a lot of promises about cleaning up Sacramento when he was really serving the interests of certain favored industries, and we really took him on in a colorful way. There was his calendar, and we had a plan to deploy the nurses, and it really engaged them.

When he went back east, we had the MA nurses show up, some of the NY nurses showed up. We had some of our officers go with some of the staff.

Political obstacles included lobbying by the hospital association crying poor and how the ratios were so expensive. We kept up our pressure and actually an event with a family member to Governor Davis caused him to sign the bill.

While I was mainly involved with direct activism in the ratio battle, it was also a matter of education, pressure from nurses and the supportive public, and unrelenting persistence. Recruiting legislative champions who we also backed gave us more legitimacy in the capital. As they say, politicians don't always see the light but they do feel the heat.

The historic first-in-the-nation Safe Staffing RN Ratios took 13 years to win, with continued efforts of the hospital industry to overturn, with many bogus claims, a court action, changes in political parties, big money invested in the fight per the hospital industry, corporate greed, amending and renaming the bill, changes in coauthors, and an 11th hour lawsuit, but in spite of all of the above, we buckled down for the long haul, jumped through hundreds of hoops, lost battles, fought back from what seemed insurmountable odds, and won the war.

The main political obstacle we encountered was the California Hospital Association lobby. We had much RN visibility in the capital with large rallies, got patients on our side and had a political alliance with Governor Gray Davis. CNA is good at inspiring nurses to stand up and fight for patient rights.

Of course as one might know, the hospital industry are major contributors to their campaigns, to the campaigns of our elected officials. So the elected officials of course have a conflict because, do they listen to their constituents or do they listen to their major contributors? So that was one of the major obstacles. As I noted earlier, we put pressure on the elected officials to say that they needed to listen to their constituents. You need to listen to the people that actually voted for you, people that put you in office. I think some of them got the message quickly, but some of them were still very hesitant to listen to the public, to us as the nurses.

So we also exposed officials who were into taking care of their major contributors, more than us. We exposed them and we shamed them everywhere at any opportunity we got.

The big problem was the hospital industry of course, who were against the ratios and remain so. It was just a matter of grassroots organizing, getting people out there, explaining what most people don't know about hospitals. They don't know what a ratio is, they don't know what a nurse does, you have to explain that in town hall meetings, etc.. What is 1:3, 1:5? Education, I think that's what did it.

Obstacles? Well you know you always have the hospital associations, they lobbied really strongly against the ratios because they felt the RN's were going to cost a lot of money and the law meant they would really have to hire up. They were more into the bottom line, and if they could use the less expensive person, the LVN, they really wanted to try and do that. But we pushed really hard.

When the nurse to patient ratio bill passed, it really didn't say RN ratio. It just said nurse. So that included the LVN. But CNA's position was that it is the RN when you think in terms of nurse to patient ratio. Over the years we made it known that we are talking about the RN to patient ratio that a lot of hospitals have let their LVN's go on the hospital side. They've placed them in the clinics and other places. CNA never really said you need to get rid of them completely. What we said was, put them in a position where they can work with their limited skills for practice, because really an LVN cannot assume an assignment. They need to be overseen by a registered nurse. So we made enough noise that most hospitals still limit the numbers of the LVNs.

I guess we came across a lot of fear and loathing of individual legislators going against the healthcare industry, because they were given lots of money from them. My knowledge is pretty limited here. I can't remember individual legislators. I wasn't involved in any of that because I was in communications. I knew of it, but I can't recall any particulars. Again, it was absolutely a campaign to pick off individual legislators and really get in their face in terms of endorsement, pac money. We published the information too. It was just all there and we tied people to the vested money that was backing them.

Well there's the general conservatism of the legislators themselves, the massive lobbying resources of the hospital industry, with the California Hospital Association the primary agent of the industry here. In terms of counteracting that, we just kept

hammering at it with all the things we had.

We sent delegations to people's local offices. Actually we had a very militant and spirited demonstration against Wilma Chan who was on the East Bay area, I can't remember whether she was in the Assembly or the Senate, but she was on a key Committee. She refused to vote for the ratio bill at that time and we took about 500 nurses down to her office. Boy that was intense. We were certainly looking for events like that.

It's surprising. From my perspective, the nursing profession has had a great deal of public support, and legislative support, so when CNA goes to the state capital, by and large we're welcome. There isn't at the capital, with the exception of the governor and a few republican legislators, any obstacles. We're well received, and people are excited when we are there. Yes, the republican party is an obstacle, whether it be the governor or the legislators. But at this point I really should mention that the mayors of Oakland and assembly people that are in the Bay area, they support the nursing profession. I've seen a largely welcoming climate.

The obstacles were all that you can see today on healthcare reform. When they held their first hearings, there were a few of us who went up there, put on scrubs that had a message on them, stood up silently. We got arrested because you're not supposed to do that in the senate. We weren't at the table to debate. You know, the notion that a social movement, a fact I try to emphasize here, that a social movement would reject its fundamental principles, its objectives, in order to make some kind of political compromise, is a joke. Day after day, when you get involved up there in the beltway, that's the challenge you face.

And you know, that's the same thing that happens in the AFL-CIO. That's all people do is they compromise. They don't have any principles left other than to gouge profit. Those guys, on that side, know how to do it. So as a labor organization you represent members but as a social movement, you have a guide or focus. The minute that gets lost, a lot of people like me would leave. In the nursing leadership, and the staff leadership, that is our focus. It's singular, but it takes beatings from time to time. It's not a static world you know, it's a continuing flow of a progressive movement.

Well, the political obstacles are the same ones you see in Congress right now with healthcare reform. It's the *&\$#@ influence of the corporate interests and all the money that the insurance companies spend on lobbying- the insurance companies, the hospitals, the drug companies and the medical manufacturers. Healthcare is obviously 1/6 of the economy and we're the only country in the world that has corporations profiting off suffering and pain and they make millions and millions of dollars in profits and they will spend whatever it takes to protect that. That includes buying influence in a legislative process and CA is as subject, if not more subject, to being bought off by corporate interests as any other state in the country. The only place you see it worse is in our U.S. Congress.

So that's really the obstacles we had to overcome to get the ratio law passed, and

other legislation too, like the clean whistle blower protection, and other stuff. There's a whole list of legislative accomplishments we've had, and we've had to use the grassroots work to persuade legislators to go past the campaign contributions and the lobbying from the industry, even from some liberal groups and other labor groups.

One of the great mythologies of the last 4 years is that Arnold Schwarzenegger is a liberal. Arnold Schwarzenegger is the most corporate governor in CA we've ever had, well at least since Reagan. He is down in the pocket of the insurance companies and the healthcare industry and when he tried to roll back the ratios here a few years ago, he was doing it at the express direction of the hospital industry.

Well we couldn't contribute as much money as the CA hospital association or the insurance companies which I'm sure you know all about. We tried a couple of different times to get the ratio bill passed, but it was difficult. We introduced the bill once and it didn't get through the legislative process. We introduced it again, and it got through the process but to get it through the ENTIRE process, we had to amend the bill to say that the DHS, after a public hearing, would set the actual ratios. SO we got that bill through and Governor Davis signed it, and it was a great step forward. But then it took several more years of public hearings where we had to do the same kind fight again with letter writing, getting patients to testify, getting families to testify. We had to do the whole campaign again to get them to set appropriate ratios because once the employers knew that you could fight the ratio numbers, they just took up that fight. There was some kind of fight every step of the way.

We also ended up fighting some other unions, because we were seeking ratios for ourselves, but there are plenty of other healthcare workers and other classifications of nurses. Like, should LPNs be included in the ratios. In the bill that ended up passing, since they can't do patient assessment and patient education in California, the ratios applied only to RNs. We've insisted on that. I know this may be different in other states. So we've had various levels of obstacles around us and I think the employers are still fighting ratios. The employers seem to really hate that you're supposed to have a nurse providing care at all times, and my director even goes so far as to say that it's unsafe to have another nurse care for your patients, even if that nurse is unit competent and qualified. She says there are more errors that way, but I don't think she can substantiate that in any way. She continues to fight us in negotiation talks, in contract language around getting implementation of break-relief nurses to make sure the ratios are maintained at all times. They keep attacking around the edges, looking for a weakness.

They used the nursing shortage issue. They used that a lot because at the time in the mid-90s there was another huge nursing shortage. And there were objections from county facilities, it would be too difficult for the public system because of the cost. And the rural hospitals, a lot of stuff about the rural hospitals, how they shouldn't apply to the rural hospitals. The Republicans, of course, didn't like it and really didn't consistently vote with us. The Democrats, this was a Democratic bill, it was a Democratic legislator who carried the bill for us, and a Democratic Governor who signed it, more often than not supported it. But it was sometimes surprising to me who did support it, generally related to their personal experiences, like having a sister

or mother being a nurse. Some people surprise you no matter what their party.

I think the CA legislature is a diverse group. You've got the Bay area which is fairly liberal, progressive. You've got the central valley and northern CA and southern CA if you don't look at the LA area that is fairly conservative. So I think one of the obstacles was a lot of those individuals thought that this was more government regulation and it wasn't a good thing. So that was one thing.

The other thing, of course, was the hospital industry, that didn't like the idea. I've heard stories that in Sacramento they had 100 lobbyists and we had one, so obviously we were outnumbered. So a lot of our strategy was just meeting with people and convincing people that this was the best thing for patients and hospitals. And when you start to talk to people, you find that almost everybody has been a patient or their mom's been a patient, or their dad has, or their brother has. So they know what it's like to have someone in their family in a hospital. So then you start to explain the difference in terms of, particularly in medical/surgical floors, your loved one having a nurse that's taking care of five patients vs. taking care of 10; people start to understand that.

So that was part of it. And then we also had some large rallies where nurses from all over the state of CA came and we rallied at the capital and met with our legislators up there, met with their assistants, talked to them. There were legislative hearings involving the ratios once the law was in place, as to what the actual numbers would be and how they were enforced. SO we made sure we went to those and that we spoke up about our point of view on the subject. I think that was a lot of the strategy. Demonstrate and be at the hearings. Our message was easy, it was very consistent. It was about patient care and about patient safety. I think I answered two questions here. Sorry.

10. What advice would you give other state associations who want ratio laws and/or minimum salaries for RN's in their states?

My advice is to be ready for a long fight. Keep up the pressure, change your tactics as needed but always keep the nurses and the public engaged.

Organize, work collectively, educate and learn how to use the media and the public to support ratios. Be unrelenting in your persistence and learn to get involved in local politics for mutual community benefit. Direct care nurses generally have to learn to be comfortable with political and public activism so direct involvement in the organization is essential as well as staff support of members. Once nurses have achieved a goal and feel empowered they become dedicated activists.

That it is a battle worth fighting for. That the journey will not be easy, nor the battle won on the first round, but the end result of being able to provide safe, therapeutic care to our patients is well worth it. They will face many ups and downs, but the way has been paved, many of the trees removed, that there is a comparison, that it has

been done before, and will be done on a national level. The CNA/NNOC is willing to lend support as much as is needed. We have the right to work, and to make enough to only work one job, to be able to retire, have healthcare, and financial stability.

Other state associations have to be prepared for the fight. They have to help RNs recognize their value to all members of their communities, they have to get patients to get behind the nurses and run a public campaign of support and they have to be able to show the losses that can happen for people without nurses advocating at the bedside. It is a combination of using the media wisely, making contact with the politicians and supporting nurses through the fight- having patient advocacy language in the RN law, whistle blower protection and getting rid of right to work rules are all helpful. Nurses who fear for their jobs are less likely to speak up.

I would say that if they put their hearts and their minds into the real issue which would be staffing ratios and better pay for RNs, they would get it. They need to work hard for it. They need to engage each other and every member of their organization to fight and stand up for what they believe in.

Start with the nurses in the hospitals and educate them, get a broad base there and have them take it to the public.

They need to really organize and do an action plan and really get the nurses to understand that this is about patient safety and quality of care, and outcomes. SO I think if they really want it, they really need to organize and make it happen.

What we're seeing here in California is that we get a lot of travelers, so we have a lot of nurses that come from other states and so when you ask the question, why are you here, it's because the work isn't as hard and I can make more money than in my hometown. So then we need to go there and say you really need to get nurse patient ratios in your state and raise the salaries for your nurses so there isn't this strain for us having nurses coming from Florida.

Copy us. I mean, do the same thing. I don't know what else to say. I'd begin with education. I'd educate as often as possible. Educate the members originally. Educate them in the analysis of how healthcare became incorporated, that it is now a "for profit" system. It's lost that old tacit social contract between a hospital, the people who work in the hospital: nurses, doctors, healthcare professionals and the public. It is now a for-profit business, Wall Street, capitalism, call it what you like, they saw in the early '90's that there's money to be made out of this and they swept in.

So educate on that, where the money goes, who are the players, and educate the nurses to be confident what their own position is in this healthcare system because it was evident then and it is evident now as we go to other states, that's what nurses don't see. They're under economic terrorism. WE as a society do not pay nurses, their employer pays them. There isn't much of a safety net in this country. People are anxious in my view, of falling out of work and falling onto a net that doesn't exist. It's my personal belief.

Educate them on economics, give them amore sophisticated voice so that they have more confidence to talk about this. It's hard for them to articulate this. It's been my experience, based on years of working with nurses, that a lot of them are the bread-winners. Lord knows what their personal relationships are like at home, but you kind of get the sense nurses are caregivers. They go to hospitals to work hard there and I think they're taking care of everybody at home too. This is about co-dependency, and when I've organized nurses, and been to their homes, they're the caretakers. It's not research, it's just been my experience.

We need to nurture those nurses somehow and I think we do that by acknowledging what they are, the fabulous things that they do, the high esteem in which they are held. Then educate them, give them a more sophisticated understanding of financing and the political process and that they are a powerful force. We educate them on the numbers of RNs who are voters, one in 44 but this data is about four years old.

Well, there are two things, although it all really comes down to one thing. What changed the objective circumstances in California, because we had been doing this since the early '90s, pushing it and either not getting it through the legislature or getting it vetoed, but what changed was the organizing we did. When we started doing it we were primarily a northern California, primarily a Bay area union, which meant that the legislators out there in the hinterlands basically didn't feel like they needed to answer to us. But as we organized further into northern California, and then especially into southern California, then all of a sudden most of these legislators had our members in their districts. That was huge! That really changed the objective circumstances. So the building of the union, in some sense, whether through regular organizing or through the organization of nurses on a geographical or regional/metropolitan type basis, that creates an organized force throughout the major areas of the state.

The second thing is something that permeates our work throughout and that is a militancy and a strategic analysis where we don't - and we've been accused of and sometimes we accuse ourselves - of taking no allies. What we don't do is to put ourselves in the service of anyone else. So we have maintained a kind of distant relationship with the state Democratic structure, the state political structure. We work with individual legislators, we support people in elections, but we're very picky about it and we never allow ourselves to get co-opted by that.

We've had a rocky relationship with the AFL-CIO structure in California. We joined the AFL a few years ago, 2 or 3 years ago, but before that we were independent. We've worked with other unions, individual unions. We've worked with the state labor structure on certain issues when we saw an interest to push there, but we never allowed ourselves to get sucked into that. SO maintaining a militant, independent existence and basically keeping one's eyes on the prize so you look at what it is you are trying to accomplish and continue to judge where you're at, who you should be working with on that rather than compromising from the start, which is a criticism we have generally about politicians and much of the labor structure. The current healthcare so-called debate is a case in point.

Well it's important to be visible. It's important to be on the ground. I don't think that you achieve those things through making telephone calls to legislators. There has to be an element of activism and an element of being out in the street. When you have hundreds or thousands of nurses that are rallying at a state capital or rallying through the streets, it really grabs attention. And I don't think that a successful campaign for the change like ratios or working conditions will be successful without that street level activity.

In our bylaws now, we have patient advocacy and collective patient advocacy as duties of members. But that is something that developed over time. You have to start by organizing where you work because that's where your getting it. Once you start organizing where you work and have a focus on your responsibilities as a nurse, what's happening to the patient and why, the trappings of the industry that's holding you down (AKA: the ANA), things will quickly become apparent. It should become apparent.

So for state nursing associations that are still trapped in the maternal back world, there's no way to compromise your principles with them. That's a lot of tough stuff I'm saying. We're about to undergo a significant test because we've just merged and we're trying to kick off a "partnership" with a lot of these folks who are still deep into that culture. Even though they've split from ANA, it's still a culture problem. So we'll see. It's a grand experiment, because after many, many years, we're going to have discipline, purpose and force here about these things. You don't have to spend more than 10 seconds with anyone here in leadership before you can see that. We've got great leadership here. The principles are solid, good for patients and nurses, and they know it.

Well if they are in the ANA, they should get out of the ANA. They should be aggressive. They should never compromise the interests of the patients for narrow reasons because the greatest successes nurses have is when they're representing the interest of the patients and the public at large, and that's not just true for nurses. When you look at the greatest successes of the labor movement, they've come when the movement is representing the working people in this country. Labor advocated for social security, and 8-hour day, a 40-hour week, weekends off, unemployment insurance, and rural electrification- all the things enacted in the 1930's. It's not a coincidence that that marked or created the greatest growth in the labor movement because it was not viewed as a special interest, it was viewed as the public interest. You know the Gallop Poll that comes out every year that shows every year, except for the 911 years, that nurses are viewed as the most trusted profession and that's not something the nurses can ever allow to be eroded.

Join us! We are doing national organizing. We've helped nurses in various states sponsor ratios bills. In Arizona, we got 2:1 in the ICU's, the same as we have here. We were able to introduce that. We don't even have an organized hospital in Arizona, but we got it there for those nurses. And we're working on getting a staffing bill in Arizona, Texas, Florida, Illinois, and Michigan. We've done it in Maine, and

Massachusetts has one. They haven't gotten it through yet, but we're all working together.

We've also been working with Senator Barbara Boxer here in California, who's introduced national legislation on staffing, and education. We need to reverse the Kentucky River decision. We've been working to make sure that we put it into every contract language, but we haven't been able to get it reversed. It's something that is on our priority list. As far as the new Obama administration is concerned, we're just trying to appeal that he keep the public option in the pending legislation.

I would say, involve as many people as possible in attempting to get it and build a coalition with the patients and their families because that's who's going to benefit. We sometimes say it's not about us per se, it's about our ability to provide patient care, and the public will be on your side if they understand that what you're struggling for is your ability to care for them. It's not JUST that "I don't want to go home exhausted," or "I need a 15-minute break." It's about being able to think clearly and do what I need to do to give the patients the care they need. I think that putting the patient first is something we've been good at and partly because it's natural for nurses to do that, it gives the public a different idea about what we're struggling for. Some may say it's just a "full-employment" act for nurses, or just a matter of job security, not wanting to be laid off, whatever. As long as they really understand that what you're looking for is your ability to provide safe patient care, most people will be on your side.

Well I think the obvious starting point is, they have to organize and represent as many nurses in their state as possible so they have a power base. If you and I, if we have 15 nurses and we go show up at any state capital and maybe get lucky enough to convince a legislator to introduce a bill, we're not going to get very far if we don't have a large base that we're speaking for. And so really I think what I talked about before, you need to organize. It would be hard for me to come up with a percentage, but I'm sure you'd need to represent at least 10% of the working nurses (in 1994, the ANA represented 10% of American nurses) in the state where you are to have a good shot at passing the bill.

You can have the best intentions in the world, but if you don't have the public opinion to back it up- it's going to be really tough! There are other groups, other than your own members, who are going to be natural allies. I guess I didn't speak to that before. I remember, for example, the Gray Panthers were at our rallies a lot. They're senior citizens and they're concerned about healthcare. A lot of them have been in the hospital or their friends or family members have, so find the groups who are your natural allies. Actually, the public is your natural ally, once they understand the issue, that you're really talking about patient care and safety. But I think, if your base is large enough that you have some money, and you need money to get anything started, you then need enough individuals who are going to come forward. It doesn't matter what the issue is.

I don't have to give them advice, they already know. I mean, the beauty of having travelers, nurses that sign up to travel from one state to another, is that they come to CA and they think they've died and gone to heaven because in other states, there is no regulation of staffing ratios, there are no real acuity systems, there is no "let's just use nursing judgment," even though the ANA talks about "let's just use nursing judgment." Well, if that could have been done, we wouldn't have needed the ratio law. But there is no advice I can give because everybody understands that it works at the bedside, that ratios work and that they want them. It's just how to get them that you have to overcome, and that's just keeping the pressure on the politicians to man up and pass them. They have to go up against some of the wishes of their contributors, that don't ELECT them by the way, to pass that legislation. But they do fund them, don't they.

11. When did you realize that Governor Schwarzenegger was opposing the ratio law, who was the driving force behind the court case, and how did you gain the legal victory?

From day one I knew Governor Schwarzenegger would oppose the law because of the lobbying by the hospital industry. After having ratios for a year and experiencing a reduction in the ratios we knew we couldn't give up so we took the battle to the courts. We gained the legal victory because of the expertise of our legal team and again the pressure from the nurses.

Of course we knew that the governor as a business republican would not support the bill and so our PR department, working with supportive legislators, and the CNA, networking with other labor and progressive organizations as well as persistent public rallies and educational outreach over 10 years finally won the goal of ratios.

Jan 2004 immediately after becoming law. CNA was the driving force behind the court case. There was massive mobilization of members to rally at the courthouse in protest. Legal victory was gained with the lawsuit filed against Schwarzenegger by CNA charging that the governor exceeded his authority to overturn a legislative mandate order. We launched an immediate campaign including more than 100 public protests, radio and TV ads, and RN letters to the editor, garnering extensive media coverage from around the world.

Governor Schwarzenegger almost immediately wanted to repeal the ratio law when he became Governor. He made multiple mistakes which helped our cause - comment at the women's convention that nurses represent special interests and he likes to kick our butts, we dogged him at every fund raiser he held. CNA was the driving force behind the court case- we were able to successfully show the consequences of not following the ratio law at all times and in all circumstances. We had a good judge on this case. The ratios are always addressed in context to patient safety- what makes sense for your mother?!

From the get-go we knew that he was going to oppose the ratios, Governor Davis had supported us for the ratios. Governor Davis was the person who signed the ratio bill into law. When he lost the recall election, we knew that Schwarzenegger was going to do something bad because we knew that the hospital industry was 2000% behind Schwarzenegger. The people he was dealing with were the same people that had opposed the ratios to begin with.

We knew he was going to fight back. What we did was to sue him; we took him to court and each time we won and I think we sued him 3 times, and we won each time, because he had always overstepped his bounds. He went over and beyond his powers in order to fight the ratios. We proved that and the judge ruled that he had done that each time, so it was always a victory for us. 3 rounds, and he was always defeated.

Immediately. We knew immediately, it was just his swagger. I was not on any level of the organization at that time to know the response. The hospital associations were against us, and were fighting the ratio law. It was only our power, the CNA, our legal department, and the honesty of what we were doing and why we voted for ratios, and why we needed them. We explained that to the public.

I think right from the beginning. I think as soon as he took over. I believe that with the help of the hospital association, he really wanted to roll back the ratios because the hospital's really felt that, at least that is what they said, they didn't have the funding and they didn't want to add the additional nurses. They really pushed hard, they lobbied, and so, in my opinion, he really wanted to push the ratios back.

We pushed harder, and so wherever he went, we followed him and we also took it to court and I think we just kept adding the pressure. Wherever he was we made noise. We were an irritant in the media.

Well the driving force is Orange County, and the neo loonies who live there. That's always been my understanding of it. The Schwarzenegger backers are ideologues, extremely wealthy people mainly out of Irvine, Orange County. Extremely, shockingly conservative. They have a real neo-conservative view of things. Healthcare professionals are an obstacle to an "efficient" healthcare system. My sense is they feel we're overpaid. What we can do is a series of tests, and that can be done by a cheaper workforce.

In terms of the legal victory, it's funny, you kind of think you know this but it's hard to remember specifics. I remember lots of meetings, but I can't remember which districts, or which way we went legally. The first day he came in power we knew, it was one of the first things he did- the emergency orders. I can't remember which court system or how we appealed it, I just knew we were doing it. We guessed absolutely it was coming. We did a lot of work to stop Schwarzenegger from getting elected, put all hands on deck on that one. And frankly I was shocked he won. So we knew there's be an assault, whether we knew it was going to be that rapid and that clear cut, I'm not so sure.

Well you know the history, Schwarzenegger became governor through a recall election. Gray Davis, who was a kind of centrist democrat, and who we had been successful in putting enough pressure on to sign the ratios law, was re-elected in 2002 (?). It was about a year later he got recalled by Schwarzenegger, and it was like a month, month and a half before the implementation date of the ratios. We knew it was highly likely that Schwarz was going to take some action because, if for no other reason, the hospital association, the California Hospital Association, was vehemently and aggressively opposed to the ratios, and they were a big contributor to him. So it was not a surprise when that happened.

We were able, in terms of a legal strategy, to challenge, first of all, the method that Schwarz used, which was through emergency regulations. He declared an emergency regulation. He was going to suspend the ratios. It was sloppy what he did. So we were able to take advantage of that and get it thrown out because there was no evidence to support his “emergency”. That was essentially the legal strategy we used.

So to answer the first part of the question, we knew it was very likely to happen, and it did within days.

Oh well definitely the hospital association was the driving force. I mean the association has really been for years the primary opponent of what we try to do at CNA on many, many levels. Even today, when we’re trying to deal with Swine Flu and protecting nurses who have come in contact with patients, and the nurses might need certain types of masks, the hospitals either don’t want to pay for them or don’t want to provide them for whatever reason. The association has always been against our goals. SO I believe that when Schwarz was elected, and he was seen as a mostly pro-business person, the hospital association went to him.

Well Schwarz is a big business guy, and he got a lot of money from the hospital industry. We knew that from the get go. I can’t remember how much he got, but it was a lot! Of course the regulatory proceedings after the law was passed lasted 3 years, and were probably the longest ever. The law delegated and mandated that the health agency develop the ratios. AND, there was a legislative delay in between this. SO they were constantly fighting. In fact, written into the law was a sunset provision that allowed the legislature to look at a study on how it was going. So there was continuous pressure on the law.

SO it wasn’t surprising. In some respects, it was surprising it took them a year to do it even though he misused some proclamations early on. But you know, this guy, just like the Bush’s or so many other of these big banks, corporate politicians, they just don’t give a shit. They’re not strategists, they just don’t give a shit. They just plunder, which was kind of fortunate, because when they did they’re emergency regulations, their shit wasn’t together. Schwarz and the industry wanted to slow down the ratios. It was hits on certain areas, but it was the precursor for more to come.

The suggestions were supposed to be an improvement on the ratios, things like going from 1:5 to 1:6 on the med/surg units, but it wasn’t scientific. They just introduced what the industry wanted. In court, they had to support their actions, and this was all available for attack. We took it much farther than a simple ratio, and went after the

entire theory. They were screaming about hospitals closing, the sky is falling and all that kind of stuff - which are the same things they said during the regulatory proceedings.

SO everything they said had been considered and rejected out of hand because the purpose of the statute was to repair staffing that had been ravaged by managed care financing. Economics, the nursing shortage were not to be factors. SO we took that approach when we took the case to court, we got an intelligent judge. We got several injunctions and almost a contempt citation against them. The statute was a remedial statute, what they call a remedial statute, which is one which has to be interpreted broadly for the benefit of the remedy. So when the legislature says that managed care staffing practices endanger patients, and we need a regulation to fix that, objective ratios, and it cites all those regs in the statute about how to do it, economics is not an issue. The regs have to be set according to patient need and some other factors. They came in with emergency regulations claiming economics and the nursing shortage. SO they were recycling the same old tired regulatory arguments- it was a stupid legal move because of the essence of the statute.

They are not the brightest guys. I remember reminding people that you have to have a license to operate a hospital in California. That's a privilege in this state, granted by the people under certain conditions. If you can't make those conditions, they should shut down and turn over their license. No one is "entitled" to do this business here. Basically, they think they are. But you know the judge didn't decide that the executive branch had exceeded its authority and power and not obeyed the legislative branch. It presented again, the objective issue of the day, which is the same issue today and why we need single payer- These hospitals' staffing practices are the product of an insurance profit risk assessment by the direct provider, the hospital, and they are instituting practices to get a piece of the premium dollar. The staffing has nothing to do with patient care.

Well the driving force behind that was the hospitals, they never stopped fighting that, and still are. The CHA/AHA are one and the same. The CHA is well off in its own right though. They did everything they could to block the law from being passed. Once passed, they continued to try and overthrow it through legal and extra legal means. You know the law got amended, and the department of health services had to set the ratios, the actual ratios, and they invited all the stakeholders to submit proposals on what the ratios should be. We were the only ones who actually did any research to come up with what the ratios should be. We had a study done based on examining 2 million patient discharge records that came up with the ratio numbers, what they should be.

The AHA invented numbers that were totally ludicrous that they then pushed for, like 1:10 in med/surg, which is what they were doing then anyway. They lost that battle because ultimately Governor Davis was still in office and the DHS came up with the ratios closer to the ones we proposed than the CHA/AH ones. Then the CHA held seminars all over CA, covert seminars for managers advising them how to undermine the law and break the law really. We infiltrated a couple of those and let people know about them. They then filed a lawsuit when the ratio law was being implemented, in

December '03, right after Schwarzenegger came into office. He didn't have to do anything, it was their program. We were able to mobilize and campaign against it and defeat that lawsuit in the Spring of '04. When they lost that lawsuit, they began a massive campaign to try and get the law overturned.

Ridiculous nonsense really. Hospital closures, the nursing shortage- those were the 2 main arguments. They were putting together a briefing package for Schwarzenegger about the horrible threat to public health because of the ratio law. And that September of '04, Schwarzenegger goes and campaigns for Bush in Ohio, the key state of the national election in '04. He comes back believing he won the election for Bush. Well it wasn't Schwarzenegger, it was the election officials in Ohio that stole the election there. Literally 2 days after the national election, he issues his emergency order and cites, almost word for word, the September memo that the CHA had written. And then records reported in the media about Schwarzenegger's minutes show that he'd been meeting with the CHA. SO they clearly colluded with CHA to produce, to come up with this strategy. And it continues today.

They did these things. They used state money to fund these fake videos that then they tried to get TV stations to run using public money in which they interviewed nurse executives, probably ANA members, talking about how wonderful the emergency orders were. So then we did a campaign against him that I'm sure you know about, that went on for a year. When we started that campaign, everyone, including all the democrats and all the people in the movement, said: "Don't fight." "Don't fight Schwarzenegger, he's too popular." "You can't beat him." "You should just be happy he didn't do worse to the ratios." "Just accept it, go along with it." "Negotiate a deal." Well, our members refuse to do that. Our leaders refused to do that. So we put a campaign together, and it included over 107 protests over a period of a year - a lot of very creative and aggressive and inspiring and militant tactics. In the course of that process we won a legal victory in court, overturning the emergency orders. The legal victory said they couldn't use contrived fantasies about hospital closures as an excuse for violating the law. But things don't happen in a vacuum, even legal victories, so I'm sure the campaign we waged contributed to our legal victory. They said they were going to appeal that decision, but they ultimately dropped their appeal.

Oops, I think I answered this in the last section.

I don't think many of us voted for Schwarz. We opposed him in the election bid the first time when he ran against Davis, who signed the ratio bill. We supported Davis in his recall. Schwarz won the governorship and it wasn't soon after his election I guess that he went after the ratios. He removed somebody who'd been favorable to ratios from the DHS, a political appointee. He put someone in who wasn't pro ratio. And then we heard that he had promulgated an emergency regulation to say that ratios would not be in effect at all times. We were actually in the headquarters building, here in Oakland, at an executive committee meeting and one of the staff got a call. I remember it was at the end of a week, a Thursday or Friday. We immediately went into planning a fight back campaign.

It's like I always say, the employers are always trying to take another bite out of the apple, to nip away at the bill at every opportunity. First, they fought us on the ratios, actual ratios, so they made us do the bill without actual ratios and go through the public hearing process. Then they fought us on the numerical ratios. Then we got numerical ratios we could live with, with improvements over time, and then they said it shouldn't be in effect at all times. For all practical purposes, if you don't have ratios all the time, than you don't have ratios at all. So Schwarz did that, and we immediately started a fight-back campaign.

We did a legal as well as a public demonstration thing to fight that back. And we won both legally and socially. We won the hearings they had on the emergency regulations. We just kept doing it over and over again.

This is a sequence sort of thing. What I remember personally about Gov. Schwarz is, we were having a Catholic HCW nurses meeting in San Diego, and Maria, his wife, was having a woman's conference at the same time in San Diego. We were at odds with AS at that point because he had come out against the nurses and their ratios. He was a kind of anti-regulation sort of a governor. You may know the whole ting about him being elected was so weird and I'm sure you know Davis got recalled. There's like, literally, 120 people running for governor at the same time. He jumps in at the last minute, a movie start with lots of charisma, and people vote for him and he gets elected. Nobody really knows anything about him and he starts making statements.

So I'm not sure how long he'd been in office at that point. Maybe a year. But anyway, we're having a protest outside this woman's conference that Maria was having because we knew Arnold was going to speak. So I think we bought 10 tickets and we had some women go in who were our members and Schwarz was speaking and they stood up and I think they had a banner. I forget what the banner said, but Arnold, and I'm sure he'd say it was the dumbest thing he ever said publicly, he said, "Don't pay any attention to them, they're just mad because I'm kicking their butts." Well, we're outside having this rally and the press couldn't get out fast enough to quote Schwarz and then the whole thing kind of took off in terms of going after Arnold.

And again, in terms of our members and in terms of our public groups who supported us, it was a very easy sort of a process because they all knew that we needed the ratios, that they were important. There were a lot of groups who represented patients who knew this was important. That's about the best answer I can give.

I know that it was the hospital association that was opposed. As soon as Gray Davis signed the ratios we knew they would be attacked. They knew they were coming into law in 2004, and then there was another year where it would be phased in, and then 2005 and 2006 that there would be further patient number reductions for nurses. I knew that Arnold, if he got elected, would try to mess with them. We all did, because there was so much pressure on anyone to try and undo the law, to somehow put the genie back in the bottle.

It was interesting, because there were all of these articles after the legislation went into place, in the news, all of these articles about this hospital closing, this hospital closing, that hospital struggling, going bankrupt. But when we actually started looking

at the stories, it was mental health institution, or a hospital so poorly run that they were planning on closing it anyway, before the ratios. It was just that they happened to close it after the ratios so it was considered part of closures because of the ratios when it really wasn't.

After Arnold got elected, it seemed like overnight he implemented those emergency regulations that would put a hold on the ratios, the phase in, making sure the ratios were in effect at all times vs most of the time or some of the time. Then there was the fact they couldn't really honor the ratios in the ER, and so they did away with the documentation in the ER that you were really complying with the ratio law. And in court, Arnold used all of those articles from the newspapers. So these articles had been planted in the newspapers to build this case and we were extremely fortunate that we got a judge that could see their arguments for what they were. It was the only good thing about the fact that it took 10 years to get that law into effect- it had been the most scrutinized, most vetted piece of legislation ever to go through the CA legislature. Ten years going through, against the testimony of the CHA. And then the period from 1999 to 2004, where the hospital industry claimed they didn't know that the ratio law meant "at all times", even during lunch and breaks, that the law had unintended consequences. They said they didn't know any of this. And the judge went- Well, here's your testimony during those hearings saying that you couldn't possibly cover these nurses during meal and breaks, so you did know this. You've had 4 years to plan for this.

So this was all a godsend, that the case had taken that long to go through. They were proven to be wrong.

12. When did the concept of a National Nurse Organizing Committee begin?

The concept began about 10 years ago when we realized that we needed to bring our message to the nurses throughout the nation and ANA was not leading in advocating for patients and nurses. The nation's nurses needed another choice from ANA who seemed to follow the employer's agenda.

I believe it was in 2006 according to my BOD minutes in response to requests and inquiries from out-of-state and interest in our nurse staffing ratios.

Began in 2003. Founded in the spring of 2004 with the support of a growing number of nurse organizations that were seeking a more effective representation and wished to have CNA as the representative for them.

We realized as soon as we got ratios that in order to keep them we had to move our nursing agenda outside of California. We started working on NNOC in the late 90s.

I think it was after a Board meeting and we said that California's not an island and if we do not go out of California, everything that we have fought for here in California will be eroded because we will be the only state that has them. So I think in 2004 we

made a decision that we should move outside California and that's when we started organizing outside California.

I think we've been thinking about it for maybe a decade. We got responses from other state associations after the break up, started going out and soliciting, and that is how we got where we are today.

Early 2000, I think it was early 2000, where again, having the successes that we'd had within the state of California, we had nurses from other states calling CNA saying - we want to join you, we want your assistance. There are really a lot of disenfranchised nurses because of the ANA influence, and there isn't a voice for the staff nurses, and they really want more empowerment. So that's around 2000/ We started in Chicago, and then we added Maine. I think it was early 2000.

I cannot remember a day. I know for a long time we were mainly focused on California. We knew we had to repair some damage, post-revolution. We lost some members, but the kind of members we wanted to lose. We were down to about 18,000 members, pretty shabby income. We spent what we had on organizing and got the organizing ball rolling. And it was a sort of self-funding ball, and we just kept doing it.

But it's hard to remember a date. We always had a vision, but when that became formalized, I'm not too sure. I remember talking to someone around '86 and he wanted a single payer system. It was always inherent inferred in everything we did, and at some point we wanted to make CNA the Nurse's association of the country, which we were extremely confident we would do. 2004 maybe?

I left in 2004 and went back to England for five years. Kept in touch, wrote some articles for the CNA journal. I was working as a freelance photojournalist, off of my own buck because I love this stuff. I was traveling the world, looking at healthcare systems. I was amazed at the condition of nursing internationally. It almost wasn't discontent, just defeatism. We're kindly people who want a nicer world and we work in adverse conditions and that just seems to be the way it is. Nursing is weak everywhere; it's amazingly weak, mind-bogglingly weak. In England there are 350,000 dues-paying members.

When I went back, I made it my business to hang out with the RCN. I had a journalist credential, so that got me a dinner with Peter Carter. In England, if they got a pay raise from the government, the RCN would write a disgruntled letter which they then brag about to their members: We've written a letter telling the government we're displeased with this. And that's it! SO there's a deeply rooted cynicism in bedside nurses in the U.K. "I join the RNC and I don't really know why, I guess it's my professional organization."

There is no money being made, it's a socialized system, but the nurses are incredibly badly paid. They use the wrong tactics. All the nurses' unions in the U.K. use the wrong tactics. The nurses could really make a statement if they all pulled out of the RNC. That would be a dream! The Royal College of Nurses is incredibly like the ANA. Beverly Malone was just over there. They got rid of her, all kinds of mini-scandals. Here's the kicker- she got her mother over from America to have an

operation in England because it was going to cost us them and she jumped queues in England.

The RCN is in a lot of trouble because it's made bad financial decisions. It's not big public knowledge but I did some investigating. They've got a lease on a building in Cavendish Square, some of the most expensive real estate in England, and they've managed to screw that up. They're in a lot of debt. See, there's no political activism within the Royal College of Nurses. It's just all nursing process stuff. Same old, same old. Let's just be the handmaidens and do what we're told. Just like here in most areas.

Probably about 5 years ago, so after we'd won the ratios. There was this big fight with Schwarz following the ratio fight, a statewide fight where he was attacking public employee pensions and a bunch of other stuff. He had this reform package on the ballot so we followed him around, across the whole state for a year. We were actually able to collect some allies on that and beat all the stuff back. We had won, overwhelmingly won the organizing in Catholic Healthcare West in southern California. This was probably around 2000, 2001. CHW is either the largest or the second largest chain in California, and we had organized almost all their hospitals. They had a hospital in Arizona and a couple in Nevada too.

We had another strategic organizing campaign to organize the TENET hospitals, again primarily in southern California. There were also a few up here in northern California, and we already represented them. TENET also has hospitals in FL, all across the South from west to east and a few scattered in other places as well. It wasn't exactly rocket science that, in terms of expanding our influence on key issues like ratios and like Single Payer (which had been a key component since day one with us), that we would not be able to effectively carry those campaigns forward just in CA. It's the biggest state but not the only state. SO in order to do that, we needed to build a national organization.

We looked at some of the existing nursing unions and organizations across the country. The UAN (the United American Nurses) was an offshoot of the ANA and was just sort of sitting out there. We talked to those folks but they clearly weren't on the same page on those issues like we were. SEIU, which does represent nurses even if they are a tiny part of their overall union, but it's not an insignificant number of RN's across the country, had clearly gone down the road of partnership, employer partnership, and sell-out as far as we were concerned. SO there was no other nursing organization nationally that we could align ourselves with and move on to the national scene, like we felt we needed to. And so we started the NNOC in a formal way, about five years ago I think.

I would say roughly within the last eight years, probably this decade. We had our website up, the internet, electronic communications were becoming more developed and more mainstream, and that broke down the barriers between state lines. Now a nurse from Florida, from Ohio, from Arizona can see what's happening in CA. And there was interest in what was happening, and so I knew Beth K who was an organizing director at one time, she would receive various calls or letters: How can we get here what you have there? Or, How do we get involved? So it seemed to be a very

dynamic two-way sort of connection between CNA wanting to expand and sort of an evolutionary growth. When things don't grow, they become stale and die. They become irrelevant. So there was the genesis of the NNOC.

When you start organizing at TENET or HCA, or virtually anybody else these days, you have to keep in mind that you have the hospital industry in front of you, because of the financing partnerships with insurance. These hospitals aren't local storefronts. These insurance companies and HMO's, they determine what happens. Look across the country, hospitals have certain plans, but behind these business plans, is the plan that tells the hospital what to do utilization-wise. These national systems are working very much in tandem, in the language of "standards".

It's interesting. I spent a lot of time at the hospital over the years with my wife because she had cancer. A few years ago, I met an oncology nurse from Florida who heard about the ratios and came out here. She and a bunch of buddies just dropped everything. She had been working at an HCA facility in Florida, and she was not pro-union. She didn't understand the union. I kept bringing in stuff to hand out, met her and we talked. She told me about taking care of 12 to 15 patients, and so came out here. After being here for about six months, she asked me where she could sign up to be a union steward. Now here's a person who had never even been ideologically acquainted with unions, she shows up here, and six months later wants to be a shop steward.

If we want to protect standards, OUR standards, we have to fight for them elsewhere as well. We haven't yet won a ratio bill elsewhere. But putting up the fight is important. Massachusetts has a bill, but it hasn't been signed. The fact that it's pending is very significant though. We can't sit out here and pretend we're in a cottage industry, because we're not. There's another wave of restructuring coming and this time its going to hurt. The first wave had all these fancy little gimmicks, spent money on technology. This is going to be a simple lopping off.

This wave has terms like QSEN and all this other bullshit. We're in a position to bust them now. We have decisions that recognize our control over staffing. Go after the power, they have no legal foot to stand on. We're in ultimate control of staffing, until they outlaw the nursing process anyway.

I don't know exactly when, but it was a direct response to the fact that nurses around the country wanted to be able to achieve what had been done here, the passage of a ratio law, but also the organizational growth, the contracts we negotiated were the best in the country for nurses. So for years there were constant calls and appeals from nurses around the US for help, help with winning better contracts, stopping the layoffs, from people who weren't happy anymore with their ANA style leadership. Ultimately, the CNA leadership decided to create the NNOC, and I think that was in 2004.

I can tell you when it was launched, 2004. When it began was probably after CNA disaffiliated from the ANA which was '95 I think. We'd been talking about this since the day I met Rose Ann on the picket line. She wanted to have retirement for RNs, which we didn't have in any of our contracts except for the County hospitals or UC.

That was number 1. The next thing she asked was, why aren't the staff nurses in charge? And I remember us talking about single payer, Medicare for all, and how we all agreed with this position. This was the genesis of it all.

The ability to put it down on a piece of paper in black and white did not come about until 2004. We had, in 2000, decided to try to form the American Association of RN's, the AARN. It had Maine, and maybe Pennsylvania, and Massachusetts, and us. We would meet once or twice a year, the Presidents, the vice presidents, executive directors, whomever, we would come together and try to do things together. It never got off the ground. The only thing that happened was that it was obvious that Maine wanted to join us but Massachusetts felt threatened.

We did, however, help Maine and Massachusetts to leave the ANA. They asked us to help but we had been talking for years. PASNAP also asked for help, and we gave them money to be able to go back and to try and get out of their union because we felt that RN's should be in their own union and they should be able to come together with the same interests and the same desires. Nurses from across the country have been contacting CNA for a period of years, well before 2004, saying, "What can we do?" "Help us here," "We need help!" SO the NNOC was launched in 2004.

Well in the late 90s, after we got out of the ANA and started doing organizing and there was no longer a nursing shortage and people were getting jobs, we were starting to really carry out a pro bedside nurse campaign. Nurses started calling us from all around the state: We want to become members, or How do we organize, or Will you come to our hospital and organize us. We were able to sign an organizing agreement with Catholic Hospitals because we represented some Catholic Hospitals in northern California and we won those campaigns through the early 2000s. We more than doubled our numbers and we were growing by leaps and bounds.

Nurses outside of California, because of the ratios, because of what they could see was going on, were reading about and hearing about, they wanted us to come to their hospitals. So we started getting all these calls from all over the country and we didn't really have a vehicle for that. SO we had a couple different presentations, we had somebody come and talk to the Board of Directors about how other unions had done, had grown. What vehicles they used. With a motion of our Board of Directors, we created the NNOC and started using it as both a collective bargaining organizing vehicle to bring nurses in groups, as well as just individual memberships, to reach out into areas where we knew we weren't going to be able to go and organize, at least for a while.

I want to say we did the motion in 2004. Partly because people were coming to us, and also because we'd been working on and off with the Massachusetts Nursing Association and with the Maine Nurses Association about them getting out of ANA. Since we'd gotten out of ANA, we'd also been talking about how the ANA had hindered the process of who was going to speak nationally for nurses. SO we were talking with other nursing groups around the country. We didn't think the ANA was a legitimate voice. What were we going to create in its place? So there were several prongs or impetus to create another vehicle that was going outside of CA and organize members outside CA.

That probably began five, six, seven years ago. I'm sure Kay can give you the exact date. I think we were hearing from a lot of nurses who were interested in what we were doing in CA. They wanted the same thing in their state whether it be IL, TX, FL, or NV. They wanted patient ratios; they wanted better working conditions; they wanted better wages. The word was getting out. There were nurses who were moving here, orienting where I work. I would go around and ask people where did they work before, where were they from. It was interesting. There'd almost always be one nurse who'd say, "Oh, I moved from IO because of the nursing ratios and I wanted to be able to work in better conditions."

I think that's when it became apparent that there was a need and certainly patients everywhere in the US are entitled to the same level of care. It shouldn't be just a CA thing. It should be the same in every state. So now that we realized there was a need, we acted to go national. There were nurses who wanted us to come to their states and help them organized either for collective bargaining purposes or help them to try and get a staffing bill passed.

It was early on. We knew that we wanted to be a national nurses organizing group. We didn't really have the finances and the wherewithal to do it, but it was something that was out there. Once we got the ratios, there were nurses from all over that wanted to be part of CNA, in Maine and Massachusetts, and Pennsylvania and many groups. All of us were in a different sort of mind on how to form a new association though. In 2004, I think, we formed the NNOC because we were saying, OK, we've gotten lots of calls and there's a few places that really are ready. The nurses leaders are practically going to organize themselves so we've got to come up with the mechanisms. So we formed the National Nurse Organizing Committee, trying to figure out how to avoid CNA TEXAS, or CNA Arizona, because they had a state identity too. How do you overcome that?

So we formed the NNOC and Cook County was the first group that called us and said, We just saw your announcement, we've been looking at your website, and we want to be your first group. They were immediately NNOC Chicago, NNOC Illinois! Immediately, they started identifying themselves that way. So when you talk to nurses outside of California that are now organized by us, they identify themselves as NNOC Texas, or NNOC Nevada.

13. What was, and is the strategic plan for the NNOC? Has it changed in the last 4 years?

I believe the strategic plan is as I mentioned above. Ratios in all states. Protection of RN scope of practice. Protection of nurses to speak out against bad employers. Lastly fighting for single payer healthcare that would solve so many of our healthcare issues.

Basically the goal is to unite all professional nurses in one professional, collaborative, cohesive, democratic and supportive organization so nurses have the power to advocate for their patients, their profession and to exert strong legislative influence

with one powerful voice.
To develop a National Nurses Organization to act as a national vehicle to address the crisis faced by nurses across the United States, and to bring nurse-patient ratios and patient advocacy laws to all states. To give nurses throughout the country a way to pursue a more effective, organized, collective way to act as patient advocates while protecting the interest of their patients, families, communities, and practice environment. To defend the role of the professional nurse against encroachment from other professions. The plan has not changed, but we are closer to obtaining our goals.
The strategic plan of the NNOC is to have a national nurses organization/union with the same standards for nurses and patients across all state lines. In order to accomplish this all hospitals need to be unionized with contracts that support RNs being able to provide safe patient care to patients and having rights to a decent wage and working conditions to accomplish this. An RN union is in the best position to accomplish this. NNOC has evolved in accordance to changes in the health care and political environment of this country influenced by the large hospital chains, union political winds, economy, etc.
The strategic plan was to have each and every RN belonging to a union, belonging to us. They need to be a part of this national organization that we have put together. And our membership has gone up the last five years, a lot. We have won elections in NV, not only Reno but also in LV. We have won elections in MN and we have affiliates in PA and also in TX. We have won elections there. And we are still continuing to organize, in Chicago, I forgot Chicago. We won elections there too. And so our membership growth has been enormous the last five years.
It just continues to grow, all the time. So strategically, we want all nurses to be coming under one unit and build our political stance there. That's our plan. Currently we're out to get Single Payer throughout the U.S. Building the NNOC and working towards a single payer system, that's the plan.
In my opinion, we still have an emphasis in California, but we also have that national organizing piece where nurses in other states have already come in. Chicago nurses from Cook County, Maine nurses, Texas nurses. So what is the strategy for increasing that? I think that when we look at the bigger picture, we really want to have a national nurses association where it covers all the states. I think we are in the process of doing that. CNA/NNOC will probably remain that way for a while, until we can sort through the bigger picture and become a larger unit. Until we lose our identity? Part of me says that I think we still need to be California. We still need to be that CNA/NNOC but maybe if the other states are joining a larger union. I don't know, I'm not sure, to be honest with you. But I think the bigger picture is becoming one national organization, and I'm all for it.

In a nutshell, the strategic plan of the NNOC is to build the social advocacy movement. So that basic tenet of it has not changed whatsoever. That's the kind of strong thread that runs through it all. I'm not sure again, I've been out of the picture for the last five years. I've been back six months and I'm still not on top of everything because the first six weeks back I was in Pennsylvania, organizing. The strategic plan has not changed except in terms of bringing other nursing associations that are already established into the fold and coalescing that way.

The idea of the "Super Union" is new in the last four or five years. I don't remember that seven or eight years ago. I think maybe Rose Ann did that.

I don't think the overall plan has changed that much. What we're looking to do to simplify everything, is to organize all the nurses in the country, at least all the staff nurses in the country. That's what we're all about. So one of the things that we've done is to build committees of nurses who are interested in activity, either around organizing hospitals or around single payer or around fighting for ratios, or any combination of these, without regard to whether they're organized or not. They're primarily not. SO we've got, I don't know what the number is because I don't work directly with those folks most of the time, but thousands of nurses across the country in most of the metropolitan areas that are members of the NNOC. We don't represent them for collective bargaining but we work with them on a local basis, doing local things. SO that's one aspect of it.

The second aspect of it is organizing, organizing for collective bargaining and so that's an ongoing piece of our work. We now represent, for collective bargaining, nurses in two areas, in the Reno area and in the Las Vegas area in Nevada. In Texas, in Chicago, where the Cook County nurses voted to come into NNOC. They were previously in the IL state nurses association. We have affiliated existing state organizations in Maine and Pennsylvania based on common programs and commitments to the fight. You are probably aware that there's a pending, well we're sort of halfway through a merger with the Massachusetts Nurses Association and what exists today as the UAN, which is about half of what it originally was because they had a split there. It's primarily a substantial nursing organization in Minnesota, Michigan, and then some in Illinois and Hawaii and then some of the smaller groups that are scattered around. So all of that is gone.

It's kind of a 3-pronged approach. One is to where possible, where we could do it on a programmatic basis, to work with existing organizations and to incorporate them or merge with them as appropriate and therefore involve them in the work that we're doing. Organization of new facilities where the nurses have been unorganized and then working with nurses on a regional basis on issues regardless of whether they're organized nurses or not.

Well every year we have a retreat and there's a map put up and the map becomes more filled in every year with our members. We have members now in all 50 states. A couple of years ago that wasn't the case. I've visually seen the map getting filled in. At my clerical level, I don't know what the intended goal is, but I can see the results that we are gaining new members nationwide and we have new offices year after year.

That's my observation.
No.
I don't know about this.
I don't think so. It's the national union of RN's. It's there to lead the change in healthcare, to secure the kind of single payer standard of care for each and every person in the U.S., regardless of citizenship or residency.
The real plan for NNOC was to get a single standard of care. I mean that's a grandiose plan, to get a single standard of care for patients throughout the country, to win healthcare for every patient in the country, for every American, every resident, and to bring nurses in to defend what we had. That was one reason ratios were so important, it leveled the playing field for all the employers. Also, nurses wanted to do this.
<p>Well, yeah. I think in the last couple of years we've realized that there are, in some states, there's already a lot of nurses who are organized who maybe were in the same position we were years ago, who just, their leadership didn't really have the ideas we did or the goals that we do in terms of patient care. And maybe they didn't have the national healthcare reform ideas we did, and hadn't organized as many nurses as we have. So a lot of these nurses, they're already organized, the groups are already in place. The groups doing the collective bargaining are, I think, a lot of them are very dissatisfied with their associations, their ANA associations. I guess we realize we can't organize everyone ourselves.</p> <p>So when people who were already organized started coming to us, looking to our leadership for guidance, well it just seems to make a lot of sense to have 1 national nursing organization in the US that can work towards a common goal: Single Payer healthcare, nurse to patient ratios, making sure nurses have good collective bargaining agreements where they're working.</p>
<p>Our plan is to organize nurses nationally so that we can get single payer, Medicare for all, enhanced, in our country, and in our lifetime. And that's it, really. We have evolved into like this social justice organization. That's really what happened. And it comes from the fact that nurses are at the bedside every day, and they see, like I do, patients that can't afford their medications, and who are desperate to get treatment. Even if they have insurance, like I work at Kaiser and it's an HMO, because of the way things have evolved, and Kaiser's got to remain competitive, they've gone from just- pay your monthly premiums and you get your doctor, your medications, blah, blah, blah - to that multi-tiered premium co-pay, to satisfy the buyer. And I used to think, in my naïve brain, that that meant the patient! No, it was to satisfy the employer.</p> <p>So they would undercut these packages so the employer could say they offered Kaiser benefit plan, but you had premiums, and co-pays, and deductibles that were out of this world. Even today, there are some patients, if they want a colonoscopy, they have to come up with an upfront payment of \$5,000. And I think, I make good money,</p>

but \$5,000? And that's just for the colonoscopy that lasts an hour. They still have their medications that they have to buy, and their treatments if they're on cancer drugs. They've got the equipment that they have to get if they need infusions. It's insane!

This is the stuff that I think woke up our members the most, because we've been doing this outreach on single payer for a long time. Medicare for all, the need for healthcare reform. Particularly after we sent the nurses into the gulf region after Katrina. They saw not only the physical devastation, the physical horror that was there, but when they got into the hospitals, or the tents, or the Astrodome to provide the care, they were talking to people who had never even seen a doctor or a nurse practitioner. They knew they had some kind of family history, like hypertension, or diabetes, a history of something. To see those people suffering unnecessarily, because they couldn't afford care, or because it wasn't available for them, just opened their eyes to how bad it is in our country. All these people living in hovels, with most nurses working in not-for-profit or for-profit facilities where insurance is the norm.

There's a portion of our membership that work in public health facilities, but even these facilities are sort of disappearing. So, it was seeing this right before their eyes, people that knew they had AIDS, knew it but weren't taking the drugs, couldn't afford the drugs. And these weren't our leadership nurses, these were just nurses that volunteered to go, that were in our facilities and were tangentially involved like I was initially with CNA. SO they went down there, and came back on their own and said, "We need Medicare for all." It was probably one of the best things that happened to the organization, one of the worst things for our country, but one of the best things for the purpose of educating our members. It could not have happened so effectively any other way.

The pharm people not have these "clinics" that are trying to go around the country offering free drugs or reduced cost drugs, but that is such horseshit because they provide maybe 2 months worth of the drug but, of course, you need it for the rest of your life. There was 1 patient here at Kaiser, he was 62, so he wasn't Medicare yet, but he had some kind of COBRA insurance. He went in for one of his adjunct infusions, not the cancer treatment, it was for his platelets and stuff. The pharmacy pulled him up on the computer and they told him he wasn't covered. So they sent him over to member financial services. We never saw him back that day, and I was off the next, so I had no idea what happened, but they said he wasn't covered. The medication was already drawn up, labeled for him, delivered to the unit for him - he was supposed to get it. I don't know that he ever came back. They tossed it, tossed it. Now if that drug really cost \$4,000, would they have thrown it in the garbage like they did?

Even Kaiser can negotiate drug prices, something our country can't do for Medicare patients. But Kaiser can. All these big hospitals and corporations can negotiate drug prices, but Medicare can't. Another irritation! It is really interesting, because Kaiser has a formulary, and you think you get a real bargain when you get a co-pay of \$5 and you can buy your prescription for the \$5. Well, what they don't tell you is that with some of these prescription drugs, they get a month or two, for three or two cents. So even though you THINK you're getting a bargain, they're still making money. And the Kaiser pharmacy is "for profit." The medical group is "for profit." The only thing that's not for profit is their foundation health, their foundation hospitals.

14. What kind of response has there been from bedside nurses around the country to the NNOC?

<p>Bedside nurses who learn about NNOC are hungry for our message and ask NNOC to help them achieve ratios and help them in their daily practice.</p>
<p>There is great and growing interest as both previously organized and unorganized nurses ask about or inquire about joining CNA; most nurses feel so alone and unsupported and threatened that they are fearful of speaking up. Of course there is also concern about a loss of independence if there is one united umbrella organization for nurses, but that can be worked out at conferences and conventions as trust and understanding is developed.</p>
<p>The response has been overwhelming with members in all 50 states. Advocacy is sprouting in unforeseen places. There have been a large number of requests from multiple states requesting education, support, assistance with mobilization, and legislative actions.</p>
<p>There has been a very favorable response from bedside nurses. Most nurses in this country are not unionized, don't make a great wage and take care of more patients than they feel they can safely handle on a regular basis. They are ripe for change.</p>
<p>There has been a tremendous response because they know that we are the leaders of this organization, bedside RNs who know what's going on, we are there. When we bargain, when we set policies and put forward agendas, we know what we are talking about. We ourselves are there at the bedside, so we know what the issues are.</p> <p>As we go from state to state, the nurses say the same thing. Ratios are important to us and working conditions are important to us. We kind of bond together because we say the same thing. Nursing practice is another issue that is very passionate to the nurses and so when we talk about ratios, nursing practice and working conditions, then you know we agree. That kind of sets the ball rolling.</p> <p>By working conditions, we mean things like floating, mandatory overtime, pay, competencies. You know you have to be competent, you can't just float to a unit where you're not competent. We talk to nurses, kind of informally, take the pulse, and we find we are passionate about the same things.</p>
<p>I think they are really pleased to be a part of it. I was talking to my sister who lives in PA, and we're aligned with the PA nurses. They are NNOC and they just organized a hospital not far from where we were born and brought up. So nurses want to be a part of it. They want the professional organization and labor union we represent. They want that, the power it represents, and the benefits that all nurses should have.</p>
<p>I think it's been very positive. I think we have a lot of good response. I haven't gone to other states but my colleagues have gone to the different states and they enjoy the educational classes that we provide for them. They learn a lot. They feel that they are more empowered and feel like they can do this. The one thing we tell nurses, even here</p>

<p>in California, is that when you're by yourself, it's hard. But I think collectively you can make a difference. And it's how you move nurses. And I think when they recognize the power that they have, they really want to do more.</p>
<p>I think nurses around the country love the idea of the NNOC. I think they love what CNA's doing. As evidence in Florida, they're still not sure they can do it. They may ascribe to the notion that, well, that's California. They're radical and this and that. There's this mystical view of California that's held both in the States and other places as well. My sense is nurses across this country love what CNA has done as well as the NNOC. They get it and they see it.</p>
<p>Well there's been a substantially favorable response. SO we've been able to build up the NNOC, the sort of general structure of the NNOC to 5, 10 thousand. I don't know what the number is exactly, but it's in that range. AND we've been able to organize new nurses in new hospitals and now to attract additional affiliations. SO that's all been positive. At the same time, we're running into a tremendous blow-back on the part of the employers, especially the dominant corporations. TENET, HCA are fighting us tooth and nail and they have a lot of resources at their hands. So, even though we make substantial inroads on the winning over the hearts and minds so to speak, of the bedside nurses, actually consolidating that into organized hospitals, still has that major stumbling block of the employer opposition and the current state of labor law in the country.</p>
<p>I think it's grabbed, NNOC has grabbed staff nurses' attention. Nurses are women by and large, and so women's voices speaking to other nurses around the country- that's a different perspective, and there's an authenticity that a nurse might not receive from a doctor or any other medical professional. When you look at the materials that are prepared for classes, or for meetings for demos, nurses are seeing nurses who look like them. There's diversity and there's excitement about what NNOC is doing, and that's drawing a lot of nurses who want to improve the larger collective of nursing.</p> <p>So I think it's been positive for nurses who are approaching NNOC and signing up and going to classes. It's a positive experience. And we have new members joining every week. They send in their cards. We're opening up a lot of offices nationwide.</p>
<p>There has been a good response from nurses around the country, even some communication internationally. In fairness, there's not a health system this bad out there.</p>
<p>A great response.</p>
<p>When we are able to get out and talk to them, when we have our classes that we send out, it's a good response, because most of the bedside RN's really do want to do a good job for their patients and they are able to recognize that they are hindered in doing this by their own professional associations as we were here in CA, and by their hospital administration. They also recognize that they do not have the organizing</p>

behind them to help them. Quite frankly, we wouldn't be where we are today if it hadn't been for the nurses that came together in the '80s and early '90s. It's very difficult for that to occur, and I don't know if people look at society the same anymore.

I think it's been great! I think some people are still really afraid of the idea of becoming a union, and they're not ready, in their towns and their facilities, to sign up. But a lot of people are ready to sign up for information and education and participation and conferences and meeting with us if we go to their areas, to figure out how to get involved and implement those kinds of bills that we've managed in California. I also think that nurses are responding really positively in terms of recreating the national, with other nurses' associations that have gotten out of ANA, that are part of the AFL, but not a part of CNA and NNOC. We're really looking at that next step. The nurses that I talk to face-to-face, you know nurse to nurse, really get excited about what we've achieved in CA and they want to bring it to their facilities, their states, their patients.

I think there's actually been a pretty good response. For example, I've helped organize in NV. In Las Vegas, those nurses are very interested; they like the message that we have: patient to nurse ratios, patient safety, improved working conditions, improved benefits. And they're close enough to CA that they've reached out to us and sometimes we've realized it was a good opportunity to organize, increase our membership. In some states it's been a little trickier.

I think in TX and major metropolitan areas, we've gotten some good responses from nurses who found other states more challenging to try and organize in because of the difference in state laws, at least in terms of collective bargaining. I think when we have the chance to speak to nurses on a level playing field, it makes sense what we're doing. I think most nurses like the message. I have a sister who's been a nurse for 35 years in Springfield, IL, and she's been involved in organizing efforts there a couple of times. It's hasn't worked out, but she still thinks it's important. She has friends who think it's important. She has a daughter who has just become a nurse, and her daughter understands it's important. I think our message, when people hear it, I think it resonates well.

15. What media utilization strategies are in place within the CNA/NNOC, and what do you anticipate is the need for media presencing?

Multi media utilization is the key to success, radio, newspaper (op. ed letters to the editor, articles) in as many as possible in as many states as possible, use of real nurses in interviews and of course the web (NNOC website, blogs, etc.)

We have our own very dedicated and professional media department and they are involved in all aspects of media presentation. We also work with local supportive groups for radio announcements and encourage and develop our nurses to cultivate the media and seek public commentary. We are currently developing websites to involve

nurse and public interest, education and commentary.
We understand that the public love, trust, and respect nurses and the profession of nursing. We tend to keep nurses on the ground and in front of any patient care concerns. We united nurses, patients, families, and communities for local/state struggles to regulate the healthcare industry. Our strength is in numbers and the honest intent of doing what is in the best interest of patient, families, and community. We need the presence of the media to expand our reach. We use the CNA/NNOC website, media center, In the News, You Tube videos, Facebook, Flickr, Bus Tours, Photo albums - online, and Publications to reach as many/varied population as possible.
CNA is really clever about media coverage- They use street theatre at rallies, wrap busses that keep a message moving from one locale to the next, they capitalize as much as possible on the internet because of its broad coverage and low, Cheney Care. Media presence is everything.
The types of media things that we use, we do an all out press on issues. We do have a very good communications department that sends out email messages or a press release and then when we have events, we do get a lot of media coverage. Like I noted earlier, we've done radio; we've done television and newspapers and we also have a very good website that people can access and it's updated.
We use radio, we use the occasional TV ad, we use bulletin boards, we use email, we use mailings. We use everything that we can, depending on how it's going to reach people we want to reach. We have been on some national TV interview shows (not Oprah), and I think that's the best. That has gotten our word out the best nationally. I guess we need to grow more nationally, but that's a finance issue. Of course we lobby too, in Sacramento, in other states, and in Washington, so that adds to it.
When we were really doing the ratio thing, even after Schwarzenegger, we really began to look at doing the couple of second ads. We started to use the TV ads a lot more, and radio, and they were pretty effective. One of the things I can say about CNA /NNOC is that we're very mindful of when and how to use certain things within the media. We are really very selective of the timing of certain ads, or having a radio ad, or having one of those big billboards, or having the bus. We're using all of that, but we're very strategic with it all. Financially, we have to be very mindful of getting the approval from the Board as to whether or not we should do this or not. I think we have to pick and choose, but I think we've made some really good decisions.
I think our media strategy is just extremely aggressive. I always think it's probably been our secret weapon, certainly one of our strongest weapons. I once did a little research, not scientific, but it's decent research. Over a 6-month period I checked how many times we were in the newspaper and it was an average of 3 or 4 times a day-across the country. This was back in maybe 2002, during the ratio thing and that was hot and heavy. Other issues too were hot and heavy and we were in the newspaper

more than SEIU by about 3 times as much. Of course Schwarzenegger was a very nationally known figure. His “kick your butts” comment was his greatest error. If he’d just taken a breath, we might not be where we are today, really. I think that was a real political moment, and spontaneous.

We’re extremely good at gorilla media, extremely good at the street theatre. Some people call it gimmicky, but it’s been a matchless strength to this organization. The coffin marches for example. It’s always been our strategy. Just get out and about and be extremely aggressive in the press, which we have. We got on the IOM report straightaway. Any kind of report, it’s extremely sophisticated here. We took advantage of everything that popped up.

It doesn’t surprise me at all to here new reports coming our about how the industry has failed to improve things since the IOM report. I think another strength of CNA is the people we’ve employed, how good they are. We seem to be extremely good at employing the right people, who get it, who formulate these ideas and opinions themselves through and from their experience.

We’ve had, since the staff nurses took control of CNA in ’93, a significant and building presence in the media. Because we see our fight as inextricably linked with patients and the public, in order for us to win what’s important to win, especially in the broader sense, we need the media presence. Patient’s rights, safe patient staffing and the big banana of single payer, all those things really require public mobilization and public support. And that’s the focus of our media operation. We have a significant presence on the web. We have a department that handles that. They can give you more details.

Well it’s interesting, because about 10 years ago we weren’t in the media a lot, just a little bit. But I’ve noticed that as the CNA grew and as our campaigns were winning both our organizing campaigns and various political campaigns, like the ratios law and the mandatory overtime campaign, the media started paying more attention to CNA and writing us up. At the same time I remember thinking that the media is largely corporate owned and CNA is not a corporate oriented organization. SO it was sort of a double victory that they were publishing our wins and also that they were publishing at all, because they could have just been silenced like academia has.

So about 10 years ago we started getting more media and it has really bolstered CNA’s position as being powerful and active, an activist organization. There are some negative portrayals of CNA, and I think that just goes with the territory. You know 10 years ago, Huffington Post didn’t exist. Now we have staff writing articles and opinion pieces. The electronic media is now very important, and we’re doing that.

Unbelievable strategy developed over time. Chuck is the one to focus on that question. The media stuff here is excellent. I know because I watch it. It’s based in nurse leadership participation. We’re in the news a lot, and if you read journals, we’re the “hated people”. But with this national organizing movement and the merger, they should have heard something.

The website is pretty open. I’m fairly active with the electronics, and while I know

my generation has been slow to come to it, if you're on the web and looking at nursing, we're pretty hard to miss. Plus, we would probably not be able to get a full page ad in Spectrum, or Nurse Advance, or any of that. We put our ads in the New York Times anyway, or the LA Times. They're issue ads. I don't know if the editors would allow our ad. Given what they would be. We've had things rejected over the years. I mean we're an organization at odds with the organizations that publish these. Most of these are dependent on the industry.

Well the whole purpose of media with CNA, the media strategy, derives from the fundamental thing of what I have said before, the ideological orientation of Rose Ann and the staff and the leadership, which was patient advocacy. How do you confront a trillion dollar industry? How do you confront these hospitals and the HMO's, the drug companies, with the billions of dollars of resources they have, and the choke-hold they have on the legislative process? The way you do that is by uncompromisingly, fearlessly, representing patients and the public's interest. Part of that is being able to try and influence, to communicate, with the public through as many ways as possible, and the media is obviously an important part of that. So that's the genesis of the media program here. A large part of what we've tried to do here was to be proactive with the media, not just reactive, to set the agenda, not just react to someone else's.

Take the Hawthorne commercial (national commercial on the TV show Hawthorne put on by CNA in 2009). Historically, even though the public knows the value of nurses when they need hospital care, nurses have been poorly portrayed by the people who run mass culture, and even not recognized as significant by the policy makers. The media portrays nurses as well, looking for Mr. Goodbar, pretty poorly. So the thinking about Hawthorne was it was one of the first shows that actually featured, prominently, a nurse in a leading role as opposed to the doctor. And even then they had to qualify it by making it a nurse manager, not a bedside nurse. One of the biggest amusements for any real nurse who watched that show was that they actually had this nurse manager, this CNO, doing patient care, which EVERY bedside nurse knows never happens.

SO I think the idea was that because this was a rare show in the major media that was featuring a positive portrayal of RNs, that it was a way to reach some people that might not otherwise be aware of our organization or some of the activities we do. I think it was a pretty good ad. We'll continue to use it in a variety of ways.

You are in Florida, right? We haven't been very visible in Florida but we've begun to be visible in FL and we're going to be more visible in FL. We're just beginning to grow there. We could run an ad in Spectrum there. But some of the problems with some of these publications like Nursing Spectrum is they're very expensive. We've actually had an occasion, there's another one called Nurse Week, there was a time we tried to run an ad in Nurse Week and they refused to run it. These publications tend to be anti-union, and that's certainly reflected in their copy, in their coverage, and in their editorial content. They derive their income from the hospital industry, so they're not exactly receptive to organizations like ours. In fact, the only one I can think of that is our own, not nursing magazines so much. I hear AJN is changing, it's detached itself from ANA. They seem to be becoming more independent in their focus. I think the

changes they've made have been positive and it's a direction we hope they continue in.

That's really a question for the communications department. We have bought some commercials, TV commercials. We've had ads in the New York Times, in the LA Times. They cost a fortune. We do it periodically if it's an issue that we really think needs to get out there to the public. I think we actually had a small ad in Role Call once, but I can't remember what that one was about. But we have a jewel in our communications department and he has been with us through the whole nine yards of what we've gone through. He has the ability to get us in a lot of places. We're in newspapers in France, in Beijing. We're in Spain. We're able to do that because of how he has been able to contact and to get the information to the different reporters. And these reporters move around. We lost one at the Chronicle, but another one who adopted us moved from the LA Times to USA Today. They're tireless. It's a small communications department, but we definitely "get it" that having the media focus on the issues that we care about is just critical to making progress.

Boy we've done a lot of stuff with media. We've really been creative. We've been really creative with several kinds of things. In our anti-Arnold campaign around the ratios, we just sort of doxed him. When a bunch of nurses showed up in scrubs, people paid attention. We have that sort of natural advantage. You take a whole bunch of nurses in scrubs and it's a good media event almost. We used letters to the editor in community newspapers, especially in communities that were open to that sort of thing. Like if you're a nurse in say, Chico, CA, a smaller community that's more influenced by a smaller paper, you can use media that way.

We've had the New Orleans style bands where we have the parade of coffins and patients who are losing their health coverage. We've worked with families. Families and patients attract a fair amount of media. Unfortunately, the media appears to be really attracted to bad patient outcomes, stories I don't really like to tell. I don't want to be the one that has to tell bad patient stories. I want to fix these before we get there. But the media does seem to like them.

We have a GREAT communications department who spend a lot of time doing background, doing press releases, putting out information. We've even had bunches of nurses call up local media and say, "Why aren't you doing a story about this? This story is really important to the patients in your community or to your hospital."

We're using the new media, like YouTube and email and blogging and internet. We've done ads, we've done billboards, we've done mobile billboards. We've done all kinds of stuff because media is really, really, really expensive. Just to put an ad in somewhere, it's very expensive. We do use them, but we try to find other ways to get the message out.

Well obviously the media presence is incredibly important because, while we can reach our own members well through our own publications, we have a media department to get the press in the US to pick up on what our issues are and what our point of view is. Single payer healthcare would be one example of that kind of issue. I think we, and a lot of other people, have been very disappointed in terms of the press'

coverage of the whole healthcare debate in this country. I think OUR strategy, certainly in terms of single payer healthcare, is to do everything we can do to let the press know what our point of view is.

We make people, speakers, available for interviews. I know we're talking about using the media to advertise in targeted areas. Of course, that becomes a lot more expensive, a lot more complex depending on the issue. Well, unless you're a huge corporation and have the money to spend, incredible amounts, like the pharmaceutical industry. I hear, since they seem to be big winners in Obama's healthcare reform, that they're going to be coming out soon with ads in support of the reforms. But you know, unless you are able to involve the media in this country, you're out of luck.

This is very interesting, because like I told you earlier, when we first got out of ANA we were almost, well, we had no money. It was the Board that sort of figured out ways to get free media, things like letters to the editor. We did rallies, that's how we got into the news. Chuck, who's now the communications director, he spent every waking moment trying to figure out how to get CNA out there. That was what he lived and breathed. I kept thinking, God forbid he ever died or something happened to him, we'd have to hire like 4 people to do what he did, because it was like EVERY little minute. And the joke was, before there were cell phones, he'd always have a pocket full of change that he carried around to feed the pay phones, because he was always calling people, the media people, when we were out doing the rallies, to let them know. And then when cell phones came out, and they were THAT big, and they had the battery pack you had to carry around, he was always lugging that thing around.

We didn't really have a budget for media, and in fact there only three huge events we funded- through the United Auto Workers, the United Steel Workers, and alone- that we gave our strike funds to. One was the patient care watch when we were trying to get ratios, a huge campaign (someone probably still has the pictures) where a patient pushes the call button at night and the message is, "Who will be there for you." I can't remember now if it was the steel workers during the Kaiser strike, maybe the auto workers? And then there was when they were substituting the nursing assistants for RN's. Meanwhile, Kaiser was advertising on their media that they were improving care and that each patient would have a nurse or something like that, very much a false advertising, and Jim E. came up with this mad idea about going after them and tying this to false advertisement. So we got rallies and we got notoriety, even still we were operating on a shoe string .

When we had the Kaiser fight, March 14th, 1999, the fight over the mass of take-aways they were planning. We organized around the quality liaisons and making sure that nurses had a say in the quality of care that was provided at Kaiser. Kaiser was sort of an easy target because most of the nurses knew that Kaiser had all these committees and there were lots of mucky muck administrative nurses and supervisors and managers that were on these committees. They'd spend days at meetings and stuff but they never really did anything. Finally, because of our position in the public, finally after a year and a half fight, we brought Kaiser to its knees. We got a lot of publicity in that one.

Where I lived, there was a nurse, Rebecca Lairman, who did her Master's in nursing.

She did an internship at one of the TV stations, a local station, and that was really good because during that time she brought the cameras to our strike line. It was fantastic! What was interesting about that strike, it was not just about the media. It gets back to the education of our members. During that strike, the Kaiser nurses became even more militant, and in fact when Rebecca brought the first TV camera, they wouldn't talk to her. They had me, or Betty, or the labor reps talk. But by the third strike that we had, they never came to find me. The cameras would show up, the nurses would grab the mike, and they'd be saying, "I want to tell you why we're out here. Were out here for patient care and blah, blah, blah. They all had the message! We didn't have to coach them, we didn't have to do anything. They knew exactly what was going on.

And you could go from the Kaiser Santa Rosa to the Kaiser Sacramento to Concord to Hayward – EVERY Kaiser nurse that you talked to, even the ones out on the periphery, knew the message, knew what they needed to say, and they needed no training, media training, at all. It was because they had it, they understood the issues we were fighting for. We didn't have to have PR people put together a campaign because the nurses lived it.

Have you seen the Sarah Palin thing we did during the campaign? It was when she was running with McCain, and we did the heartbeat away thing: we had him disappearing like he was being sucked down this black hole, and then Sarah Palin coming out and she sort of looks attractive at first, but then it starts listing all the take aways that she had. We've started using more of that to get our message out, because you can't have nurses everywhere. When you start going nationally, you have to be able to get out the message, and it DOES cost some money, but with our dues increase, we've been able to do it. It's sort of a natural progression. As your little budget grows, and your pocketbook grows, there's a few more things you can do, but the message is still the same. We still get the nurses involved, we have rallies and gather the nurses. It's still the nurses' message, but now we're getting it to a bigger and bigger audience.

16. Given the increasing breakup of the ANA, and the historic alienation of the AONE from the interests of the bedside nurse, what role do you anticipate the CNA/NNOC will have in the profession of nursing?

CNA/NNOC is filling a void that many nurses feel from their state organizations. CNA is an activist organization that gets things done, doesn't always do the easy thing, but does the right thing to accomplish our goal.

CNA is dedicated to represent the interests of the RN and to protect and advocate for the patient and health care consumer and for social and economic justice. Given this purpose and our democratic structure nurses will increasingly turn to CNA/NNOC to organize and promote the profession of nursing; with CNA/NNOC they finally have a voice.

To be the front-most authority for healthcare decisions. To be the leader for RN's across the nation. To set standards, laws, regulations in California, and make it a

realization, that as California goes, so goes the rest of the world in matters of patient ratios, patient acuity systems, staffing matrixes, patient advocacy laws, and whistle blower protection. We believe that CNA/NNOC should represent all RN's and as we push forward with the goal of being the union of choice for all RN's, we plan to involve our fellow nurses with the duty of advocating for the rights of the patients we serve. We believe that we should be the voice for patients and families as we have the interest of them at heart and not the corporate dollar. As we march forward with the goal of obtaining Single Payer, we look forward to everyone receiving the same standard of care regardless of ability to pay. We would love to have a positive influence on the nurses just entering the profession. To help them realize that nursing is an art and science, that patient care is individualized after making a nursing assessment. That technology should be controlled, not just used to replace nursing judgment. That in nursing, the norm is never, that patients shouldn't be placed in a category based on their presenting symptoms, to expect variations.

The hospital organizations try to keep the ANA voice going because it helps their interest whether in the form of magnet status or getting legislation that will allow the local hospital to determine staffing by committee consensus. The CNA/NNOC recognizes that nurses need to understand the reasons behind the ratios, problems with EMR, and union partnerships with the employer so they are very good at offering ongoing education for nurses on the topics influencing health care policies. With this approach I think they will be quite successful.

Because we speak for and on behalf of bedside nurses, we do have, with all due respect to the people or to the RNs in management roles who belong to the AONE and ANA, a lot more credibility with the working, bedside nurses. And we know that our management people do not have first hand information with what's going on down here at the bedside. They're in their offices; they are in meetings and nothing, they don't see, maybe they don't want to see. So I think CNA will survive, because of the type of membership we have.

I think we'll be the number one premiere nursing organization over the ANA. A bedside nursing model. We will take over as the voice of nursing.

Personally I think we are making headway. A lot of young nurses really, when they're in school, the only thing that they're really told about is ANA. You've got to join the ANA because you're part of the student nurses' association and then the next step because it's the professional association. But I think that over the years, CNA/NNOC has gained so much respect from the other states and here that I think we are making headway. We are at the state capital here, we have Bonnie F. who is part of the government relations here. We have our educator. I also work for the California Nurses' Foundation that is the 501 C part of CNA. We write grants and we do demonstration projects so we're out there providing education to staff nurses who had been doing it for the last six years.

SO I think we're making significant strides. I think that when nurses look at ANA and CNA, I think the tendency is to come toward us, that we're the rank and file. We represent the staff nurse. We know what we do day in and day out. The ANA and AONE, these are all nurse execs. They're so far removed from the bedside nurse - I think nurses recognize that.

I think it will be extremely significant. Given those two factors, it's apparent to 85% of nurses that the ANA is ineffective, if they even know about it. They are living in economic terrorism - most nurses go to work, they work hard, they come home, where they do what they need to do. They're not looking at the bigger picture. They're certainly not looking at whether the ANA and AONE are doing a good job! Nor are they looking at the relevance of what they do to improving either the economic or general welfare conditions of the direct care nurses or even anything to do with their personal practice. It's absolutely agonizing. SO there's huge potential, and I think we will fill that void.

Well, we see ourselves in the broader sense, in reality, as supplanting what the ANA once was and pretends they still are. AONE that we always call A1, is the organization of nurse "executives". And it is, in fact, almost identical with what ANA is today. They represent substantially the interests of the industry. Both A1 and ANA have done this for years, and A1 has never quibbled about that. ANA will pretend to represent nursing but in reality they represent the hospital industry overwhelmingly. So to the extent that there is to be a national organization which will represent the voice of nurses in this country, it's going to be the CNA and NNOC, or some future entity of which we're a major part and which we've helped to build, whatever its going to end up being called. We're going to have, what's being called these days a "Super Union" by MNA and UAN. This should be consolidated in December (2009) at a convention that has been set for Arizona.

So that will be the next step. There are still, I don't know what they call themselves these days, but what used to be the other half of the UAN, which is the NY state nurses association and I think Oregon and Washington, a couple of others. Those folks are still out there and we think that eventually they should be a part of our overall organization. There are nurses who are represented for collective bargaining by SEIU, by AFSCME, by the American Federation of Teachers, and in smaller numbers, in smaller unions, the Teamsters, Communication Workers, Operating Engineers, the laborers.

We would like to see eventually a united organization that represents all those folks and that would be the organization that speaks for nurses nationally. The ANA is, really other than that fact that they've got some history, in reality they're pretty irrelevant these days for bedside nurses. And of course the A1 group is a chapter of the AHA. There's no hidden agenda there!

I think as a secretary I really don't have any sort of strategic input or even part of listening to and discussing the issues. My sense is that the main mission and main goal of CNA will be to support the bedside nurse. I don't think that we'll have much activity with the executives, or management. But I don't have any detail on this

question.
The same role as was charted out in the “revolution” representing staff nurses, the workers who are the most abused. A response to the searing contradiction of this continuing hospital and employer abandonment forced by the insurance method of financing. Until there is a single payer healthcare system, staff nurses in hospitals are the bloody frontline. The crunch of the matter in the hospital industry falls squarely and increasingly on the staff nurse who does the work. SO that’s where this organization was born and will continue as a social movement because that’s where there’s an opportunity to organize the community - an absolute need if you think healthcare is important. We think it’s a right.
Well it already has had a huge influence. It’s sort of helped redefine bedside nurses as the true voice of nursing and not the nurse executives. There are some people who are slow to recognize that, but I think the vast majority of nurses know better. You know, after hurricane Katrina, we were the ones who organized missions to the Gulf Coast, not the ANA.
A big influence, I don’t know how it will end up, but a big influence.
I think we’ll get to control our practice. I mean, that’s what this is all about to me. This is about me being able to work as a professional, when I go into work, to say, “I can only do this much work because I have to do this, and this, and this, and this. This patient needs some hand-holding, this parent just found out their kid has cancer, and blah, blah, blah.” That I get to control my work environment and that we’re in charge of our profession. I think we speak for nurses, and I think that’s the reason we will continue to speak for nurses because the people who are doing the care are the only ones who can really say what’s needed on that kind of day-to-day basis. I think it’s illegitimate for those other organizations that aren’t actually doing that care to say that they’re speaking for nurses. I understand. I want an infectious disease control expert to help me in terms of the H1N1, in preventing the spread of this disease. But in terms of those preventative measures impact how my work is, that infectious disease specialist might not completely understand how gowning, gloving, masking, goggling, how much time that takes in terms of actually getting into a patient’s room to provide the care that that patient needs. I think we will continue to work with the experts we need from other organizations, but it’s really us who are going to speak for the bedside nurses. We’re creating that national vehicle as we speak you know, by uniting with the nurses who are getting out of ANA. Almost all of them are direct care, bedside nurses like me.
I think California is a great example of what we can do, and we’re hoping with the NNOC and with our affiliation in the future with other nursing groups, well, we see ourselves as being the natural leader for nursing. The majority of the nurses in this country are actually involved in taking care of patients, whether it’s in hospitals or clinics or schools or as occupational nurses, or home health. We think that we, and the

other nursing organizations that represent direct care nurses, staff nurses, that we should be the natural leaders. We can speak best for the majority of nurses and certainly the patients, in this country. I think we've done well in California. How do we carry that over nationally?

Well, if the meetings we've been having are any example, I think it's going to turn politics as usual on its head quite substantially. Not just nursing politics, but politics in general. Nursing in specific, but politics in the big picture. One of the things I'm struck by is the number of physicians in this country, only around 800,500. But the number of nurses is around 2.7 MILLION. Yet, the physicians have much more influence on healthcare policy. They're organization is more conservative and money oriented, and they're all out there to make the bucks, so their policies align. Nurses have very little influence yet they have the ANA, and some use that as a cover to pretend they support nursing. The ANA is really an arm of the hospital industry, and the AMA is too when you look at it. Their policies and politics are very conservative, like the ones who are controlling them.

The ANA talks about how they don't attack politicians, they try to work both sides. (Florida Nurses Association broke with that tradition and openly supported Jeb Bush in his run for Governor. NP's are still powerless in Florida.) Well, if you're beating me with a baseball bat, I'm not really going to try and be gracious to you! I'm going to fight back. And yet the ANA tries to do this, "Let's make nice with everyone." Well, that doesn't work. In your family it might work, but in the dark alley of politics, it doesn't.

Well, during one of the proposition elections, not during the recall of Davis, but in that campaign time, Richie Ross, one of the bigger CA candidate groomers, and his campaign staff, did a poll to find out which groups tended to have more credibility with voters. The interesting fact was that the American Lung Association was No. 1. Number 2 was CNA specifically. Number 3 was Registered Nurses. So out of all the groups that they polled, CNA polled higher than registered nurses as a group, which says something for what we're doing.

Getting back to the point though. The ANA is being outed as really an arm of the hospital industry, to the public. The politicians won't be able to use the ANA as their, "look, they're standing tall with us" and the "the nurses support what we're doing" people any more. We'll be out there saying, "NO, the real nurses don't support this legislation!" "They don't support this agenda!" I think you probably saw where we had nurses arrested in the Capital for supporting single payer. There is no place for anyone to hide. Politicians are still trying to find cover, and they're getting it from the AMA and the AARP, which are sell-out groups. But more and more, we're out there blowing the cover. SO, nationally, not only are we going to affect the nursing profession and how we're seen, but politically it's going to change because all the nurses' groups that we've joined with, last Tuesday as I write this, are just as committed to single payer and changing the national landscape for real social justice as we are. It's like we've worked with them forever. SO we're really, as one nurse said, "we're on a snowball ride". We're going down that mountain, gathering momentum.

17. Has there been a response from the academic community to the CNA or CNA/NNOC movement, and what explains this?

I don't know. Don't think there has been much response from the academic community but that is not unexpected since many of the leaders of ANA are in the academic community and they see CNA/NNOC as a threat.

The educational community, represented by the ANA and often believing that bedside nursing is something you eventually want to leave, has not been supportive of our movement. We have tried to interface with the students by speaking at the schools and working with them on the floors as they learn the reality of nursing and how essential it is to be represented by a professional nursing organization. We also give scholarships to nursing students and have an excellent research and development department that gives classes, open to all nurses and provides research articles for public dissemination.

Not that much response from the academic community. In California the student nurse organization is under the ANA umbrella, so far we do not have a CNA student nurse organization. CNA is opposed to looking at nurses differently depending on educational level. CNA promotes clinical ladders and supports education for the sake of education but doesn't consider an RN with a BSN any better than an ADN RN. Some nursing programs see the benefit and invite CNA to speak to the students and they are very excited about CNA.

I don't know. I can't think of any, if you mean professors. We have had nursing students come to us and approach us to talk to them. And the professors did allow us to go in and talk to the students during their supposed nursing classes. I myself have gone to Mills College, and I've gone to San Francisco Community College, Community College of San Francisco. I've gone there several times to talk to nurses about CNA and NNOC. I don't remember what class or what part of the curriculum it was, but I think they were just about to graduate.

Everybody in academia wants nurses to be college-degree nurses, a BSN and above. We are opposed to that. We have AA nurses, and diploma nurses, and what makes a better bedside nurse anyway?

You know I think of my other role, part of CNF, I've actually gone to a lot of different meetings where there are nurse educators. And what they're recognizing is that the nursing students are not prepared once they get out - the critical thinking and problem-solving. So they're recognizing that they're not doing a very good job at preparing these nurses. So they're saying, well maybe we need more clinical.

This is something CNA has always said. Really invite us in to show you what you need to do to prepare these student nurses to come to work at a hospital because a lot of them are struggling with problem solving. You know they don't even know how to

really talk to patients. They do a lot of simulated learning in place of clinical and so we're very aware of that. We try to bring it back to the educators and say, simulation is good but it shouldn't be in place of clinical experience. So I think they're starting to slowly come towards us to come and talk to them. SO I think there's some respect there.

I think that with CNF, where we have a mentor program, we have a preceptor program for the staff nurses, and they see the value in that. But again, ANA has their own idea of what they want a mentoring program to look like and that's not what we have. SO we have all the data, and they know that, and I think they want to see what we have, but we have to be very mindful of our programs so that they don't take them and change them.

I think we've had two or three friendly ones, two or three who do research and come across findings that we find helpful in our causes, support what we claim to be the case- that nurse staffing ratios improve care, that the corporatization of healthcare takes resources away from direct care to harm patients. That's maybe two academics. Linda Akins, there was another woman, a friend of Suzanne Gordon, I think she came out of Boston but I can't remember her name. Suzanne Gordon's been very supportive, her work helped us a great deal. We find the academics, in general, not interested.

Some are worse, pseudo-academics. Like the CAL-NOC group. I can indulge in rhetoric as much as the next person, but when I look at it, just take away the CNA/NNOC hat and just read these reports (on the outcomes after the ratio law), which I do constantly, I'm amazed at the lack of discipline and the ridiculousness of them. The last Joanne ... research piece that came out, in an attempt to "dis" the ratios was based on interviewing a limited number of nurse managers about the ratios and whether they think it improved care. She's interviewing people that have a direct opposition to the ratio law, and inherent both in her questions and answers was a lack of understanding and a political bias. Most of the nurse managers talked about how it's thwarted quality care because they are so rigid and they cannot staff UP. But of course they can staff up, it's a minimum not a maximum.

The analogy I use is "field negro" and "house negro," but I use the term slave. It just boggles my mind. The nurses get it. There's a concerted effort on the part of the AHA to overturn this. They don't want to take nurses on directly, so they use other nurses, like the AONE, CAL-NOC. And then they do that thing that we all do. You just keep throwing things out there and most people don't have time to sift through it. I mean I'm paid to do it at work, I'm paid to sift through the journals. Are hospitals closing? Are they closing in Florida? Can you answer that question? We can. I'll go to my deathbed strangled on the whole "house slave" "field slave" thing. It keeps me going. It's like the industry is saying, "How dare they stop singing and look around them!". It's incredibly disappointing. I worked at UC, and in a sense I was committing political suicide or career suicide on joining the revolution, not that I cared. But I know nurses in NY, Ph.D.'s who HATE CNA. I mean they HATE CNA irrationally.

I'll tell a quick story. I know a nurse: she works in SF, a Canadian nurse. She's gone through a career - she suffers from self-loathing as a lot of nurses do, as a lot of people do. So her reaction to self-loathing was to loathe her status as a nurse. SO in order to

cure that within herself, she did a Master's and a Ph.D. to disassociate herself from "nursing." I met her in London, and she told me a tale - When she was a nurse she looked after her parents, and now she's an academic. She's talking to her mother one day, and her mother's saying we want to come out and see you, and she says no, I have a career now, mom. I think it's all there in that moment. She has a career as an academic, but not as a nurse. It just crystallized the whole issue for me. She's bright, but has the whole self-loathing thing.

I don't understand the fear of unionization. Nursing professors are unionized, many of them. Why is it drives so many nurses insane? That we would be represented by a union. In England, when I used to observe this, long before I had anything to do with CNA or ANA, I used to think it was the class system encounter. You have the aristocracy, your doctors. You have levels of petty bourgeois, the little middle class, and fine gradations of the nurse, the staff, and paraprofessionals, and then you have your housekeepers and gardeners, etc. SO military really. In England a male nurse wears Epilates. The nurse administrators are the sergeants, but they'll never be officers. They're not allowed in the officers club.

Well there hasn't been a direct, explicit reaction, well until now with you. What there has been, and we need to mention CALNOC, is there has been some degree of "research" sponsored, either directly or indirectly, by the industry, by A1, research around the ratios, attempts to discredit the ratios in essence. So I think it would be fair to say that that's an "academic" response. But from the organized academics, there really hasn't been one, until now. Its speculation on my part, but I think that the traditional nursing academics simply don't know what to make of us.

I haven't seen a huge academic response to the CNA history or the CNA achievements. I haven't really thought about it that much but it seems like academia is more interested in the rigors of scholarship, going to libraries, reading, writing, whereas the CNA experience is more of an experience. If you are a member, you're doing bedside nursing, you're coming to meetings that might be part of a collective bargaining experience, either voting or helping to prepare some items for negotiation, or you might be going to a rally. We have a House of Delegates coming up. The CNA experience is not an academic experience per se, it's not about doing research, no offense, or being in a building. It's about being out in the world and trying to change the world and moving it forward.

Depends who is funding things as far as educators are concerned. They are from a different planet anyway. They're so unattached. They're not based in any reality but they're own selfish interest, and so they just swirl about.

One day, a few years ago, a great CNA advocate and a personal injury attorney who was always talking to people, was talking to this young nursing student from CSF. The student tells her that her professor told them that the reason there had been an increase in wages (now this was right after a major strike was threatened at CSF) is that there are more males in the profession now. SO she told the student, "What are you talking about?" That's how looned out they are.

There's a couple of "research" groups over there that continue to publish idiocy, incendiary stuff about the ratios. CALNOC is an example of this type of "research." What planet are they from? It's just endemic in them, there's no scientific validity in any of this "research." It's unbelievable, just PR firm research. It makes me wonder if they even know what they are doing. A history of junk articles to bring in and show some kind of record over time. I love that. I used to do a lot of litigation that involved experts, and I'd love to get these people in court.

I think it's been weak. Part of that is that I don't know if there is "one" unified academic community. There are nurse educators, and there are social liberals in academia, there is a lot of divergence within academia. I don't know if there is one kind of response here. I think historically, there are educators who see their interests aligned more with nurse managers, much more than with bedside nurses, to their detriment. That allegiance has also hurt them.

One of the things that happened to them is their ranks have been gutted. When the corporate consultants came in and started restructuring healthcare in the early '90s, which was the direct cause of the nursing shortage in the mid '90s, one result was that the HMO's were sending a message either directly or indirectly to all the nursing schools all over the country, and the universities and colleges all over the country, that we wouldn't need as many registered nurses in the future because they were changing the way healthcare was going to be delivered. And more of that care was going to be delivered by unlicensed staff, or robots. All the money being spent on nursing education, which is very labor intensive, doesn't need to be spent, you don't need to waste that money. And they all said, "Whoopie"! We don't have to spend so much money on nursing education anymore.

So we started seeing all the cuts to the nursing programs. And guess what, a lot of these nurse educators were so tied to the ANA and A1, we started seeing them lose their jobs as well. They really had to scramble to try and reroute their infrastructure as a result.

That's not your question though. I think nursing education has, nursing educators have been very complicit in the crisis that's affected bedside nurses. And a lot of them still don't get it. A lot of them oppose the unionization of nurses. A lot of them still oppose ratios. A lot of them still oppose nurses building alliances with patients. A lot of them train nurses in nursing schools that don't need anyone else, and tell them they should be aspiring to be a nurse manager, not a bedside nurse. A lot of them still have a very backward mentality. Those don't get it and they probably never will.

They simply don't have any critical thinking skills, which is ironic since they are supposed to be teaching them to their students.

Actually, several of us are really working towards getting an inroad into academia because academia's letting nurse down, in my opinion. They're not holding the standards that they should be holding. I'm sure it's because of the pressures that are on them. I know that clinical nursing requires you to have something like 10 students to every instructor, and I think that's too many depending on where you are. But these students are not getting "basic" nursing. You cannot substitute hands on care in my

opinion. I'm not a qualified "doctor" on this, but you have to have a real human being to learn on. That real human being is going to have a different response to whatever is prescribed than the computer. And you have to know that, you have to be looking for that. You have to understand that. That is not being taught!

What's being taught is that, if they're a certain age, and they don't respond right away, then don't worry about it because they're not going to respond to anything. Talk about death panels! It's a death sentence for a good number of people, be they children or older adults, or seniors. I'm hearing this from a lot of nurses. This organization is very worried about this, but we don't know how to really go about getting into this.

One of the reasons I was so thrilled about you contacting us is I thought, wow, someone who really understands bedside nursing and academia is interested in us. We need to do this! This work needs to get out on a national level. It needs to get out nationally, to be spoken about, looked at, real research being done, because up to now it's just been, "Oh, you're just a union." It's not just about being a union. We are professionals and we do care, and we want to see nursing continue. We want the people in charge of nursing, including the academics, to have the same dedication to bedside nursing that we do. For the old CNA people, it was all about resume building, it wasn't about caring for people. We need to get back to caring for people.

There are academics that are reaching out. But there are also people from the old CNA who don't like us. Some are very prejudiced, and yet call themselves academics. I just read another article attacking ratios - very biased and shoddy. But I have been contacted to come and speak about what CNA is all about. I've done it twice now. I have no idea what they say after I leave. But I put this out there each time, the need to touch, the need to listen, those kinds of things. Most of the time they are two year programs. It will take us another 20 years to get invited into the UC system because that's owned and operated by the old CNA people, the academics from the old CNA.

But you know, I have a neighbor who recently did a Ph.D. program of nursing at UC. Having worked at UCSF for a number of years, she decided to go back and get her Ph.D. so she could teach. She told me about Donna G visiting her class and how powerful she was and how inspiring she was to the students. Donna was, until her retirement last year, our government relations director. She was one of the ones who got fired.

I don't know if others have contacted us or not, because most of that would go through someone else. Again, one of the reasons I got so excited when you contacted us was that I thought, could this be the start of being able to bring academia into the fray? I mean, the industry is destroying nursing, it's dumbing it down. You won't have to be an RN soon, the only RN will probably be Master's prepared and will sit at some desk. Might put on a white coat sometimes, but that's not nursing.

Actually, a lot of nursing faculty are unionized too, so they should appreciate this. You'd never know that by the way they write and act though. I can't speak for all of them, but they seem to take their unions pretty seriously.

Well I hear from some every once in a while. My contact with the academic community is somewhat limited, partly because many of the academics who are involved in CNA sort of withdrew because they decided that we were too union. Even

so, I still have contact with nursing school instructors, not just clinical instructors but the instructors who come to see how their senior students are doing at my facility, that kind of stuff. And some of the response is actually positive, they find out you're into CNA and they ask you to come and speak to their class.

On the other hand, I hear from students that they get these sort of lectures on whether you should be union, or should you be professional. Like they are still doing that old mind set that there's some kind of dichotomy between being collective, being a patient advocate, and being a professional. They still sort of put that out there like that's a real debate still. It's kind of annoying. I don't know why they do that. Maybe they believe it. I mean, there's a lot of anti-union sentiment in America, right?

Listen to how people talk about the UAW and their pensions. Like they didn't trade wages away year after year after year to get a decent retirement. Somehow they were greedy that they wanted to buy homes and support their families. There's just a real anti-union sentiment and partly that's because the union movement and union numbers have gone down. I do occasionally hear resentment that I'm paid a really decent wage now and have achieved improvements for my profession and myself and my family over time. I don't know why people are so anti-union. Some of it is just being "anti-union", and some of it, I think, is that they really think that you can't collectively advocate and be a professional at the same time; that somehow being professional means you're not doing the care. Why else would they have promoted the idea that it was good to not do the care yourself? I used to have arguments with my co-workers, you don't have to have a BSN to push a stretcher down the hallway, it's kind of a waste of my time. On the other hand, show me it's a needed thing, that it makes a kid feel better or something like that, and if I have the time, I'm going to do it.

Airline pilots are unionized. Many physician groups are unionized. Government workers are unionized. And teachers themselves are unionized, including many faculty! So why would they promulgate the idea that it's unprofessional to be in a union??? I don't know. You're the professor, you tell me.

Well, what I see from the academic community, at least in the state of California, well, they're the people who lost control of CNA, so I think they're frustrated about the fact that they lost the control of a large organization. I think a lot of them, particularly in the BSN programs, try to convince nurses that real nursing isn't at the bedside in hospitals, it's things like case management, nurse educators, nurse executives, the sort of work where you're not going to get your hands dirty. I wouldn't say all nurse educators are like that, but I think the majority of them, they don't tend to let their students know why nursing ratios are important, why it's important for staff nurses to be involved in the political process in terms of representing themselves and their concerns and their concerns for their patients. I think they have a different agenda.

They might have to if their students had to carry a full patient load in school. It's only when nurses get out of school and it's always great to meet with younger nurses and talk to them like the one I met yesterday. They find out quickly once they're in the working world that it wasn't like what they learned in school, and that they're nurse manager may or may not be their friend depending on how things are going.

It's an interesting dynamic, and I have yet to figure out what's in it for them. I mean, really. There have been little cracks in that armor of anti-CNA. Some of the ADN program instructors. It makes sense when you realize that they've been looked down on for ever with the Diploma/ADN/BSN/MSN/Ph.D. controversy in nursing over the last several decades. You know there's a real insidious nastiness about it. We feel like there are these building blocks, and everyone should honor and respect everyone else's work, and I really don't understand this, but there is a hierarchy where the nursing instructors that teach at the universities, including state universities, like the UCF, they look down on the ADN's as, well, they're not REAL nurses or they're not REAL nursing instructors, this kind of thing.

Well, our position has always been that in order to make nursing open to everyone, not just the white middle class, you need to make the education available and a great way to get into nursing is the ADN program. Once you've got your RN, then as time goes by, you can get your baccalaureate, you can get your Master's, whatever. You can go up the ladder. Another problem is they don't make it easy. There's a lot of interference from the programs that bring in the money. Faculty salaries are not comparable between nursing and other professions. While you can bring in 400 students and pack an auditorium with an English course, entry into nursing programs is generally capped, and the students have to take all the pre-requisites, which nursing has no control over. It can take much longer for nurses to get through the programs, since you have to build in all the nursing stuff and the clinicals. You have more sway with the chancellors and regents than nursing programs do when you control larger FTE's. Maybe allowing students to move from one program to another if they need to. One problem with nursing is it's usually women, and what do women do? They stop to have babies. They stop for family reasons. They stop to help their families out because it usually falls to the women to be the healthcare provider to the family, to take care of the family's emergencies. And then they wonder why they have such a poor completion rate. We've got to do a better job of educating nurses. They'd have more nurses if they really wanted more. But that's my feeling.

18. What has been the response to the CNA/NNOC from the AONE or nursing administrations in general?

Response has been to "bad mouth" CNA/NNOC as noted in their publications.

Depending on the organization it varies from open hostility to more subtle but still intense opposition. Even those administrations that promote neutrality really want "partnerships" for their benefit. Over time some organizations like Kaiser have become less directly oppositional, but real collaboration is rare and will probably not be seen until we have single payer healthcare.

Other than a few nursing articles (research articles on the effects of ratios), I have not seen or heard from AONE or other nursing administration. I am just as sure, behind closed doors there is much discussion.

They are generally opposed to our agenda but I think we are mostly ignored by them. There is no public dissension except in rare instances. At Kaiser, CNA nurses and union reps have regularly scheduled meetings with nurse administrators and get to voice our views on changes occurring in clinical care. We are treated with respect and our opinions are taken into consideration.

I think they probably hate our guts because we tell it like it is. They may be more focused on academia vs. the clinical aspect. I don't regret belonging to their organization because as an RN you really need to have that clinical experience. And you know, academia is good! I'm not saying it's bad. But it should focus more on the clinical aspects vs. academic interests if you're really interested in taking care of patients.

Well, they don't like the labor part of our organization, the part that is unionized and represents union labor. A lot of people feel that hospitals and nurses should not be unionized.

What has been their response? HmMMMM. You know I think that they respect us from afar and they would like for us to come to the table. But the problem is that they already have a set agenda. So it's more about picking our brains and seeing how they can put a spin on it for themselves. That's my sense. I don't know if they really have the staff nurse, I mean I don't know if they're really thinking of the bedside nurses like they should.

We're in the year of looking at the staffing ratios; this is the year of review and they're doing everything that they can to say that the ratios are not working so that they can roll back or get rid of them altogether. I think they want to know how they can prevent us from doing what we're doing. I'm always suspicious of them. It's important to keep your enemies close, right?

Opposed.

Hostile primarily. Every once in a while we run across someone who's not, but that's very much the exception. It's been a hostile relationship. It sort of started out that way when we disaffiliated from the ANA back in '95 and the ANA set up a California chapter called ANAC, ANA CA, which was essentially congruous with the A1 chapter in California. Now CALNOC is different. They're a lot of the same people involved but CALNOC is extensively an independent research group. But it's a lot of the same people. There was initially, back in '95, a lot of very acrimonious rhetoric that we got from A1 and the new ANAC people because they felt like we had stolen their organization here in California. And in fact I guess, in some sense, like the sense that Robin Hood was a thief, we had certainly taken it from them. Whether it was theirs to begin with is another question. Ever since then they've essentially been quiet.

Well, for example where I work, the nursing administration realizes they have to get along with us. In a way, I've had one nurse administrator tell me that ratios were the

worst things that ever happened in hospitals here, and I said, well, that's your point of view. They're the best thing that ever happened for patients and nurses, but it was a hostile sort of discussion. I go into some areas, there's a hospital in Las Vegas now where the nurses, I think it's owned by Columbia HCA, where we're looking to organize the nurses. The administrative response is really hostile because they realize it's all about power. If we represent the nurses there, the nurses are going to have more power. If they're unrepresented, they'll have more power. It's all about who's got power with them.

Not in my capacity to know, sorry.

There was something I saw the other day in Nurse Manager or Nursing Management, whatever the AONE publication is, involving an announcement of the merger on the UAN thing. Something to be worried about now, because not they're powerful. It was about how the ratios are bad. It was so nonsensical. Raises are bad too. Talking about how hospitals are going to be forced into ratios all over the country.

Let's go back to 1995. The Supreme Court came down with a decision, the ACRA case where they rejected the long-standing patient care exception to the supervisory exemption. The NLRB had a blanket exception for RNs because obviously RNs do directly control the work of others for the interest of the patients. In 1995, the Supreme Court had another decision where THAT rule, a presumptive rule by the NLRB, was overturned. It wasn't defended well because the NLRB stood on its hands and said, well we're the agency to do it, so we get to do it. Scalia wrote the decision saying that, sorry RN's, your interest is the same as the employers, the delivery of patient care. Bad decision, a theoretical decision knocking out a rule.

The circumstance, factual circumstance of care being given in the exclusive interest of the patient as a professional duty and obligation distinguishing direction and control from the interest of the employer to the interest of the patient could have been litigated. I'll never forget that. And the ANA types, the AONE types played stupid. It was also stupid of the grand labor movement not to fight this. Instead, the strategy was to lay low, play stupid and take the easy way out, the dumb-down approach. I said, look, we have the amendments, the 1974 amendments, which say the reason we have to include RN's is for the patient care. They all said no. SO after it got started, a lot of the legal strategy for nursing unions was that RN's really don't exercise independent responsibility. RN's don't really directly control anything other than menial tasks. SO there were a series of NLRB decisions, up to the Kentucky River when the Supreme Court considered it again. My point is that between the time where the general rule of the NLRB that it's not in the interest of the employer, it's in the interest of patients, and THAT Supreme Court ruling, there was a complete abandonment of thinking. If any NLRB case had tried to trap us, I would have sued the NLRB. And of course, the AONE supported this to try and block any further unionization efforts.

I don't know, sorry.

It's not positive at all. One of the biggest problems we have is that we are a union. Just

so you know, I was passing out flyers in 1948 for Helen Gahagen Douglass who was running for Congress against Richard Nixon, so that tells you where I come from.

Managers have problems with the fact that we are a union. You know, we wouldn't have the "weekend" without the unions. We wouldn't have healthcare coverage at work. The reason we have health coverage is because the unions thought it was important, so they accepted the Taft-Hartley Act. With all the bad things that are in that Act, they felt it was necessary in order to have health coverage. I can remember when my father was SO HAPPY because he was working as a Teamster, and could get our teeth taken care of. If you haven't gone through that, you can't appreciate where your resources come from.

Like listening to these people complain about the possibility of a strike. They say, "They're making too much money already." WHOA - wait a minute. They're not making too much money, that's not the only issues in a strike.

They're worried about their retirement for the retirees.

They're worried about their healthcare for the retirees.

They're worried about their own retirement and healthcare.

Please, a union is there to help people. I remember the late '30s and '40s, it was the unions that handed out groceries, and you didn't even have to belong to the union. The problem is everyone thinks of a union as Hoffa with a scar and tattoos, and the mob. That's not what unions are all about. I'm very proud of this union. There are a lot of unions that do fantastic work. The ILWU's a tremendous example. You don't get paid more than the workers, even if you're an officer in the union. You don't get paid more, because the person doing the work is the important person. Unfortunately, the academics and managers all look down on unions.

You know, I haven't read their stuff recently. I sort of quit reading it because I assume they just don't like us. I just assume it whenever they write anything, it's just a basic assumption when I hear their opinions of us. But I don't actually know that to be the case. I would think if they are smart, that they would "get it" that we are trying to improve patient care, and that that's a good thing for everyone. I would like to think that, but they don't, do they.

Well, the AONE we really don't deal with. We've dealt with the American Nurses Association- California, and sometimes we have agendas in common. And we've worked together at the legislature when we do have issues in common. The AONE, the ANA California, their funding is from the CA Hospital association. The nurse executives all over the country, they are funded by the AHA. They are a chapter of the AHA. SO they're like, a part of the problem in nursing and in healthcare.

The thing with them is they come up with these "studies" about ratios not working, they come up with these things to prove ratios don't work, like the CALNOC studies. Our CNA research team looked at it and refuted everything because all their quality indicators really had nothing to do with nursing whatsoever. These things were not in our control, yet they used them as the rationale for why ratios don't work, which was horse shit.

Yeah, so we don't have a relationship.

19. If they are so inclined, what can nurses do to assist the CNA/NNOC in its efforts?

<p>Nurses can get more involved, become knowledgeable about the actions that need to happen to achieve our goals. Stick together, write letters, come to events, visit legislators and most of all educate each other on what is needed.</p>
<p>So many things: talk about the benefits of mutual support for patients and the public with other nurses and friends; write letters to the editors; speak at public events; go to legislative hearings; have meetings with CNA/NNOC staff to promote organizing and attend their educational presentations; go on line to nursing web sites to promote nursing unity and to network with us; join RNRN our emergency relief organization, and mainly get involved and develop a support group so nurses are not alone in their efforts.</p>
<p>Join NNOC, become active and involved in what's occurring in their facilities, state and hospitals. Fight to improve patient care standards at their facilities, understand that the interest of the employer and the patient/nurse is fundamentally different.</p> <p>Attend CNA/NNOC sponsored educational events in their states, become aware of what's occurring in the political arena, join the RN to RN Disaster Relief, run for public office, visit the CNA/NNOC website and educate themselves as to the current events/battles facing nurses.</p> <p>Educate themselves about our healthcare system as compared to the systems in Canada or many of the European countries. Understand and study the benefits of having a Single Payer system, what that system entails and understand the concept of one standard of care for everyone.</p> <p>Read and understand the pitfalls of the current health care system, be willing to step forward and stand up for the people who can't do it for themselves.</p>
<p>There is plenty of opportunity for nurses to get involved with CNA/NNOC. If they work at a hospital which is organized by CNA they can join the PPC or become a nurse rep.. If they don't they can become a member for a very small cost (\$30 per year)- get our magazine, join our rallies, communicate on our internet blogs.</p>
<p>I think the best thing they could do is to belong to CNA and NNOC (\$30/year). The more members we have, the better it is and as we all know, there's real strength in numbers. If we believe in what CNA and NNOC are all about, than we have a much stronger force. If we believe in the agenda, in the mission/ambition, then we can sweep across the country and each and every RN will belong to CNA and NNOC. That's going to be VERY powerful.</p>
<p>We have to join together and support each other. We can't have any nurses working conditions below standards. This is what we want, one standard for everyone. Getting everybody together is always the toughest part of anything, then bringing them in and making them feel connected. They have to help themselves by joining us.</p>

This is something that I've talked a lot about. The frontline staff nurse really needs to get that education on how to do their job effectively at the bedside, to know that they need to advocate for their patients, and also to know the organizational chart or how to escalate issues, who those individuals are. They really need to know their facility and to know that they have a voice. I think once we can convince staff nurses of that and that's been a slow process, and continue to educate them, I think that we will really get it.

Since I've been here with CNA, since 1982, and then becoming active with them in '87 and '89, I've seen a lot of change. Now a lot of us who have been in nursing for 20 plus years, 29 for me, we've got to educate those younger nurses on what our history was and where we need to go. So it's a constant, ongoing education of the staff nurse. And I think they need to hear it and we're really trying to do everything that we can to provide that education for the nurses. Some want to listen, others don't.

Join. Join the NNOC and implicit with this is pulling out of their state association to send the message. Not many of them are in it anyway, really. Join the NNOC and become active.

Well, the easiest and first most concrete thing they could do is join NNOC and become active locally with other nurses. Identify local issues. Then, as things develop, go out from there. We hope to see folks responding positively and militantly in organizing their places of employment, because that consolidates their power and their ability to act as patient advocates and to carry forth the program. Then additionally, for those nurses who are currently represented by other unions for collective bargaining, SEIU, AFT, etc., we would hope that they would work with us. They're eligible and welcome to be members of NNOC at the same time (\$30 per year!) as they're represented by someone else for collective bargaining. We'd hope to see that kind of activity.

I think there's a model for success with CNA with our current members. Joining the union, being involved, having unit collectives, facility collectives, hospital ownership collectives- that's where the hospitals are parts of chains and then the larger collective of the whole of CNA and NNOC. I think that any nurse who is not a member should join or come to a rally and see that adding one voice to a hundred voices or to a thousand voices really increases power, and can speed up the change.

There are a lot of issues in nursing that we've confronted in California and we've overcome them and those battles continue in other states; mandatory overtime, the ratios, pay inequalities, management favoritism, and working every weekend. There are a whole lot of issues that can translate to other states.

Support single payer, join the single payer movement. Be active for ratio regulation in their states, and become part of an actual social movement and all the things that may be part of that.

Join the NNOC. Action is called for, and staff nurses know that, but today, it's collective patient advocacy because you're not able to be protected in an exercise of individual patient advocacy. Sure, there's some whistle-blowing on this and that, but

you stand up there alone and you're going to get whacked.

Form a joint organization with us. We're going to have a new, larger organization assuming everything continues on the path it's going on right now - we're going to have a convention in December that will set up the merger, and people can be a part of that. Join the NNOC. They can be a part of it by being at-large members or seeking representatives for CNA, seeking more direct representation from their facilities. At the minimum nurses should be socially active.

They can do it numerous ways. They can be a part of the campaign for real healthcare reform. They can be a part of our network of disaster response. They can be a part of advocating for ratio bills in their state legislatures or supporting the Boxer Bill (Senator Barbara Boxer), the national bill. There's information about this on our website.

They should join our email network. What we're building is a national network of direct care nurses, a national movement of direct care nurses and we would like to see them all participating.

Organize! You have to organize and you have to act in a collective way. You have to be willing to be on the steps of the capitals of the different states. You have to be willing to be in the field offices of the different legislators. You have to be willing to stand up and be counted. You can't do it as just one person. One person cannot move the mountain. But we can move a mountain if we're all together.

There's so much nurses could do. I just came from a meeting at my hospital with my fellow nurses, and we're working on H1N1 and its impact on patient care and whether or not we're getting enough education to improve patient care. We have a professional performance committee that's taking up that issue and is going to get a meeting with the infectious disease nurse and with the director of nursing and talk about some of those impacts on patient care. Basically in preparation for if it gets worse in the winter which everyone is predicting it's going to do, right? So that's something the bedside nurse, the union is taking on and they can get involved with at their facilities.

There are healthcare issues all around us, and they can get involved in that way. We have a convention coming up and a lot of classes and there's going to be nurses from all around the country at our convention. Nurses can come to those and meet other nurses and build those bridges and help recruit other nurses. Nurses can actually help us organize.

You can be sent on campaigns and talk to nurses around the country about what we have here and why it's important and why it's important for other nurses to have it and achieve it themselves. It's important they take the time to do this stuff. It's hard for people to get outside of their day-to-day life and become active in something like this. I think it's almost like a civic duty in a way! It seems, though, that many people get "voter's fatigue" if they even have to listen to an election speech and vote.

Even single moms can get involved. They could inform their co-workers. They could keep informed. They could understand the rights they have. They could educate their co-workers. And you can do all that while you're in the break room. It doesn't have to

be the endless day commitments that some of us do. You really can do little bits at a time. You can blog. You can put information out there. You can join and it's a pretty minimal payment (\$30/year) if you just join as an NNOC member who is not being represented by us. This all helps!

Partly because it's "contacts" out there. It's like knowing who's interested in these ideas we have, knowing who you could contact some day. Knowing there's someone who might be willing to write a letter around healthcare reform and what that would do for us. This is a national debate right now, so having nurses all over the country who would be willing to even write a letter or send an email to their legislator that healthcare reform and providing Medicare for all is a good thing as opposed to a scary, bad, government-run, socialized medicine thing. This is very important for all of us.

It does matter as an organization when you're saying you represent nurses. So we're able to say we represent nurses in 47 out of the 50 states. Numbers count. It makes a big difference in terms of our political credibility because all those nurses vote as well. A lot of our campaigns are carried out not at the facility level, but at the nursing profession level and in the legislative and regulatory levels. Having contacts at all those levels and having them push in sort of a united front that the same standard of care for all patients is important, could really help the profession of nursing and our patients.

Yeah, they could join the NNOC and they could get our numbers up. If they even had a core group of nurses who were interested in patient care issues or maybe organizing for collective bargaining, they could contact us and we could strategize on how to achieve those goals. \$30 a year for the NNOC. Obviously we'd get more money we could use for organizing, but it would also mean we could say we represent 80,000 nurses, or 100,000 nurses, or a million nurses, that would make a huge difference. Particularly if you're going to Washington and you're saying you speak for a million nurses, that makes a HUGE difference.

I actually did that recently in Palo Alto where I live. I went into my representative's office, we had emailed him many times, and my wife and I went in, well I actually got introduced. I said, "I'm with the executive board of the California Nurses Association, we represent 80,000 nurses in the state. We've been a good supporter of you and I'd like you to listen to what I have to say." I think it makes a difference in terms of being able to speak to them when you represent larger numbers.

Well, see, that's the thing. It's really not an individual nurse being able to do anything. I mean, that's the reality. If that were the case, that an individual nurse could really make a difference without working in a collective, assertive unit, we wouldn't be in the place we're in right now. If a nurse could be as loud and as menacing and at the top of her game at her facility, they wouldn't even need us, really. They wouldn't need us at all.

The problem is that the system is so stacked against you- you've got one finger in one hole over here and there's another hole over here that you really have to plug Or like the Medusa, every time you cut off one part, another part grows back. And you're constantly trying in vain to deal with the problems. And then you get blackballed. I

mean in a lot of these areas you can get blackballed as a nurse. When you're in an area, we were in an area back East just recently where there were only three hospitals, and you speak out, report someone to the medical board, say, or to the department of health, you end up not only losing your job, but that hospital reports you to the board of nursing in your state, and that board of nursing is so tied to the hospital industry that they investigate YOU, and you can lose your license! I mean, that's really insidious.

There's the "safe haven" rule in Texas, for example, where you are supposed to be able to report things, but we have several nurses there now who may lose their license. If you've reported and gone through your hospital, going through the hospital committee again makes no sense. There was the nurse here in California, which is why we have the whistle-blower protection law we do in California, one that was impregnating all those women with his semen, and an anesthesiologist, I don't know the clinical term for coming in his patients mouths while they were under anesthesia, he was doing that and she tried to blow the whistle on him and ended up getting fired for it. We used her as one of our arguments for the law. But when you have states that are virtually controlled by an industry, you really have no power to deal with it on an individual basis.

20. What influence could a politically empowered nursing profession have on the national healthcare debate?

A politically empowered nursing profession would be able to influence how healthcare is delivered for the betterment of the patient and not the bottom line of the hospital or insurance company. Nurses would be in total control of their nursing practice and be able to influence how money is spent to deliver the best care possible as patient needs dictate not as dictated by the hospital or insurance company. It would be a great day!

Huge influence due to the large number of nurses in this country and the public support, trust and respect the nurses have. When nurses speak the public listens and when they speak in one united voice about healthcare and public welfare issues the politicians also heed them. United we can advocate for our patients and make healthcare a right and end the perversion of healthcare as a business for profit.

The passage of a Single Payer Healthcare System that is inclusive rather than exclusive. To make the public realize that obtaining health care should be a right, not something that we have to sacrifice something for. We could become significant players to ensure that when another natural disaster such as Katrina occurs our responses would be quick, organized, and effective.

We would ensure that healthcare would be by physicians and nurses instead of insurance companies that needed medications are affordable to all, and that good healthcare is a right, not a billion-dollar profit for big companies. To secure state and national legislation for RN staffing ratios, whistle blower protection, and other basic protection for patients and RN's, meaningful health care reforms, and block the political influence of the Hospital Association on healthcare reform.

I think there is a great opportunity for nurses to have a voice in a national healthcare debate. We are the most highly respected profession, there are many of us so we are quite an influential voting block, we are at the bedside and witness first hand the problems and priorities of being sick in the United States.

We have to realize our power, accept the responsibility of our unique knowledge and perspective and work together. I feel very optimistic about our role in the national healthcare debate but the clock is ticking and there is much work ahead of us.

I think we are there, up close and personal to the public, we have credibility, we are known for what we are fighting for, the interests of our patients. We have the best people, so our elected politicians and people we put in office should be listening to us because we know what's going on. WE know what we are fighting for and we have no hidden or vested interests controlling us. It will not give us more money if we eliminate the insurance industry but it will be better for our patients because they will have access to healthcare. They can get the care they need and even have preventative care.

If we could bring this single payer system in. One of the best things that has happened is with these Town Hall meetings on healthcare, bringing the discussions out in the open like we have, even on "end-of-life" issues. Most people have no idea what this is all about, and this is stuff we deal with every day. If we had everybody together with us as nurses, if we had one strong nursing organization we could move the public, because they trust us. You like the nurse, you trust them. It's the kind of profession that weighs good on people's minds. So if we had more numbers, we could have our own Town Hall meetings with people, talk about Single Payer Healthcare, what good healthcare really is, what you want, and what you don't want. We could be a strong political force, a winning force.

A lot! We see it every day. We see that care is being rationed. I keep hearing them say that they don't want the government to be involved, that they're going to be denying care. But we all know that right now the insurance companies are denying a lot of care. A lot of nurses that are on the front lines really see that. A lot depends on the hospital that you work for; I work for Kaiser. But you know I'm working with the hospitals over there at County Medical Center, Highland Hospital, and it's so different.

You have the "have's" and the "have nots." And Kaisers a huge organization. They've made a huge profit. Meanwhile we have a county facility and they struggle to have forks and spoons for their patients. SO I think we can make a lot of difference if we can constantly convince the nurses that they do have a voice and that they can do this.

A lot of them are scared that they'd lose their jobs, especially nowadays where they're starting to lay people off. SO there's that fear and there comes a time when you have to make a decision. We've struck before...but I'm hopeful, I'm hopeful.

Massive, just massive. You know nurses are the most trusted profession in the U.S., they conduct this poll every year. There was a study done 2 years ago, I'll try to send it

to you. It had to do with influence in the healthcare debate in California, we beat everybody hands down. We don't use that enough. 50,000 nurses marching in Washington for Single Payer would be pretty potent, it would certainly play well with the public. This study surprised me because I thought, well maybe the public just likes us (the nurses aren't they lovely), but they wouldn't trust us as experts policy, analyzing that policy, but these figures seem to indicate they do.

I think it would have a profound effect if we organized a 50,000 nurse march. Everybody knows a nurse. We're seen as politically neutral even though the hospital industry paints us as Bolsheviks. That never rings true with the public. I'm amazed, some of the things we've done are basic socialism, but there's not a reaction to that. We advocate Single Payer, but organized nurses aren't painted by that, aren't allied with communism. As long as we keep it focused on patient care. I mean if we start stepping over that line, we'll run into. . .

We've done strikes and the public supports us. Michael Savage is a rabid, right wing crazy. He's akin to Limbaugh, all that. He's pretty popular among conservatives. When we were striking Kaiser, I got him to support us. He's rabid about Kaiser. He'd ask: "Who're you going to trust, Kaiser or the nurses? You all know the answer to that one." I faxed him a ton of information and talked to him on the phone and I was amazed what he did with it. But if he looked into it a bit deeper and saw what we were about, he'd go crazy. But he's like that. So we handled him well. I think it's really one of our secrets, how we do really sophisticated media stuff and always have. We've never neglected that.

This is the last question, but I would like to add some comments. There are 367,000 nurses in California, we represent roughly 80,000 of them now. A lot of them aren't in places where we've hit for organizing. A lot of them aren't working. Some of them are in academia. Some of them are represented by other unions. There are still many places to go. Some of them are "born-again-Christians," so that's hard. You know we have a few facilities where Jesus is on the other side of the negotiating table. They'll state that, that they're taking direction from Jesus. I love this country. I kind of like Jesus on a political organizing level.

We've got some tough spots here in California. I can't remember all the details, but I did a lot of research on Schwarzenegger's backers. They're really scary people, sheer Darwinians, survival of the fittest. Pure libertarians, get government out of everything. Coming from England, you don't get that kind of rabid ideology. The Tory's look like commies from that point of view. The great irony of all this is that this country was founded on the most radical principles, the most radical left-wing concept that's ever hit this planet. These are the kinds of things that go round and round in my head- that it's gotten perverted to this conservative stuff. I love the concept of America.

Oh, unbelievable influence. We think that if nurses nationally were mobilized around the healthcare debate, that we could basically point it in the direction that it needs to go. What we see right now is a debate dominated by the insurance and healthcare industries and pharmaceuticals. And the AMA. But even the AMA is taking a back seat to the direct industry representatives. If we were talking about a national health system for instance, you know that the AMA would be on top of that one. It's always

the question about whose ox is going to be gored. And so the single payer, even the so-called public option, is a threat to the insurance industry, and so it's not surprising that they are out there.

But there needs to be an organized force fighting for the rights of the public. Traditionally, in most industrialized countries, the union movement to be that force. Well, that's not happening in the U.S. The union movement is weak and represents only 12% of the population right now. But specifically on the healthcare issue, because RN's are patient advocates, required to be by their code (the ANA code of ethics ironically), they should be that force. We are the most trusted profession in the U.S., year after year. So RN's are both in a unique place as well as uniquely qualified to play a leading role on this. So if we were able to organize effectively, RN's nationally around this, it would make all the difference in the world.

I think that politically active nurses can have great influence. Nurses are a well-respected, well-trusted group of professionals up against corporate interests and in light of the economy meltdown over the last year or so, I think there's some skepticism towards corporations right now. They are not the end all and be all in our country. A politically active nurse, even still in California, is still a novelty and something that is different and can grow attention. We've had one of our Presidents on TV, debating on the Moyer show. We've had other leadership debating in national news and it's fresh. It's new. It's raw because you really have politically active nurses and progressive women, working women speaking on healthcare issues. I think it helps our cause.

The nurses deliver the care in a hospital, so that is the start of all this bullshit. The "death panels" we hear about, they stem from the HMO's right down to the hospital nurse manager who's implementing a capitation finance staffing method which is intended to withdraw needed care. THAT'S a death panel implementation. Nurses can forcefully talk about that.

Now in terms of what to do, well we're about to undergo another wave of restructuring that will involve staffing ratios. You know the ratios are no good unless the PCS (patient classification system) operates. It has to be effective, transparent. It makes the patients 1:1, 1:2, etc.. Control the work and you save the job. We have to be on top of this. Nurses have that kind of power.

Big effect, we'll see.

It would certainly have a big affect. We have an office now in Washington DC. We now have ties to national legislation. We would and should be at the table instead of the ANA at Barack Obama's healthcare conference. They do not represent our ends. They do not represent the patients. Yet they speak as the "voice of nursing"? They should no longer be allowed to do that. That's something we need to ensure that we can do. That is our goal, to be able to speak as the voice of nurses because we are the voice of nurses, bedside nurses.

I have to say, we do not all agree all the time on everything here. When we have our Board meetings, we have some knock-down, drag-out discussions. But those nurses

are INVOLVED! They have the ability to influence and make decisions. That's important, that we talk things through and work them out, because you have to have things that people agree to, and that they fell in their hearts and guts is right, before they can really move on it.

We need to be able to speak up. We're very fortunate in California because we do have the ability to organize and we are strong and we are respected. There are 12 nurses in Texas facing possible prison terms because they didn't have whistle blower protection when they reported a physician. We don't want nurses having to put themselves in that position. That's not what we're asking for. They were very brave doing what they did. Supposedly Texas has a rule to protect them, but it doesn't. It's not real. We tell everyone at the NNOC meetings and rallies, there are going to be cameras, we even point them put. We only got the whistle blower protection after the RN from Irvine reported the doctor who was using his own semen to inseminate his patients. She called us and we worked with her. She wasn't even a member until after we won her case.

I think nurses speaking out about what is wrong with the current system and understanding how to fix it and having an idea about HOW to fix it would actually influence the debate. I don't think enough nurses understand that. I think we spend a lot of time as an organization trying to get that information out to nurses and trying to help them make a connection between the cutbacks at the bedside or lack of access to care and the insurance companies. It's a really hard thing to get people, nurses, to fundamentally understand their level of power. I'm one of those children of the '60s, I understand collective action. I got involved. I went to a union hospital because I WANTED to have a union job, and I got involved in MY union. I don't feel like an oppressed minority. I feel like I'm thrilled, happy, and blessed to be a nurse and I'm controlling my OWN destiny through all this stuff and it shocks me that some people won't do that. It shocks me that some people don't want to control their own destiny more. They just don't get it!

It makes everything so much better if you feel like you have a say in the world. To me it does anyway. And it takes a little bit of coaxing and it takes a little bit of winning people over to get them to sort of take some of those first steps, and to understand it because we have a culture that says, don't get publicly involved. I meet some nurses, not many, but some nurses who don't even vote! They're not even registered to vote! Like spending a few hours every four years is asking too much. I think we spend a lot of time doing nurse education.

Voter fatigue! That one really pisses me off. There was a huge amount of media coverage on voter fatigue, and I kept thinking, "Who's getting fatigued?" They're getting fatigued from voting once every four years for President? What are they fatigued about? If they're fatigued listening to all the media, maybe they need to turn off the TV and read, or get involved somewhere. Go to a town hall meeting and discuss the issues with your fellow citizens. Just voting is the bare minimum.

APPENDIX C

CORROBORATION OF INTERVIEW DATA

A large quantity of documents were sent by CNA, not at the request of this researcher but voluntarily submitted, to corroborate many of the stories in the responses to the questionnaire. All the documents are listed below, with dates highlighted. Since many of the documents came “bundled” or organized by “someone,” the organization will be maintained and presented as they came.

BINDER

Brown binder, no label or title.

First Section- Title: May, 1995

May 4, 1995- Annual Legal Report from James E. Eggleston to the CNA Board of Directors RE: Review of Significant Cases and Developments.

Distribution and Priority of Legal Services.

Defensive Litigation- Decertification Defense

Hospital Industry Restructuring- Offensive litigation- CNA v. ABMC, ABHS and CHS

Restructuring Arbitrations- CNA v Kaiser, Santa Clara, CNA v. Kaiser, Santa Theresa

April 8, 1995- Legal Update – Restructuring from James E. Eggleston to the Economic & General Welfare Congress, CNA

Protecting Seniority Rights- CNA v. Kaiser, Santa Clara: (unit-based seniority), CNA v.

Hospital, Oakland: (seniority credit for non-unit service)

PFC- Consumer Fraud Update- CNA, et. al. v. Alta Bates Medical Center, ABHS,
CHS (consumer fraud – PFC, gagrule, “shell game”)

Official Recognition of “PFC Fraud”

Evaluating the Impact of PFC-Style Redesign- Affirmative Use of PFC Contract &
Information

March 21st ARBITRATION: Seniority Grievance No. 92-498, Opinion and Award-
Kaiser Permanente Northern California Region (Employer) and California Nurses
Association (Union) Award - The employer violated the agreement by its unilateral
definition of “departments” as set forth in Joint Exhibit 7.

Filed **March 13th 1995**- U.S. District Court for the Northern District of California
California Nurses Association et al Plaintiffs, v Alta Bates Medical Center; et al
Defendants. Order granting plaintiffs motion to remand

Health Care Fraud Papers-

Paper entitled: The Problem: Health Care Fraud: Crisis of The Nineties (1 pg.)

Newspaper article, no paper identified, no date given: By David R. Olmos (Times Staff
Writer) - Title: Search For a Fraud Cure: Federal Task Force Is Looking Into
Abuse in Managed-Care Field

Newspaper article, no paper identified, Wednesday, **March 29, 1995**: By Edwin Chen
(Times Staff Writer) Title: Gingrich Calls for an Investigation of Managed Care.

Resolution calling for Trust Fund action on Kaiser Fraud- Adopted March 28, 1995.

Submitted to the California Labor Federation Executive Council by the
Secretary of Alameda Central Labor Council and Vice President California
Labor Federation

New Section- Title - February, 1995

July 23rd, 1995 Legal Update To: Economic & General Welfare Congress from Jim
Eggleston - Restructuring

CNA, et al. v. ABMC, ABHS, CHS (consumer fraud- PFC, gag rule & shell game)

CNA v. ABMC, ABHS, CHS (petition to compel arbitration)

CNA v. St. Joseph's Medical Center (arbitration of grievances challenging PFC
redesign)

PPC Investigative Reporting- Obtaining and Reporting Evidence on Risks of Patient
Harm In Restructuring

Kaiser restructuring- some highlights

Calrptr - Copy of Civil Codes § 52.1, 51.7

Endorsed, Filed **July 05, 1995**- Superior Court of the State of California in and for the
County of Alameda. Plaintiffs: California Nurses Association; Committee for
Patient and Health Care Workers Rights; Stephanie Allan. Gregory Bergman;
Mary Lewis; Nathan Newman; John French; Doris Burleson; Karen Gabrielson;
Theresa Pello-MaCauley; Marilyn Pon, individually and on behalf of all the
others similarly situated,

vs.

Defendants: Alta Bates Medical Center, Alta Bates Health System, California Health System, and DOES 1 – 20, inclusive

First Amended Class Action Complaint for Injunctive Relief Prohibiting Unfair Business Practices and Requiring Truthful Public Disclosures About The Impact Of Hospital Industry Restructuring on Patient Care Standards

Letter from Lori Liederman (Labor representative) to Ms. Joanne Carder (Director: Employee/Labor Relations, Alta Bates Medical Center) on **August 29, 1994**, Notification of grievance by all affected RN's, asking Alta Bates to refrain from distributing the 'Work Redesign Applicant Preparation Information' packets.

United State District Court Northern District of California, Filed **June 16, 1995**.

Plaintiff: California Nurses Association vs. Defendant: Alta Bates Medical Center et al. - Order denying defendants' motion to dismiss and granting plaintiff's cross-motion to compel

Arbitration – Includes copy of redesign plan and arbitration transcript.

Kaiser Permanente Southern California Region Business Plan **1995 – 1997**

May 29, 1995- Letter to Cary Badger- Trust Fund Request For Information From

Kaiser Permanente – Protesting advertisements carried in various newspapers on May, 8, 1995, where Kaiser stated that “we put 96.5 cents of every dollar into caring for our members.”

Article in Business Week, **July 24, 1995**- These Insurers Are In It For The Long Haul,
article concerned with long-term care.

Newspaper article- No paper, written by Robert Pear- Dated **Washington, July 16**, no year. G.O.P. Proposing Greater Choices About Medicare

Memorandum, **December 8, 1994**- To: Rose Ann DeMoro, From: Jim Eggleston
(Eggleston, Siegel & LeWitter, Attorneys at Law) - Supreme Court HCRC
Decision and TQM

November, 1994 – Article in Labor Law Journal - Total Quality Management and the
National Labor Relations Act. By Richard S. Meyer

Article in **December, 1993** issue of Patient-Focused Care, the Health Care Executives
Guide to Organizational Restructuring. No author

New Section- Title: Use of Supportive Funds

January 4, 1994- To: Executive Committees CEGW & CNA Board of Directors.
From: Jim Eggleston (Eggleston, Siegel & LeWitter, Attorneys at Law) Re:
CEGW Supportive Fund

New Section- Title: Sent 1995

December 19, 1993- To: Jim Ryder From: Jim Eggleston (et al). RE: Response to
Gateways Restructuring Plan

New Section- Title: Court HCRCA/TQM

Page 4 of memo to Jim Ryder on **December 19, 1993**

Overview of Operations Planning Approach

Care Delivery Model

Meeting Schedule, **December 23rd 1993-** CNA, Oakland

December 10, 1994- To: Economic & General Welfare Congress, CNA; From: Jim

Eggleston (et al). Legal Update- Significant Cases: CNA. et al. v Alta Bates

Medical Center, et al. United States District Court, ND Cal. No. C-94-3555-CW;

CNA v. Alta Bates Medical Center, et al. United States District Court, ND Cal.

No. C-94-3524-SBA; Alta Bates Medical Center v. CNA- Alameda County

Superior Court No. 744567-5; Brookside Hospital v. CNA- Contra Costa

County Superior Court No. C-94-05357

Article in The Oakland Tribune- **Friday, December 9, 1994-** By Rachele Kanigel: Alta

Bates acts against nurse

Article in "Cityside," **January, 1993-** By Dashka Slater: Alta Bates Nurses Fight

Restructuring

Superior Court Of The State of California In And For The County Of Alameda-

Endorsed, **December 2, 1994;** Complaint for Declaratory Relief, For Damages,

and Demand for Jury Trial. Plaintiff: Alta Bates Medical Center vs. Defendants:
California Nurses Association and DOES 1 through 50, inclusive.

New Section- No Title

Memorandum, **December 10, 1994**. To: Economic & General Welfare Congress, CNA

From: Jim Eggleston (et al) RE: Corporate Strategies - Bargaining Response
Corporate Scoreboard - Financial statements of 18 corporations in healthcare.

Justice Dept./Federal Trade Commission- Policy Statements in Health Care (9/27/94).

Relief From Antitrust Laws For Monopolization of Hospital Industry.

Newspaper article (no paper, no date given) By: Sabin Russell and Alex Barnum

(Chronicle staff writers) California Medical Industry Already Reforming

Newspaper article (no paper, no date given) By: Alex Barnum (Chronicle staff writer)

Big Firms Draft New Health Plans

San Francisco Business Times, **Week of January 21 – 27**. By: Chris Rauber. Medical
supplier puts squeeze on local market.

Los Angeles Times, **May 4, 1994**. Page B7. By Suzanne Gordon and Judith Shindul-
Rothschild. The Bean-Counters Target Hands-On Care.

Modern Healthcare, **August 8, 1994**. Cover Story by David Burda. A profit by any
other name would still give hospitals the fits.

Modern Healthcare, **August 15, 1994**. Cover Story by Karen Pallarito. Acquisitions

United States Supreme Court National Labor Relations Board v. Health Care &

Retirement Corporation of America- Interpretation of the “in the interest of the
Employer” language.

Memorandum from Jim Eggleston (et al) to Rose Ann DeMoro - Supreme Court

HCRC Decision and TQM **December 8, 1994**

Labor Law Journal, **November 1994**. By Richard S. Meyer (with the firm of Blank, Rome, Comisky & McCauley in Philadelphia) Total Quality Management and the National Labor Relations Board

December, 1993 issue of Patient-Focused Care, the Health Care Executives' guide to Organizational Restructuring. Beware of "Cooperative" Restructuring.

December 9, 1994- NURSE ALERT- CNA & Marin General Hospital Reach Agreement

Issues '94- The Candidate's Briefing Book (The Heritage Foundation) Chapter 11- Health Care By Stuart M. Butler and Peter Warren

New Section- untitled

Memorandum on **February 18, 1995**. From Jim Eggleston (et al) to Economic & General Welfare Congress, CNA. Legal Update – Significant Cases. CNA v. Kaiser (charger nurse super-seniority); CNA v. Children's Hospital – Oakland (seniority credit for non-unit service); CNA v. Mt. Diablo (restructuring/"layoff"); CNA v. St. Joseph's Stockton (restructuring); CNA et al. v. Alta Bates Medical Center, ABHS, CHS. United States District Court, ND Cal. No. C-94-3555-CW; CNA v. Alta Bates Medical Center- United States District Court, ND Cal. No. 94-3524-SBA

Arbitration Decision and Award, The Permanente Medical Group, Inc. and Kaiser Foundation Hospitals and California Nurses Association (charge nurse seniority Grievance. The grievance is granted **January 3, 1995**.

Arbitration Opinion and Decision, **December 1, 1994** between California Nurses Association, Union and Children's Hospital Medical Center of Northern California, employer- RE: Seniority/Denial of Position Grievance No. 09-02
Arbitration transcript- CNA vs St. Joseph's RE: Restructuring (no date given)

New Section- untitled

May 14, 1994, Legal Update - Significant Pending Cases. From James Eggleston (et al) to CNA Board of Directors. City of Hope v. CNA (Los Angeles Superior Court); Kaiser, Santa Theresa (Pesek Arbitration).

Legal Paper, Eggleston, Siegel, and DeWitter Law Firm- Case outline for CNA v. City of Hope - Plaintiff attempting to recover damages allegedly caused by CAN strike.

United States Bankruptcy Court For The Northern District of California- Case No. 94-42864-J. **April 29, 1994**. In re: Los Medanos Health Care Corporation, a California non-profit public benefit corporation, Debtor Tax identification 68-0063134-Opposition To Debtors Motion For Order Approving Stipulation RE Receiver's Duties; Request For Proper Notice And Hearing By: CNA, Party in Interest and Creditor.

Superior Court Of The State Of California For The County Of Alameda- Endorsed and

Filed **May 14, 1994**. Plaintiff: Paz Capalad vs. Defendants: Alta Bates Medical

Center, Alta Bates Health Systems, and DOES 1 through 20, inclusive

Complaint For Damages and Reinstatement (Breach of Contract, Breach of

Implied Covenant of Good Faith and Fair Dealing, Violation of Public Policy)

United States Bankruptcy Court For The Northern District Of California - In re: Debtor:

Los Mendanos Health Care Corporation, a California non-profit public benefit

corporation. Tax Identification No. 68-0063134. Stipulation For Order

Permitting Interim Proceedings Under Chapter 9 And Approving Continuing

Appointment And Authority Of John Connolly IV As Receiver For Los Medanos

Health Care Corporation. By: CNA

New Section- Untitled

April 24, 1994- Legal Update- Significant Pending Cases. From Jim Eggleston (et al)

To: Economic & General Welfare Congress, CNA. City of Hope v. CNA (Los

Angeles Superior Court); CNA v. Kaiser, Santa Clara (Seniority Arbitration);

CNA v. Kaiser, Santa Theresa (Pesek Arbitration); CNA v. Alta Bates Medical

Center (NLRB- Unfair Labor Practice); CNA v. Los Medanos Healthcare Corp.

(Contra Costa Superior Ct.).

Legal Papers, no date although this action was filed on **June 15, 1993**. City of Hope

seeking recovery of damages related to CNA strike.

July 9, 1994- Free Speech Update. To: Economic & General Welfare Congress, CNA

From: James Eggleston (et al). Implications of New Supreme Court decisions in NLRB v. HCRC and Waters v. Churchill.

July 9, 1994- Supreme Court Decision Waters v. Churchill- To: Economic & General Welfare Congress, CNA From: James Eggleston (et al).

July 8, 1994- Legal Update- Significant Pending Cases & Issues. From: James Eggleston (et al) To: Economic & General Welfare Congress, CNA. City of Hope v. CNA (Los Angeles Superior Court); Ventura County Medical Center (layoff arbitration); Mt. Diablo Medical Center (layoff arbitration); Retaliation for Exercising Free Speech Rights- Alta Bates; Ventura County Medical Center.

Last Section- no title

February 20, 1994, Access to CEGW Mailing Lists. To: CEGW Executive Committee From: James Eggleston (et al). “A serious concern about access to mailing lists has arisen in light of new requests for access from Regions and other structural units and the apparent aid and support some units are directly and indirectly providing to the NCAN/AFSCME raid on CNA.”

February 20, 1994. Policy for removal of Nurse Representatives. To: CEGW Executive Committee From: James Eggleston (et al).

New Binder

Title: Restructuring

Article in RN Times, **January 17, 1994**. By Diane Taylor. Recruitment 1994: Big Changes with Healthcare Reform

Article San Francisco Business Times “*Where Bay Area Business Comes First*”. **Week Of March** 25-31, 1994. By: Chris Rauber. Kaiser sews up Medicare contract worth \$500 million.

Editorial in AJN, **November 1993**. By: Virginia Trotter Betts (President of the ANA). The Best Buy in Healthcare. “ANA intends to confront downsizing in the name of Health reform.”

Article in Modern Healthcare, **March 21, 1994**. By: David Burda. Hospital feels heat from ruling on management-employee committees.

Article in Los Angeles Times (date unreadable). By: David R. Olmos. Hospital Merger Plans Raise the Question: Is Bigger Better

Article in Business Times, **March 6, 1994** By: Joyce Routson. Nurses worried that staff cuts harm patients.

Article in The Wall Street Journal, **January 20, 1994**. By: George Anders. Nurses Decry Cost-Cutting Plan That Uses Aides to Do More Jobs.

Article in Nursing Economics- **July-August 1993**. Vol. 11/No.4 By: Patricia A. Prescott Ph.D. RN, FAAN (Professor at the University of Maryland) Nursing: An Important Component of Hospital Survival Under a Reformed Health Care System.

Article in Modern Healthcare, **November 8, 1993**. By: Bruce Japsen Headline: Study-downsizing causes more deaths and paperwork.

Article in Minneapolis Star Tribune, **November 2, 1993**. Byline: Tony Carideo.

Changes in healthcare are here already, well ahead of Clinton plan

Article in Los Angeles Times, **November 5, 1993**. Byline Deborah Schoch. Little

Company Of Mary Hospital To Cut Staff 12%; Health Care: Torrance Facility Is Not The First To Use Layoffs To Counter Shorter Patient Stays And A Growing Emphasis On Outpatient Treatment.

Article in The Seattle Times, **November 21, 1993**. Byline: Aly Colon. Making House

Calls—As Home Health Care Grows, So Does The Need For Visiting Nurses, Other Qualified Caregivers

Editorial Opinion, Nursing Management, **September 1993**. Leah Curtin, Editor. Unsafe

At Any Price

Article in AJN, **September 1992**. Tom Peters (syndicated columnist) Rx for hospitals:

A whole new system

Article in Modern Healthcare, **October 7, 1991** (no author) Patient-focused approach

demonstrates advantages

Article in Hospitals, **February 5, 1993**. Jack Fries (President, CEO, St. Luke's

Hospital) Title un-readable, deals with restructuring efforts at St. Luke's

Hospital

Lakeland Regional Medical Center paper by Dennis Shortridge (Executive Vice

President/COO (no date). Talks about advantages of "multi-skilled practitioner."

Several un-related short articles (no dates and no authors/publications) Explanation of Roles: At a Patient Focused Care Hospital (Sunnydale Medical Center); Nursing has come full circle; An “idea” whose time has come; The wave of the future? A review of hundreds of pages of “Patient Focused Care” done for CNA by Trande P. Recruitment; Drivers to change; FTE impact

Article in Modern Healthcare, **December 20-27, 1993**. By: David Burda. Cutting Down: Hospitals’ labor costs are top target, annual human resources survey shows.

Article in AJN, **November 1993**. (no author) The Newest Layoff Strategy: Forcing Nurses to Compete to Keep Their Jobs

Article in The Atlanta Journal and Constitution, **December 19, 1993**. Byline: Andy Miller. Health Care Industry: Changing role of hospitals puts squeeze on work force

Article in San Francisco Examiner, **December 21, 1993**. Reuter. Health care No. 1 in Profits

Article in RN, **October 1993**. By: Helen Lippman (managing editor) 1993 Earnings Survey: Double-digit raises disappear.

Article (no publication) **Fall 1993**. By: David Lawrence, MD (Chairman and CEO Kaiser Foundation Health Plan) and Ian H. Leverton, MD (Director Permanente Medical). Learning to Adapt: A Critical Message

Articles, multiple. SPECTRUM (a service mark of Kaiser Permanente), **Fall 1993**. The Race For Georgia. (Deals with Kaiser Permanente move into Georgia. no author); PACE Communicators: Keep the Info Flowing by E. Marie Robertson

(HR Communications team tasked to “inform and energize those staff members not directly involved in a breakthrough or business planning team.); Business Planning Teams Create Ambitious Strategies; Changing Into What? By Francine Redick (Kaiser “change team”); The Mother of Invention: Meeting The Challenge of AIDS by E. Marie Robertson (regional health system response to HIV/AIDS care); Looking Back: The beginning of an Epidemic by E. Marie Robertson; Notes on Health Care Reform, open letters from Kaiser Permanente staff.

Paper entitled “Jackson Hole Initiatives for 21st Century American Health Care System”. (The Jackson Hole group is an informal group of health industry leaders, public officials, health services researchers, business people, and insurers). No date, no author noted.

Article in Revolution- The Journal of Nurse Empowerment, **Fall 1993**. Healthcare Reform: How “The System” Works Against Nurses, by Suzanne Gordon.

ANA Nursing And Health Care Reform Bulletin, **October 1, 1993**.

FutureFax from Lawrence-Leiter and Company (strategic planners/Future studies/executive search, etc.) Trends Affecting Associations and Professional Societies. Marked for delivery to Barbara L. Nicols

Article in Consumer Reports, **August 1992**. Health Care in Crisis: Are HMOs The Answer? (Part 2 of a 3-part series)

Article in The Washington Post Weekly Edition of The Economic Pulse, **July 6-12, 1992** By Albert B. Crenshaw. Managed Health Care Isn’t Always Managing To Work

Publication from CNA, **January 27, 1993**. Comments on Medi-Cal Managed Care Strategic Plan, by Beth Capell Ph.D. (Legislative Advocate)

Articles marked Consumer Reports (hardly legible) **July 1992** (hardly legible). Wasted Health Care Dollars (Part 1 of a 3 part series); Medical Red Flags: Is This Treatment Necessary; The “Crisis” That Isn’t: Malpractice: A Straw Man; The Cardiac Money Machine.

Article in Nursing Management (Vol. 24 No. 9) no date noted. Accepting and Refusing Assignments. By Judith Powers

Article in Nursing Management (Vol.24 No.9) no date noted. The AONE Update: When Work Redesign Prompts Unionization Activity

Article written by Sandra Davis Flood (MSN, Director of Planning at John Dempsey Hospital, University of Connecticut Health Center) and Donna Diers (MSN, Professor at Yale for Social and Policy Studies) Title: Nurse Staffing, Patient Outcome and Cost: Nurse staffing levels are found to make a very significant difference in patient length of stay.

Article in Nursing Management, **June, 198**_ (14(6), 36-38, 42, 46-48) by Eric H. Helt (Ph.D. and President of Helt Associates) and Richard C. Jelinek (Ph.D. and Chairman) Title: In The Wake of Cost Cutting, Nursing Productivity and Quality Improve. Margin comment: Careful of interpretation

Article in Hospitals, **February 5, 1989** Quality Watch: Quality - thy name is nursing care, CEO’s say, by Mary T. Koska

Article in Health Affairs, **Spring 1992**. State Report: Measuring Quality in California
by Lucy Johns (consultant at Health Care Planning and Policy in San Francisco,
CA)

Article in Nursing Economics, **July-August 1993** (Vol.11, No.4) Nursing: An
Important Component of Hospital Survival Under a Reformed Health Care
System by Patricia A. Prescott (Ph.D. FAAN Nursing Professor University of
Maryland)

Article in AJN, **April 1993**. Annual Nursing Salary Survey: Where Did All The Jobs
Go? By Patricia Brider (News Editor)

Memorandum from the Desk of Rose Ann DeMoro, **August 19, 1993**. To: CNA Staff &
Program Directors, Barbara Nichols, Executive Director, E&GW Congress,
CAN Board Members, E&GW Leadership. AONE statements: Support for
workplace Restructuring; Financial support (PAC) of the AHA; Their opposition
to the bill before the Senate which would prohibit permanent replacements of
strikers.

Article in Nursing Management (Vol. 24, No.2) no date noted. Strategic Planning: A
Practical Approach by Alice M. Thomas (RN MBA; Consultant, Management
Consultant Services, Calgary, Canada)

Cover article in Hospitals (The Magazine for Health Care Executives) **April 20, 1993**.
Will health care reform REWRITE nursing's role? AHA marked on front cover.
Health care reform: Nursing's vision of change; Nursing's Agenda by Carol
Boston; Nursing and the AHA by Barbara Donaho; The Outsider's View: The
ACPE and ACHE; The primary care-giver debate by Virginia Trotter Betts;

Agents of Change; Nursing education: addressing post-reform needs by Janet Rogers

Paper based on an extensive research project undertaken by the Hospital Council between **December 1992 and March 1993** with APM, Inc. and Kamer/Singer & Associates, Inc. Soaring Costs- Shrinking Resources: The Impact of Health Care Trends on Bay Area Hospitals

Letter addressed to Ms. Valerie Gonzalez, District of Columbia Nurses Association, Inc. from Jill Kastris, Senior Policy Analyst, ANA. "ANA is aware of the situation at Children's Hospital wherein nurses and other hospital employees will be laid off while executives will receive bonuses."

Story in The Washington Post, **December 23, 1992** Hospitals Giving Bonuses Despite Job Cuts. Byline: Amy Goldstein

Cover Story, Hospitals, **September 5, 1992**. Annual survey; executive compensation under fire. By: Joan Lambert Ph.D. (regional director of health care consulting for New England) and David Bjork Ph.D. (Hays Management Consultants)

New Binder

Title: Hospital Industry Restructuring: Legal Strategies to Preserve Jobs and Protect Practice

From: James E. Eggleston of Eggleston, Siegel & LeWitter

To: CNA, E & GW Congress

Dated: February 19, 1994

Multiple Sections:

- 1) Typical features of Industry Restructuring
 - a) Corporate Reorganization
 - b) Clinical Restructuring
 - c) RN Job/Practice Restructuring
 - d) Impact of Restructuring on Collective Bargaining
- 2) Identifying Potential Strategies
 - a) Recognizing Early Warning Signs
 - b) Prompt Response to Early Warning Signs
- 3) Contract Grievance/Arbitration Strategies
 - a) Identify Contract Provisions
 - b) Develop Tactical Grievance/Arbitration Plan
 - c) Status Quo Injunctions
- 4) Bargaining Rights & Demands
 - a) Decision Bargaining
 - b) Effects Bargaining
 - c) Information Rights
- 5) Unfair Labor Practice Charges
 - a) Jurisdiction
 - b) Procedural Considerations
 - c) Remedies

Attachments: Union Information Rights; The Changing Duty to Bargain; CAN Bargaining Demand & Information Request to Kaiser (Gateways Restructuring Project); CNA Information Request to San Mateo County (Transfer of RN work to

unlicensed personnel); CNA Bargaining Demand & Information Request to Alta Bates (Creation of RN “Case Managers”, elimination of Charger Nurse position, and transfer of RN work to unlicensed personnel); CNA Unfair Labor Practice Charge Against Alta Bates (refusal to provide notice, information, and bargain); CNA Subpoena to Kaiser (seniority arbitration/staffing changes); CNA Subpoena to Alta Bates (single Employer/alter ego); CNA Offer to Proof re Alta Bates (single employer/alter ego)

New Binder- No Title

California Nurses Association Staffing Survey **November 1993**. Summary Results.

Question 1: How has the staffing changed in your area recently? Worse 80%,
Better 6%, No Change 14%

Question 2: Does your staffing allow time for unexpected events? No 86%, Yes
14%

Question 3: How does the overall patient acuity changed? Increased 85%,
Decreased, 0%, Same 15%

Question 4: What effect have changes in skill mix and/or layoffs of other
personnel had on patient care in your area? Negative effect 83%, Positive
3%, Doesn't Apply 14%

Question 5: Have you seen inappropriate transfers of patients to less acute areas?
Yes 63%, No 22%, Doesn't Apply 15%

Second section includes representative quoted responses for each question. Binder includes numerous letters from patients and nurses to Congressmen and hospital administrators with complaints about care and processing.

New Binder

Title: California Nurses Association, Current Legal Liabilities and Potential Litigation, dated September 26, 1993, Confidential Attorney client communication to CNA Board of Directors.

Sections:

- 1) Partial accounting of costs of anti-CEGW and Board Election Campaigns
- 2) Excerpts of notes of conferences regarding anti-CEGW and Board election Campaigns
- 3) Excerpts from anti-CEGW/Board election campaign plan solicited by Barbara Nichols from campaign consultants
- 4) Selected campaign expense invoices and consultant contracts/materials
- 5) Selected material produced by the PBN Company
- 6) Internal campaign plan and related correspondence
- 7) Selected materials regarding ANA involvement
- 8) Campaign plan for September House of Delegates meeting
- 9) Selected documents regarding Carswell contracts
- 10) Resignation letter from Barbara Nicols, RN, MS, FAAN to the CNA Board of Directors dated September 5, 1993.

New Binder

Title: Blue vs Red Book

Section 1: Chronology of Events regarding CNA's Internal Dispute

December 20, 1992- CNA Executive Director terminates the E&GW Program

Director, 4 Assistant Directors, and 7 probationary employees, believing that these individuals were acting against the multipurpose goals of CNA in attempting to separate and isolate the E&GW Program from the totality of CNA.

December 23, 1992- E&GW Congress Chair, terminated E&GW Program Director,

and President of SEIU Local @%) visit head of labor relations at Kaiser demanding that Kaiser not remit CNA dues payment for December. Letter from E&GW Congress Executive Committee to Executive Director announcing that it would hire its own staff, its own attorney, demanding that all dues money of members represented by CNA for collective bargaining purposes be turned over to the Congress for its sole use. It also demanded that all resources and facilities of the E&GW Program be used exclusively for collective bargaining.

December 24, 1992- E&GW Congress Chair sends letter to all employers holding CAN

collective bargaining contracts demanding that CNA dues not be remitted to CNA, but remitted to the E&GW Congress or alternatively, help in an escrow account. Executive Director requests line of credit from ANA to assist with maintenance of revenue not knowing employer response to E&GW demand letter regarding dues.

December 29, 1992- A flyer appears at several facilities, issued by SEIU Local 250

President Sal Rosselli and Secretary-Treasurer Shirley Ware. The flyer charges that the termination of the fired CNA employees poses a serious threat to Local 250 members, and supports the efforts of the CNA E&GW Congress to “take back” CNA.

January 5, 1993- CNA issues a letter to all the facilities in which it represents nurses, emphasizing the hospitals' contractual and legal duty to continue to recognize CNA as the collective bargaining agent and to continue forwarding dues money to it.

January 5, 1993- The Congress files a lawsuit in federal District Court in San Francisco, seeking injunctive relief on a number of counts. E&GW Congress sues CNA; files a class action suit on their own behalf. The suit Claims that the E&GW Congress is threatened with a loss of fundamental democratic and representative rights guaranteed by CNA Bylaws and the Landrum-Griffin Act. The Congress argues that CNA has implemented an illicit scheme and attempt to seize Control of the collective bargaining program. They seek to vindicate federal statutory Rights and union constitutional rights under CNA Bylaws. The suit states the following purposes of CNA are not germane to collective bargaining (page 9, lines 4-14):

- 1) Provide for representation of California nursing interests in ANA
- 2) Initiate or oppose legislation or government regulations which affect the health of the people of California.
- 3) To provide financial support to political candidates based on CNA Board of Directors approved policies.

January 6, 1993- CNA President, Mary Foley, RN responds to the "open letter" from Local 250 with a statement urging them to maintain the close working relationship that has existed between the two organizations but admonishing them to "stay out of CNA's affairs."

January 7, 1993 (approximately)- The first of several hospitals informs CNA that it is withholding dues money from CNA and will instead deposit it into an escrow account, citing the communications it has received from the Congress. In addition to these hospitals, others subsequently inform CNA that they will not participate in contract negotiations, offering the same reason.

January 27, 1993- Five E&GW members file a complaint against the Executive Committee of the E&GW congress alleging that the Executive Committee of the Congress has violated CNA Bylaws. In accordance with the Bylaws, the CNA President suspends the Executive Committee of the Congress pending an investigation and hearing regarding the charges.

January 29, 1993- E&GW goes to court seeking a temporary restraining order. E&GW Congress, terminated staff, members of SEIU Local 250 and President of the San Francisco Administrative Office.

February 8, 1993- Hearing regarding temporary restraining order.

February 10, 1993- Magistrate orders the following:

- 1) Rescind the suspension of the E&GW Executive Committee to the extent that such Ruling affects any office or position relating to collective bargaining.
- 2) Neither the CNA Board or Executive Director shall develop policy for or participate in the conduct of the collective bargaining program.
- 3) The E&GW Congress shall cease writing employers demanding that dues money be sent to the Congress or alternatively held in escrow.
- 4) CNA and the Congress shall jointly write employers, in accordance with the orders of the Court identifying CNA as the exclusive collective bargaining

representative of staff nurses and to comply with all terms and conditions of collective bargaining agreements.

- 5) The E&GW Congress shall not represent to employers of staff nurses represented by CNA that the Program Director of the E&GW Program or staff are not authorized to represent such staff nurses in collective bargaining.
- 6) The E&GW Congress shall not attempt to cause said employers to refuse to deal with or recognize the E&GW Program of the CNA as the collective bargaining representative of staff nurses.
- 7) The Court authorized the Federal Mediation and Conciliation Services to appoint an experienced and qualified mediator acceptable to both parties to conduct mediation.
- 8) Both parties shall prepare and mail to the CNA membership a presentation of Opposing views of the parties concerning the dispute between them.
- 9) Any future meetings or distribution of literature to CNA members must provide equal right of access to the E&GW.
- 10) The next immediate issue of the *California Nurse* shall provide editorial space to the E&GW Congress to provide its views.
- 11) CNA shall not interfere with reasonable access of the E&GW Congress to the Offices and facilities of the CNA E&GW Program.
- 12) The E&GW Program Director shall provide to the E&GW Congress all informational reports requested.

13) If CNA hires and person(s) to fill existing vacancies created by the terminations of staff on December 20, 1992, such vacancies shall be filled on a temporary basis only.

14) A hearing on the motions for preliminary injunction is scheduled for February 24, 1993.

February 13, 1993- Investigative hearing held by CNA Executive Committee on charges filed by E&GW Executive Committee.

February 24, 1993- Hearing conducted on the preliminary injunction motions.

March 10, 1993- Magistrate ruled; orders mandated in the temporary restraining order Sustained and further ordered all terminated staff be reinstated.

Ruling appealed to Magistrate at 9th Circuit Court of Appeals to deny reinstatement of terminated staff.

March 11, 1993- Seven of the twelve terminated staff returned. Chair of the Congress and E&GW Program Director fire the Besson et al. law firm and hire Eggleston, et al law firm to represent the E&GW Program. Appeal not to reinstate terminated staff denied by Magistrates.

March 11, 1993- Three reinstated individuals return.

March 24, 1993- Motion by CNA to clarify who shall be the attorney to represent the E&GW Congress.

March 29, 1993- Charges filed by E&GW Congress stating CNA in contempt of the Court order preliminary injunction.

March 31, 1993- The Circuit Court of Appeals denies appeal not to reinstate terminated employees; states the issue should be dealt with during the trial.

April 16, 1993- Met with Magistrates in chambers. Magistrate identified that the Eggleston firm could not represent the E&GW Program and be the attorney of record Suing CNA. CNA was directed to seek new legal counsel.

April 25, 1993- Special House of Delegates held to clarify intent of Bylaws. The House Reaffirms CNA's multipurpose nature.

May 10, 1993- New attorney for E&GW selected.

June 4, 1993- CNA files for partial request for summary judgment.

Letter from Barbara L. Nichols, RN, MS, FAAN Executive Director/CEO of CNA dated **December 20, 1992** To: Dear CNA Member: "We are writing to inform you, after serious consideration, we have decided to replace the CNA Economic and General Welfare Program Director and other staff." Rationales given for firings, replacement team assembled, postponement of Staff Nurse Assembly scheduled for January 1993.

Letter from Barbara L. Nichols, RN, MS, FAAN Executive Director/CEO of CNA dated **December 23, 1992** To: Dear CNA Member; "Categorically, and without hesitation, I can assure you that CNA is and will continue to be an effective labor and workplace advocate for you." New collective bargaining staff to be in place by January. Announces selection of Peggy Graham (managed NY State Nurses Association collective bargaining for last 13 years) as Executive Director.

Letter from Economic and General Welfare Congress dated **December 23, 1992** To: Barbara Nichols; Demands immediate compliance with Article 8. Notifies of intent to retain independent legal counsel. Orders the return of office equipment

and facilities of E&GW. Signed by: Kit Costello, Chair; Kay McVay, Vice Chair; Martha Kuhl; and Marilynne Kenefick.

Notice of Public Meeting scheduled for **January 11, 1993**. NURSE ALERT: Attention all Staff Nurses; Topics: 1) Firing of E&GW staff; 2) 1993 Bargaining: Hospital Management's Agenda/CNA's "New Agenda." 3) What happened to our dues increase? and 4) Staff Nurse control over 90% of the dues of CNA, which we pay.

NOTICE: Since the Staff Nurse Assembly was cancelled by CNA, we will not be able to provide CE credits for these meetings.

Letter to Dear Colleague from CNA E&GW Congress dated **January 4, 1993**:

Notification of urgent crisis in CNA. Notice of firings. Notification of legal representation. Nature of problem with CNA involving Nurse Managers and administrators having disproportionate control over CNA.

Letter from Rosemary Bergin RN (government relations commissioner) to The Board of Directors, North Bay Coastal Region 9, CNA dated **October 11, 1993**:

Protesting actions taken by new board: "We strongly protest the way in which business was abruptly conducted by the new board as soon as the delegates were dismissed. Without warning or consultation (even to their fellow members), the 8 majority members voted to 1) Fire our interim Director 2) Hire Rose Ann DeMoro 3) Fire our legal and accounting firms 4) Hire the lawyer who sued us and used our limited funds to pay him back fees (for suing us!) 5) Neglected to hire an Interim Director of the Congress, thereby leaving Ms. DeMoro in dual positions.

Letter from Joan Lautenberger dated **September 28, 1993** to Trendy Phillips, Director to CNA RE: DeMoro installation as Executive Director of CNA; “I think this was very irresponsible of you especially after putting a well qualified, and still another person of color, out of the position and into limbo on administrative leave.” “ Your fiduciary irresponsibility in paying lawyer Eggleston for his charges in handling the suit against CNA is unbelievable and revolting.” “What kind of a leader are you for CNA?”

Letter from Theresa Stephany MS, RN, CS (CNA Director, Region 11) To: Debbie Bayer Dated **October 9, 1993** RE: Alta Bates Medical Center; Response to phone call on

October 7, 1993. “I remain a member of the Board because I am committed to Nursing, to turning this Association around at the next election in 1995!” Addresses implications of deceit efforts. Angry “that you questioned me about my lover who is an Alta Bates nurse and implications about breach of trust with information. Angry Debbie questioned her integrity.

Letter dated **October 9, 1993** To: Kurt Lauman, Martha Kuhl, Marilynne Kenefick, Mila O’Brien, Donna Sandoval, Kit Costello, Greg Miller and Trande Phillips (majority Staff nurse slate recently elected to Board of Directors) From: Gail Melander, Elissa Brown, Patricia Bufalino, Marla Pruznick, Theresa Stephany, and Sister M. Eilene Egan (minority members of newly elected Board of Directors). RE: Letter to Membership (Dear Colleague) dated 9/30/93. They are protesting the letter wherein the newly elected Board notified the membership

that they had, 1) appointed Rose Ann DeMoro after a closed meeting at the offices in Oakland; 2) That the October Meeting itself had been held in violation of the CNA Bylaws, which they claim is supported by the Chair of the CNA Bylaws Committee; 3) That there had been no “Board” agreement on Ms. DeMoro’s decision to “eliminate the unnecessary and costly position of Deputy Director.” 4) Vehement disagreement that Ms. DeMoro’s attendance at the Oakland meeting was in accordance with the Bylaws of CNA and that the inference in the letter that “Previously some staff often worked independently from the elected leadership.” 5) Used a biased interpretation of the events surrounding internal conflict within the association when they described the “unwanted fiscal legacy” to the members. And 6) that their descriptions of the “New Challenges” facing the association are also misleading. They insist that the new majority Board cease imposing their own agenda on the CNA membership. This letter was cc’d to: CNA Congresspersons, Commissioners, Regional Presidents, Executive Director, and the ANA Board of Directors.

Letter dated **October 6, 1993** To: Linda Sawyer, President, California Nurses

Association, From: Kay McVay (Chair JABC) and the bargaining team which Includes- Deborah Burger (Kaiser Santa Rosa and current President in CNA), Linda Evangelista (Kaiser South San Francisco), Nancy Casazza (Kaiser Oakland), Connie West (Kaiser Hayward), Greg Miller (Kaiser Santa Clara and Board member), Claudia A. Farris (Kaiser Santa Clara), Margaret A. Trefren (Kaiser Santa Clara), Donna J. Abenroth (Kaiser Milpitas), Vicki Friedman (Kaiser Sacramento), Eileen M. Parker (Kaiser Santa Teresa), Pam Herron

(Kaiser Martinez), Pat Barron (Kaiser Walnut Creek), Rosemary Wood (Kaiser Pleasanton), Lesley Johnson (Kaiser Fresno), and Debra M. Giusto (Kaiser South San Francisco). They write representing the 8,000 Kaiser nurses in negotiations which began October 1, 1993 and they state “we are not Responsible and cannot accept the continues disruptive behavior by you and the Board of Director’s minority.” They accuse that decerts are in progress at several CAN contract hospitals, being led by six ex-CNA employees, four of which are their supporters who they allege: intentionally left unsigned contracts, removed bargaining notes and tentative agreements from CNA files, and initiated raids by another Union. They demand that the minority Board members: 1) condemn the raids 2) work to achieve unity 3) provide leadership to fight the decert 4) allow CNA to do its job, and 5) support Kaiser RNs, Letter is cc’d to: BOD, E&GW Congress, Rose Ann DeMoro (Executive Director), and All Structural Units.

Letter dated **October 6, 1993** from Linda Sawyer (CNA President) to: Costello, Sandoval, Miller, Phillips, O’Brien, Lauman, Kenefick, Kuhl. This letter is protesting what Linda Sawyer perceives to be abusive treatment of her by the “new” Board. “. . . you asked me to participate in the meeting, then you threw me out.” “Is this clear? You asked me to call a board meeting, I did so, and you didn’t show up. Instead you decided to have your own meeting somewhere else.” “In light of my activities on behalf of CNA during the last month, and the manner in which I have been treated by the executive committee and the Board majority, it

is impossible to take your letter seriously.” Cc’d to CNA Board of Directors and E&GW Congress

Letter dated **October 5, 1993** from Trande A. Phillips (CNA Board of Directors) to Sally Burke-Wingard (President, Region 9). Trande is responding to a letter from Sally dated September 30, 1993, a letter Trande notes, “seems to have been written during a period of extraordinary frustration for you. Many of your comments are too unusual to respond to.”

Letter dated **October 4, 1993** from CNA Administrative offices to: Linda Sawyer (President CNA). The letter discusses the UNAN/AFSCMA raid as “deadly serious” and questions why Linda “will not return phone calls or correspondence from staff and elected officials” and why she “and the regions are distributing anti-CNA literature which UNAC/AFSCME is using against CNA in its raid.” It accuses Linda of misrepresenting the facts about the last Board meeting.

Letter dated **October 2, 1993** from Linda Sawyer (President CNA) to Rose Ann DeMoro (Executive Director) notifying her of the intent to meet with ANA President Virginia Trotter Betts and Linda Shinn (Interim Executive Director), the CNA Board and the Executive Director regarding the current situation in CNA.

Letter dated **October 1, 1993** from Gail Melander, Elissa Brown, Patricia Bufalino, Maria Pruznick, Theresa Stephany, and Sister M. Eilene Egan (minority Board members) to: Kurt Lauman, Martha Kuhl, Marilynne Kenefick, Mila O’Brien, Donna Sandoval, Kit Costello, Greg Miller, and Trande Phillips (majority Board members). Letter expresses “concern about the tone of your letter to the CNA

President, finding it Condescending, demeaning, and possibly threatening.”

They end by stating “Your refusal to attend the special Board Meeting, your letter berating our duly elected President, and your obvious bias towards one structural unit of the Association, leads us to question your sincerity” (in wanting to work together). Cc’d to Congresspersons, Commissioners, and Regional Presidents.

Letter dated **September 30, 1993** from Sally Burke-Wingard (President Region 9) to Trandy Phillips (CNA Region 9 Board Representative). Letter expresses concern about her behavior at the House, the decision to appoint Rose Ann DeMoro, to hire Jim Eggleston, to dismiss the interim Executive Director. “The events that have taken place since the House of Delegates are equally as outrageous.” “I can see by the FAX your husband sent me or perhaps it was you, you’re not even dealing with reality. Is this a joke or what? I can hardly wait to see what comes out next.” “When you’re ready to start representing your region please call me.” Cc to Linda Sawyer, President

“Dear Colleague letter” dated **September 30, 1993** from CNA. Letter expresses “new direction” for CNA, mandate from members to enact this change, and recent actions taken by the new Board to actualize this effort.

Letter dated **September 29, 1993** from minority Board members Gail Melander (Region 1), Elissa Brown Region 3), Patti Buffalino (Region 4), Marla Pruznick (Region 6), Theresa Stephany (Region 11), and Sister M. Eilene Egan (Region 12). To: Rose Ann DeMoro CNA. Letter regarding DeMoro memo to Board about the need to address pending resolutions from the House. Letter states there

are NO resolutions pending to this Board. It questions why DeMoro did not attend the meeting held on September 26, 1993 at the Oakland Hilton. "We trust we shall see you, and the other CNA staff, at the next Board of Director's meeting. Cc'd to CEGW, Regional Presidents, Commissioners.

Letter dated **September 27, 1993** from Rose Ann DeMoro (Executive Director) to Linda Sawyer (President) RE: Your letter of September 26. The letter notes the ongoing raid and encloses a flyer with the comment: "I would like to know if you produced this flyer?"

Flyer distributed at raid on CNA facility:

The SEIU TAKEOVER OF CNA IS NOW COMPLETE
A NON-NURSE IS EXECUTIVE DIRECTOR
IF THIS TRADE UNION RAID OF PROFESSIONAL NURSES UPSETS YOU,
WRITE TO:
Linda Sawyer, RN
President
California Nurses Association
c/o Alameda County Nurses Association
1900 Powell Street, Suite 220
Emeryville, CA 94608-1812
FAX: (510) 428-0655

Letter dated **September 28, 1993** from Deborah Bayer to Linda Sawyer (President CNA). Letter states: "Letters have been posted at Children's Hospital Oakland,

signed by you and on CNA letterhead, complaining about the current CNA Board. I assume you have distributed similar letters around the state. This is not very smart.” “It is your responsibility to develop a working relationship with the current Board majority.”

Letter dated **September 26, 1993** from Linda Sawyer (President CNA) to Rose Ann DeMoro expressing concern she did not attend the Special Meeting of the Board of Directors held at the Oakland Airport Hilton on September 26, 1993.

Referring to “rumors that there are attempts at a number of CNA contract hospitals to decertify CNA bargaining units.” and “If these rumors are true we want to be assured that you are taking immediate and urgent steps to protect CNA, and that you are in contact with the Congress and working closely with the Congress and the staff.”

Letter dated **September 24, 1993** to “Dear Members of the CNA” From: New CAN President Linda Sawyer. She laments “being forced to inform you that I am not being allowed to fulfill my duties as your President.” 1) The majority Board is “denying the historic authority of the President to assign Board members to Committees.” 2) The “agenda” signed by the “majority of eight” which she was not informed of and her exclusion from a special meeting of the Board. In that meeting, the Board voted against the advice to - drop the lawsuit, in which CNA was the defendant; dismiss the interim Executive Director, without seeing her contract; hire Rose Ann DeMoro as CNA Executive Director without a search; hire Jim Eggleston as the new attorney for CNA after firing the existing attorneys and accountants; voting to provide a mechanism, essentially using

member dues to pay, to pay Jim Eggleston. 3) The executive committee (Kurt Lauman, Martha Kuhl, Marilynne Kennefick, and Kit Costello) scheduled 2 Executive Committee meetings without contacting her, in violation of the CNA Bylaws. 4) The Executive Committee did not allow her to “participate in the full meeting of the Executive Committee held in Jim Eggleston’s office on September 18, with the members claiming a “conflict of interest” which was unsubstantiated.

Letter dated **September 21, 1993** to Rose Ann DeMoro (Executive Director) from Mills -Peninsula Negotiating Team (Kate Bond, Pat Hunter, Penny Grier, Genel Mergan, J.M. Innes and illegible) Letter expresses grave concern over recent changes at CNA, in particular, “keeping CNA a *nursing organization* with your mistreatment of the labor reps and RN staff, and “your hiring of Local 250 linked accountants, attorneys, and labor reps.” “Frankly, your actions smack of a Local 250 takeover!” “Need we remind you that the elections were far from a landslide (8 to 7 majority), and hardly a mandate for disruption of our *nurse founded and run organization*. We are appalled by the blatant labor union Hoffa-style tactics we have seen of late, and want no part of it.” “We, as your employer, will be watching you, the Board, and EGW Congress very closely.” Cc’d to: CNA Board and EGW Congress members, EGW Director: Willard Hatch, ANA President, and Region 12 Hospital LUCS.

Letter dated **September 13, 1993** from Genel Morgan and Kate Bond (Mills-Peninsula Negotiating Team members) to Rose Ann DeMoro (CNA Executive Director). RE: a pamphlet published by CNA entitled: “Big Business Means Bad Care for

Bay Area Communities”. “We were under the impression it was an informational pamphlet, but did not expect the inflammatory nature of it. Our quotes were correct, but neither of us were asked for nor gave permission for use of our pictures.” They feel they have a good working relationship with their Administration and this pamphlet has jeopardized this relationship. “In the future no interviews by nurses at Mills-Peninsula Hospitals will be given without research as to the use of information obtained and approval of a designated representative of the LUC.”

An “OPEN LETTER to California’s RNs” dated **September 10, 1993** and published in NURSEweek. Nurses are encouraged to “write about their outrage” to “Professional Nursing Network” with the instructions that “We will forward all letters to the appropriate parties.” The letter expresses outrage that “an individual who is not a nurse has been handed control of our nurses association! “The new BOD with it’s new single majority and single focus has initiated the final destruction of the CNA.” Voting to permanently hire Rose Ann DeMoro (and replacing the interim director, an African-American woman named Argene Carswell RN JD whom the 1991-1993 BOD Had hired to “begin the healing process;” voting “to pay off the legal fees of the attorney that she and her cohorts used to sue their own professional association; voting “to ransack offices and computers and personal files of loyal members on staff who are nurses;” voting to “change the locks on all CNA offices” effectively excluding “the nurse membership of the CNA from participation.” “The new Board has no mandate

to change the direction and focus of the CNA.” “WHAT HAS HAPPENED TO DEMOCRACY?”

Letter dated **September 9, 1993** to Linda Sawyer RN, President CNA from Mary E.

Foley RN (staff nurse St. Francis Memorial Hospital but also immediate past-president of CNA)- “I am shocked and appalled at the actions taken by the 1993-1995 CNA Board of Directors at the post convention Executive Session on 9/7/93. Within hours of a meeting of the House of Delegates, and without a member mandate, the BOD decided to remove Argene Carswell, RN as Interim Executive Director, appoint Rose Ann DeMoro Executive Director without a search, remove the Beeson firm and establish a relationship with James Eggleston as well as approve payment of legal fees to an attorney for the costs of suing CNA and individual representatives of CNA.” She expresses concern about the adverse effects these decisions will have on fiscal stability, and the direct harm to the CNA nurses who have CNA representing them. She demands, as a “dues paying member of CNA and a member of the Congress on Economic and General Welfare” that Linda call for an “immediate accounting of the fiscal implications of the decisions” and to have this “made available to all members.” “Moreover, the eight members of the board elected on the Prescription for Change Slate did not state an intention to alter the mission, goals, member rights, or basic nature of CNA.”

An unsigned letter dated **September 24, 1993** addressed to “Dear PCC Delegates”

which: Talks about the frustrating 1993 HOD, the “divided House”, the intent to work for a “bipartisan consensus”, how the time at the HOD was wasted on

“bitter procedural fights” including the secret ballot, the incompetence or dereliction of duty by Mary Foley, as Chair, to block these issues and her failure to warn the House “that Resolutions would not be forwarded to the Board unless we made a motion to do so. Telling us after the fact that it was now too late was very poor chairing, and reveals an obstructive intent.”

New Section entitled “Investigative”

Addendum to employment agreement between CNA and Argene Carswell on

September 5, 1993 signed by Argene Carswell RN JD and Mary Foley, CNA President.

CNA Board Resolution Approving Employment of Argene Carswell as Interim

Executive Director of CNA. No date is provided.

New Section (no title)

Invoice to Barbara Nichols (CNA Executive Director) dated **February 17, 1993** from

Derish Associates, Inc. billing \$933.75 for Surveillance of A.T.U. Local 192. cc to Duane B. Beeson, Esq.

1) Full list of Sal Roselli’s enemies - in the gay community, Agnos supporters, labor community, SEIU etc. Should be a very long list! Also, how can we approach them.

2) Full list of Local 250 staff and positions; names and pics; how many women in professional positions??

- 3) Demographics on (Local) 250 members- they are mostly women of color
(while staff is white men)
- 4) Need photos and other proof of CNA former staff working out of Local 250
- 5) Photo of Sal
- 6) List of his Executive Board; how many men and how many women who on
his E Board hates him
- 7) How much he's spending on this; phone bills (who is being called out of
Local 250 office, that is, CNA members); what his budget is; what slush funds
he has; did his members vote on this expenditure?
- 8) Exactly what job classifications Local 250 represents; samples of pathetic
contracts and low wages; quotes from members who got screwed
- 9) Quotes from members who hate Sal (John Mehring? Blanche Babb or Bebb?)
- 10) Police records, charges lodged against men on Local 250- check all Bay
Area counties. We need info on this!
- 11) BACKGROUND on fired staff
- 12) Political organizations they belong(ed) to
- 13) Organizations they infiltrated and destroyed
- 14) People who hate them; how we can get to them; quotes from them
- 15) Background on Eggleston

New section (no title)

CNA Financial Summary for Fiscal Year Ending June 30, 1993 (no date, no author)

Document shows the CNA administration spent an extra \$551,974 over budget.

“It can be assumed that the bulk of these extraordinary variances ranging from 26% to 454% over budget, are the result of the unanticipated costs of the internal dispute.” Itemized expenses included: 43% increase in salaries and wages; 1004% increase in legal fees; 297% increase in Consultation; 216% increase in CNA elections; 56% increase in printing; 185% increase in President travel; 43% increase in BOD travel; 152% increase in Regional Pres. travel; and a 195% increase in Admin. Telephone. Side notes: “At the time of the December firings, the E&GW Program was actually under budget.” “These expenses, I included moving Peggy Graham here from New York, severance pay (for example Maleva Saulo received three months severance for her three weeks work as replacement UC assistant director)” Total = \$725,000 and is composed of \$552,000 in Administrative cost overruns, \$23,000 in E&GW legal fees, and \$150,000 from ANA loan.

Report dated **September 18, 1993** from Jim Eggleston (et al) to CNA Board Executive Committee RE: ANA & Prior Board/Officer Liability for Current Financial Crisis. Includes hand written estimates of costs for internal dispute.

Report on Suggested Agenda Items Conference Call dated **January 26, 11:15 am**. Participants include: CNA Program Directors, Marilyn Chou, Catherine Dodd (phone at Sacramento residence), Peggy Graham, Mary Foley, Sue Thurman, and Mary Kaems (916/441-XXXX) Section A: Message Coordination; Section B: Review of Activities; Section C: Update on Congress’ Activities

Handwritten notes from Conference calls dated **1/31/93, 2/9/93, 2/15/93, and Friday, 2/5**. Notes talk about utility of ANA staff; ongoing investigation; deciding what

CNA's message will be in 2/4 document; identification of people for ANA training; hearing on preliminary injunction; what's really happening?; ANA organizers (2) to hot spots (Kathy Scott) by middle of next week(?); Media training; membership outreach; Talking points for charges and law suit; ID for people who are OUR supporters; "Friends of CNA"; SP Action Packet.

CNA BOD Executive Session minutes dated **March 20, 1993** submitted by O. Dietz, CNA Secretary. Attendance: Full Board Present Staff: Barbara Nichols.

Discussion:

1. Costello/Nichols Litigation: guests present- D.Beeson & K.Absclom, CNA legal Council; D. Kipnews, CNA Regulatory; Argeene Carswell, ANA Labor Relations.
2. Presentation by: D. Beeson & K. Absolom; CNA Legal Counsel
3. Ratified motion of xxx 3/10/93: Conference call: Suspension of M. Kenefick from CNA BOD, Secret Ballot: 14 votes case: 12- yes 1- no 1- abstain

Handwritten notes on single page, no date, no author. Generalized headings, not very legible. Sections include: Role of ANA Parliament: Legal, SNA, Lobbying for RT to vote, Dev. of our floor strategy, Save CNA.

Dual unionism- Claudia's Husband linked to SEIU; ACCESS CODE; Computer @ home

Parliamentarian- How badly they can amend, in terms of germaneness to Article and Section. Dueling Bylaws; Substitute for the substitute; Use Argene.

14 page document that deals with talking points for: CNA: HERE TO STAY

CAMPAIGN launched by CNA "regulars". Sections include: Purpose, Priority,

CE&GW Messages, CNA's Messages, 2nd section deals with strategy, and includes Communicating CNA Messages and Grassroots Communications: Volunteers; Staff Response Team; Internal Volunteer communication plan; External Communication Plan; 6 Examples of Content of CNA Messages; Staff response team goals, etc.

Letter dated **January 8, 1993** from "Marilyn" to Cynthia (on CNA letterhead). Thanks for helping us out, I'll send "a more formal notice of your hourly employment after Barbara reviews terms." Notice to fax background documents. Advises her to "keep track of your calls, and maintain a data base of callers." She is to "regularly take off the messages to CNA's "hotline." Procedure for taking off calls is given. "When you call people, say that Barbara has asked that you call on her behalf. Also mention that you would be conveying their questions and concerns. Keep a log of concerns, and when you respond with a letter, you should write something to the effect that "Cynthia has conveyed your concerns to me, etc." This is to make it personal. The letter is to be from Barbara.

Memo on CNA letterhead dated **March 10, 1993** to Peg Graham (Director, E&GW) from Barbara Nichols (CNA Executive Director/CEO) RE: Action plan— Follow-up. "The purpose of this correspondence is to follow-up on your areas of responsibility as discussed in our March 3, 1993 administrative staff meeting." They had agreed to "restructure our programmatic activities to emphasize the interrelated nature of collective bargaining, nursing practice, and government relations." They had also agreed to "develop leadership development activities at staff nurses in contract facilities which emphasize the

interrelatedness of collective bargaining, nursing practice, and government relations. It was “mentioned that Mileva Saulo was requesting train-the-trainer type information to assist in their nurse rep training.” She was to work with “Maureen Anderson to develop campaign materials.” This memo was marked Confidential.

Memo on CNA letterhead dated **March 10, 1993** to Pat Orr (Labor Organizer) from Barbara Nichols (CNA Executive Director/CEO) RE: Action plan—Follow-up. Areas of responsibility are reviewed: 1) Restructuring programmatic activities to emphasize the interrelated nature of collective bargaining, nursing practice, and government relations (including the incorporation of two to three organizers); 2)Assisting with the development of campaign materials; 3) Identifying leadership development activities which are targeted at staff nurses in contract facilities; and 4) Assisting with the design and implementation of membership phonebanking activities. Memo asks for a progress report by Friday, March 12, 1993.

Memo on CNA letterhead dated **March 10, 1993** to Marilyn Chow (Director, Nursing Practice) from Barbara Nichols (CNA Executive Director/CEO) RE: Action plan—Follow-up. Areas of responsibility are outlined: “Pat Orr indicated that she needed information from you which would outline which duties and areas of responsibility Chris Kinavey and Pat Ljusic were available to perform.” Also, how practice issues could be incorporated throughout the entire Action Plan process.” Asks to” provide progress report from East Bay/West Bay staff nurse meeting on March 16.” Status report on “compiling a document which presents

CNA's history." "Finally, you agreed to assume responsibility for the CNA Here To Stay Hotline. To date, I have not received a report from Cynthia Gunderson. Would you please provide an update in your summary?"

Memo on CNA letterhead dated **March 10, 1993** to Maureen Anderson

(Communications Manager) from Barbara Nichols (Executive Director/CEO)

RE: Action plan—Follow-up. Areas of responsibility are outlined. She has "the responsibility for the production of campaign materials and member communication. It was agreed that you would work with Peg Graham, and other E&GW staff as appropriate, to prepare these materials. As you are aware, time is of the essence as it relates to this component of our strategy."

CNA Member Outreach document for "reaching out to CNA members during this time of uncertainty. Call results to Sally Burke Wingard **daily**. "She is tracking our hot spots and successes." (no date, no author)

CNA Suggested Phone Script for addressing Title 22 regulations. Refers to December's Government Relations Alert about Title 22. (no date, no author)

CNA Phonebank Operation Preliminary Plan for Regional Leaders. Outlines goals of phonebank and organizational structure of regional leaders, team leaders for each area in California.

New Section

Title: Ron Plan

9 pages faxed to (206) 443-9722 on **March 11, 1993** from Cathy Allen and Tony Fazio (consultants) Outlines a strategy to identify CNA vs "dissident" messages.

General premises: (1 – 3 not presented); 4) Elections will be tied to the “same mailed ballot scheduled to be mailed out around April 9.” 5) CNA members are probably aware of dissidents’ actions and staff firings, but “probably not aware of the entire story, which prompted the firings, nor the fronting of the dissidents by Local 250.” 6) “Every message delivered by CNA to its membership, which is antidissident, must be accompanied by an “equal time” message developed by the dissidents.” 7) Every message delivered by CNA to its members, which is auto_Local 250, need not be accompanied by other “equal time” material.” 8) “CNA elections traditionally are not costly nor highly contested affairs, but this upcoming one is likely to be both.” 9) “Current CNA leadership-supported candidates are just beginning an organized campaign which is showing great potential, however, the dissidents are ready with a slate and have begun active campaigning.” 10) There is a distinct difference in the style and tactics CNA is perceived to have as opposed to the more guerilla, street-fighting approach already exhibited by the dissidents.”

The following table presents the sections and distinctions:

Section Heading	CNA Position	Dissident position
Themes	Trust and professionalism, mixed with a sense of unity and a fierce desire to tell the truth	These men (local 250 reps) want to control our futures, and we shouldn't let them. We don't need men from a service union telling us how to run our professional organization.
	Get back to basics. Healthcare reform doesn't mean putting ourselves or our patients at risk.	They just don't get it. The dissidents are just another front for the male-dominated leadership of Local 250.
	Professional nurses, building a better future for nurses	Radical extremists, out to build jobs for themselves, which is why they were fired.
Possible Slogan for CNA backed group: "Nurses First"	Stay on course for professional nursing, building a better future	Small, militant group of members, who are more into control than leadership.
CNA Style	Moral leadership with ethics, care, compassion, responsibility for others	Sneaky, egotistical and with little regard for the good of the whole.
Seeing the connections and patterns	Sees connections with health care reform and the impact on nurses	"single issue" "my way or the highway" "disruption for the sake of disruption" "How" more important than accomplishing meaningful, realistic reform.
Tackling issues	CNA takes on tough issues and not play games with people's lives. CNA way is selfless, playing fair, and playing by the rules.	Dissidents play political and courtroom games. Dissidents are selfish, protecting egos and creating chaos.

Section Heading	CNA Position	Dissident position
Listening to Nurses	CNA way is inclusive, to listen to membership, all the membership, representing people of color, the gay/lesbian members, and the physically disabled community.	Talk past the membership, represent a small, radical faction that is not as ethnically diverse nor inclusive as the CNA team
Combining personal values with professional values	What you see is what you get with the CNA team	Radical fringe, shooting from the hip, making up an organization as it goes. Campaign is typical of the way they will govern if elected.
Sharing power and empowering others, as opposed to abusing power	CNA way is to use power that comes from respect in working with people. The CNA way is to lead.	Assume power and use it to intimidate and control. The dissident way is to control.

General Tactical plan is outlined. 2 sections: 1) An in-house campaign, which would be directed at strengthening the perception of the current CNA leadership. 2) A general campaign strategy for our Board of Director candidates that allows us to aggressively take on the dissidents.

In House Campaign Strategies:

- 1) Create a broad-based group of supporters, the front line
- 2) A letter writing campaign or petition of support should begin
- 3) Opposition research needs to be done on each of the dissident leaders
- 4) We need to bring the “national” team in to build a better sense of unity within the big picture. Important to “build credibility by getting support from the national nurses (ANA). Great general press can help us and a national ANA

leader as well as other locally-elected officials could bring added strength to our cause now.

- 5) Direct mailings need to be sent to the membership (Of course, our mailings would “not ever mention the radical extremists, as our goal would not be to prompt a court-ordered mailing by the dissidents) First mailing: “Back to Basics” message. 2nd mailing: “They just don’t get it” message.
- 6) A series of walk-throughs need to be scheduled in different bargaining units, locations, to talk person-to-person with the membership. A personal letter from CNA leadership (probably from Mary Foley) to better explain responses to voiced concerns.
- 7) Infiltrate the dissidents’ and Local 250 organization- “A consolidated effort needs to be undertaken to find out what the dissidents are doing.” A guerilla force to attend their meetings, about a dozen people with very tough skins, sent to the dissident meetings with “Nurses First” or “Take Back The Honor” buttons/stickers/signs.
- 8) Offer a “Nurses Bill of Rights”.

Board of Directors Campaign:

Move quickly into a campaign planning phase. Build a strategy to clearly defeat the dissident’s team.

- a) Fundraising- Need for a campaign that is not funded by the CNA.
- b) Scheduling of the CNA-backed candidates- targeted voters for specific meetings and events.

- c) Message development- Similar to in-house campaign messages, but these people briefed on the entire strategy and helped to ready their own biography flyers, “as well as key speeches.
- d) Joint mailings/joint strategy- Mailings to be direct hits on the distortions and style of the dissidents. Use the opposition research, the “hug our opponents to death” approach.

“The campaign strategy needs to be united, well-funded and organized. It needs to begin yesterday. We know the opponents have some money and will probably get more. They also have not yet discovered graphic artists nor political consultants. However, it’s possible they will. We need to move.”

Cathy Allen is President of Campaign Connection

Tony Fazio is President of Winning Directions

Hourly rate is \$150/hr.

New Section

Title: CNA/ANA Retainer

Monthly Retainer Record dated **02/11/93**: Circled events are presented:

General headings: File CNA:CNA Costello- Costello et al v. Nichols et al

1/15/93- Telephone conferences w/ Dushkes and Lindsey and ANA (Sapin) re: EGWC

1/21/93- Meet w/Dushkes and Ken Absalom; Telephone conference w/Sapin re; EGWC

2/16/93- Telephone conf. w/Sapin, Maureen Anderson-re: Costello v. Nichols

2/19/93- Telephone conf. w/ Ed. Conklin w/ Linda Sawyer re: Costello v. Nichols

Telephone conf. w/NLRB re:charges

3/13/93- General research, strategy conference w/Beeson. Telephone conf. w/Sabin and
Duane Beeson re: Costello

3/18/93- Conf. w/Sapin; conf. w/Kelli Murray w/Ken Absalom re: transfer of cases.
Telephone conferences with Graham, Eggleston; call to FMCS

4/1/93- Telephone conf's. w/Pat Orr and Nichols re: Costello. Preparation of brief in
Marin General Hospital, Millie Hart arbitration

4/19/93- Tel. conf. w/Barbara Sapin re: Costello

4/19/93- Meeting w/Nussbaum, draft memos., tel. conf. w/Nichols

4/27/93- Meet w/ Nichols, Foley and Carswell; draft correspondence re: appointment of
attorneys

4/30/93- Prepared and faxed memo to Carsnell (Carswell) re: request for copies of
personnel files

5/4/93- Tel. conf's. w/Peter Nussbaum and Barry Jellison re: Costello

5/7/93- Tel. conf's. w/Nichols, Nussbaum and Stemerman re: Costello

5/10/93- Tel. conf. w/Nichols and conf. w/ Nussbaum re: Costello. Conf. w/Albright re:
election protest

5/18/93- Tel. conf. w/Pat Orr re: elections

6.22.93- Tel. conf's. w/Nichols, Albright re: election matters

New Section

Title: PBN/PR

Memo dated **December 11, 1992** from Susan Thurman (The PBN Company) to Barbara

Nichols (CNA) RE: (blank). Draft statement attached for use this weekend. “Since it is unclear what they will be charging, the statement at this time is rather generic.” Beep me at any time this weekend. Call me at any time. I’m happy to drop anything I’m doing to help you.

Memo dated **January 12, 1993** from Sue Thurman to Barbara Nichols RE: Media Statement on Staff Changes. Attached to generic media statement for use with external media. “We are updating the Q&A adding some new charges we are hearing.” “It is important that you place calls into the reporters who have called thus far. However, if at all possible, the tactic should be to delay having to speak to the reporter for at least a couple of days by inviting them to speak to you personally regarding this issue.” We need to move quickly on “reaching out to other major reporters to schedule one-on-one meetings.”

Memorandum dated **January 14, 1993** from: Ralph to: Peter N., Sue, Carri Z. & Kristina RE: CNA Background Materials & SEIU analysis. Author states he has pulled together a “fairly comprehensive research package on SEIU as well as other pertinent facts on unions and federal labor law. Notes that Steve Rosensweig has compiled background materials for Carri on Title 22 issues with copies forthcoming. Research materials include: Articles on the state of unions, aggressive tactics of SEIU, Newsday article outlining the steps for organizing non-unionized workers, articles on a recent U.S. Supreme Court case which gave larger unions (SEIU) a green light to actively organize in healthcare, local stories from Washington State describing SEIU events there dubbed The Battle of Puget Sound, and from Florida where SEIU took over another venerable

nursing organization there, miscellaneous stories on SEIU, their political prowess.

Memo dated **January 25, 1993** from Susan Thurman (PBN Company) to Mary Kaems, Catherine Dobbs, and Marilyn Chow RE: Attached Draft Flyer. Flyer attempts to “put the blame for the disruption back on the terminated staff and E&GW Congress members.” Put together as a response to HEARTBEAT. Strategy is to: 1) Tear apart Kit’s chronology of events- what really happened and when. 2) “better describe our vision of the new E&GW Department. We need to put “meat” on the bones of our new approach.” 3) Organize a letter writing campaign to respond to the HEARTBEAT’s “Sound Off’.”

Copy of flyer faxed on **April 26, 1993** and marked “Please Deliver Immediately”.

Faxed to “Guest- Room 1622 Mary Foley from Sue Thurman. Special instructions read: Mary- Our Sacramento office can help copy & hand out the release. Let us know.

Message matrix detailing when and to whom to communicate messages to primary internal audiences at CNA. Grid distinguishes between critical need and important need and groups to be targeted. Strategies are given for every particular group and identifies the CNA personnel to make the contacts.

Final Section

Title: PBN Plan

Heading “Carswell” on paper, no date, no author. 3 sections labeled 6/28/93 (details on Deputy Director contract), 8/27/93 (details on Deputy Director contract), and

9/5/93- (details on Interim Executive Director contract, with section stating “may not be terminated for 6 mos).

Memo on CNA letterhead dated **June 23, 1993** from Barbara Nichols (CNA Executive Director/CEO) to Argene Carswell. Confirms position of Deputy Director with CNA and notes her acceptance. Position is effective June 21, 1993 and the salary is \$7,083.33 per month. Memo is marked “Hand Delivered”.

Memo on CNA letterhead dated **June 24, 1993** from Barbara Nichols (CNA Exec. Dir./CEO) to Walter Geist (Payroll Services Mgr.) and Tessie Aguila (Payroll Dept.) Subject: Salary for Deputy Executive Director, Argene Carswell. Notifies them of hiring effective 6/21/93 and sets probationary period of 30 days. refers them to attached salary increase notification.

Employment agreement for Argene Carswell, Deputy Executive Director dated **6/28/93**. Signed by both Argene Carswell and Barbara Nichols.

Individual Salary Increase Notification form for Arlene Carswell dated **6/24/93** and signed by Barbara Nichols. cc: Payroll - Personnel File

Side Letter Agreement between CNA and Argene Carswell dated **6/28/93**. Outlines 1 time moving expense payment of \$4,500, payment of her June rent (\$1,490) and an advance of \$1,132.54 for move-in expenses and deposit on rental furnishings.

Confidential Employment Agreement between CNA and Argene Carswell dated **8/27/93** and signed by Argene Carswell and Barbara Nichols.

Modification to Employment Agreement between CNA and Argene Carswell dated **8/31/93** sent to “file”. Modifications include: cannot be terminated for 3 years without reasonable cause, provides for arbitration to resolve any disputes.

References Argenes move from the East Coast and her value to present and future Executive Directors.

Addendum to employment agreement between CNA and Argene Carswell dated **9/5/93**.

Signed by Argene Carswell and Mary Foley (President), document basically outlines a succession plan in the event the executive director position becomes vacant.

CNA Board Resolution approving employment of Argene Carswell as Interim

Executive Director upon the resignation of Barbara Nichols. (no date, no time)

Resignation letter to CNA Board of Directors dated **9/5/93**.

Acceptance of resignation letter from Barbara Nichols by Mary Foley (President) RE:

Resignation and Severance

Letter on CNA letterhead dated **February 22, 1993** hiring Ms. Leslie Crane-Perry as a

Nurse Consultant for a CNA Membership Recruitment and Retention project effective 3/16/93 and ending 5/31/93.

Consulting agreement dated **4/22/93** between CNA and Leslie Crane-Perry as an independent contractor.

Consulting agreement dated **2/22/93** (Barbara Nichol signature) and **3/16/93** (Leslie Crane-Perry signature). Ms. Crane-Perry will work on Membership Retention and Recruitment.

Professional Staff Weekly Time records for Leslie Crane-Perry for weeks 3/9–3/14, 3/15-3/21, 3/22-3/28, 3/29-4/4, 4/5-4/11, 5/10-5/16, 5/17-5/23, 5/24-5/30, 5/31-6/6, 6/7-6/13, 6/14-6/21, 6/21-6/27, 6/28-6/30.

United States District Court for the Northern District of California - Judgment dated **1/6/94** in the case of Plaintiffs: Kit Costello, Marilynne Kenefick, Martha Kuhl, Kay McVay, individually and on behalf of all others similarly situated, and the Congress of Economic and general Welfare of the CNA vs. Defendants: Barbara Nichols, Mary Foley, Julie Armstrong, Elizabeth Dietz, Mary Hardwick.

Findings are as follows:

- 1) Plaintiffs' motion to voluntarily dismiss its claims without prejudice under Federal Rule of Civil Procedure 41(a)(2) is GRANTED.
- 2) Plaintiffs' motion to dismiss defendants' counterclaims without prejudice under Federal Rule of Civil Procedure 19(b) is DENIED.
- 3) Defendants' motion for partial summary judgment is DENIED.
- 4) Defendants' counterclaims are DISMISSED as moot.

CNA PUBLICATIONS:

RNs in Motion: Your guide to CNA/NNOC

Contents:

1. *Welcome from the Board of Directors*
2. *Our History: Over 100 years of RN Power; What a difference 15 years makes*
3. *How We Are Organized: Professional Association and RN Union- Departments and Programs; Navigating the CNA/NNOC Website; Our Facilities; Elected Nurse Leadership Structure*
4. *Patient Advocacy: Our Guiding Principle- Know Your Practice; RN Safe Staffing Ratios; Collective Bargaining; Social Advocacy*

5. *Get Involved*: Make a Difference in Your Facility; Make a Difference in Your Community
6. *Know Your Rights*: Your right to Representation; Claim Your Overtime; Claim and Report Missed Breaks
7. Workplace Issues: The Organizing Model in Your Facility; Grievance Policy and Organizing
8. Your Membership
9. CNA/NNOC Board of Directors
10. Contact CNA/NNOC

California Nurses Association: 100 Years of RN Power

Published in **2003**

Contents:

- 1) Preface: 100 Years of RN Power
- 2) 1903 – 1940: The Birth of a Union
- 3) 1941 – 1965: The Early Days of Collective Bargaining
- 4) 1966 – 1991: Bay Area Nurses Take a Stand
- 5) 1992 – 1995: The Staff Nurse Uprising in CNA
- 6) 1996 – 2003: CNA Becomes a National Presence
- 7) Nursing History: Changes in the Nursing Profession
- 8) The Deconstruction of Healthcare
- 9) The Future: RNs and the Transformation of Health Care
- 10) Photo Credits & Captions, Editor's Sources

CNA/NNOC Executive Board Meeting “Magnet” Hospitals Aptos, CA May 19-21,

2007 The “Fourteen Forces of Magnetism” and Total Quality Management

Power Point Presentation Format:

History of the Magnet Program; Magnet “Eligibility” Criteria; “Forces of Magnetism”;

The Price of the Force\$ of Magneti\$m; The New Certainty: Statistical

Probability; Magnet Hospitals: Marketing “Culture”; Health Care Restructuring

(Dynamics, Phase1- 1991-1997, Phase 2-1998-2000, Phase 3?- 2001-2002;

Magnet Hospitals; TQM & Health Care: Consolidating Corporate Power and

Profits; W.E. Deming- The “Father” of TQM; Total Quality Management &

Joseph Juran; TQM’s Fascination with Statistical Control; Industry Definitions

of TQM; Edward W. Deming and the Classical Statement of TQM’s 14

Principles; The 14 “Forces of Magnetism”; Deming on the “Totalizing” Culture

of TQM; TQM Enculturation- Beyond Community, Family, Nation or Self;

TQM’s First Principle- Elimination of Services; TQM. Decision Making &

Employee “Empowerment”; Unifying Themes of TQM/”Forces of Magnetism:-

Implementation Tactics; TQM & Magnet Hospitals- Reifying Technology

Squared; Cerner: Rendering Caregivers Redundant; St. John’s, St.Louis Goes

ICU Digital with VISICU; Hi Tech. . .Not So High Quality; Virtual Care and

Skill Degradation; Born Again Magnet Status- Why Now?; U.S. Hospital

Aggregate Profits \$309.7 Billion (1986-2005); Powerlessness is Learned: A

Short History; Advocacy for . . What?; Advocating for Power & the Power of

Advocacy IHSP Institute For Health & Socio-Economic Policy

Market Based Health Care: Big Money, Politics, and the Unraveling of U.S. Civil
Democracy (Embargoed for release until June 22, 2007)

1) The Financialization of U.S. Politics

a) The Money

b) The “Health Care War Economy”

- The Medicare Modernization Act of 2003 and Overpayment for drugs to
Medicare Advantage Plans

c) Health Care Industry Constitutive Stakeholders

- International Finance Sector and Insurers Find a Commonality of
Interests

- Management Consulting Industry

2) Conclusion

3) Addendum

-Three Management Consulting Firms and Industries Represented

4) References

Nursing Ethics: Uniting Caring, Patient Advocacy, and Social Action Lisa Tose-

CNA/NNOC Educator

Contents:

1) Ethics And Retention

2) Non-Profit Hospitals Outperform For-Profit Rivals

3) Quarter Of A Billion Dollars In Profits Club

4) Kaiser’s Profit More Than Doubles

- 5) Two Hospitals Got Millions, Spent Little on Charity
- 6) Cash Before Chemo
- 7) Denial Management Industry Grows
- 8) A Short History of Healthcare
- 9) Market-Based Failure
- 10) Healthy Way To Choose Who Gets Care
- 11) Insurance Won't Solve The Healthcare Crisis
- 12) Canada's Single Payer Healthcare System
- 13) Taiwan Gets Healthy
- 14) Further reading and Research

“Shared Governance”: The Impact of Partnership Councils on RN Autonomy,

Independent Judgment, and Advocacy **June 2009**

Faculty: Hedy Dumpel, RN, JD (National Chief Director of Nursing Practice and Patient Advocacy) BRN Provider Number 00754 for 6.0 Contact Hours

PowerPoint

Collective Patient Advocacy Series: Strategies to Secure Safe Staffing Standards and

RN Patient Advocacy Rights **August 2009**

Faculty: Hedy Dumpel, RN, JD (National Chief Director of Nursing Practice and Patient Advocacy) BRN Provider Number 00754 for 6.0 contact Hours

PowerPoint

The “Forces of Magnetism”: Their Impact on RN Autonomy, Independent Judgment,
and Advocacy

Faculty: Hedy Dumpel, RN, JD (National Chief Director of Nursing Practice
and Patient Advocacy) BRN Provider Number 00754 for 6.0 Contact Hours

PowerPoint

“Collective Patient Advocacy: Preserving the Art & Science of Nursing” July 2009

Faculty: Hedy Dumpel, RN, JD (National Chief Director of Nursing Practice
and Patient Advocacy) BRN Provider Number 00754 for 6.0 Contact Hours

PowerPoint/articles

From Wall Street to Well Street: Patient Advocacy in the New World of Healthcare

Jane Morrison CNA/NNOC Educator

Contents:

- 1) Wall Street vs Well Street
- 2) Street Salivates Over VEBA Cash Pile
- 3) CPMC Performance Standards
- 4) Summit Evaluation
- 5) Ardito Memo and CNA Response
- 6) Senior Transformation Consultant Job Description
- 7) Sutterville Discussion Questions
- 8) CNA Press Release – St. Luke’s Redlining
- 9) Sutter Expands its Reach

- 10) Scott Eveland Case
- 11) Nurses' Rally Supports Frankfort Family
- 12) We All Deserve Cheney Care
- 13) Emergency Room Wait Times Getting Longer
- 14) CNA Press Release – Waiting Times
- 15) CA Historic Ratios
- 16) Ratios Solve RN Shortage
- 17) Cost of Healthcare Facts
- 18) Top 10 Reasons for Single Payer
- 19) Single Payer FAQ

Nursing Contexts: Caring as Effective Patient Advocacy Linette Davis CNA/NNOC

Educator

Multiple Articles from Multiple Sources:

- 1) “Banks Gone Wild,” by Paul Krugman
- 2) “Three Phases in the Development of Corporate Rights,” by Ted Nace
- 3) “Hospitals’ charity work hard to assess,” by Mary Engel
- 4) “Kaiser Permanente’s 9-months’ profit more than doubles to \$2.5 million,” by Chris Rauber
- 5) “Health Plan Overhauled at Wal-Mart,” by Michael Barbaro
- 6) Sutter Health Memo, by Chief Nursing Officer Viki Ardito
- 7) CNA Press Release on Ardito Memo
- 8) “The Stern Gang and the SEIU,” by Ken Silverstein

- 9) "Andy Stern: Savior or Sellout?" by Liza Featherstone
- 10) "Union Disunity," by Matt Smith
- 11) "Stern Reprimand," by Matt Smith
- 12) "Unhealthy Union," by Matt Smith
- 13) "Rosselli Resigns from SEIU Exec Committee," by Michelle Amber
- 14) CNA flyer on SEIU collaboration with Ohio CHP
- 15) "What Really Happened in Ohio," by Marilyn Albert, RN
- 16) CNA Press Release on SEIU collaboration with Ohio CHP
- 17) SEIU Agreement to Advance the Future of Nursing Home Care in California,
excerpt
- 18) CNA flyer on SEIU collaboration with Schwarzenegger on AB1x
- 19) "More: The DeMoro Code," by Karen Breslau
- 20) "Let's Avoid Serious Mistakes in the Next California Healthcare Reform Bill," by
Rose Ann DeMoro
- 21) CNA Press Release on March Sutter strike
- 22) Sources of Film Clips

ARTICLES and COPIES OF LEGAL DOCUMENTS

Where Were You, ANA?

Where were you ANA, when Kaiser Permanente eliminated 800 RN positions the past year? You were telling the world that restructuring is inevitable, and encouraging us to sit on powerless, management-dominated committees implementing redesign.

Where were you ANA, when St. Joseph's (Stockton), Children's (Oakland), St. Luke's (San Francisco), and Valley Medical Center (Fresno) were paying management consultant APM (American Practice Management) millions of dollars to eliminate nursing positions? You and your Foundation were giving APM's Connie Curran a "distinguished scholar" research grant.

Where were you ANA, when 800 RNs were on strike at Summit Medical Center in Oakland? A New York union gave Summit employees \$100,000 in strike support. You sent a telegram of support- to the hospital's address instead of to CNA.

Where were you ANA, when CNA filed a consumer fraud class action lawsuit against Alta Bates Medical Center for launching a redesign program that cut nursing positions by 50%, gagged nurses, and threatened patient care? You attacked CNA for running "Patient Watch" ads critiquing Alta Bates' unsafe plan, offered no financial support for the suit despite repeated requests, and waited weeks to respond to management's use of ANA positions to bolster its arguments.

Where were you ANA, when a major union (with whom you've recently held secret meetings) pumped in \$1.5 million to raid CNA and erode nursing practice across California? You offered not one penny of support.

Where were you ANA, when CNA members worked tirelessly to pass Proposition 186 to implement genuine healthcare reform in California, and protect RN jobs and practice? You had just voted at your 1994 House to oppose single payer healthcare reform; you spent millions of dollars promoting a national plan that

offered no concrete help for direct care RNs; and you contributed nothing to the Proposition 186 campaign.

Where were you ANA, when we were campaigning for California legislation to improve RN-to-patient ratios, and to limit drive-by deliveries? You failed to generate critically needed support.

Where were you ANA, when the Supreme Court acted to sharply restrict RN patient advocacy rights with its notorious case of NLRB v. Health Care Retirement Corp. of America? You failed to mount a campaign-despite months of advance notice-to fight this case, and to educate the court and the public in advance, and you were ineffective in winning action to overturn the decision.

Where were you ANA, when Congress defeated the Workplace Fairness Act (barring permanent replacement of striking employees) at a time when City of Hope RNs were being fired for striking over safe care? You failed to exercise national leadership to influence the Senate to pass the law.

Where were you ANA, when nurses and consumers demanded that the healthcare industry be made accountable for the decline of patient care standards? You spent over \$100,000 to hire Lewin-VHI to survey linkages between nursing care and patient outcomes, despite warnings by CNA that Lewin-VHI had a long history as a consultant for the hospital and insurance industries. The Lewin report found no specific linkages, and recommended more research. Your letter noting the report's findings was used by the hospital industry group to defend redesign plans that reduce skilled nursing care.

Where were you ANA, when the former CNA President and the Executive Director suspended our elected leaders and carried out a mass firing of our labor staff? You sent staff and money to support their illegal actions, and to assist with an election campaign against a staff nurse slate for CNA office.

Where were you ANA, when the hospital industry implemented plans to assign most RN duties to lesser skilled personnel? You sought to create a two-tiered status within nursing by urging adoption of a BSN minimum requirement for RN practice, and limiting ADN and Diploma RNs to “technical” roles. This echoes healthcare industry justification for displacement of RNs, and erosion of self care.

WHERE WERE YOU ANA? YOU WEREN’T WITH US.

Article in the Oakland Tribune, **October 3, 1995** by Matt Richtel- *California’s crusading nurses split with national association.*

Notice from CNA to members regarding “92%” vote to disaffiliate from ANA

CNA “official” notice dated **October 3, 1995** (for immediate release) of disaffiliation vote noting: “The vote was greeted with cheers, hugs, and a thundering standing ovation.”

Article in “RNA” from The Bureau of National Affairs, Inc. dated **9/26/95** discussing “California Nurses Association members set to vote on disaffiliating from

ANA,” “ANA’s Role in Fighting Restructuring at Issue,” “ANA’s Response To Charges,” “Nurses As Advocates,” and “CNA, ANA History of Conflict.”

Article in Modern Healthcare dated **September 25, 1995** by J. Duncan Moore Jr. and titled: *ANA Fires Back at California Secessionists*

Article in The American Nurse (The official publication of the ANA) dated **September 1995** (no author) titled: *CNA Leaders propose bylaws changes, plan to leave ANA*. “ANA leaders have received many letters from individual CNA members to ANA, citing concerns about the anti-ANA tone emanating from CNA leaders.”

Article in The American Nurse (The official publication of the ANA) dated **September 1995** (no author) titled: *If California leaves, what do nurses stand to lose?* “The CNA is a constituent member of the ANA, and has been since CNA was founded. Some members of CNA are now actively advocating proposals that will permanently sever this longstanding heritage of unity.”

News Release from ANA marked “for immediate release” dated **October 2, 1995**

Titled: *American Nurses Association Leader Denounces State Split; Announces Formation of New Nurses Organization*. “ANA President Virginia Trotter Betts (JD, MSN, RN) called the move “misguided, short sighted and exceedingly troubling to thousands of nurses who wish to remain ties to their colleagues

nationally and internationally. Betts immediately announced the formation of ANA/California, a new statewide nurses association with ANA affiliation.”

Article in the Los Angeles Times dated **Wednesday, September 27, 1995** by Shari Roan and titled: *Condition: Critical*. “In Washington, 5,000 nurses march down Pennsylvania Avenue to protest nursing layoffs.” “They usually shun activism. But threats to patient care and their profession have pushed nurses over the edge and onto sidewalks in protest.”

An online article (<http://www.chron.com/disp/story.mpl/deadbymistake/6555095.html>) from *chron.com dated **August 10, 2009** by Cathleen F. Crowley and Eric Nalder (Hearst Newspapers) titled: *Within health care hides massive, avoidable death toll* “Ten years ago, a highly publicized federal report called the death toll shocking and challenged the medical community to cut it in half - within 5 years.” “A national investigation by Hearst Newspapers found that the medical community, the federal government and most states have overwhelmingly failed to take the effective steps outlined in the report a decade ago. Hearst also found that in states like California that have put some regulations in place, hospitals often ignore the rules without penalty.”

CNA/NNOC Contract Standards (Draft) dated **July 13, 2009** and marked (Privileged)

Contents:

- 1) Union Rights- Union Shop, Recognition Clause, Payroll Deduction of Dues, Payroll Deduction of PAC Funds, Organizing Agreements, Integrity of the Bargaining Unit, New Employee Orientation, Grievance Procedure and the Binding Arbitration, Just Cause, Right to Representation, Visitation Rights and Bulletin Boards, Paid Time for Nurse Reps, Paid Time for Bargaining Team, Union Leave.
- 2) Working Conditions- No Mandatory Overtime, Seniority, No Cancellation, Every other Weekend Off, Reduced Work Week, Meal and Break Relief, Rest between Shifts, Posted Schedules, Lift Teams/Patient Handling.
- 3) Staffing and Professional Practice- Arbitration of Staffing Disputes, Staffing Ratios, Nursing Practice Standards, Floating Clusters, Model of RN Jurisdiction, Professional Practice Committee, Charge Nurse out of the Count, Patient Classification System, Paid education Leave, Technology Language.
- 4) Benefits- Defined Benefit Pension, Retiree Health Care, Employee Health Plans, Sick Leave/Vacation/Holidays, Jury Duty, Funeral Bereavement Leave.
- 5) Wages- Steps, Credit for Previous Experience, Standby and Callback pay, Per Diem Differential, Overtime Rates.\

Attachment A- Staffing Ratios

Attachment B- Nursing Practice Standards

Attachment C- Pension Plans

Attachment D- Sick Leave, Vacation and Holidays

Report titled: Regional Diversion of CNA Member Dues (no author, no date)-

Reports on the efforts over 2 years by officers in 4 Regional Associations within CNA to divert CNA members' funds to competing organizations. Within "just three days after the close of the 1993 House of Delegates, officers of Regions 3, 4, 5, 8, 9, 10, and 12 retained lawyers to advise them regarding strategies to secede from CNA.

Region 9 – "Sally Burke-Wingard used the Mt. Diablo attorneys to file for incorporation of Region 9 as an independent corporation free from any obligations" to CNA. Members of Region 9 and CNA sued Burke-Wingard and forced a settlement requiring a membership vote on the issue, the members voted overwhelmingly against the Burke-Wingard plan, and the assets were returned. This scheme cost the Region 9 members \$25,000.

Region 2- "Lisa Gifford and other officers depleted 2/3 of the regional treasury on an illegal severance package (\$12,500), defaulted on state and federal tax obligations, attempted to liquidate over \$7,000 in scholarship funds, abandoned the Region 2 office and ceased operations in an attempt to disband the Region, all without any notice to members.

Region 12- "The region's officers led by Tony Leone and Stan Walker implemented a plan beginning in November, 1994 to secede from CNA and divert members' assets to competing organizations. In July, 1995, Leone & Walker filed false amended articles of incorporation for region 12 with the Secretary of State purporting to separate the Region from Golden Gate Nurses

Association, Inc. On September 6, 1995, the Superior Court issues an injunction against the Leone secessionist group finding that their “separation plan” violated the CNA and Region 12 Bylaws” and were therefore invalid. The group was placed under new CNA leadership, who are still trying to recover the diverted assets, which totaled more than \$250,000.

Region 11- “Regional officers paid a sweetheart severance package estimated at \$50,000 to Executive Director Sharon Wicher (using the same attorneys who advised the Leone group in Region 12 to give an illegal severance package of \$65,000 to Executive Director Joanne Powell).” Despite this “severance” Wicher continued to work as a consultant to the region. Region 11 officers refuse to allow CNA or the officers-elect of the Region access to the financial records to see how much money has been diverted.

A variety of CNA Brochures

A New Day for RNs: The National Nurses Movement Takes Off – Join Us!

CNA/NNOC 101- Your Guide to Joining the National RN Movement

Introducing The New CNA/NNOC Retiree Division; Wanted- Retired CNA/NNOC

RN’s

The Ratio Solution: CNA/NNOC’s RN-to-Patient Ratios Work- Better Care, More

Nurses

Registered Nurse (The CNA NNOC Journal of Patient Advocacy) dated **June 2009**

Cover Story: *Retirement? What Retirement? RN life after work ends (or not)*

Registered Nurse (The CNA NNOC Journal of Patient Advocacy) dated **March 2009**

Cover story: *Ratios: Five Years Later- What's Working and What Still Must Change.*

3 copies of legal papers

- 1) Findings of Fact and Conclusions of Law in Support of PRELIMINARY INJUNCTION by the United States District Court Northern District of California dated **March 10, 1993** involving Plaintiff Kit Costello, et al., v. Defendants Barbara Nichols, et al. No. C-93-0041 SAW (CW)
- 2) RPELIMINARY INJUNCTION by the United States District Court Northern District of California dated **March 10, 1993** involving Plaintiff Kit Costello, et al. v. Defendant Barbara Nichols, et al. No. C-93-0041 SAW (CW)
- 3) Order granting PRELIMINARY INJUNCTION in case #970296 and denying preliminary injunction in case #970934 by The Superior Court of the State of California in and for the City and County of San Francisco dated **September 6, 1995.**

Case No. 970296 involving plaintiffs California Nurses Association; Craig Allen Fitzpatrick, Barbara Coleman, individually, and as members, and on the behalf of all members of the Golden Gate Nurses' Association, Inc., California Nurses Association, Region 12 vs. Tony Leone, Elaine McKenna, Stan Walker, Fran Koperniak, Roberta Romeo, Betsy Stetson, James Romeo, Sister M. Ellene Egan, Jo Anne Powell, Golden Gate Nurses Foundation, Inc. and DOES 1 through 20, inclusive.

Case No. 970934 involving plaintiffs Golden Gate Nurses' Association, Inc., a 501(c) 6 Mutual Benefit Corporation vs. defendant California Nurses Association, a

public benefit corporation Barbara Coleman, Ron Bennet, Beth Anderson, Mary Wynne, and DOES 1 – 50, inclusive.

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Census Bureau. <http://www.census.gov/>

Democratic National Committee. <http://www.democrats.org/index.html>

Department of Health and Human Services. <http://www.dhhs.gov/>

Resources Available:

Office of the Secretary of Health and Human Services (OS)

Administration for Children and Families (ACF)

Administration on Aging (AOA)

Agency for Healthcare Research and Quality (AHRQ)

Agency for Toxic Substances and Disease Registry (ATSDR)

Centers for Disease Control and Prevention (CDC)

Centers for Medicare & Medicaid Services (CMS) Food and Drug Administration (FDA)

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Participation of Nurses in Health Services Decision Making and Policy Development

ICN Position:

Nurses have an important contribution to make in health services planning and decision-making, and in development of appropriate and effective health policy. They can and should contribute to public policy pertaining to the determinants of health.

In addition, nurses are involved in strategic planning, budgeting, efficient resource planning and utilization, and the planning, management and evaluation of programs and services. Nurses must accept their responsibilities in health services policy and decision-making, including their responsibility for relevant professional development.

Professional nursing organizations have a responsibility to promote and advocate the participation of nursing in local, national and international health decision-making and policy development bodies and committees. They also have a responsibility to help ensure nurse leaders have adequate preparation to enable them to fully assume policy-making roles.

Background:

Because of their close interaction with patients/clients and their families in all settings, nurses help interpret people's needs and expectations for health care. They are involved in decision-making at clinical practice level as well as in management. They use the results of research and trials to contribute to decisions on quality, cost-effective health care delivery. They conduct nursing and health research that contributes evidence to policy development. Because nurses are often coordinators of care provided by others, they contribute their knowledge and experience to strategic planning and the efficient utilization of resources.

To participate and to be effectively utilized in health planning and decision-making, and health and public policy development, nurses must be able to demonstrate their value and convince others of the contribution they can make. This may involve improving and expanding the scope of the preparation of nurses for management and leadership, including their understanding of political and governmental processes. It may also involve increasing their exposure through management and leadership roles and positions in both nursing and other health care services, encouraging nurses to participate in government and political affairs, and improving and marketing the image of nursing.

ICN and its member associations promote and support all efforts to improve the preparation of nurses for management, leadership and policy development. This preparation should be broad and must include the development of knowledge and skills for influencing change, engaging in the political process, social marketing, forming coalitions, and working with the media and other means of exerting influence. It must recognize the complex processes and factors involved in effective decision-making.

Professional nursing organizations need to employ a number of strategies to contribute to effective policy development, including monitoring the utilization of nurses in the workforce, incorporating new models and management strategies, continually marketing a positive image of nursing to key management and policy stakeholders nationally and internationally, disseminating relevant knowledge and research, and continually developing and maintaining appropriate networks to enable collaborative working relationships with governmental and non-governmental organizations. For its part, ICN will promote and make available information regarding the contribution of nursing in health decision-making and policy development.