Organizing Filipino Registered Nurses: A Social Movement Unionism Approach

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The Filipino Nurses Hymn

We pledge our lives to aid the sick
To help and serve all those in need
To build a better nation that is healthy and great
We'll bring relief to every place
In towns and upland terraces
In plains in hills and mountains
We shall tend all those in pain
Beneath the sun or stormy weather
We shall travel on
To heed the call that we must be there
With our tender care
We pray the Lord to guide our way to carry on our work each day
And grant us grace to serve the sick and love to help the weak.[1]

[1] Catherine Ceniza Choy, "The Export of Womanpower: A Transnational History of Filipino Nurse Migration to the United States," (Ph.D diss., University of California Los Angeles, 1998), 73.

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Glossary of Terms:

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

Traveler—A traveler is an RN who accepts temporary contracts throughout the U.S. that generally run for thirteen weeks or more.

Registry—RNs that act as temps for a hospital on a day-to-day basis.

Licensed Vocational Nurse—Give general nursing care which includes collecting information, contributing to the plan of care, and providing care in predictable situations with minimal supervision, or in fluctuating situations under direct supervision of a registered nurse, licensed physician or dentist.

Charge Nurse—A nurse who manages a specific unit. These nurses are on the management level and cannot be part of the union.

Intensive/Critical Care— A critical-care nurse is a licensed professional nurse who is responsible for ensuring that all critically ill patients and their families receive optimal care.

Neo-natal— Neonatal refers to the first 28 days of life and a neonatal nurse works in specialized nurseries or intensive care.

Operating Room/PACU—Perioperative registered nurses provide surgical patient care by assessing, planning, and implementing the nursing care patients receive before, during and after surgery.

Labor and Delivery/Antepartum—Labor and delivery nurses care for women who are laboring, having complications of pregnancy or having recently delivered.

Postpartum Couplets—A postpartum nurse performs postpartum and newborn care with a focus on the family.

Pediatrics—Pediatric nurse works with the pediatrician on staff at the hospital and monitors a wide range of illnesses from trauma to cancer to broken bones.

Emergency Room—Emergency nurses specialize in rapid assessment and treatment and must be ready to treat a wide variety of illnesses or injury situations, ranging from a sore throat to a heat attack.

Step Down— Step down nurses monitor general surgical, trauma, cardiac surgical, peripheral vascular, and thoracic surgical patients who continue to require close monitoring after leaving surgery.

Telemetry—Telemetry nurses monitor patients with non-invasive cardiac problems.

MedSurg— Nurses provide care for adult and pediatric medical and surgical patients who require pre- and post-surgical care or those who are in varying stages of recuperation.

Other Specialty Care—Nurses provide care for patients in other hospital units such as oncology and orthopedics.

Psychiatry— Psychiatry nurses work with individuals, families, groups, and communities to assess mental health needs, develop diagnoses, and plan, implement, and evaluate nursing care.

Introduction

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

Currently healthcare is the fastest growing industry in the United States. As the industry grows, the hospitals have started to decrease patient stays. At the same time, there has been a shortage in nurses that has created the need to bring foreign-trained nurses to the U.S., with unqualified nurses' aides also taking responsibility for procedures a more licensed nurse should perform. Rather than trying to uphold the best patient care, many for-profit hospitals have turned into corporate enterprises looking to turn beds faster so that more patients can come and go from the hospital; thus, increasing their profit. These conditions present an opportunity for unions to organize within the healthcare industry because people working on the shop floor, such as registered nurses, have become more and more frustrated with the newly established system. In California, out of 500 hospitals, 35 percent have registered nurses unions. However, there is room and a necessity for more organizing to occur. Not only will organizing nurses help improve their benefits and patient care, but it will also target issues faced by foreign trained nurses, particularly Filipino nurses due to the large representation of Filipinos working as RNs.

Despite the large representation of Filipinos working as RNs in American hospitals, and more specifically Southern California hospitals, little research has been conducted about why and how these RNs unionize and whether they are responsive to a union organizing initiative. Organizing Filipino RNs benefits the labor movement while also providing a resource for RNs to address broader social justice issues. Although organizing efforts have occurred in hospitals since the early 1900s, not until the past 30 years have unions started to significantly target

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

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

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

licensing issues in the U.S. In the third chapter I talk about the history of the U.S. labor movement and the rise and importance of the concept of social movement unionism as a strategy to organize workers. The chapter also addresses the current views about unions among the American public as well as the need to organize immigrants, women and registered nurses. The fourth chapter looks at the history of organizing in hospitals and how unionization in hospitals can improve the quality of care. In the fifth chapter, I discuss the issues affecting RNs today and more specifically those affecting Filipino RNs. Here I draw upon the research I conducted through interviews and surveys. Lastly, the sixth chapter presents recommendations to unions on areas to focus on when organizing Filipino RNs, as well as RNs as a whole, the possibility of creating a new nursing curriculum, and possible areas for future research.

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

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

However, during American colonization in the Philippines, social constructs, such as an established hierarchy placing Americans on top and Filipinos on the bottom, were developed that have led to cultural problems that affect the current state of unionization today. From the early 1900s to the 1940s, the U.S. government, individuals, and philanthropic organizations sponsored Filipino nursing students to study in the U.S. Nursing served to justify the "white man's and white woman's burden" and created a cultural and racial hierarchy with Americans on top.[4] The established American programs created a hierarchy that placed racial divides and created a situation where Filipinos were viewed as a "lesser" race. In addition, this established hierarchy "impose[d] physical and social control on Filipinos," which later played a role in how Filipinos

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[2] Paul Ong and Tania Azores, "The Migration and Incorporation of Filipino Nurses," in The New Asian Immigration in Los Angeles and Global Restructuring, ed. by Paul Ong, Edna Bonacich, and Lucie Cheng (Temple University Press: Philadelphia, 1994), 164-5.
[3] "Census 2000 Data for the State of California," U.S. Census Bureau, 18 June 2003, www.census.gov (24 February 2004).
[4] Catherine Ceniza Choy, "The Export of Womanpower: A Transnational History of Filipino Nurse Migration to the United States," (Ph.D diss., University of California Los Angeles, 1998), 38.

are often taken advantage of by their employers in U.S. hospitals.[5] Originally, these sponsored programs were created in order to perpetuate the use of Americanized nursing in the Philippines—an attempt to change the cultural practices regarding how Filipinos work and care for their patients, while also establishing similar nursing programs as those taught in the U.S. This was done by creating a Filipino labor force with the English language skills, work skills, and academic credentials necessary to work in hospitals in the U.S. and the Philippines. Though the established American colonial policies reproduced "gendered assumptions" about the work of men and women, Filipino nurses chose to go into nursing because they viewed American colonial policies as "progressive" for their gender.[7] The notion of Filipino women working as nurses was an idea that had to be overcome both by older generation Filipinos and young women because women historically took on the domestic roles, while the men were the bread winners of the family. This idea of independence due to their occupation was important to Filipino women because under Spanish rule women were not educated and while Americans viewed nursing as "women's work," Filipinos viewed nursing as an opportunity for progressive change in the Filipino education system.[9]

While nursing schools had been established since the 1800s in the Philippines, in 1907, at the urging of Mary Coleman, Dean of Women at the Philippine Normal School, the U.S. government established its first nursing school in the Philippines, which utilized white American women to teach nursing. Similar to trends in the U.S., Filipino nurse recruits were typically young women from "respectable" families who were interested in nursing as a way to become

[5] Ibid., 38.

[7] Ibid., 39.

[9] Ibid., 38.

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

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

Beginning in the 1880s and 1890s, nursing alumni associations, such as the National League of Nursing Education and the American Nurses Association, were formed in the U.S. and later transformed into professional nursing organizations. In September 1922, Anastacia Giron-Tupas, the first Filipino Chief of Nurses and Superintendent of the Philippines, and 150 Filipino graduate nurses converged to organize the Philippine Nurses Association (PNA), which sought

[10] Ibid., 52

[12]By 1948 the Philippines had established baccalaureate nursing programs in nine universities and colleges; the U.S.' first offered baccalaureate degrees in nursing in the 1920s. Ibid., 65

[13] Ibid., 56

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

Immigration Act of 1965

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

[14] Ibid., 60
[15] Ibid.
[16] Ibid., 62
[17] Some hospitals exploited this program by using the "trainees" as cheap labor to supplement their work force, and these abuses contributed to the ultimate demise of this program in the late 1970s (Ong and Azores, 174).
[18] "Census 2000 Data for the State of California."

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

With no end in sight to the critical nursing shortage, Congress passed the Immigration Nursing Relief Act of 1989 (INRA), allowing nurses who entered the U.S. with H-1 visas before September 1989, and who had worked in nursing for three years, to adjust to permanent status without regard to per country caps on immigration. In 1990, Congress was again forced to address the U.S. nursing shortage problem by including a provision in the Immigration Act that allowed foreign nurses who accepted unauthorized employment to file applications for adjustments for themselves as well as for their accompanying spouses and children. Despite the multitude of laws and regulations, the United States has not been able to regulate the flow of Filipino nurses through the occupational provisions under the immigration quotas or the temporary work programs.[21] In addition, these regulations have not been completely effective in controlling the movement and stay of Filipino nurses, since the nurses make use of modes of

[19] Nursing shortages have come in waves throughout American history and recruitment of foreign trained nurses fluctuates based on the U.S.'s need for nurses. The cause of the current nursing shortage is attributed to an ageing workforce, declining enrollment in nursing schools, and a poor image of nursing. (Heather Janiszewski Goodin, "The Nursing Shortage in the United States of America: An Integrative Review of the Literature," Journal of Advanced Nursing, August 2003, http://www.blackwell-synergy.com/links/doi/10.1046/j.1365-2648.2003.02722_1.x/full/ (9 April 2004).

[20] Ong and Azores, 174.

[21] The U.S. likes to meet specific quotas of immigrants coming from other countries and by conducting large scale recruitment efforts in the Philippines, the U.S. was unable to regulate whether they were over their quota of Filipino immigrants.

entry other than those directly related to their occupation, such as sponsorship by a family member.[22]

Why Filipino Nurses Move Abroad

In addition to the ease of immigration, Filipinos began to seek employment abroad because of the poor working conditions and salaries earned in the Philippines. Filipino RNs idealize working and living in the U.S. because the Philippines has comparatively low wages and poor working conditions, which leads the nurses to push towards sponsorship.[23]

According to a 1972 survey conducted by the *Philippine Journal of Nursing,* 147 Filipino nurses working in Illinois, Minnesota, Montreal, New York, Ohio, and Pennsylvania revealed dissatisfaction with nursing in the Philippines. When asked if their salaries in the Philippines were commensurate with their professional status and responsibilities, the vast majority, 101 of 147 nurses, responded no; 103 nurses claimed that they did not receive compensation for late shift work, and 102 responded that they did not receive compensation for working on holidays. In addition, slightly more than half of the respondents reported that they had not been paid overtime and that their hospitals had not followed the forty-hours a week labor law. In the same year, another survey of Filipino nurses abroad found that over a quarter of the nurses surveyed listed "an ineffective PNA" as one of the reasons for the decline of the nursing profession in the Philippines and why Filipino nurses chose to work abroad rather than return to the Philippines after studying abroad.[25] Understanding how the Filipino nurses felt, U.S. hospitals took advantage of the economic and professional dissatisfaction of nurses in the Philippines to recruit them to work in their institutions—publicizing other socioeconomic bonuses that the majority of

[22] Ong and Azores, 176.
[23] Personal Interview with Nurse from Midway Medical Center, October 29, 2003, Los Angeles, CA.

[25] Catherine Ceniza Choy, Empire of Care: Nursing and Migration in Filipino American History (London: Duke University Press, 2003), 107

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

Unlike Filipino exchange nurses, who arrived in the U.S. under the sponsorship of a specific hospital, immigrant nurses often came to the U.S. without prearranged employment. As a result, they actively sought the company of nursing friends and family members who could help them with the adjustment process. Filipino nurse networks also extended into the area of employment by former exchange visitor nurses who returned to the U.S. as immigrants utilizing contacts from their exchange visitor experience.[26] According to Catherine Ceniza Choy, in her study of Filipino nurses, *Empire of Care*, the majority of newly arrived Filipino nurse immigrants she interviewed were single at the time of immigration and few had been married in the Philippines. Among those with husbands, their husband's initial reaction to migration abroad varied. Nevertheless, the wives claimed that once they had received their immigrant visas, there was little debate about whether they would relocate abroad, due to the increase in wages.[27] If nurses did have families back in the Philippines, often times they would work in the U.S. while sending a portion of their earnings back home to their families. Choy further comments that in addition to the professional and family networks utilized by Filipino nurse immigrants, U.S. labor demands facilitated Filipino nurse employment and settlement. For example, many of the nurses she interviewed, who had immigrated during this time, characterized obtaining a U.S. occupational immigrant visa and finding employment in the U.S. as an "easy" process that took no longer than several months. This was partly due to U.S. hospitals' need for an increase in services due to the domestic nursing shortages.[28] Furthermore, the establishment in 1965 of two public health programs, Medicare for the elderly and Medicaid for the poor, rapidly increased the

[26] Ibid., 108.
[27] Ibid., 109.
[28] Ibid., 110.

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

The shortage of nurses both in the Philippines and in the U.S. in the 1960s allowed for Filipino entrepreneurs to open new schools of nursing in both provinces and urban areas of the Philippines. In 1950, 17 nursing schools existed in the Philippines, but by 1970 that number rose to 140, and, in 1966, the Philippine Republic Act 4704 relaxed the minimum standards for nursing school operation, making it easier for nursing schools to open up.[30] Perla Sanchez, the president of the Association of Nursing Service Administrators of the Philippines (ANSAP) in 1968, lamented that the Philippines was losing nurses faster than the Filipino nursing schools could produce them, and further complicating this issue was the problem that those nurses who had left and returned and those who had stayed were becoming discontented and filled with frustration over the nursing shortages in the Philippines.[31] Also, adding to the loss of nurses was the declining enrollment of nursing students by the mid-1970s; while these numbers appeared to be dropping, however, the *1989 Philippine Statistical Yearbook* reported that there were more than sixty-five thousand newly registered nurses in the period from 1979 to 1988. Thus, while there was a nursing shortage in the Philippines, the problem was not completely due to a lack of students enrolling in nursing schools but rather the large percentage of nursing students moving abroad.[32]

Noticing the problem, in an attempt to keep Filipino nurse graduates from seeking employment abroad, in 1973, President Ferdinand Marcos issued a presidential decree requiring nursing graduates to work four months in a rural area as a condition for obtaining a license. The

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[30] Ibid., 111.
[31] Ibid., 113.
[32] Ong and Azores, 172.

purpose of these service requirements was to alleviate general nursing shortages in the Philippines, specifically the urban versus rural maldistribution of nurses within the country. Marcos and the PNA presidents justified mandatory health service requirements by comparing the nurse-to-patient ratios in the Philippines with those in other countries. At the time, the Philippines' ratio was 8 nurses for every 10,000 people, whereas, the U.S. ratio was 49 for every 10,000.[33]

Around this same time, however, the Filipino government had already begun to send nurses and other laborers abroad as a means of obtaining currency to the Philippines, which helped to transform the Philippines into an "export-oriented" economy.[34] Marcos issued decrees that committed the Philippine government and economy to a new model of development based on the export-oriented model of industrialization, which included his commitment to the export of both people and goods. Government officials even promoted the export of laborers, including nurses, when the ratios of Filipino nurses serving the general population were very low. By using the nurses as an export, the Filipino nurses would build the Philippine national economy by depositing their earnings abroad in Philippine banks. Marcos encouraged Filipino nurses abroad "to earn for the country as well as for themselves."[36] Filipino nurses were no longer viewed as abandoning their role in Philippine nation building but rather became an integral part of it—now, Filipino nurses working abroad and earning dollars became the Philippines' new national heroes.

[33] Choy, Empire of Care, 113-114.
[34] Choy, "Export of Womanpower," 47.

[36] Choy, Empire of Care, 115.

Chapter Two: Activism Within the Filipino Community

As discussed in Chapter One, historically Filipinos, specifically Filipino women, have been viewed as docile, passive, and reluctant to challenge the status quo. However, in recent Philippine history, Filipinos have been organizing around issues such as corrupt dictatorships and worker's rights. While men did play a key role in both of these movements, the development of the Kilusan ng Manggagawang Kababaihan—Women's Workers Movement (KMK) in the Philippines, and the fight against licensing disputes in the U.S., have demonstrated two key periods when Filipinos have organized. These examples further show that while Filipinos deal with cultural issues that may deter them from organizing, cultural stereotypes do not always hold true and even with less assertive Filipinos, if given the opportunity and the willpower, they will participate in organizing efforts. In addition, Filipinos' background in grassroots organizing efforts contributes to their desire for unionization. Many of the nurses who live in the U.S. today have been exposed to unions or other political organizing efforts in the Philippines.

Unions in the Philippines

Ideologically and politically, the trade union movement in the Philippines had unusual beginnings—regional uprisings, revolts, mutinies and other forms of resistance during the second half of almost four centuries of Spanish colonial rule in the country. The trade union movement at that time, rather than focusing on organizing around labor issues, focused more on organizing around broader national issues. Furthermore, the opening of the Suez Canal, in November 1869, ended the long search for a shorter route between West and East, reducing by about 6,000 miles the old trade route. This opening in turn resulted in easier access to liberal ideas from Europe, such as the ideas associated with the French Revolution of 1789 that influenced Filipino

reformers.[37] Trade unionism in the Philippines first emerged in the 1890s when Filipino wage earners—such as printers, barbers, tobacco, and wood workers—started to organize into craft unions. In 1901, the first formal organization, the Union Impresores e Litograficos de Filipinas (UILF), was formed, and by 1902, a federation, Union Obrera Democratica (UOD), was created, with the UILF its largest organization.[38]

Shortly after the formation of the federation, the workers at the Commercial Tobacco Factory in Malabon staged their first strike on August 2, 1902. This was followed by walkouts in different factories organized by the UOD in Manila and nearby regions. On August 15, 1902, four union leaders were arrested when they ordered the foreman and the employees of a factory to not return to work. The president of the federation, Don Belong, was accused of having ordered the strike and was sentenced to four-month imprisonment. His arrest had been based on a Spanish conspiracy law, which was still in force during American colonization. Belong was charged with violating the provision of the penal code which prohibited the organization of workers to demand for higher wages. Shortly thereafter he was pardoned but only on the condition that he would keep away from future labor organizing efforts or association with labor organizations[39] Dr. Dominador Gomez, a Spanish physician took Belong's place as president of the UOD. Under Gomez, in 1903, the UOD established the eight-hour workday, and, after a year of extensive outreach, the number of organized worker groups had risen to 20,000 in Manila and immediate environs, and the number of federated unions rose to 150.[40]

[37] Dante G. Guevarra, "History of the Philippine Labor Movement" (Ph.D. diss., Polytechnic University of the Philippines: Manila, 1991), 121.
[38] Elias T. Ramos, "Trade Unions and Industrial Relations in the Philippines" (Ph.D. diss., University of Wisconsin-Madison, 1976), 93.
[39] Guevarra, 17.
[40] Ibid, 20.

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

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

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[41] Ramos, 94.
[42] Marcos declared martial law in the Philippines in order to ensure that "what he called the 'oligarchy' and communist insurgency" could not take over the government. (Calixto V. Chikiamco, "Martial Law?," The Manila Times, 16 September 2003, http://www.manilatimes.net (9 April 2004).
[43] Ibid.
[44] Ibid, 170.

Kilusan ng Manggagawang Kababaihan—Women's Workers Movement

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

Wanting to work within political and social justice frameworks, some trade unions turned towards political party activism, a form of social movement unionism defined in this context as "an effort to raise the living standards of the working class as a whole, rather than to protect individually defined interests of union members."[45] Using this approach, the Philippine May First Movement—Kilusang Mayo Uno (KMU)—ran political party candidates with mixed results, mainly attributed to internal conflicts within the union over whether the movement was more reformist or revolutionary, which inhibited the movement form generating broad-based support. However, the KMU's ties to the larger Communist Party of the Philippines, and its armed wing, the New People's Army, differentiated it from other militant labor movements.[46]

Part of this differentiation was attributed to KMU's affiliation with the General Assembly Binding Women for Reforms, Integrity, Equality, Leadership and Action (GABRIELA), which was named after Gabriela Silang, a woman revolutionary fighter against the Spanish colonists. Organized in March, 1984, as an umbrella feminist group of middle-class women, GRABRIELA grew by 1987 to include 100 women's organizations claiming a

[45] Lois A. West, Militant Labor in the Philippines (Temple University Press: Philadelphia, 1997), 2. In chapter 3 a more in-depth discussion of social movement unionism along with an explanation of its historical presence in the U.S. labor movement.
[46] Ibid.

membership of 28,000, which included the Kilusan ng Manggagawang Kababaihan (KMK) or Women's Workers Movement, organized by women from the KMU. KMK represented approximately three percent of total KMU membership, and consisted predominantly of women from the working class.[47]

By the mid-1990s, the democratization processes and splintering of the left had taken a toll on the leftist women's movement. Critics of GABRIELA and the KMK argued that these organizations had too many ties to the Communist Party of the Philippines. These "feminist nationalist" social movements, critics also argued, had competing agendas, among them, their representation of women's concerns, worker's concerns, and the nationalist agenda of the national democratic movement, due in part to GABRIELA and KMK's commitment to the premise that there could be no women's liberation without national liberation.[48] This belief was based on the historical reality that all women face more barriers than men because of their dual labor roles in the workplace and in the home. Concurrently, women are more the targets of sexual harassment by men in the workplace, and they face greater threats of labor union repression; women are not placed as often as men in management ranks of businesses or in leadership positions within unions. KMK attempted to address these barriers, as well as the class differences between women workers and Filipina middle-class women. Also, women involved in the KMK noted how difficult it was to have their interests represented in movements dominated by men. Nevertheless, the Philippines, as described in this chapter, established a rich tradition of women's activism and political organizing.[49]

As part of their mission to form women's committees in trade unions, the KMK developed "women orientations," or educational modules focusing on the historical roots of

[47] Ibid., 73.
[48] West, 74.
[49] Ibid.

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

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

[50] West, 80.
[51] Ibid, 81.

care facility, by paying the union directly to hire a child care worker and providing the space for the facility.

Throughout the 1980s, despite the fact that it represented one of the largest constituencies of the women's movement, the KMK had difficulties in effectively changing policies, which can be attributed to a number of factors. First, class differences set up distinctions among women that made organizing difficult in certain industries. For instance, KMK women organizers commented that in businesses where women workers are paid a high salary, women are not interested in being organized. Second, many women were reluctant to organize because their husbands often felt that their wives already had too many responsibilities on top of organizing. Furthermore, the husbands didn't understand that by organizing the women, the KMK was attempting to develop a larger movement to support the overall struggle of workers.[52] While women have been involved in broader social movements and the labor movement within the Philippines, they still deal with the everyday struggle of balancing family with activist responsibilities. In addition, in the case of many of the women wanting to become involved, they shy away due to the effects it might have on their family.

The example of women's involvement in the Philippines labor movement demonstrates that there has been an active radical women's movement. It also demonstrates that while other factors may have inhibited the women from participating in these movements—such as family—the women have chosen to break out of their gender roles and fight for what they felt was a justified cause.[53] Many of the women that have moved to the U.S. have been involved in this movement, which contributes to their interest in U.S. labor unions.

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[52] West, 85.

[53] In chapter 5 I will further discuss the need for Filipinos to feel passionate about the cause they are fighting for. This especially holds true to Filipinos living in the U.S. because they have commitments, such as family, both in the U.S. and in the Philippines, on top of their work that cuts down on the amount of time they can dedicate to a cause.

Filipino Nurses Organize Around Licensing Requirements

As discussed in Chapter One, during the mid-1970s, Filipino nurses entered the U.S. through new visa categories and encountered new licensing requirements. Philippine and U.S. recruitment agencies took advantage of these new migration opportunities by exploiting Filipino nurse migrants with misleading advertisements, low wages, and poor working conditions. By the late 1970s, exploitive recruitment practices, controversial licensing examinations, and a growing awareness of their complex and unique situation in the U.S. motivated Filipino nurses to organize. These problems led to the formation of three U.S. national organizations—the Philippine Nurses Association of America, the National Alliance for Fair Licensure of Foreign Nurses Graduates, and the Foreign Nurse Defense Fund.[54] Concurrently, Filipino nurses in the U.S. were beginning to feel a growing sense of alienation from Philippine nursing, in particular the Philippine Nurses Association (PNA), because the Filipino nurses in the U.S. no longer felt that the PNA represented their same beliefs. At the same time, however, racist sentiments expressed by American nurses, including a commission of the American Nurses Association, transformed Filipino nurses from a welcome exchange visitor and immigrant into an alleged threat to the U.S. healthcare system. These beliefs stemmed from the American nurses idea that the Filipinos received an inadequate education and training program because they were not educated in the U.S.[55] Although the racist sentiments expressed by American nurses pitted American against Filipino nurses, division within the international nursing community could not be reduced to a simplistic dichotomy. Filipino nurses' creation of a number of different organizations within the U.S. illustrated that their agendas were distinct from those of nursing

[54] Choy, Empire of Care, 160.
[55] Also possibly contributing to the belief that Filipino nurses were a threat to the U.S. healthcare system was the 1975 arrest of two Filipino nurses charged with murdering patients at the VA Hospital in Ann Arbor, Michigan by poisoning the patients. The two nurses were convicted in 1977 but the case was dismissed in 1978 after the defense team appealed the verdict. (Choy, Empire of Care, 121).

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

In the late 1960s and early 1970s, the use of the Exchange Visitor Program decreased, causing occupational immigrant visas to become the major avenue of entry for Filipino nurses wishing to work in the U.S. However, as foreign professionals took advantage of available occupational immigrant visas, backlogs for these visas increased and the waiting period for a third preference visa from Asia was approximately thirteen months.[57] The controversy surrounding U.S. nursing licensing examinations began in 1970 when an immigration amendment dramatically increased employment opportunities for temporary foreign workers; Filipino RNs, with H-1 temporary visas could now fill permanent positions. The waiting time for an H-1 visa was comparatively shorter at approximately 30 to 90 days. Between 1972 and 1978, 15, 291 H-1 visa nurses entered the U.S. and Filipino nurses made up approximately 60 percent, or 9,158 of this total.[58]

Further complicating the issue has been the way licensing is done in the U.S.—each state regulates its own licensing laws. Due to the increasing demand for nursing services, individual states started to implement policies that would ease the licensing process for foreign trained nurses. However, in 1971, New York amended this approach, and other states soon followed, by requiring foreign nurses to pass the State Board Test Pool Examination (SBTPE), which evaluated the knowledge of U.S. nursing practice in five areas—medical, surgical, psychiatric,

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[56] The PNA had established smaller sister organizations in major cities throughout the U.S. However, Filipino nurses were beginning to feel that the PNA in the Philippines did not hold the same desires for how the organization should be run or the mission of the organization. Filipino nurses then started to create other non-affiliated organizations. (Choy, Empire of Care, 167).

[57] A third preference visa is designed for individuals who are "skilled workers, professionals, and other workers," but in order to qualify for the visa, the immigrant must have a job offer from a U.S. institution. (C. Matthew Schulz, "SchulzLaw: Employment Based Third Preference Immigrant Visa," 16 March 2003, http://www.schulzlaw.com/mschulz_e3memo.php (9 April 2004).

[58] Ibid., 168.

obstetric nursing and nursing of children. The National Council of State Boards of Nursing, as part of the American Nurses Association, developed the examination and individual state licensing agencies then contracted with the National Council for its use. According to a 1976 national report, as many as 77 percent of foreign trained nurses failed the SBTPE; in California, 80 to 90 percent of Filipinos failed the exam on their first attempt.[59] While many factors might have influenced the high failure rates, Rosario DeGracio, a professor of nursing at Seattle University and president of the local Filipino Nurses Association, identified influences specific to the Filipino community for its high failure rate. First, Filipino nurses in the Philippines have less training in psychiatric nursing compared with U.S. educated nurses, which could contribute to difficulties in passing the psychology portion of the SBTPE. Second, Filipino nurses claimed that the multiple-choice format of the examination was confusing—also inhibiting their ability to successfully pass the test. Filipinos' failure to pass the examination had a detrimental effect on the visa status of H-I nurses because their temporary work visa status was revoked upon failing the licensing examination and they could no longer work as RNs.[60]

The significance of these state nurse licensing requirements became apparent in the early 1970s when states started to realize the high failure rate among foreign-trained nurses regarding the SBTPE. Trying to counter the problem, the Board of Nurse Examiners in Texas started to grant temporary work permits to H-I visa nurses until they passed the SBTPE. As these permits came available, the number of foreign trained nurses working in Texas increased from 60 in 1970 to 1,752 in 1973. However, still only one of every four or five foreign-trained nurses passed the examination, causing alarm, and in 1973, the State Board of Nurse Examiners refused to grant temporary permits. As a result the INS decided to stop issuing H-I visas for Texas-

[59] Ibid., 169.
[60] Ibid., 173.

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

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

Still upset that foreign-trained nurses were able to earn licenses when they were still failing the SBTPE, the American Nurses Association Commission on Nursing Services, in June 1974, presented a resolution at the ANA biennial convention that had two objectives: to remove the preferential status of foreign nurses with respect to the U.S. immigration policies, and to support the authority of state nurses associations to evaluate the practice of foreign-trained nurses. Unlike the Texas controversy, which focused on Texas hospitals' use of H-I visa nurses that had high failure rates on the SBTPE, the ANA Commission's resolution lumped all foreign-trained nurses together. The ANA looked to pit the interests of U.S. nurses against those of foreign-trained nurses by insisting that U.S. citizens should be given priority in U.S. nursing education, suggesting that the educational needs of foreign nurses with "academic deficiencies" competed with those of American nursing students. The ANA also argued that the presence of foreign-trained nurses in the U.S. was detrimental because they accepted "salaries lower than the acceptable rates for U.S. nurses" and they were "attracted to areas where U.S. nurses cannot find employment."[63]

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[61] Ibid., 173.
[62] Ibid.
[63] Ibid., 172.

Disgruntled with the Commission's decision, nurses and ANA leaders who disagreed with the resolution formed a committee and created an alternative resolution that downplayed a foreign-versus-U.S. dichotomy and instead emphasized the international mobility of all nurses by arguing that "the world-wide mobility of all nurses is impeded by language difficulties and dissimilarities in educational preparation."[64] The resolution also called for the ANA to collaborate with the International Labor Organization and World Health Organization to eliminate misleading U.S. recruitment practices. In conjunction with these resolutions, the committee also proposed the creation of a prescreening examination for foreign-trained nurses to be created by the ANA and other relevant U.S. national organizations. With minimal opposition, the ANA hearing committee and House of Delegates passed the alternative resolution.

As part of the resolution, in 1977, the ANA and the National League for Nursing cosponsored the creation of a new nonprofit U.S. nursing organization, the Commission on Graduates of Foreign Nursing Schools (CGFNS).[65] The Commission would oversee the implementation and administration of a two-part prescreening examination, known as the CGFNS examinations. The two-part exam tested nurses on their nursing competency, which included the five areas of nursing covered by the SBTPE and on their English-language competency. CGFNS leadership attempted to bridge the multiple concerns about foreign-trained nurses by emphasizing both American patients' safety and foreign-trained nurses' welfare; however, the Commission, the INS, and the U.S. Department of Labor also used the CGFNS examination in ways that angered some American and Filipino nurses.

Some American nurses became upset because they felt that the

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[64] Ibid.

[65] Whereas the ANA acts as a professional union for nurses, the National League for Nursing's mission is to advance the quality of nursing education in the U.S. ("About NLN," The National League for Nursing, 2003, http://www.nln.org/aboutnln/ourmission.htm (9 April 2004).

> "Nurses in this country are fighting for a new image, for better salaries, and for other things, and here is the ANA, our representative, helping undermine our efforts. These foreign nurses are not members of our professional organization. They do nothing to further our professional cause!…What is there to be gained by promoting immigration of foreign trained nurses while many young men and women here are unable to enter the profession due to lack of space in available schools?"[66]

Filipino nurses who were upset by this reaction, however, took the opposite point of view, characterizing the Commission and its use of the CGFNS examination as "anti-Filipino." In 1979, the Commission's Executive Director claimed that "the constant and on-going harassment from the various organized groups of Filipinos in this country" was a "major problem."[67] Filipino nurses' dissatisfactions led to the formation of three U.S. national organizations: The National Federation of Philippine Nurses Associations in the United States, the National Alliance for Fair Licensure of Foreign Nurse Graduates, and the Foreign Nurse Defense Fund. The National Federation of Philippine Nurses Associations in the United States was formed to unite Filipino nurses whereas the Foreign Nurse Defense Fund formed to reflect the alliance's inclusion of Filipino nurses as well as non-nurses. The Foreign Nurse Defense Fund functions as an organization that defends the rights of foreign nurses in the U.S. through the use of civil rights legislation.[68]

Though these organizations claimed that they represented the interests of Filipino nurses, each organization had distinct agendas and interpretations of the licensure and foreign-trained nurses controversy. The National Federation leadership struggled for mainstream recognition of the contributions of Filipino nurses in the United States, while the National Alliance for Fair Licensure of Foreign Nurse Graduates demanded an end to what they considered to be a culturally biased nursing licensure examination. Finally, the Foreign Nurse Defense Fund

[66] Ibid., 176.
[67] Ibid.
[68] Choy, "Export of Womanpower," 285.

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

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

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

[69] Ibid., 179.
[70] Choy, Empire of Care, 182.

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

> A comparative perspective on labor unions reveals that the best of all worlds for the workers is coordinated bargaining at the national level and significant rank-and-file engagement at the local level. But the achievement of national and coordinated bargaining is an unrealistic goal in the foreseeable future in the United States. What American labor can do, however, is to become once again a social movement. In order for organized labor to play its critical role as a countervailing power within the American political system, there must be intensified organizing, internal democratization, increased electoral and lobbying clout, and social-movement unions willing to mobilize with others and, if necessary, on the streets.[71]

Today the labor movement continues to struggle to survive; unions are seeking to recruit and mobilize more members on a daily basis and John Sweeney, head of the AFL-CIO, has asked its unions to make a conscious effort to organize new groups of workers. Through these organizing efforts, labor has been able to unionize in fields, such as healthcare, that have not been known for their union representation. While there has been a push to organize in this field, currently only 9.4% of those who work in the healthcare field are unionized, compared to 35.3% of those that work in education, both fields typically considered "white collar."[72] In addition, the healthcare field, especially registered nurses, is largely comprised of a growing population of immigrant, specifically Filipino, workers, with both groups often ignored by labor unions in the past. To revitalize the labor movement, unions need to tap into these "lost" laborers—white-collar workers, immigrants, and women—as a way of refocusing and organizing outside of the original unionized fields.

Impressions of Labor Unions Today

The state of the labor movement and union members feelings about unions have been shaped by the role unions have taken in both unionized and non-unionized workers lives. A

[71] Margaret Levi, "Organizing Power: The Prospects for an American Labor Movement," Perspectives on Politics 1, No.1 (March 2003): 45-68, 45.
[72] Stephen Lerner, "An Immodest Proposal: A New Architecture for the House of Labor," New Labor Forum 12, No. 2 (2003): 9-30, 12.

recent Gallup poll found that in 1999, 66 percent of the public approved of labor unions, a percentage that had increased by 11 points from 55 percent in 1981. In addition, that same Gallup poll discussed that we may be witnessing a revival of organized labor because there has been a growing gap between the haves and the have-nots in the U.S., which may increase the demand for unionization. Between 1967 and 1997, the degree of income inequality increased by 15 percent. However, for about this same time period, unions have increased their members' wages above those of non-union members.[73] In fact, a study conducted by SEIU found that RNs in highly unionized markets of Minneapolis, New York, San Francisco, and Seattle, earn 17.4 percent more than RNs in a nonunion market such as Chicago.[74] Furthermore, union members are so pleased with the benefits they have received through their membership that when asked "would they vote for or against a union in an National Labor Relations Board (NLRB) election at their workplaces," 90 percent of respondents said they would vote yes.[75]

Racism and sexism, two issues once plaguing the union movement, has become more effectively addressed over the years. Today, with unions looking to organize in the service sector, unions are embracing the opportunity to organize more women and immigrants of color. Historically during the time of the New Deal, unions, particularly the craft unions, excluded African Americans and women from joining the unions' membership ranks, and often times "union eligibility was limited to a particular ethnic group or even to the offspring of current members."[76] As unions have attempted to revitalize the movement, this has occurred in the past through the inclusion and organizing of immigrants and people of color, particularly those who

[73] Daniel B. Cornfield, "Shifts In Public Approval of Labor Unions in the United States: 1936-1999," 2 September 1999, http://www.gallup.com (11 April 2004).
[74] "United We Win: A Discussion of the Crisis Facing Workers and the Labor Movement," Service Employees International Union, February 2003.
[75] Richard B. Freeman and Joel Rogers, What Workers Want (Ithica: Cornell University Press (1999), 69.
[76] Nelson Lichtenstein, State of the Union: A Century of American Labor (Princeton: Princeton University Press, 2002), 70.

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

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

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

[77] Jane Slaughter, "Big Labor's Little Problem," The Nation, 25 October 1999, http://www.thenation.com/doc.mhtml?i=19991025&s=slaughter (14 October 2003)., 57.

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

Social Movement Unionism

Through social movement unionism, a type of unionism based on member involvement and activism that can lay the groundwork for the next generation of social movements, unions can provide their members with an outlet to fight for other social justice causes.[79] Social movement unionism differs from other social movements because, according to Lowell Turner and Richard W. Hurd, social movements are "broad society-wide phenomena that rise and fall in

[78] Ibid., 58.
[79] Lowell Turner and Richard W. Hurd, "Building Social Movement Unionism: The Transformation of the American Labor Movement," In Rekindling the Movement: Labor's Quest for Relevance in the Twenty-First Century, ed. Lowell Turner, Harry C. Katz, and Richard W. Hurd. Ithaca: Cornell University Press, 2001., 11.

unpredictable historical waves." Social movement unionism on the other hand is "a type of unionism based on member involvement and activism." Turner and Hurd further argue that "although it is possible to build social movement unions in the absence of the broader social movement, the broader movement more easily sweeps away obstacles and breaks down resistance from entrenched office-holders and conservative forces inside and outside of unions."[80] As part of moving towards social movement unionism, unions would internally restructure their organizing process and shift towards organizing workers similar to the style of the 1930s and 1940s' rank and file approach. In addition, new models of unionism need to be invented in which women, immigrants, and people of color are in the majority.[81] Organizing based on a rank and file process includes: creating worker committees; conducting house visits in which organizers have significant face-to-face contact with workers; focusing on issues such as justice and dignity, rather than solely on economics; and promoting solidarity actions on the job, such as wearing union buttons or organizing groups of workers to "delegate" to the boss what the workers' want. This approach encourages worker militancy as well as leadership development and worker empowerment.[82] This shift in organizing practice has stemmed from today's union activists' beliefs that the transition from the social movement unionism of the 1930s to the business unionism of the 1950s to 1980s left American unions demobilized and to a large extent defenseless in the face of growing employer opposition from the 1970s on.

In the 1930s labor's social movement approach was led by rank-and-file activists and union leaders in mass production industries who had been excluded from membership in the old

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[80] Ibid.
[81] Dorothy Sue Cobble, "Lost Ways of Unionism: Historical Perspectives on Reinventing the Labor Movement," Rekindling the Movement: Labor's Quest for Relevance in the Twenty-First Century, ed by Lowell Turner, Harry C. Katz, and Richard W. Hurd. Ithaca: Cornell University Press, 2001., 83.
[82] Rachel Sherman and Kim Voss, "Organize or Die: Labor's New Tactics and Immigrant Workers," Organizing Immigrants: The Challenge for Unions in Contemporary California, ed. by Ruth Milkman. Ithaca: Cornell University Press, 2000., 84.

AFL and demanded union membership and recognition. The years during and following World War II brought a system of labor relations that was engaged in sharp, seemingly intractable conflicts with the nation's corporate giants—conflicts which were guided by solidarity, militant collective action, a broad sense of class interest and considerable membership initiative and authority—now characterized as social movement unionism. Social movement unionism of the New Deal-era "included a significant number of workers who questioned the very assumptions on which capitalist relations of production were founded and who had an alternative, socialist vision for society."[83] Social movement unionism combined the values and desires of one group to the broader picture of what was best for society as a whole.

During the years following WWII, the national economy began to expand and increase people's yearly incomes; there was greater job security, home ownership, consumer credit, and opportunities for the working class to send their children on to higher education. These economic advancements, however, did not accompany comparable advances in the workplace. Job stress and alienation continued and even worsened as production systems were rationalized. Furthermore, labor force segmentation began to create two divergent tracks, relegating a large portion of women and people of color to the most poorly paid, insecure, low-skilled jobs in sectors that had been largely bypassed by the labor movement during earlier periods.[84] This shift contributed to a change in how unions were viewed and, by 1955 and the merging of the AFL and CIO, union participation levels began to drop. Unions had moved away from social movement unionism and began to use what was known as a business unionism approach—provide collective bargaining, enforcement of the contract, and representational and other groups

[83] Michael Eisenscher, "Labor: Turing the Corner Will Take More than Mobilization," The Transformation of U.S. Unions: Voices, Visions, and Strategies from the Grassroots, ed. by Ray M. Tillman and Michael S. Cummings. Boulder: Lynne Rienner Publishers, Inc., 1999, 61.
[84] Ibid., 65.

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

Furthermore, due to this move towards business unionism, most labor leaders excluded Black and Hispanic workers from skilled jobs because their first loyalty was to their existing, mainly white male, members.[87] Labor's lack of support for the social movements of the 1960s further hurt the labor movement because there was a powerful movement that was transforming society and could well have transformed and reinvigorated labor as well. One exception to this came during the Civil Rights Movement when two unions, AFSCME and the United Auto Workers (UAW), actively participated in a rally that addressed issues with labor practices and unionizing, as well as the civil rights of the workers. During the sanitation workers strike in Memphis in 1968, a thousand black sanitation workers successfully fought for union recognition; this strike victory was used as a springboard for organizing other municipal employees across the South. Unlike the 1960s, labor leaders today are promoting social movement unionism in the absence of a broader social movement, but with the explicit goal of instigating that wider movement to provide the power necessary for institutional change.[88]

Today, despite labor's laudable efforts, most union officials continue to embrace a concept of unionism that rests on an assumption of mutual interests between workers and employers that masks or ignores the imbalance of power between the two. Returning to the Kaiser AFL-CIO

[85] Turner and Hurd, 13-14.
[86] Eisenscher, 61.
[87] Turner and Hurd, 15.
[88] Ibid., 23.

partnership, management promised advanced discussion of strategic business decisions and employer neutrality in union efforts to organize the remaining unorganized Kaiser workers—yet the agreement did not discuss the different cost cutting measures Kaiser was attempting (i.e. facilities closures and job cuts). Kaiser retained the right to act as it saw fit when management and the union did not agree and the AFL-CIO would promote Kaiser as a "preferred" union provider of healthcare.[89] By allowing these deals to be created between a union and business, the union ignored the role the labor movement could play in creating social change beyond the benefits won for the workers; likewise, these agreements undermined labor's long-standing tradition of using the union label as a symbol of decent treatment and working conditions. Rather than cutting deals and only providing a direct service to its members, labor unions need to change their organizational culture by looking to connect communities and create alliances with forces outside of the labor movement. This includes groups that focus on the rights of women, people of color, immigrants, and others. Lastly, unions "need to build a labor movement that recognizes, articulates, and practices values that are fundamentally different from those of the market, namely, solidarity, equality, inclusivity, community, and democracy." By implementing a program based on these values, the labor movement could develop strong ties to communities and to the various struggles against the oppression of others—one that respects struggles for gender, racial, ethnic, and other forms of equality and justice.[90]

Organizing Immigrants

The need to organize immigrants stems from past mistakes of the labor movement when unions would not organize immigrants, particularly those immigrants of color, due to the ability of businesses' to pit workers of color against their white counterparts. Unions within the AFL,

[89] Eisenscher, 71.
[90] Ibid., 78.

for instance, during the early 1900s, "sacrificed members' larger interests to the hope for 'a share of the promised imperial benefits and to the shared psychological satisfactions of personal superiority…over all the lowly, whether foreign, female, or non-white."[91] While unions do not deal with the same amount of prejudice today, immigrants are still currently less likely to be organized than their native-born counterparts.[92] Immigrants who settle in California are even more unlikely to unionize than those who have immigrated to other parts of the U.S.[93] Immigrants in California, where one out of every four workers is not native born, have altered the composition of Southern California's working class. By 1990, one in three Los Angeles County residents were born outside the U.S.; whereas as recently as 1970, only 12% of employed persons in the five-county Los Angeles area (i.e. Los Angeles, Orange, Riverside, San Bernadino, and Ventura counties) were foreign born—by 1990 the figure had shot up to 33%.[94]

However, according to Roger Waldinger and Claudia Der-Martirosian, as immigrants begin to assimilate and become more "Americanized," they decide that they want and deserve the advantages promised by American life—unionization. Also, if immigrants have acquired "'a diploma in exploitation,' to quote a rank-and file immigrant janitor union leader, and have come to resent the maltreatment and stigmatization experienced at the hands of employers and society alike," then immigrant workers may decide that unions provide them with a powerful instrument of collective voice.[95] In fact, immigrants with 18 years or more of residence in the U.S. are just

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[91] Slaughter, 3.
[92] Ruth Milkman, ed. Organizing Immigrants: The Challenge for Unions in Contemporary California, Ithaca: Cornell University Press, 2000., 3.
[93] Roger Waldinger and Claudia Der-Martirosian, "Immigrant Workers and American Labor: Challenge or Disaster?" Organizing Immigrants: The Challenge for Unions in Contemporary California, ed. by Ruth Milkman, Ithaca: Cornell University Press, 2000., 64.
[94] Ruth Milkman and Kent Wong, "Organizing Immigrant Workers: Case Studies from Southern California," Rekindling the Movement: Labor's Quest for Relevance in the Twenty-First Century, ed by Lowell Turner, Harry C. Katz, and Richard W. Hurd. Ithaca: Cornell University Press, 2001., 105-6.
[95] Waldinger and Der-Martirosian, 51.

as likely to be union members as their native born counterparts. Unfortunately California immigrants, even those most settled, are unlikely to hold a union job.[96]

Since the 1960s, highly skilled immigrants have played a modest but significant role in immigration to the U.S., which has allowed immigrants, such as Filipinos, to come to the U.S. as part of the middle class. The movement of immigrants into professional, managerial, and entrepreneurial positions implies that many can move ahead without the benefits that union jobs provide.[97] In the 1990s, as labor unions began to realize the tenacity that many immigrant workers could bring to the movement, immigrants emerged as a core source of union militancy.[98] Immigrants have proved their ability and desire to fight back against those oppressing them and have demonstrated that including them in labor unions not only provides an outlet to recruit more members, but also an added force to the voice of labor.

Organizing Registered Nurses

Similarly to the immigrant labor force, organizing registered nurses (RNs) is key to the revitalization of the labor movement because it provides unions with two areas of the workforce that desperately need to organize—women and white-collar workers. With the exception of the California Nurses Association (CNA) and the Service Employees International Union (SEIU), both of whom looked to organize healthcare workers in California, unions were historically not interested in organizing female occupational categories such as clerical workers and nurses because conservative male union leaders felt threatened by the rising new women's liberation movement during the 1960s to 1970s.[99] Today, labor activists' views have changed towards this workforce and unions throughout the country have pushed towards organizing healthcare

[96] Ibid., 73.
[97] Ibid., 55.
[98] Milkman and Wong, 107.
[99] Turner and Hurd, 15-16.

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

Organizing within hospitals is also good for the labor movement because unlike other industries, such as the garment or other manufacturing industries, hospitals do not have the luxury of capital flight.[100] In addition, there is currently a shortage of RNs in the field because many nurses no longer want to work at the bedside but instead would prefer to go into healthcare management. These two factors give unions a prime opportunity to unionize because hospitals do not have other outlets to find replacement RNs. Concurrently, these two factors add to the sad state of healthcare today, which leads many RNs to desire unionization—and the eventual push towards healthcare reform.

[100] Milkman and Wong, 104.

Chapter Four: Organizing in Hospitals

Unions have been present in hospitals since the early 1900s but only during the past 30 years have union organizing efforts taken off.[101] While independent unions were able to organize in hospitals prior to WWII, the AFL did not see its first real victory in organizing workers in the healthcare sector until 1936 when it successfully organized the engineers and institutional workers (i.e. janitors, kitchen staff, and aides) in three large San Francisco hospitals. The group that was organized included engine room, housekeeping, laundry, kitchen employees, nurses' aides, and orderlies. Soon after the AFL successfully organized those three hospitals, recognition of the benefits of unionization to workers spread and ten other hospitals were able to be organized.[102] The success of the AFL in 1936 can partially be attributed to the passage of the National Labor Relations Act of 1935—also known as the Wagner Act—which protected the right of workers to organize and to elect representatives for collective bargaining. Nonprofit hospitals also fell under the jurisdiction of the Wagner Act, which held significance because prior to the act, nonprofit hospitals did not have the same ability as private hospitals to organize.[103]

Historically, nurses have not wanted to join unions or similar organizations because they believed that these institutions were nonprofessional in nature. The American Nurses Association, the leading nurses organization during the early 1900s, in 1937 announced that it did not "recommend nurses' membership in unions because, in the opinion of the organization, nurses had in the professional organization an instrument better equipped to improve every phase

[101] On June 8, 1919, the *San Francisco Chronicle* ran an article discussing the creation of the California State Federation of Labor and the San Jose Central Labor Council's efforts to organize five state hospitals in the San Francisco Bay Area. The principal demands of the union were shorter hours and better working conditions**.** **(**Leo Benedict Osterhaus, "Labor Unions in the Hospital and Their Effect on Management" (Ph.D. diss., The University of Texas, 1966), 42.)
[102] Ibid., 43.
[103] Ibid., 62.

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

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

Although Federal law and ANA policies hindered the unions' ability to organize within hospitals, by the 1960s, unionization in healthcare started to spread and by 1978, roughly 24 percent of hospital workers had joined unions or associations to bargain with employers over working conditions and for political action.[106] Part of this boom in unionization is also due to the rapid expansion of the healthcare industry, which made the industry fertile ground for labor organizing. Following the enactment of federal and state healthcare programs in 1965, such as Medicaid and Medicare, which expanded the number of nursing homes, healthcare grew from a $42 billion industry to a $212 billion industry in 1979. In addition to the rapid growth of the industry, the composition of the healthcare workforce, particularly in recent years, contributes to the drive for worker organization and collective action. Historically the healthcare industry had been comprised predominantly of women and minority workers in the bottom and middle rung

[104] Ibid., 68.
[105] Leon J. Davis and Moe Foner, "Organization and Unionization of Health Workers in the United States: The Trade Union Perspective," in Organization of Health Workers and Labor Conflict, ed. Samuel Wolfe (New York: Baywood Publishing Company, Inc., 1976), 18.
[106] Ibid., 45.

jobs, which allowed hospital managers to lower their labor costs because hospitals were able to further exploit the already existing patterns of wage and job discrimination in the U.S.[107] Also contributing to the need for unions to organize within the for-profit healthcare sector is hospitals' need to control costs. Managers, trying to cut down on what the hospital spends in order to increase profit have in turn justified placing the burden of cost containment efforts on workers by increasing workloads, while resisting workers' wage and welfare demands.[108]

Still trying to cut costs, hospitals during the 1980s, began to identify the need to restructure how patient care services in order to insure that workers delivered care in the most cost effective way. Through this restructuring, hospitals often put unlicensed assistant personnel in a role that more appropriately required professional training of RNs.[109] Furthermore, between 1995 and 2000, 23 out of some 500 hospitals in California closed. Out of those closures, 65 percent of them occurred in Southern California and over the next few years it is estimated that another 150 hospitals will close. 48 percent of the closures are in for-profit hospitals that attribute the closures to declining reimbursements for services and a low income per bed.[110] These closures have decreased occupancy rates in hospitals and increased the number of patients in outpatient care, causing hospitals to cut the number of acute care positions and increasing the use of unlicensed personnel to perform those tasks that traditionally had been performed by an RN.[111] Frustrated with the direction hospitals are taking within the healthcare industry, RNs are starting to fight back—not only for their safety and worker's rights but also for their patients.

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[107] Ibid., 47.
[108] Ibid., 58.
[109] Susan Harris, "The Union Movement: Legislative and Regulatory Issues in California," Seminars for Nurse Managers 4, vol. 1 (1996): 78-82, 78.
[110] "Financial Problems Most Common Reason Cited for Recent California Hospital Closures Findings in New Study Requested by Attorney General," Office of the Attorney General, 9 May 2001, http://caag.state.ca.us/newsalerts/2001/01-046.htm (11 April 2004).
[111] Ibid.

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

The Unions

While many unions have chosen to organize the healthcare industry, in Southern California, the California Nurses Association and the Service Employees International Union are the two most visible forces in the field today. For the past decade, the two unions have been battling against each other for members and going as far as telling nurses to vote against the other union if that union was attempting to collect cards.[113] However, in a press release on December 15, 2003, the two unions announced their joint cooperation agreement to confront the healthcare industry and the growing number of attacks on healthcare in the state and around the country. As part of this agreement, the two unions will begin working to:

- "Ensure that California's landmark law requiring staffing ratios for registered nurses in acute care hospitals (AB 394) is properly implemented and fully enforced.
- Oppose the displacement of other healthcare employees, and support minimum staffing standards for other caregivers.
- Oppose the repeal of SB 2, which requires additional employers to provide health care coverage for the uninsured.
- Support other efforts to expand access to health care for all Californians and to improve the overall quality of care.
- Defend health care services in the wake of California's budget crisis.

[112] Karen Lucas Breda, "Professional Nurses in Unions: Working Together Pays Off," Journal of Professional Nursing 2, vol. 13 (1997): 99-109, 100.
[113]The two unions had been fighting over the rights to unionizing a group of for-profit hospitals owned by the Tenet Healthcare Corporation.

- Help all hospital employees in California achieve union representation to work for affordable, quality care and fair treatment on the job.
- SEIU will support campaigns by RNs to join CNA, and CNA will support campaigns by professional, licensed, certified and other health care workers to join SEIU."[114]

CNA

Established in 1903, the California Nurses Association (CNA), originally called the California State Nurses Association, currently represents over 50,000 RNs in 150 different hospitals throughout California and is one of the fastest growing professional associations and unions for RNs in the country. In the past seven years CNA membership has doubled and in 2001 to 2002 alone, CNA organized 7, 200 RNs in 17 hospitals.[115] From the beginning, CNA established itself as a professional organization that was not only a voice for RNs but also a voice for policy changes within the health care field. It endorsed the women's suffrage movement in 1908 and fought for the First Nurse Practice Bill, which created a licensing board for RNs.[116] By 1913, technological improvements in healthcare moved patients from seeking care in their homes, to seeking care in hospitals; however, hospitals relied on unpaid students nurses to provide care, which left many graduates without employment opportunities. As labor unions across the country grew, CNA, due to its affiliation with the American Nurses Association (ANA), opposed unionizing because it did not believe that nurses could continue to

[114] "California Nurses Association and Service Employees International Union to Work Together for Quality Health Care in California," California Nurses Association 15 December 2003, http://www.calnurse.org/cna/press/121503.html (14 March 2004).
[115] California Nurses Association, www.calnurse.org (13 November 2003).
[116] Charles Idelson, ed., California Nurses Association: 100 Years of RN Power, (Glendale, CA: Autumn Press, 2003), 4.

be considered a "profession" if they joined labor unions. In accordance with this belief, CNA implemented a "no strike" policy.[117] This was demonstrated though the relationship between CNA and the California Hospital Association, where CHA claimed that they were more willing to cooperate with CNA because of their "voluntary hospital cooperation."[118]

By 1943, CNA had decided to abandon its voluntary cooperation standards and move towards a collective bargaining method of negotiation; the change in policy occurred because World War II enabled RNs to work overseas, receiving better pay than at home, which created a shortage in nurses in the U.S. RN leaders viewed the nursing shortage as an opportunity to press for improved conditions, higher wages, and better benefits. CNA asked the hospitals to recognize it as the formal negotiator for RNs, but initially the hospitals declined to provide such recognition. In July 1946, CNA signed its first collective bargaining contracts, the first contract by any nurses' association in the country, with six Oakland, Alameda, and Berkeley hospitals. The RNs successfully won minimum entry salaries of $200 a month, overtime pay, on call pay, shift differentials, health benefits, a 40-hour work week, and paid holidays, vacations, and sick leave.[119] Looking to divide the RNs, the hospitals began to develop an assembly line-type approach with one nurse in charge of performing a single task, such as administering medication, starting intravenous lines, or caring for wounds. As part of this approach to nursing, RNs, Licensed Practical Nurses, aides and student nurses were clumped into teams responsible for up to 50 patients at one time because economists claimed that team nursing would bring efficiency and profit to the hospitals.[120]

[117] Historically RNs have been taught that fighting for better work conditions or wages is viewed as selfish and against the profession. This idea will later be addressed and expanded on in Chapter 5.
[118] Ibid., 5.
[119] Ibid., 8.
[120] Ibid., 9.

By the mid-1960s, RNs decided that they needed to take more forceful action in order to improve wages and working conditions, while also addressing issues associated with understaffing and heavy workloads. Frustrated by the issues they faced, and because the nurses were not allowed to strike per ANA and CNA's rules, RNs in Northern California Kaiser hospitals launched informational picketing which led RNs in 33 different hospitals to submit mass resignations that later won them salary increases of $600 to $700 a month, eight paid holidays and improved shift differentials. CNA's Board of Directors repealed its "no strike" policy in 1966 that had dated from CNA's affiliation with the ANA, because they felt that striking was less drastic than mass resignations. In 1968, CNA's Board adopted a report recommending specific staffing ratios of 1:2 for patients needing intensive nursing care and in 1976, California enacted the nation's first ICU mandated ratios law.[121] CNA's first sanctioned strike came in June 1969 at eight Bay Area Hospitals participating—after 21 days RNs settled with salary gains and new patient care committees. By June 1974, 4,000 RNs at 42 different Northern California hospitals and clinics went on strike against the large hospitals that had attempted to re-assert control. Finally, in the 1980s, University of California employees won collective bargaining rights and 4,420 UC Medical Center RNs voted to join CNA, which is now regarded as one of the single biggest organizing victories ever for RNs.[122] Parallel to the growth of union contracts, by the end of the 1980s, healthcare had become more like big business and the opportunity to organize an increasingly frustrated RN workforce continued to be available.

The hospitals however, sought to reduce or eliminate even existing union representation. During the early 90s, due to hospital mergers that created record profits, staggering executive compensation, and stock wealth, hospital officials began to pick fights with 1,700 employees at

[121] Ibid., 12.
[122] Ibid., 13.

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

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

[123] Ibid., 16.
[124] www.calnurses.org.

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

SEIU

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

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[125] "Health Care. Consumer Protection. Taxes on Corporate Restructuring. Initiative Statute.," 5 November 1996, http://vote96.ss.ca.gov/Vote96/html/BP/216.htm (13 November 2003).
[126] Idelson, 21.
[127] C. Schoen, "The Labour Movement in Health Care: USA," in Industrial Relations and Health Services, ed. Amarjit Singh Sethi and Stuart J. Dimmock (New York: St. Martin's Press, 1982), 63.
[128] Ronald D. White, "Unions Battle for Nurses," Los Angeles Times, 3 August 2003, sec. C, 1.

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

> "Local Unions are the heart of our organization. They are free to elect their own officers, to adopt their own by-laws, to negotiate their own contracts, to set up their own dues structure, to conduct their own strike votes (if they choose to) and, generally, to function as an autonomous labor organization."[129]

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

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

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

[129] Schoen, 64.
[130] Ibid., 64.

recruitment and retention of nurses in our hospitals and other healthcare institutions."[131] The nurses alliance provides an opportunity for nurses to join an organization that creates a collective voice in order to influence public policy decisions. Currently, members of the nursing alliance are working to enforce the staffing standards, voted into law in California, by ensuring that safe nurse-patient ratios are implemented, which also address the problems associated with the nursing shortage. The alliance is also looking to stop mandatory overtime, protect professional standards by convincing state nursing boards and other regulatory agencies to take a stand against unsafe practices, and to reach the community in order to build support among the public, patient advocates, elected officials, and community leaders, while also promoting our interest in quality patient care.

SEIU's nurses alliance also lead the fight to implement the use of safe needles in hospitals; the first safe needle bill passed in the U.S. In October 1998, SEIU successfully pushed for the passage of California bill, AB 1208 which required the California Occupational Safety and Health Administration (CALOSHA) to issue final safety needle regulations by August 1999. Upset that nearly one million healthcare workers were unintentionally jabbed with needles each year, SEIU wanted to know why federal agencies such as OSHA and the Food and Drug Administration (FDA) had not done something about the problem. In the ten years leading up to the 1998 decision, tens of thousand of nurses, doctors, lab technicians, and other medical workers contracted HIV, Hepatitis B and C and other serious blood-borne disease from accidental needle sticks. Instead of initiating new regulations, OSHA and the FDA supported additional studies, despite strong evidence that would have supported action.

To get the safe needle bill passed in California, SEIU held a series of public actions and candlelight vigils in Sacramento, San Francisco and Los Angeles. SEIU nurses also handed over

[131] "About," SEIU Nurse Alliance of California, http://www.nursealliancecа.org/about/where.cfm (23 March 2004).

1,000 fax messages from healthcare workers across the state to California's then governor, Pete Wilson. Kaiser Permanente, due to pressure from the Coalition of Unions at Kaiser Permanente, joined SEIU in urging Wilson to sign the bill. The joint partnership between management and unions at Kaiser marked the first time the healthcare industry, including the California Health Care Association, supported the safe needle legislation.[132]

Benefits to Unionization for the Hospital

While little research has been conducted on the benefits to unionization for hospitals and patient care outcomes, a few key studies have demonstrated that unionized hospitals do provide an increased quality of care for their patients. Part of this increase in quality of care may correlate to unionization because in unionized hospitals nurses can better negotiate staffing levels, have a greater voice when dealing with the RN-MD communication, and increase nurses' wages, which can contribute to decreasing the turnover rate.[133] In the next chapter I will further discuss these benefits based on responses from RNs through surveys and other original research; here I would like to review the existing literature about the impacts from unionization on quality of care.

A study conducted by Jean Ann Seago, PhD, RN and Michael Ash, PhD, both professors at the University of California, San Francisco, for the *Journal of Nursing Administration*, found a direct correlation existed between union representation and decreased patient mortality in acute myocardial infarction (AMI)—or cardiac arrest patients. The study obtained data from the California Office of Statewide Health Planning and Development (OSHPD) Hospital Disclosure Report database. With this data, Seago and Ash were able to find information from all hospitals

[132] "SEIU Nurses and Healthcare Workers Cheer Passage Of Life-Saving Safe Needle Law," 1 October 1998, http://www.findarticles.com/cf_dls/m4PRN/1998_Oct_1/53048908/p1/article.jhtml?term= (3 March 2004).
[133] Jean Ann Seago and Michael Ash, "Registered Nurse Unions and Patient Outcomes," The Journal of Nursing Administration 32 no. 3 (2002): 143-151, 144.

in the state of California about service provision, finances, and resource utilization; the database also includes information about capital acquisition, labor staffing, and the provision of medical care in each revenue unit of the hospital. The sample used came from all acute care hospitals in California. The dependent variable was the average hospital risk-adjusted AMI mortality rate and was developed in the California Hospital Outcomes Project (CHOP) for years 1991-1993. The independent or predictor variable of interest in this study was RN union status.[134]

The study found that the unionized hospitals in California had more AMI-related discharges, more MDs per AMI-related discharge, and more complex technology, specifically heart surgery services and open-heart surgery. In addition, hospitals with an RN union provided more cardiac services (i.e. cardiac catheterization, a cardiology clinic, coronary ICU, mobile cardiac services, and heart surgery services), which significantly correlated to the 5.7% decrease in mortality rates.[135] According to the President of the Massachusetts Nurses Association, Karen Higgins, this study further points out that "a patient's greatest advocate is a unionized nurse, because unionized nurses have the protected right and the power to stand up for their practice and their profession…and the ability of nurses to stand up to health care administrators over patient care issues have had direct impact on the quality of care patients receive."[136]

A study conducted by Karen Luca Breda, PhD, RNC, explored the need for one "voice." Breda concluded that a collective voice, particularly in a female dominated field in a male dominated society, ultimately benefits the RNs and patient outcomes. Breda found that union membership offered RNs not only the protection of a workers' collective but also a vehicle to bond together for common causes and to develop professional. The union culture in the hospital

[134] Ibid., 145.
[135] Ibid., 148.
[136] David Schieldmeier, "Nursing Journal Study Shows Nurses Unions Improve Patient Outcomes in Hospitals: Patients Treated for Heart Attacks Have Lower Mortality Rate at RN-Unionized Hospitals," California Nurses Association, 26 March 2002 http://www.calnurse.org (7 November 2003), 1.

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

Unions' activity in hospitals over the past 30 years has created an environment for nurses to speak out and fight for their rights; demonstrated through the advancements CNA and SEIU have made in the healthcare industry, such as the passage of the safe needle law. Unions have also proven vital in improving the quality of care hospitals give. Nurses, by creating a collective voice, can improve the quality of care given in hospitals while also protecting their own safety.

[137] Breda, 107.
[138] Ibid., 107.

Chapter Five: Issues Affecting Nurses Today

Within the healthcare system, Filipinos deal with the same set of issues that other RNs face in their work, such as nursing shortages, forced overtime, and unsafe labor practices. However, these issues compound the other problems Filipinos face everyday. In addressing how to organize Filipinos, we must first understand the problems nurses face on a daily basis and then examine Filipinos' feelings about those problems while also looking at issues that specifically affect the Filipino RNs. This chapter will look at how a nurse can develop an "agency for voice"[139]—a way to openly communicate what they do while demanding resources to support their work, the issues most affecting RNs today, and lastly the issues affecting Filipino RNs.

Methods

For the purpose of this research I did an open-ended interview with six nurses, all members of the California Nurses Association.[140] I also distributed surveys to a broad sample of Filipino RNs via nurse leaders that I had spoken with throughout the past year. 100 surveys were distributed and 23 were completed. Other sources of primary research came from my attendance at union meetings during the time I interned with CNA, which provided me an opportunity for direct observation of how these meetings worked and how the different RNs interacted with each other. To help with my recommendations, I interviewed three union organizers, two with CNA and one with SEIU. By focusing on nurses who belong to CNA, the research has been limited to the views of a select group of Filipino nurses. This both benefits and hinders the research. The benefit to only working with a small group of RNs is that all of the nurses have gone through the same organizing process and can therefore speak to a similar set of experiences. However, this

[139] "Agency is the capacity for acting or the condition of acting or exerting power…For nurses, expressing agency depends not only on recognizing the importance of nursing work but their own importance…Agency involves being able to speak for one's self." (Bernice Buresh and Suzanne Gordon, From Silence to Voice: What Nurses Know an Must Communicate to the Public (Canada: Dollco Printing, 2000), 35.

[140] All interviews conducted were done on the basis that all identities were held confidential.

focus precluded developing a larger sampling of nurse voices. The same issues apply to the survey—all respondents worked in CNA organized hospitals or at least a hospital where CNA is currently undertaking a campaign.

Research Findings

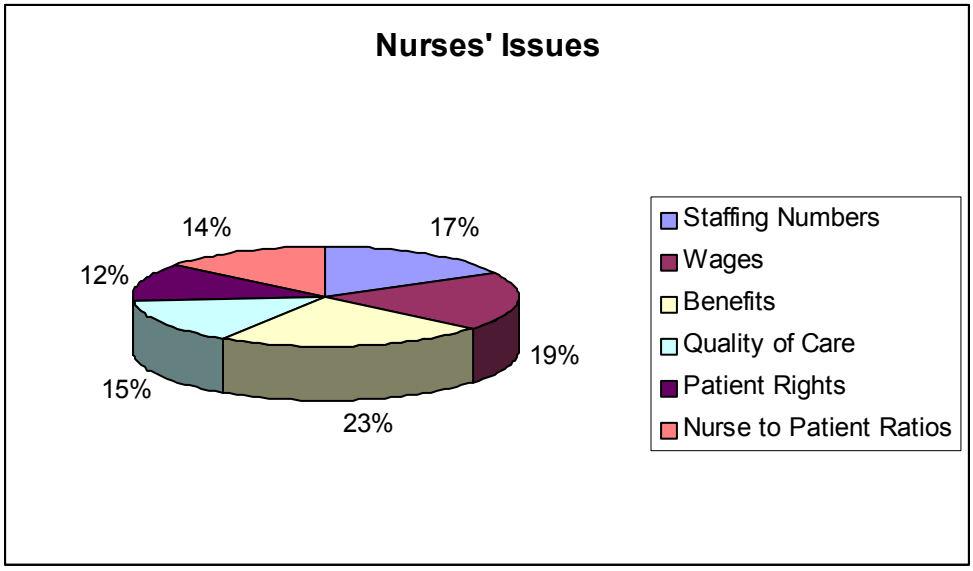
When I first started this research I hypothesized that in order to organize Filipino RNs, an organizer would need to use specific strategies or tactics that an organizer did not use with other cultural groups. Although there are specific strategies that an organizer can use when organizing Filipino RNs, my research has demonstrated that there are not substantial differences in the tactics used when organizing Filipinos. Organizers, however, need to have sensitivity towards cultural issues specific to Filipino nurses, of importance when organizing specific immigrant, ethnic, or racial constituencies.

During my interviews with both Filipino RNs and the organizers, the underlying theme that people spoke about was the need to empower Filipino RNs by addressing the perception of passivity. This passiveness has allowed employers and coworkers to take advantage of them.[141] In addition, Filipinos are viewed by their employers as hard workers but then they are usually the last people to receive raises or promotions. The Filipino RNs that I spoke with attribute this phenomenon to underlying racism that still exists because Filipinos remain "complacent towards aggressors," which stems from the hierarchy of Americans on top and Filipinos on the bottom that developed during the American colonization of the Philippines.[142] The survey reinforced these statements as 38.5 % of the respondents felt that not wanting to challenge the status quo was an issue related to one's ethnic status, and 30.8% felt discrimination was the main issue related to one's ethnic status.

[141] Personal Interview with nurse from Cedars Sinai Medical Center, October 29, 2003, Los Angeles, CA.
[142] Personal Interview with nurses from Cedars Sinai Medical Center, November 20, 2004, Los Angeles, CA.

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

When talking about why nurses organize, the nurses I spoke with stated that quality of care was an important issue for them. However, the findings of the survey conducted showed that on a scale of 1-6, benefits were the most important issue that nurses felt needed to be addressed today, with 23.1% of the nurses selecting it as their number one choice. The second most important issue was wages, with 19.4%, and then staffing numbers, 17.6%, quality of care, 15%, nurse to patient ratios, 14.3%, and patient rights, 12.5%.



In addition, 56.3% of the respondents said that they got involved with CNA because they did not feel that the hospital provided for its workers. Lastly, 50% of the nurses said race discrimination against Filipinos contributed to why they wanted a union and 95% said that gender discrimination was also a factor in deciding to join the union.

For those nurses who had already gone through collective bargaining, 45.9% said that the largest gain they have achieved through organizing was better wages and benefits. Patient to staffing ratios was the second largest at 20.8%, the patient rights at 16.7% and quality of care at 12.5%. Only 4.7% of the respondents said that there were not gains achieved through organizing.

"Creating a Voice of Agency"[143]

Nurses often do not want to organize or join a union because they have learned that to speak out implies that one is selfish. In nursing schools, nurses learn not to question what the doctor has told them to do because the doctor knows what is best for the patient. However, as nurses have often reiterated to me, in order to protect their patients, nurses need to find their voice. Part of finding one's voice is taking credit for what one does.

Silence is a common problem in nursing, which then contributes to people not knowing or understanding what nurses do for them. The lack of understanding of the contribution of nurses to a patient's care is demonstrated through a story retold by Suzanne Gordon:

> "A nurse on the oncology floor at a major teaching hospital spends hours trying to get an intern to order a narcotic for a patient suffering from pancreatic cancer. The nurse has informed the intern that the patient is in excruciating pain. Far more familiar with cancer patients and their pain management than the intern, she recommends a course of IV morphine. The intern refuses to order the narcotic. He simply will not listen to the nurse. Over a period of several hours, she repeatedly engages with him, trying, to no avail, to teach him about cancer pain management. Finally, she corners a resident who agrees with her and directs the intern to write the order. In the patient's chart—the contemporary and historical record of the case—the nurse's struggle with the young doctor is absent. Reading the chart, one would never know that the nurse was responsible for easing the patient's pain and that the intern resisted her attempts to provide appropriate care for the patient to the very end. In this chart the new physician receives the credit for reducing the patient's suffering. Not surprisingly, the patient and her family believed the doctor was her savior. Several days later, the patient wrote letters thanking her caregivers. She expressed her heartfelt gratitude to her attending physician who, during her hospitalization, rarely saw her when she was awake. She specifically thanked

[143] Buresh and Gordon, 31.

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

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

Part of the problem of nurses not wanting to communicate to the public or to try and organize around issues is that they are taught in nursing school that to call attention to themselves takes away from the care they give to their patients. A nursing professor, upset with the idea of nurses talking about their work to patients or to the general public, "beats her fists against her chest and shakes her head vigorously. 'No me, me, me,' she says."[145] This nursing professor comes from a time when nurses were not allowed or supposed to discuss their work because drawing attention to themselves, and giving themselves credit for their work, was a sign of selfishness. In addition, the professor further commented that working with patients was enough of a reward for her and that she did not need to bring attention to her work because that would transform altruism into narcissism.[146]

What Nurses Want

A Voice

Communication is the key to providing for patients. Without communication, a nurse cannot effectively give the quality of care they desire to give. In order to have strong communication with others on staff, underlying respect needs to first develop amongst coworkers, particularly between the doctor and the nurse. As one nurse put it, when she first came to the U.S. in 1962, "we had to stand up when a doctor came into the ward, we had to

[144] Ibid., 34.
[145] Buresh and Gordon, 31.
[146] Ibid, 35

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

Further complicating the MD and RN relationship, doctors often still "think they are up there and you are still on the ground," which, as one nurse put it, hinders a RNs ability to successfully or want to communicate with the doctor.[148] The nurse further states that it is the nurses' responsibility to communicate with the doctor because if something happens to a patient, typically it is the nurse who is directly involved in taking care of the patient, not the doctor. Since the nurse is the one continually around and monitoring the patient, "if [the nurse does] not agree with the treatment [the nurse] should say something because [the nurses] are there 24 hours and [the nurse] does know what the patient needs."[149] In order to fully care for the patients, camaraderie needs to develop between the nurse and the doctor.

Lastly, nurses need to know that they can speak up when a doctor or hospital is practicing unethical medicine. For instance, a doctor at Western Santa Ana Hospital had been performing more neurosurgeries than normal in order to bring in more revenue for the hospital and himself. The RNs, outraged by this practice, mobilized RNs around the issue, while educating the other RNs about the need for a union in order to have a strong voice against unethical practices, eventually the doctor was removed from the hospital.[150] By banding together and voicing their concerns the nurses successfully removed a doctor that they felt practiced unethical medicine.

[147] Personal Interview with nurse from Midway Hospital Medical Center, October 29, 2003, Los Angeles, CA.
[148] Personal Interview with nurse from Cedars Sinai Medical Center, November 20, 2003, Los Angeles, CA.
[149] Ibid.
[150] Author's Notes, CNA Meeting With Western Santa Ana Nurses, September 24, 2004, Santa Ana, CA.

Staffing Ratios

On Saturday, October 10, 1999, Governor Gray Davis signed AB394, the Safe Staffing Bill—a law requiring hospitals to meet fixed nurse-to-patient ratios in an effort to force hospitals to provide high quality patient care. In 1994, CNA proposed its first staffing bill in California but with a Republican majority in the assembly, it never got out of the committee. Realizing that the fight for a staffing bill was going to be a long battle, CNA started to collect stories of patients who had suffered from short staffing and developed advertisements from the stories that ran in California newspapers and the New York Times. One of the most famous ads, "It's 3 a.m. Who will come when you need help?" asserted that "hospitals and HMOs are cutting care to make record profits. Patients are paying the price."[151] CNA also ran articles in its publication, the California Nurse, that explained why hospitals were so short staffed and why legislation was needed in order to insure better patient care. CNA organizers, RN leaders, and other activists distributed leaflets on the issue in both unionized and non-unionized hospitals and in their workplaces, RNs signed petitions to unit managers and administrators asking them to support the bill. Understanding that they needed more than just the RNs' backing, CNA began to distribute educational material to California nursing schools and to different organizations and listservs. Lastly, they encouraged nurses, patients, and other supporters to write letters to state senators and assembly members about their stories and why hospitals' needed the staffing ratios.[152]

After the bill was passed in the assembly, CNA to encourage the more reluctant Senate to follow suit, organized 2,4000 RNs, from unionized and non-unionized hospitals, to gather at the state capital building in Sacramento and in Los Angeles in order to show grassroots support for the bill. The outpouring of grassroots support pushed a sufficient number of Senators to pass the

[151] Buresh and Gordon, 186.
[152] Ibid., 189.

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

The law, which went into effect on January 1, 2004, has, as of early February 2004, improved staffing conditions in 68% of the 111 hospitals CNA surveyed, which accounts for nearly 30% of the acute care hospitals in California.[154] According to the law, each unit would have a set safe nurse to patient ratio:

Units— (nurse:patient[s])

- Intensive/Critical Care 1:2
- Neo-natal ICU 1:2
- Operating Room/PACU 1:2
- Labor and Delivery 1:2/Antepartum 1:4
- Postpartum Couplets 1:4/Women Only 1:6
- Pediatrics 1:6
- Emergency Room 1:4/ ICU Patients in the ER 1:2/Trauma Patients in the ER 1:1
- Step Down 1:4
- Telemetry 1:5
- MedSurg 1:6

[153] Ibid., 190.
[154] "Staffing Improved at Nearly 70% of California Hospitals: Safe Staffing Laws Off to a Good Start Says CNA," 4 February 2004, http://www.calnurse.org/cna/press/2404a.html (12 March 2004).

- Other Specialty Care 1:6
- Psychiatry 1:6[155]

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

According to my survey, staffing numbers was an important issue to RNs today. Nurses care about the staffing issue because the shortage of nurses creates a larger burden on the nurse, it also improves the quality of care given to the patient because RNs are able to give each patient the attention and care they need. Further impacting the problem is that nurses are choosing to not remain bedside nurses because the work is too hard. As one nurse commented, there are a lot of nurses that would like to work the bedside but it is too stressful a job right now; "even when you are off work you are always thinking about work because you are thinking about your patients and trying to remember if you did everything. You think you could have done better for a patient."[156] Without the ratios, the nurse is continually trying to juggle multiple patients and often worries that they have not fully provided for their patient to the best of their ability.

Included in the issue of staffing ratios is the use of unqualified staff to perform RN jobs. For instance, in order to meet staffing ratios, some hospitals have started to ask LVNs, or licensed vocational nurses, to take on the bedside care for a patient. However, this does not reduce a RN's workload because state law only authorizes an LVN to practice under the direction of a licensed physician or RN. The use of LVNs, rather than helping the RNs, forces RNs to have to monitor their own patients as well as the patients the LVN has been assigned:

> In outpatient surgery we usually have a 1 to 5 ratio. On the floor, we had 18 patients sometimes that you had to split between you and an LVN but you still have to supervise the LVNs' patients. It would be better if we had 3 RNs and one LVN. An RN should only have a 1 to 6 ratio at the most and that is with

[155] "Safe Staffing Ratios Questions and Answers Index," 2 February 2004, http://www.calnurse.org/102103/safestaffqa2.html (12 March 2004).
[156] Personal Interview with nurse from Cedars Sinai Medical Center, November 6, 2004, Los Angeles, CA.

> the nursing assistant. If you don't have an assistant then that is still too many patients. It also depends on how sick the patients are. When they do the schedule and assign you patients then they try to even out how sick your patients are…you split up the bad ones and the good ones among the nurses so then one nurse doesn't have all of them.[157]

In order to keep the staffing ratios in effect, nurses need to continue organizing around the issue. Unionization can help this effort by creating on large collective voice around the issue. Unionization can also help prevent the floating of nurses from one unit to another, which is impacted by a shortage in nurses. While most of the tasks nurses are required to do in each individual unit do not typically differ, as one nurse explained, the paperwork required for the different units are not the same; thus, causing a problem if a nurse is not familiar with that particular unit's paperwork.[158] Also causing frustration for the RNs is the use of registry and travel nurses. These nurses, hired by a hospital for a limited time, may not understand how each hospital runs its units. Registry nurses particularly create more work for RNs because the RNs have to supervise registry nurses the same way they have to supervise LVNs. RNs need ratios in order to provide the best quality of care possible. Without the ratios, not only are RNs overworked but the patients could also be placed in jeopardy.

Better Wages and Benefits

The issues that nurses feel most affect RNs today are benefits and wages. Part of this stems from the idea that the nurses are not properly compensated for the work they put into the hospital. For instance, at one hospital in Los Angeles County, Cedars Sinai Medical Center, nurses work 12-hour shifts and after the first 8 hours, the nurse should earn time and a half because technically they are working overtime. To avoid paying time and a half

> But still with the law…when we work 12 hours after 8 hours they lower our rate. So it is still within the law because they just lower our rate. So when you

[157] Personal Interview with nurse from Midway Hospital Medical Center, October 29, 2003, Los Angeles, CA.
[158] Personal Interview with nurse from Midway Hospital Medical Center, February 11, 2004, Los Angeles, CA.

> work time and a half it is like you work straight time during an 8-hour day. The truth is that you are busting it working 12 hours and you should be compensated for your work…before we would get 5 weeks of paid vacation. After a certain year you can only get 4 weeks. So this affects the new nurses. That is a lot of money that Cedars is taking away from you.[159]

Similar to this issue, also at Cedars, hospital administration started to commit time card fraud by asking department managers to roll back people's time cards so that the nurses and other staff were not paid for a full day's work. Fortunately, nurses and CNA uncovered this fraud and the Cedar's administration has started to pay hospital staff back pay.[160]

Though some nurses would say, "the nurse [doesn't] work for money, you work for humanity,"[161] other nurses admit that wages and benefits are very important—in fact, so important that 42.5% of respondents to the survey marked that wages and benefits were the number one issue that most affects RNs today. 56.3% of respondents said they got involved with the union because they did not feel that the hospital provides for its workers. Additionally, Filipino RNs care about wages and benefits because many of them still have family in the Philippines that they send money back home to.

Stop Forced Overtime

In the nursing profession forced overtime becomes an issue particularly when hospitals do not hire enough staff to keep up with the staffing ratios. Unfortunately, the hospital's lack of concern about nurse's needs becomes the nurses' issue. According to one nurse, forced overtime is one of the biggest issues affecting her because she has a family and needs to take care of her children. She knows that other nurses feel the same way but at the same time they understand that if another nurse is not available to care for the patient, then they have to stay until a nurse can relieve them.

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[159] Personal Interview with nurse from Cedars Sinai Medical Center, November 20, 2003, Los Angeles, CA.
[160] Author's notes, CNA Meeting With Cedar's Nurses, October 29, 2004, Los Angeles, CA.
[161] Personal Interview with nurse from Cedars Sinai Medical Center, November 6, 2003, Los Angeles, CA.

Although mandatory overtime affects nurses by forcing them to work longer shifts than normal, forced overtime also endangers the patient because it "contributes significantly to errors by workers who know when they are too tired to work but are required to continue working."[162] Hoping to end forced overtime, in 2001 unions across the country tried to pass The Safe Nursing and Patient Care Act, which would have prohibited a hospital from demanding a nurse to work in excess of his or her scheduled shift—12 hours in a 24-hour period or 80 hours in a consecutive 14-day period. Also included in the bill was the allowance of nurses to refuse to work mandatory overtime.[163] Unfortunately, the law did not pass and unions and nurses have to negotiate a ban on forced overtime on a case-by-case basis.

Filipino RNs and the Hospital

From the time Filipino RNs were first recruited to come to the U.S., they have endured discrimination from both hospital management and their fellow coworkers, especially their fellow RNs. Fifty percent of the respondents to the survey believe that they are or have been "(Mis)-Perceived by others (or self-perception) as 'quiet' or not 'verbally assertive." This perception of Filipino RNs as shy, timid, and docile creates problems among RNs because Filipinos are not viewed as people who will speak out against management or their coworkers. While this impression of Filipinos has proven wrong in the past, as discussed in Chapter Two, Filipinos themselves believe that due to cultural upbringings and standards, Filipinos and more specifically Filipinas, learn to not question authority, or, as one nurse put it, "rock the boat."[164] Also, Filipinas who are shy, hard workers won't complain, "Unless you do really bad things to

[162] "Mandatory Overtime is Hurting Health Care Workers and Damaging Quality Patient Care," 15 September 2000, http://www.uswa.org/uswa/program/content/78.php (31 March 2004).
[163] Ibid.
[164] Personal Interview with nurse from Cedars Sinai Medical Center, November 6, 2003, Los Angeles, CA.

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

Historically Filipino nurses have come to the U.S. through sponsorship by a hospital or family member. Of the nurses interviewed, 66.7% said that they came to the U.S. on a visa sponsored by the hospital. Visa sponsorship by the hospital further complicates the issues Filipino RNs deal with because the Filipino RNs often feel as if they are indebted to the hospital due to the hospital's generosity. For the first few years the Filipino RNs, when given assignments or asked to do something, always "say 'yes, yes, yes,' but if [they] don't start to speak out then people will really take advantage of [them]."[166] The more vocal nurses most always say they no longer feel indebted to the hospital because they have repaid the hospital time and time again. If nurses continue to believe that "they owe [the hospital] a favor," then the hospital will continue to manipulate them.[167]

Part of the manipulation Filipino nurses experience is also attributed to the discrimination they encounter every day on the job. Filipino nurses typically do not earn the same wages as the other RNs, specifically white American RNs. When one nurse first came to the U.S. she knew her salary was lower than the other nurses but she didn't care because she was happy just to live in the U.S. After a year, however, her salary remained lower and she realized that she could earn a higher wage.[168] Another nurse talked about the difficulty in getting raises because she was

[165] Personal Interview with nurse from Midway Hospital Medical Center, October 29, 2003, Los Angeles, CA.
[166] Ibid.
[167] Personal Interview with nurse from Cedars Sinai Medical Center, November 6, 2003, Los Angeles, CA.
[168] Personal Interview with nurse from Midway Hospital Medical Center, February 11, 2004, Los Angeles, CA.

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

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

[169] Personal Interview with nurse from Cedars Sinai Medical Center, November 20, 2003, Los Angeles, CA.
[170] Personal Interview with nurse from Cedars Sinai Medical Center, November 20, 2003, Los Angeles, CA.

Chapter 6: Recommendations and Conclusion

Filipino RNs make up the largest minority working as nurses in the U.S. today. Due to their numbers, they also are the largest targets for union organizing—Filipinos are the one single ethnic group where the union could get a substantial amount of votes because they are the majority in many hospitals[171]. In fact, as stated in Chapter One, 67% of RNs in Southern California are Filipino.[172] Here I will discuss a few recommendations I have for organizers looking to mobilize Filipino RNs. I should point out that these recommendations could act as a universal recommendation for organizing all RNs because although Filipinos deal with separate issues distinct from other RNs, they still seek the same benefits from union organizing. For this reason, my recommendations are as follows:

- Include in the current nursing school curriculum a course on the importance of communication and speaking out for a nurse's rights as well as their patient's.
- Develop Filipino Leaders and Organizers.
- Organize Around Wages and Benefits.
- Promote Social Movement Unionism.

<u>Create Curriculum About the Importance of Voice in Nursing</u>

Part of creating a "voice of agency" is teaching nurses that they have the right to that voice and that their voice can improve the quality of care that they give their patients. Currently, many nursing professors continue to teach their students that nursing is about giving and not taking, which includes the idea that nurses should not speak out about work conditions, benefits, etc. because then the nurse will appear selfish as opposed to selfless.

[171] Organizer Interview, March 13, 2004, Los Angeles, CA.
[172] www.census.gov.

Some nursing schools in the U.S., such as the University of Washington's School of Nursing and the University of Michigan's School of nursing, already offer courses on how to "deliver linguistically and culturally appropriate care to their patients" and "nursing as a societal interpersonal profession."[173] Included in these types of courses should be a discussion on the importance of speaking out and how nurses can successfully have their voice heard. Though a union can provide this voice for the nurses, I am not asking for nursing schools to teach their nurses to join unions but rather asking for nursing schools to change their established and outdated idea that nurses should not communicate to their patients, the public, and their coworkers what they think is best.

Nursing schools should require nurses to read *From Silence to Voice: What Nurses Know and Must Communicate to the Public* by Bernice Buresh and Suzanne Gordon or other books dealing with the same issue because it sets up a framework for why nurses should speak out and then teaches nurses how to utilize tools to speak out, such as the media. Furthermore, the book details the problems that occur when nurses do remain quiet and then gives examples of campaigns nurses have won by developing a collective voice. The benefits of understanding the importance of vocalizing what is important is demonstrated through a story that one nurse mentioned about her friend. The friend was working in the ICU and had been assigned more patients than she felt comfortable dealing with

> "She told the charge nurse that she needed help but they told her that she didn't have proper time management but she had too many patients. She got punished and didn't want to fight. Instead she resigned and went to another hospital. She says she is not a fighter like me."[174]

[173] "BSN Curriculum, University of Washington School of Nursing, http://www.son.washington.edu/eo/bsn_curriculum.asp (6 April 2004) and "Undergraduate Courses," University of Michigan School of Nursing, http://www.nursing.umich.edu/academics/bsn/undergrad-courses.html (14 April 2004).
[174] Personal Interview with Nurse from Cedars Sinai Medical Center, November 20, 2003, Los Angeles, CA.

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

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

Organizing Filipino RNs

Although organizing Filipinos is not that much different than organizing other nurses, there are three key areas of organizing that unions and organizers should focus on in order to have a strong organizing campaign

Develop Filipino Leaders and Organizers

When organizing a diverse population, good organizers will usually try to develop leaders that represent the different groups. This especially holds true when organizing in a hospital because the Filipino RNs are often a little hesitant to trust the American RNs because of

past racial discrimination. However, Filipinos are still fearful to go against what an American tells them to do. In one hospital, an American nurse who was against the union was telling a group of Filipino nurses to vote against the union, which scares organizers because we fear that past issues of Filipinos not wanting to displease Americans will affect their vote.[175] While the Filipino nurses that I spoke with did not speak directly to this issue, one nurse did comment that she feels discrimination that began during the U.S. Colonization of the Philippines still remains an issue today when nurses are dealing with their employers and coworkers.[176]

Filipino nurse leaders and organizers have an easier time establishing a strong relationship with the other Filipino RNs because they can speak the language, Tagalog, as well as talk about the Philippines, where they grew up, where their family lives, and other related issues.[177] In addition, Filipino leaders can benefit the union because they already have strong networks established within the hospital. When moving from the Philippines, Filipinos typically move to areas of the country where they either have family or friends already living there. In many cases, Filipinos even will start working in a specific hospital because they already know people that work there. This helps when organizing because they have strong established bonds among their coworkers. Filipinos are also very welcoming to other Filipinos and eventually to anybody with whom they have established a relationship. In a conversation I had with a nurse, she talked about how she thinks it is easier for her to talk with the other nurses because she has worked with them, already has an idea of who may or may not go for the union, and can communicate to them as a friend rather than a representative of an organization. The nurse also felt that she had an easier time talking with nurses than organizers might because when she was

[175] Organizer Interview, March 31, 2004, Los Angeles, CA.
[176] Personal Interview with Nurse From Cedar Sinai Medical Center, November 20, 2003, Los Angeles, CA.
[177] Organizer Interview, March 13, 2004, Los Angeles, CA.

on a break she could leave her unit and go talk to the nurses in the other units, get their phone numbers so that the she or an organizer can follow up with the nurse later.[178]

As an organizer, being Filipino helps in getting the Filipino RNs to talk with you, however, in the end it doesn't make too much of a difference as long as the organizer is thoughtful.[179] Though an organizer does not need to be Filipino in order to gain the Filipino RNs' trust, it is helpful when running an organizing campaign in a hospital with a large Filipino population to have at least one Filipino organizer to establish initial relationships. Once the RNs trust the Filipino organizer they will be more willing to talk with and develop a relationship with the other organizers in the hospital.

Organize Around Fair Compensation

When organizing Filipinos, an organizer needs to identify which issues that Filipinos care enough about to help in the organizing efforts. Wages and benefits are two of these issues. Filipinos are concerned about their wages and benefits for two reasons. First, according to nurses I spoke with, Filipinos consistently earn less than other nurses and have a harder time getting promoted or receiving a raise. For instance, one nurse talked about how whenever it came time to give nurses an increase in pay she would always get a lower increase than the white nurses in the hospital, but this did not make sense because she was just as good a nurse. While she thinks that being Filipino contributed to her not getting the full increase, she also felt that being openly vocal about the union also contributed to her not receiving the pay increase.[180] Second, many Filipinos still provide for their family here and abroad, creating an extra burden on them to bring in enough income to care for their family. Also, without the proper benefits, such

[178] Personal Interview with Nurse from Cedar Sinai Medical Center, November 6, 2003, Los Angeles, CA.
[179] Organizer Interview, February 20, 2004, Los Angeles, CA.
[180] Personal Interview with Nurse from Cedars Sinai Medical Center, November 20, 2003, Los Angeles, CA.

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

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

Promote Social Movement Unionism

Another issue that Filipino RNs feel deeply about is quality of care. Many Filipino RNs go into nursing because they want to make a difference in people's lives. As one nurse commented, she works as a nurse because she wants to work for the betterment of all humanity. Part of organizing around quality of care issues can be addressed by utilizing social movement unionism tactics and strategies in order to mobilize nurses around a greater cause. Nursing is considered a professional field with a high standard of ethics and part of "being a professional means having a say in work conditions and quality of care. Without the union, we hardly have any say about these issues."[181] Social movement unionism provides a framework for these nurses to speak out about issues around quality of care while also giving those nurses who are not as comfortable speaking out a support network that will help in solving problems in the work environment.

[181] The organizer interviewed originally started as an RN and then decided that working as an organizer would benefit the healthcare industry more than working as an RN. (Organizer Interview, February 20, 2004, Los Angeles California).

Utilizing a rank-and-file approach to union organizing, social movement unionism seeks to include broader issues in organizing. With Filipino RNs, the broader issues include improving the quality of care but also organizing around issues of race and gender discrimination. Fifty percent of the survey respondents said that race discrimination against Filipinos contributed to why they wanted a union and 95% said that gender discrimination was a factor in deciding to join the union. All three of these issues—quality of care, race discrimination and gender discrimination—encompass other social problems that exist both inside and outside of the hospital. In order for nurses to enjoy their work, they need to feel like they are making a difference in peoples' lives and that they are respected for that work. Creating a voice through social movement unionism can provide the nurses an outlet to solve the issues affecting them while also improving the healthcare system. In addition, the promotion of social movement unionism allows an opportunity for unions to recruit nurses on the basis that speaking out and joining a union is not a selfish act but rather a way for a nurse to give more to their patients by fighting for the patient's rights as well as their own. Lastly, by addressing these issues through social movement unionism within the hospital, eventually unions and their members can start to move towards changing how the healthcare system is run in this country.

Further Research Needed

Through other readings and from talking with Filipino RNs, I have realized the need for further research and policy analysis on the effects of the mass migration of Filipino RNs to the U.S. on the Philippines. Currently the Philippines' healthcare system is hurting because Filipinos do not have enough qualified nurses to work in the hospitals. Additionally, Filipino doctors, trained in the Philippines, have started to take the U.S. nursing exam in order to move to the U.S. where they can make four times what they would earn as a physician in the Philippines

as a nurse in the U.S.[182] With an already struggling economy, the Philippines cannot handle losing qualified healthcare providers to the U.S. and other foreign countries.

Filipino nurses have the ability to change how people view them. Through union organizing they can use their voice as an outlet to promote quality of care while also winning the respect that they deserve in the workplace. No longer do Filipino nurses need to allow others, particularly hospital management to manipulate them. By creating their voice of agency, Filipino nurses will help revitalize the labor movement because they will provide a large membership base in a newly organized field. Concurrently, Filipino nurses, in conjunction with other nurses, will ultimately have the ability to start changing the face of the healthcare system today. Nurses know what their patients want because they are the only healthcare staff that continually work directly with the patients and have the opportunity to establish a relationship with the patients. With their voice, nurses can improve the quality of care patients receive. They can also, in the end, help in improving the structure of the healthcare system.

[182] Alan Zarembo, "Physicians Remake Thyself," Los Angeles Times, 10 January 2004, sec. A.

Appendix A: Survey Questions

Filipino RN Survey

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

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

1. Male____ Female____

2. Age?
   a: under 25
   b: 25-40
   c: 40-60
   d: 60+

3. Were you born in the United States? If yes, please skip to question #6.
   Yes____ No____

4. How long have you lived in the United States?
   a: less than 5 years
   b: 5-10 years
   c: 10-20 years
   d: 20+years

5. How did you move to the U.S.?"
   a: Visa sponsored by the hospital
   b: Visa sponsored by a family member
   c: Came to the U.S. with a student Visa
   d: Came as a tourist
   e: Other_____

6. What hospital do you currently work at? _____

7. How long have you worked at your current hospital?
   a: less than 5 years
   b: 5-10 years
   c: 10-20 years
   d: 20+years

8. What made you decide on nursing as a career?
   a: Family and/or friends
   b: Felt it was a good professional opportunity
   c: Wanted to help people
   d: Decent pay
   e: Other_____

9. Why did you move to the U.S.?
   a: Family and/or friends had already moved here
   b: Training program opportunities
   c: Job opportunities
   d: Other_____

10. Do you belong to any groups besides CNA?
   a: Alumni Associations
   b: Social Clubs
   c: Church or Synagogues
   d: Filipino organizations
   e: Political groups
   f: None
   g: Other_____

11. If yes to question #10
- Please list the name(s) of the organizations
- Do you hold office?
- Do you think the organization would be interested in working with CNA?

12. Why did you get involved with CNA?
   a: Had experience with unions or similar organizations in the Philippines
   b: Wanted to join an organization that dealt with quality of care issues
   c: Feel that the hospital does not provide for its workers
   d: Other_____

13. What issues do you feel most affect and need to be addressed by RNs today? Please number your answers in order of importance, 1 being the highest 7 the lowest.
   a: Staffing numbers
   b: Wages
   c: Benefits
   d: Quality of care
   e: Patient rights

f: Nurse to patient ratios
g: Other_____

14. What issues in hospital work do you feel are related to one's ethnic status?
a: Discrimination
b: Having a work visa
c: Not wanting to challenge the status quo
d: None
e: Other_____

15.What kinds of discriminatory conditions (if any) do you think Filipinos face at your work?
a: None, different from other nationalities.
b: More vulnerable to the employer due to immigration issues.
c: (Mis)-Perceived by others (or self-perception) as "quiet" or not "verbally assertive."
d: Other_____
*Do you think the factors listed above played a role in your interest in unionization?

16. What kinds of discriminatory conditions (if any) do you think women face at your workplace?
a: None, different from males
b: economic disparities in salaries / benefits
c: Disparities in promotion/ advancement and opinions solicited
e: Other_____
*Do you think the factors listed above played a role in your interest in unionization?

17. What gains have you and your colleagues achieved through organizing?
a: Better wages and benefits
b: Patient to staffing ratios have improved
c: Quality of care has improved
d: Patient rights are addressed
e: None
f: Other_____

Appendix B: Interview Questions

Filipino RN Interview Questions:

1. Why and how did you become an RN?
2. What made you decide on nursing as a career?
3. What requirements did you have to meet to become an RN? Are they the same as in the United States?
4. Why did you move to the United States?
5. What process did you go through to get here? Did a hospital pay for you to move?
6. When did you come to the United States?
7. What were the challenges to making the adjustment to the U.S.?
8. How are the working conditions compared to back home?
9. Was there anything that you wished for when you first arrived?
10. What was nursing like when you first came to the U.S.?
11. Do you belong to any groups besides CNA? Alumni Associations? Clubs? If so, do you hold office or have you in the past?
12. What are the activities of these groups?
13. Why do you participate?
14. Would there be a way to have these groups work with CNA?
15. Why did you get involved with CNA?
16. What issues do you feel most affect RNs today? Discrimination?
17. That most affect Filipino RNs today?
18. Do you believe that patient rights and quality of care are important issues to address? Why?

19. If so, how would you like to address these issues?
20. How would you describe to me your experience in organizing your colleagues?
21. What tactics or strategies did you use to organize your colleagues?
22. Do you feel that being Filipino has played a role in how you organize? Being a woman?
23. What gains have you and your colleagues achieved through organizing?
24. What challenges and obstacles have you encountered through organizing?
25. What advice would you give to other RNs looking to organize? To other Filipino RNs?
26. Do you feel that the struggle was worth it?

Organizer Interview Questions:

1. When did you become an organizer and what motivated you?
2. What challenges and obstacles have you encountered through organizing?
3. What issues do you feel most affect RNs today? Discrimination?
4. That most affect Filipino RNs today?
5. Let's talk about organizing. What tactics or strategies do you use when organizing (i.e. what issues do you raise, how do you reach the nurses, for example, community groups or associations)?
6. Do your organizing tactics differ in relation to the ethnicity of those you are organizing? If yes, why?
7. What are the advantages of focusing on Filipinos?
8. If Filipino, do you think that being Filipino helps when organizing Filipinos? If yes, why?
9. What advice would you give to RNs looking to organize? To Filipino RNs?

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