“We Aren’t Widget-Builders!” Nursing, the Unionist/Professional Contention and its Consequences for Collective Identity

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Abstract

TUNEKA TUCKER: “We Aren’t Widget-Builders!” Nursing, the Unionist/Professional Contention and its Consequences for Collective Identity (Under the direction of Kenneth T. Andrews)

I examine to what extent members of an occupation group share a collective identity, and whether this identity is enough to foster agreement about the utility of unions to the profession. I interviewed nurses at three hospitals about nursing as a field, their careers, their relationships at work and organizational memberships. I uncovered a collective identity created among nurses across workplaces, positions, and levels of education, and I develop a framework for how these symbolic ties are formed. Nurses connect to one another on one or more of four overlapping dimensions: the community (hospital or unit), category (position or title), practice (patient care) or institutional (nursing as a profession) levels. Each nurse identifies most closely to at least one of these dimensions, which connects them to other nurses who they recognize as being part of a collectivity. They enact this collective identity in the way that they describe what being a nurse means.

Because each category is not mutually exclusive and nurses may have more than one strong connection to a dimension, a collective identity is formed. I also found that collective identity is not sufficient to bring about solidarity for any group, that is that solidarity and collective identity are distinct. My research makes new contributions to the sociological literature on the mechanisms of collective identity and solidarity, professional work, and organizational and institutional solidarity. Its broader impacts are
largely to nursing scholarship and policy. As the population ages, healthcare policy changes, and nursing continues to gain legitimacy as a profession, many of the workplace dynamics that I uncovered will become increasingly important to consider as hospitals try to recruit and retain nurses.
To those who helped me get this far in my academic journey, especially my parents and Joe.
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Table of Contents

Chapter 1: Introduction ................................................. 1

Chapter 2: Review of Literature .................................... 3

  Social Movement Participation .................................... 5
  Identity Processes .................................................. 7
  The Nursing Profession ........................................... 10

Chapter 3: Methodology .............................................. 25

Chapter 4: Findings ..................................................... 29

  Collective Identity Formation .................................... 30
  Solidarity ........................................................... 38

Chapter 5: Conclusion ................................................. 47

References ............................................................... 50
List of Tables

Table 1 .................................................................26
INTRODUCTION

Professionals’ opinions on the instrumentality of unions vary widely, as has been shown throughout the study of work and occupations. These opinions vary on the basis of age, occupation, sex, race, occupation, job commitment, organizational context, and other individual characteristics (Alutto and Belasco 1974, Feuille and Blandin 1976, Griffin 1981). In particular, nurses were found to have a higher degree of attitudinal militancy than teachers (Alutto and Belasco 1974), yet in 2009 only 22.6% of nurses were unionized and this number has been fairly stable since 1983 (unionstats.com).

One enduring puzzle in the social movement literature is differential participation – what drives people to participate in collective action. One of the most influential theories posited is the importance of the formation of a collective identity among protesters. Nursing is a profession with a history of unionization and social movement scholars have been paying attention to the potential of a resurgence of the union movement. Therefore, nursing serves as an excellent case to explore the context for collective identity in the workplace. I explore how nurses’ identities as nurses and as professionals are formed using open-ended qualitative interviewing with registered nurses from 3 different hospital settings. I then use inductive analysis to examine how institutions effect the development of a collective identity among members. The purpose of this paper is to integrate knowledge of the social movements, and organizational literatures to more fully understand the barriers to social movement mobilization, and how professionals develop collective identity. From the exploratory research design, I
identified how educational institutions, organizational membership and occupational status interact to shape collective identity and constrain the potential for collective action.

This research will help us understand what factors prevent workers with grievances from mobilizing and more broadly, determinants of participation and nonparticipation in movements. It will also clarify how the conflict between professionalism and unionization affects nursing work and whether the two ways of understanding work can co-exist, or if it will pose difficulties in certain geographic and professional areas of nursing in creating and maintaining a national nurse’s movement.
CHAPTER 2: REVIEW OF LITERATURE

Professionalization is an important phenomenon for explaining the relationship that occupations have with their own work and within their own associations. While the relationship to other occupations and jurisdiction over work is important (Abbott 1991), it is only part of the process. Once an occupation has differentiated itself from other occupations, it must then maintain its professional status through the promotion of professional ideals to its members and constituents. Professionals are characterized by their expertise, autonomy, commitment to the work and profession, identification with others sharing their profession, ethics and maintenance of the profession’s standards (Kerr et al 1977).

Unionization has traditionally been viewed as leading to deprofessionalization, or the degradation of professional status (Raelin 1988). In this view, a healthy profession would not need to seek out unionism as a solution to threats to the profession, because it would be able to sustain itself without unionization. Therefore, unions do not necessarily lead to de-professionalization, but deprofessionalization can lead to unionism (Raelin 1988). Nurses have been found to place greater professional standards in higher regard in contract negotiations than typical items like pay and benefits (Ponak 1981). This “expansion of bargaining thesis” assumes that professionals differentiate “professional” goals and “traditional” goals when involved in collective bargaining and that those “professional” goals are the more important than the “traditional” ones (Ponak 1981).
Besides suffering from an image problem, unions face difficulties in being able to meet the needs of professionals to create a mutually beneficial relationship. A union with diverse tactics, decentralized control, and worker empowerment that also had extensive experience with organizing professionals would most likely experience the most success with mobilization because they would be most likely to provide the voice that professionals would require. Comprehensive organizing strategies, which use a variety of organizing techniques, are more effective in securing higher win rates in NLRB elections, in almost all organizing environments, including organizing professionals (Bronfenbrenner and Hickey 2004). However, they are not regularly used and most unions in the United States run weak campaigns; even those unions that use the comprehensive strategies most (SEIU, HERE, and UNITE) use 5 or more strategies in only 30 percent of their campaigns (Bronfenbrenner and Hickey 2004). To be successful in organizing professionals, an organization should allow the professionals to set the agenda, therefore retaining control of the professional ideology. Professional unions have lower win rates overall but those rates can be improved by diversifying tactics (Brofenbrenner and Hickey 2004) and using the “social movement” orientation such as in the cases of the Service Employees International Union (SEIU) and National Nurses United (NNU) (Clawson 2003, Fantasia and Voss 2004, Voss and Sherman 2000). A social movement orientation is adopted by a union that promotes rank-and-file leadership -thereby avoiding the traditional top-down approach, frames union membership as a vehicle for social change, uses corporate campaigns to gain leverage over powerful employers, uses the “card check” system, circumventing the cumbersome NLRB procedure, has a social justice orientation, and uses diverse organization strategies
Fantasia and Voss 2000 126-130). Care may be required to ensure that the tactics are not so ostentatious as to undermine the professionals’ perceptions of their own professionalism. Some unions have attempted to branch into professional units in order to increase density, (Brofenbrenner and Hickey 2004) but the challenge remains to convince a professional unit that a manufacturing union can meet its needs, which includes maintaining the professional identity. In order for a unionization attempt to be successful, there needs to be some consensus on its utility in the particular workplace for all of the professionals that it would represent. Because the union as an institution has had a turbulent history and its expansion into organizing professionals is new, unions will have difficulties in securing such a consensus.

Social Movement Participation

Why would some professionals be more receptive to unionization while others are less so? I draw on recent theories of social movement participation to identify major explanatory factors. Numerous explanations have been offered for why individuals choose to participate in collective action, including the social networks they belong to, their biographical availability, the organizations of which they are members, and their attitudes about the movement and some combination of all of these. Klandermans (2001) uses a supply and demand model to explain differential movement participation. Mobilization is the joining of the supply and demand and brings together the social movement actors with opportunities to participate. Social networks, persuasiveness and the perceived cost and benefits of participation will determine the ability for a movement to mobilize constituents. On the demand side, participants will be motivated to act if they
understand the instrumentality of the movement, share a collective identity with the aggrieved and identify with the ideology of the movement. On the supply side, movement organizations will portray the movement as a force that can provide gains for its participants and try to establish an identity for the aggrieved to associate with, thereby lessening the costs of movement participation and diffuse the ideas of movement participation to get them to identify and act.

When unionizing professionals, any mobilization attempts are confounded by the professionalization/unionism tension. Therefore, the mobilization literature alone is important but not sufficient in these cases to explain differences in participation. I argue that cultural explanations may help because they include symbolic concepts beyond rational explanations for actions that may be particularly important to professionals who are concerned with the collective maintenance and development of their identities. Emotions are cultural and ubiquitous and are present in decisions on whether not to protest and what actions to take while protesting (Jasper 1998). They permeate every form of social life (Jasper 1998), so it is reasonable to assume that beliefs and sentiments are instrumental to participation. Beliefs and feelings are themselves culturally constructed (Biggs 2006), so an understanding of those process informs participation theories. At many work sites, involvement in unions by professionals could constitute high-risk activism, requiring a commitment (McAdam 1986) not available to those who are ambivalent to unions’ effectiveness. Attitudes are not sufficient in these instances to allow for participation (McAdam 1986). In cases of high-risk activism, prior contact with other individuals involved in the protest helps is also important to the decision to participate (McAdam 1986), but is not sufficient either, as people have conflicting
pressures pushing them into and pulling them away from protest. Therefore “it is a strong subjective identification with a specific identity, reinforced by organizational or individual ties, that is especially likely to encourage protest (McAdam and Paulsen 1993)”. Becoming a professional requires a significant personal investment because of their nature and the emphasis on expertise, standards, commitment, and autonomy so the subjective identification as a professional should be more salient than professional ties and as such, identity processes receive their own treatment below.

*Identity processes*

The concept of collective identity has been used to understand individual motivations to act and the strategic choices that actors make in protest. However, scholars use the term to mean different things – leading to a critique of “definitional catholicity” of the research before 2001 (Polletta and Jasper 2001). As such, I use the following definition: “…an individual's cognitive, moral, and emotional connection with a broader community, category, practice, or institution. It is a perception of a shared status or relation, which may be imagined rather than experienced directly, and it is distinct from personal identities, although it may form part of a personal identity (Polletta and Jasper 2001: 285)”. This definition while concise and specific, is problematized when predicting politicized activity in the workplace. Due to the hierarchical and bureaucratic structure of many working environments, there are a multitude of conflicting interests represented, confounding the formation of a “worker” identity. Additionally, workers balance and negotiate multiple personal identities, which present them with conflicting interests.
Polletta and Jasper (2001) call for more research into the differences between collective identity and solidarity. Solidarity is defined as “the perceived or realized organization of individuals for group survival, interests, or purposes, which may result from either external threats or internal needs (Coates 2007).” Much social movement research treats these two concepts as one, or at the very least, assumes that if there is collective identity among the groups in the movement, there will also be solidarity. The first problem is that many scholars refer to collective identity as existing at the movement level, either as something that all movements share (Diani 1998), or as a requirement for the formulation and continuity of a movement (Melucci 1996). Because movements encompass many different organizations all with different purposes, it would be problematic to ascribe “a shared status or relation (Polletta and Jasper 2001:285)” to all members of any existing movement. Yet the presupposition that collective identity is found in movements instead of groups has led its conflation with solidarity. Saunders (2007), on the other hand, argues that movement solidarity is a potential outcome of collective identities among movement groups, but that strong collective identities can also serve as a force for preventing solidarity. If groups within a movement lack a strong subjective bond and have divergent strategies and goals, solidarity and the ensuing desire to act in concert will not occur.

Identity formation is a social process in which a person negotiates a proposed identity with people around them. Through social interaction, a person projects an image and others give feedback as to the legitimacy of that image (Hatch and Schulz 2002). In this way, a person claims an identity and others around him or her grant that person the identity (DeRue and Ashford 2010). Organizations provide an “identity workspace” in
which people can conduct identity work, by providing social defenses - collective
arrangements such as work practices or organizational processes that allow a person to
avoid anxiety and stress, sentient communities - those to which members belong that
fulfill their emotional needs and to which they commit, relate and identify, and rites of
passage – institutionalized routines of passing on a group’s culture and norms to an
initiate (Petriglieri and Petriglieri 2010). In turbulent business environments, business
school courses act as identity workspaces and socialization fields so that students
graduate fully prepared without need for additional time for this training (Petriglieri and
Petriglieri 2010). In organizations, identity processes are also social, just as they are in
individuals. Organizational identity is constructed through the interplay of external and
internal definitions, or its image - how stakeholders view the organization, and culture,
how the organization projects itself (Hatch and Schultz 2002, Scott and Lane 2000).
Organizational and personal identity intersect (Kreiner, Hollensbe and Sheep 2006),
impacting personal identity and the collective identity development in the workplace.
Therefore, much like collective identities among social movement groups, collective
identities among members of an occupational group may be specific to workplaces,
occupational ranks or education levels. Strong identification with any of these specifics
may impede solidarity.

Some of the lack of interest may be explained by a lack of oppositional
consciousness (Morris 2001). Physical segregation provides a private space for
aggrieved populations to develop this consciousness. If there is not this physical space,
as there wasn’t at the beginning of the feminist movement, then organizations are used to
create the space for the ideas that develop into the necessary collective identity (Morris
2001). For nurses, their workplaces are integrated with doctors, managers, nurse practitioners and patients. They work long hours and do not seem to socialize much outside of work. Their organizations are for all nurses, not just staff nurses or those providing direct patient care. Therefore, the needs of the front line nurses are being cared for by nurses whose main interests may not be direct patient care, but advancement of the profession. The educational and occupational stratification between the staff nurses, administrative nurses and nurse practitioners prevents the development of a collective identity but is also the source of difficulties in the workplace. One way that other nurse’s unions have met these challenges is by creating unions solely for staff nurses, ie National Nurses United. The hospitals in which they are organized are typically closed shops, creating a safe space for activism, and are led by staff nurses who are aware of and affected by issues confronting those involved in direct patient care.

*The Nursing Profession*

A brief history of nursing uncovers how some of the differences in opinion about the utility of unionization have emerged. Nursing has evolved through four main ideologies over the course of its history: professional, apprentice, managerial, and unionist (Apesoa-Verano and Verano 2003). The professional ideology posited nursing as an occupation to provide a compensated and respected role for women. Its emphasis was the promise of a better life for the nurse as opposed to factory work. From 1873-1893, nurses in the United States set up training hospitals and established the professional foundation for nursing, which had previously been private, unpaid work. The nurses sought standardized education for the practice and control over nursing school accreditation, in order to earn level of independence of similar value to that of
physicians. Professionalism was oriented to the middle-class woman, so an answer for the working-class woman- the apprenticeship ideology, materialized with the perspective that nursing was a trade and was perceived to be rigidly anti-intellectualist. The most important aspect of this ideology was hospital training and bedside understanding, and the mark of a “professional” was hard work and dedication to the craft. The managerial ideology emerged with the end of private duty nursing and the advent of the hospital nurse beginning in the years 1920-1955. With this came new opportunities to advance within the field of nursing, but the price paid was that of professional autarchy, due to the hierarchical structure found in hospitals. Nursing also became more stratified, as higher level nursing specialties separated from regular staff nursing. As an answer to this stratification and the changes in practice that have taken place because of it, nursing has seen a surge in the unionist – working class ideology since the 1980’s, coinciding with the surge of organization and job restructuring found throughout the industry. Although many nurses do see unionism as a way of meeting these challenges, they also see a conflict between the desire to mobilize in order to protect their practice, and the desire to advance the professionalism of nursing (Apesoa-Verano and Verano 2003:85-89). I would argue that these transformations have not been complete, that all of these ideologies still exist within nursing the nursing profession presently, and that nurses identify with these ideologies based on their education and workplace environments.

Nurses, as purveyors of care work, have experienced difficulty with attaining professional status because their predominantly female workforce has been subordinated to a lower status in medicine (Abbott 1991, Glazer 1991). Nurses face the general difficulties that care workers have in demonstrating that caring is actually work and
worthy of professional status (Abbott and Meerabeau 1998). The bureaucratic hospital environment in which staff nurses work can undermine professional standards and privileges. Staff nurses perform their daily duties under the close supervision of nurse managers who hold values that are completely antithetical to nurse autonomy and professional nursing practice which call for a nurse to make decisions and provide care based on the needs of the patient, not on the needs of management. Aides and licensed vocational nurses do much of the bedside care, as it is considered lower level work, thereby removing staff RNs from the bedside and causing job dissatisfaction (Clark et al. 2001). There is also an increase in “floating” for nurses, in which they are required to work in various areas in the hospital, some of which they may not be adequately trained to work in, causing further anxiety, and the perception of reduced quality of patient care (Clark et. al 2001). The increasing amount of paperwork that RNs are required to fill out reduces the time that nurses get to spend with their patients (Clark, et al. 2001).

Possibly, the factor with the most impact is that managed care has created a system where only the sickest of patients are admitted to hospitals, effectively increasing the acuity of the patients that the nurses have to care for, obviously increasing the workload. All of these add up to nurses’ perception of a reduced quality of patient care found in the hospitals (Clark et. al 2001). Given the level of dissatisfaction with the changes to our healthcare system, especially among the nurses working in hospitals, many nurses are looking for ways to make their voices heard (Corey-Lisle, et al 1999). Nurses feel a sense of duty to partake in patient advocacy, and therefore have a need to have a voice in the patient care in their workplaces (Clark et. al, 2001). Under these threats, some nurses turn to unionization as a solution to work problems, further complicating their already
nebulous professional status.

Randy Hodson (2001) defines dignity as “the ability to establish a sense of self-worth and self-respect and to enjoy the respect of others (3)”. He explains the importance of working with dignity as being a necessary component of the dignity that is a requirement in all aspects of human life. He identifies challenges to dignity as: Mismanagement and abuse, overwork, challenges to autonomy, and contradictions of employee involvement. Employees meet these challenges with resistance, citizenship, attainment of meaning, and the social aspects of work life. Hodson points out that unions have been instrumental in providing dignity to some workplaces. However, if dignity is the goal, and employees are attaining it without the use of a union, this may be yet another barrier to unionization, especially if dignity is given a higher value than the perceived gains that union can make. Nursing is not exempt from these threats to dignity; however the collective identity that nurses share in the workplace may provide enough security to meet these threats without the need to involve unions.

In terms of organizing nurses specifically, collective identity is further problematized by the structure of the nursing profession, in which is stratified by varied status positions and ranks, then further divided by fields of specialization. Much like physicians, nurses belong to a wide variety of professional nursing organizations splintering the profession into many smaller factions, giving nursing many quiet voices instead of one large collective one (Scott 2008). When different organizations come together to create a movement, their strong collective identities can actually factionalize the movement, making it more difficult for them to work together (Sanders 2008). Formal, institutionalized authority gives a person an advantage in claiming a leadership
identity that is reflected back by others (DeRue and Ashford 2010) and in this way, professional associations will use this authority to set agendas for their membership. Professional associations help create boundaries around the professional domain and foster agreement among the professionals they represent, simultaneously policing professional norms and institutionalizing practices (Greenwood, Suddaby and Hinings 2002). However the separation of interests across the roles in the nursing profession has led to dissention about fundamental principles such as educational entry to practice and the utility of nurse-patient ratios. Each nurse joins the debate based on his or her own educational, occupational and personal experiences. All of these experiences help to form a nurse’s personal identity, of which the collective identity in this case would be a part, and influences his or her opinion in the necessity of protest.
CHAPTER 3: METHODOLOGY

I set out to explore diverse reasons for perspectives on unionization among members of one occupational group, so I interviewed nurses at three different hospitals. Two of these are affiliated with universities - one public – South East University and one private – Valiant University. A third, federally-funded, unionized hospital – Washington Hospital was to serve as a comparison case. Valiant University hospital had a failed attempt at mobilization in 2000. The study began in September 2010 and was completed in February 2011. Because of the sensitive nature of the information that the nurses will be providing, I interviewed them away from their worksites. I asked the nurses to pick a public place in which they are comfortable talking about these types of issues. This worked very well in the past and the nurses were able to talk freely, allowing me to collect rich data and complete the interviews without interruption. I spoke to nurses from each site, for a total of 25 registered nurses. I did not have any requirements except the willingness to be interviewed, and as such I heard a variety of perspectives and did not interview too many nurses representing only one perspective.

I chose to rely on snowball sampling, a widely used technique in which one respondent leads me to another respondent in order to recruit participants. Any attempts to find a sponsor within the organization may increase the response rate, but could also taint the data. For example, if the sponsor was a coworker or a supervisor, the nurses may not feel comfortable or may be nervous that their answers may be held against them.
One major problem with snowball sampling technique is that it leads to selection bias, in
which the participants are very similar to one another as people tend to be in relatively homogenous groups. To avoid this, I targeted nurses from several different departments in the hospitals. This has allowed a variety of experiences and perspectives. I identified several key informants at each of the sites that do not know each other, so I gained access to different groups of nurses this way.

I use open-ended, qualitative interviewing to collect data on the nurses’ perceptions. This way, the participants could tell me in their own language what happened and how they came to their conclusions rather than being forced to use my words to describe their experiences. Semi-structured interviewing allowed me to ask probing questions when nurses gave interesting and unexpected answers. I also revised the interview guide after initial interviews to address any concerns about clarity. All interviews were audio recorded, transcribed and analyzed by hand. I used thematic coding to analyze the interviews, formulating my theories bases on themes and relationships identified in the data.

The interviews examine the following themes: Education and job history, nursing as it relates to the personal identity, community involvement, workplace relationships, and feelings about means for dealing with workplace grievances, including unionization, membership in professional associations, and hospitals internal policies. I began the interview with background questions about the nurse’s education and job history and how the profession may have changed since becoming a nurse. Next I asked about why they became a nurse and what being a nurse means to them personally. I continued with questions about their family obligations and organization and community involvement. Then, I shift to questions about the pros and cons of their nursing job and whether co-
workers are helpful in dealing with the difficulties of being a nurse. Finally, I ask them about their experiences with hospital grievance procedures, professional associations, and unions and how useful they perceive these processes to be.

I interviewed a total of 25 nurses in the three hospitals – Ten from Southeast University, six from Valliant, and six from Washington. One had worked at both Valliant and Southeast in her very short career, but had left her position at Valliant to return to graduate school in a different field. One had just been discharged from Washington Hospital, and was taking a job in information technology. Another had worked as a travel nurse at both Valliant and South East, and was unemployed at the time of the interview but has since taken a full-time job in a different state. Four of my respondents were men and 21 were women. Registered nurses can be certified for entry-level positions in one of three ways: either with a diploma from a hospital nursing program which takes three years to attain, an associate’s degree in nursing from a community college which takes two years, or a Bachelor’s degree in nursing from a Baccalaureate institution which takes four years. Twelve respondents were Bachelor prepared nurses and 3 of these had earned BSNs as second bachelor degrees. Eight of the nurses had earned either a diploma or an Associate’s Degree in Nursing (ADN) before completing a BSN or MSN and all but one of these nurses were more experienced, apparently older respondents, though I did not ask about age specifically. Four of the respondents had earned Master's degrees (MSN), and four more of the BSN nurses were enrolled in master's degree programs at the time of the interview. Two of the men were diploma-trained for nursing during military service, and later earned Bachelors of Science in Nursing (BSN). Four more nurses had ADNs with no plans to return for advanced degrees. Four of the nurses had diplomas from
hospital programs as their most advanced nursing degrees. All of them had Bachelor’s
degrees in other subjects, and one had a Masters in public health as well. Only one was a
younger, inexperienced nurse who had graduated from one of the last remaining hospital
diploma programs in the country. Sixteen of the nurses were working as staff nurses, had
just left a staffing position or were seeking a staffing position, at the time of the
interview. Two were clinical nurse specialists, two others were nurse practitioners, and
five others held some sort of administrative position or had just left an administrative
position. Their lengths of service as nurses ranged from two years to 40 years, with the
average being 17.36 years, the mode being five years, and the mean being 15 years.

Table 1. Respondent Attributes

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>South East</td>
<td>10</td>
</tr>
<tr>
<td>Valliant</td>
<td>10</td>
</tr>
<tr>
<td>Washington</td>
<td>6</td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
</tr>
<tr>
<td>Female</td>
<td>21</td>
</tr>
<tr>
<td>Diploma Prepared</td>
<td>4</td>
</tr>
<tr>
<td>ADN Prepared</td>
<td>4</td>
</tr>
<tr>
<td>BSN Prepared</td>
<td>16</td>
</tr>
<tr>
<td>Has MSN</td>
<td>4</td>
</tr>
<tr>
<td>MSN in Progress</td>
<td>4</td>
</tr>
<tr>
<td>Staff Nurse</td>
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</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>2</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
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<tr>
<td>Other Administrative Position</td>
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</tr>
<tr>
<td>Range number of years nursing</td>
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</tr>
<tr>
<td>Modal number of years nursing</td>
<td>5</td>
</tr>
<tr>
<td>Mean number of years nursing</td>
<td>15</td>
</tr>
<tr>
<td>Total respondents</td>
<td>25</td>
</tr>
</tbody>
</table>
CHAPTER 4: FINDINGS

The strongest pattern that emerged from interviews with nurses is differences between collective identity and solidarity. While there is a widely shared collective identity among the nurses, solidarity – some sort of motivation to act collectively – was lacking. The idea of being a nurse is experienced similarly whether the nurse is a nurse practitioner, staff nurse, a nurse supervisor, or holds some other administrative function in hospital. Nurses share common commitments to education, certification and the enactment of the professional ideals that they were taught in nursing school in the workplace. Variation is found in the degree to which this collective identity is translated into a motivation to act in concert with other nurses.

Building on Poletta and Jasper (2001) definition of collective identity, I created a framework for analyzing the workplace processes that lead to the formation of collective identity in the hospital. I define “community” as a nurse’s hospital or unit, because community implies a shared space, shared interest, exclusivity of relationships and synchronicity of activities (Crow 2007) and both the unit and hospital comprise all of these characteristics. In this dimension, Southeastern would be the hospital and Oncology would be the nurse’s unit. I conceptualize “category” as the nurse’s position, whether they are a nurse practitioner, other advanced practice nurse, staff nurse, supervisor or serve other function in the hospital. I use Poletta and Jasper’s (2001) term “practice” to define patient care, because the term practice is widely used to refer
to nursing work. Finally, I define “institution” as the nursing profession, including schools, professional associations and licensure organizations. All of the nurses identify with some aspect of nursing which then ties them to other nurses, regardless of position, education, or experience leading to the “shared status or relation” that Poletta and Jasper suggest are required for collective identity. It is the overlapping loyalties that lead the nurses to share a similar experience or feeling when they talk about themselves as nurses. They intersect most clearly at the institutional level.

I begin the analysis with a discussion of the development of the definition of what it means to be a nurse. Next I move into the use of cultural materials that differentiate and tie the nurses together through common expression of their profession - which include clothing and narratives. Finally I show that although nurses share these institutional and cultural similarities, these alone are not sufficient to produce solidarity which would enable them to act as a cohesive group.

Collective identity formation

A frequent point of agreement throughout the interviews is what being a nurse means to the respondents. When asked about why they became nurses and what they liked most about their jobs, the answers were quite similar in that many said that they truly want to take care of others, and they get intrinsic gratification from doing so. Monica, a young black woman working as a bedside nurse in oncology told me:

I get satisfaction and joy knowing that I am making a difference in someone else’s life, every time I go to work, because I work in oncology and people are very sick and I like to give them a little bit of laughter besides the work that I have to do when I'm there I talked to him and just try to treat them normally. It is kind of like a ministry for me, I'm a very religious person I see it as a gift that God has given me to care for them and have compassion.
Ginger works in a quality assurance role that was created for a nurse, and while she is not currently giving bedside care, she echoes Monica’s sentiment about why she is a nurse:

I'm a nurse because I have always liked taking care of people and healthcare professions fascinated me but I didn't want to be a doctor. And initially when I went back for the BSN my long-term goal was a Masters degree to become a nurse practitioner. I speak fluent Spanish, and I have always been very interested in under-served populations, and there are a lot in the counties around here. I always have felt that I have a particular skill set and it would be best served if I was practicing as a nurse. When I went back I was thinking about special ed... I put the two curricula side-by-side and the education bits and pieces were not as interesting to me as the nurse bits and pieces and that weighed into it. Also I have always honestly wanted to be a nurse and there's so much you can do with it - I worked in oncology, and gave chemo drugs, and epidemiology working with those underserved populations...

Claudia became a pediatric OR nurse after doing cancer research, but has connected with the emotional as well as the scientific aspects of her work.

It means, especially in the OR, it's nice to know that you're the patient advocate and there for them and you take a child from a mom who scared to death and you're the mom for the child in the OR, you're the one that's looking after them and taking care of them and holding their hand and they look up at you... It's to be able to hold someone's hand and be empathetic and have a personal touch to hold their hand as they're going to sleep. I think that's what's nice about being a nurse.

Even those whose initial reasons were more practical than altruistic, admit that there is something positive to giving patient care. Annmarie works at the federal hospital in telemetry and was forthright in her assertion that she was not a nurse because she wanted to take care of people. She was looking for a career change and thought it would be a smart move.

I'm gonna be real honest with you here. I would love to tell you that it's because I
just love taking care of people and it's so rewarding, and that's so not true for me. At the time that I decided to be a nurse, I was working at a dead-end job - I pretty much felt like you could put clothes on a monkey and they can do my job. There was nothing important about what I was doing and so I was kind of lost- I didn't know what to do with myself and I started thinking again about how my mother passed away almost 10 years ago. And the hospice nurse that used to come to our house was just, like, one of the best people I've ever met. And she had to drive a significant distance to get to our house and I remember her saying that there is a shortage of nurses. And it just really didn't sink in for me at that time. At this time when I was currently feeling lost in a dead-end job I started to really kind of explore the world of nursing, and my husband’s sister is a nurse and she was talking to me a lot about her days and all the joys and some of the disappointment and just the whole thing the big picture of what her life has been like as a nurse, so I started to think maybe I can do that.

She does not describe the patients as being what connected her to the idea of nursing at first, but she did find comfort in the nurse who cared for her mother and remembered that when considering the career change. She reflects that she is happy with how things have gone so far, and that she does enjoy working with patients and learning from their life experiences.

Dallas is a black male nurse in mental health. He has worked in human services his entire career and was quite concerned about the state of the health care system in terms of helping those with mental health and substance abuse issues. He spoke passionately about the need for systemic change, and did seem to recognize that he did feel strongly about patient care and making a difference in people’s lives. He told me,

I wanted to get into health care and I wanted to be able to make a decent salary and I don't think there's anything wrong with it, or to be ashamed of. I'm 56 years old and I've never had the concept of being a handmaiden... I always let my opinion be known and I'm a realist, nursing is a career, and I wasn't born thinking that I have to save the world but I've always thought that if you do something worthwhile with people and that would make me feel better than something like working with a machine, I just found working with people to be a little bit more satisfying…

Arthur became a nurse after sustaining a devastating injury working on a tugboat.
His mother was an RN and he was lured into the field with the idea of being a nurse anesthetist and drawing a $150,000 per year salary, as he was quoted an anesthesiologist. He never did become a nurse anesthetist, but he sums up his reasons for being a nurse:

I think pretty much everybody in the hospital has the same focus - number one is to draw a fairly substantial paycheck on a regular basis without having to court to get it, and the other is the safety of the person that we take care of and those two things, as far as I'm concerned, go hand-in-hand. I don't apologize for doing this for a living. I don't apologize for getting a paycheck for doing my job. By the same token I also recognize that it's a hell of a lot more than a paycheck and I wouldn't do it if it was only for the paycheck. I truly enjoy taking care of the patients, I truly enjoy interacting with their families, I truly enjoy watching people get better and I truly, truly, truly, appreciate the peace that I get when somebody has to die yet to die with somebody like me at the bedside, not being in pain and knowing that they care, because that's what we do - we facilitate the life process - the whole beginning, middle, and end thing.

To Arthur, the most important aspect of nursing is the personal connection and interaction inherent in the nursing practice. This strong connection to the practice can serve as a tie to other nurses who also identify with the profession in this manner.

Most of the respondents also referred to nursing as their profession, rather than just a job. Respondents frequently discussed their obligations to the profession, such as membership in their corresponding professional associations and made calls for nursing to become more like other allied health professions, like Physical Therapists and Physicians assistants. In fact all of the respondents were members of a professional association. For some, it was to fulfill that obligation to the profession, for others who belonged to a specialty it was a way to keep up on the latest news. Six respondents held offices at the time of their interviews. Gabriele, a Clinical Nurse specialist in Wound care and Ostomy told me:

The benefits are amazing. I cannot imagine not belonging to my specialty.
association. Even just for the networking benefits - most of my best friends are people that I met in the Association. There are educational opportunities, research opportunities. Our group is very engaged in increasing the evidence base and doing research and publishing it. There's a public policy arm of it that works with…it's not a lobbyist but it's a business of some sort in Washington that keeps tabs on all the governmental stuff that affects our specialty and reports back to us and members of the WOCN society visit on Capital - so there's a political arm and a friendship/collegial/mentoring arm. I got a scholarship out of it when I was in graduate school. I think my nursing career would be dramatically less fulfilling without my involvement.

The nurses who fell most strongly into this identification had advanced practice degrees, were in the process of obtaining them, or had definite plans to get them. As a group, they were more concerned about how nursing as a profession was perceived by people outside of the profession than were other nurses. Because of this, they tended to place heavy emphasis on a need for a resolution to the debate on the certification for entry to practice. Kimberly, one of the few diploma-educated nurses in my study took a strong stance in favor of increasing the required level of education, which surprised me, based on her own education level:

We really did ourselves a disservice by not lobbying for better compensation. If you look at the physical therapists’ association - which is mostly men, they lobbied Medicare, they have their own clinics they have freestanding areas where they can prescribe and bill Medicare. Nurses can't; we need a physician so that we can only work in hospitals. But to be freestanding… My ostomy clinic - unless I'm a nurse practitioner - I have to have a doctor over me; I cannot take legal responsibility for it. With physical therapists, they can have freestanding place and I think it's because they're mostly men, and because you have to have a minimum of a master's degree. And now it’s straight to a PhD program. Nursing on the other hand - except in Canada because when I left they were wiping out the hospital programs, and going straight to bachelor programs and I was to bridge, but I left and came to the States. But in Canada, it is straight to baccalaureate and many do a masters program. Here we seemed to go downhill, two-degrees still seems to be the norm, although you do have bachelor's programs. Master's preparedness for management positions … But other than that... And you don't see professionalism in nursing except maybe at Masters or PhD level but other than that it's an old girls network and it bothers me a lot.
She, like several others in the interviews, felt that the lack of clear and more demanding educational standards was undermining progress that nurses could have made in public perception of their profession. Three nurses provided exceptions to this dominant narrative - a senior nurse who is just a couple of years away from retirement, who wanted to just do her job and go home, a young mother with two small children who was frustrated by the fact that she and her husband live “like two single parents” and one woman who had quit nursing between the time that we scheduled the interview and when we actually met.

Once formed, collective identities are expressed through group culture which may include dress, rituals and shared narratives. Cultural materials play a role in how nurses enact their “nursehood”, the most obvious cases being the uniforms. Nurses have worn uniforms to differentiate themselves from other members of the hospital staff, since they have worked in hospitals. With the changing of nursing roles in hospitals, nursing have also changed their dress, leading to anxiety for both patients and nurses alike. Some nurses are glad to shed the old uniforms, which they viewed to be symbolic of a handmaiden status, while others are concerned about their professional appearance in the hospital. Dallas was particularly concerned about differentiating himself from others and that patients and families could not even tell who the nurses were. Lexie, an Emergency Room nurse who was educated in a BA program, was appalled at the way her college attempted this differentiation, by requiring female nurses to wear pantyhose. She felt that it was as degrading as her training in proper “hospital corners” in bed making. Monica chuckled about wearing a hat and cape when graduating from her nursing diploma program. Stephanie, a young nurse practitioner in a Neonatal ICU told me that the
Magnet Program – a hospital certification program for excellence in nursing, is pushing for different scrub colors based on different roles. She observed that: “Medicine is still very gendered so when people see a woman, they assume that they are a nurse. Different scrub colors may help with this.”

Another dimension of collective identity is the shared narrative about nursing autonomy. Most of my respondents mentioned it, whether it was to complain about not having enough, or to delight at being given plenty of it. Autonomy is an important aspect of nursing, and while units and specialties certainly differ in how much they are allowed, the frustrating thing for many of the nurses is still the fact that they are bound by the requirement to receive an order from a doctor, even though they are most often more familiar with the patient than the doctor is. Advanced practice nurses were the most adamant about nursing having a high level of autonomy, but several staff nurses also expressed satisfaction with the autonomy that they were given in their positions. There was an overwhelming consensus that doctor/nurse relations were great, and had improved dramatically since the emergence of nursing as a profession and that the nurse as subservient to the doctor was not a prevalent narrative, but this could be because all of the nurses in my study were in a teaching hospital. In teaching hospitals, nurse often engage in teaching new residents who are fresh from medical schools. Several of the nurses who had worked in community hospitals remarked on the differences in how they were treated in the two different types of facilities. According to Holli, a NICU nurse who had also worked in the Midwest:

I think up there I feel like that the docs ran the show, they gave you an order and this is what you did, but down here feel like I have a little bit more autonomy. The doc will give you a dose and you have to figure everything out with IV rates. Up north they would say your feeding is going up this much this is what you have
to do with your I am down here at the lake they give you like I said this is your total and then let you figure out what to do. I just feel like there's more autonomy down here and it just might be because it's teaching hospital whereas up there it wasn't. Residents came in occasionally but not all the time. You had all of these attendings and a few nurse practitioners and that was it. Down here we have the residents, and the attendings, and the fellows, and the nurse practitioners.

The general consensus was that nursing work is much more valued in teaching hospitals because of the team atmosphere that the teaching mission fosters.

Much has been said about the emotional nature of nursing work and my respondents did confirm that nursing has a strong emotional component to it. However, even when the emotional aspect of the work was not the initial attraction to the field, nurses develop a connection to the practice, to their communities, or to the profession as a whole. Some nurses were more fascinated with the scientific aspects of nursing, than they were with the positive emotions that came with nursing. Yet, they were still very dedicated to the practice of patient care, if not for the caring aspect of it, then for, as Susan put it “getting to put back together what the patient has taken apart” – a reference the medical knowledge that nurses have that enables them to treat and heal and as mentioned several times, deal with life and death processes. Other nurses connected to nursing at the community level, and talked about pride in their hospitals or units. They belonged to unit committees that focused on morale in the unit. This association seems to be found more often in units in which the nurses care for the same patients for a very long time. The two examples from my research are the Neonatal Intensive Care Unit (NICU) and the Oncology Unit. Both of these units used primary nursing, meaning that nurses stayed with the same patients for their entire stays. Given the nature of this practice, nurses bond with their patients. Given the sometimes tragic nature of the termination of
hospital stays in these units, especially in the NICU, the nurses turn to each other for emotional support. In fact, both of these units had grievance, or remembrance committees, and also some way of updating each other on the patients’ health after leaving the facility. Monica talked about how not all of her coworkers viewed patient care as a vocation, like she did, but that they were all very supportive of each other with very few exceptions. In this way, the nurse who is not connected to the practice, either emotionally or scientifically is still connected to the community by helping his or her coworkers with their practice.

These processes lead each nurse to associate with their own perception of the nursing collective identity. Each nurse identifies most closely to at least one of the levels of community, institutional, practice, and category connecting them to other nurses who they recognize as being part of a collectivity. They enact this collective identity in the way that they describe their experiences as nurses. For example, nurses who identify at the institutional level are very concerned with the advancement of the nursing profession and form close relationships with people in their professional associations, while nurses who connect at the practice level are fierce patient advocates and they identify with those with high levels of clinical competence. Because each category is not mutually exclusive and nurses may have more than one strong connection to a level, a collective identity is formed. The overlapping loyalties tie all of the nurses together, regardless of with which dimension they most closely identify.

**Solidarity**

Many factors stifle the formulation of solidarity across the nursing profession, at
the organizational level, and at the institutional level. My questions were specifically about unionization, because I expected that it was an issue that was salient throughout nursing, even if the respondent had not participated themselves. I also anticipated that most nurses would have an opinion about it, and I thought given the region in which the interviews took place, it would be negative. Instead, I found a diversity of opinions in my interviews. Surprisingly, the overwhelming majority of the nurses was not completely hostile to the idea of unionization, but instead views unionization as necessary for a different group of people. For example one nurse spoke about the need for unionization in large healthcare organization, conglomerates such as Kaiser Permanente and Sutter health. Others thought that nurses in other states could benefit from nursing unions, however it is not necessary in nursing generally speaking. Still others thought that unionization was reserved for more “blue-collar nurses”. This sentiment about “blue-collar nurses” was not reserved for the most highly paid and trained advanced practice nurses, and was expressed by two staff nurses as well.

Although only a few of the nurses said so explicitly, they perceived unions to be unnecessary, both because they could not see what a union could really do to improve the situation and because some of them really thought there was nothing wrong with the workplace. My respondents did not say that unions themselves were incompatible with the professional aspects of nursing, although Arthur was very adamant that as educated professionals, a union was completely useless, because in his words, “we aren’t widget-builders”. He felt that nursing should be governed by nurses and that outsiders had no business telling him how to do his job as a professional. He felt that state Boards of Nursing were much better equipped to regulate the activities of nurses and that
unionizing nurses would institutionalize bad behavior. Annmarie, non-union nurse at the
unionized hospital echoed these concerns and pointed out how difficult it is to get rid of
unionized nurses who were not doing their jobs. “What is the difference between a gun
and a Washington Hospital nurse? A gun can be fired,” she joked. However, Lillie, an
older nurse who was very active in Valiant Hospital’s unionization attempt ten years ago,
thinks people are just prejudiced against unions. “Some of Valiant’s residents will rotate
between here and Washington Hospital and they complain about the nursing care over
there, chalking it up to the fact that they have a union. But I know that they have
excellent nursing care over there. And I have worked in unionized hospitals and the care
was just as good as Valiant’s or even better. People are just plain prejudiced when it
comes to unions.” Several other people did not know what a union could do for them,
including the people who worked at the unionized hospital – one of which was a union
steward. Natalie had worked at a California hospital with a very strong union and many
other non-unionized hospitals throughout North Carolina and the rest of the country, and
she saw very little difference in the working environment in the unionized hospital and
other non-unionized hospitals. She acknowledged that nurse-to-patient ratios made her
job easier and were better for the patients, but felt that they were a luxury, “because the
patients need to be cared for no matter what the law says.”

Many of the nurses were union sympathizers in theory, but do not see themselves
as potential participants, because they did not really understand what a union would do to
improve their working conditions, having had no experience with them. Some say they
would attend a meeting if there were to be union activity at their hospital, but that is
probably the extent of their involvement. Fewer than half of the nurses at the unionized
hospital are dues paying members. While I did not ask about the level of political engagement, I did find that most nurses were very busy and just focused on work, school and family. I was told several times of being “meetinged to death”, which would affect a person’s biographical availability for protest. Those who did seem interested and knowledgeable about unions were involved in some type of social justice organizations outside of work or made their political leanings known in other ways during the interview.

A much more divisive issue than unionization in the nursing profession is entry to practice. In all states, you need a nursing license to practice nursing, and you can satisfy this requirement with a diploma from a hospital programs (RN), associate’s degrees (ADN) and bachelor’s degrees (BSN). They are all RNs, but their preparation is different, with the BSN nurses being socialized into ambition that led them away from staff nursing. Most of my respondents were either in graduate school, had been to graduate school or had plans to go to graduate school. The other respondents were already in clinical positions or may have had one at some point in their careers. Most people saw the staff nursing position as an entry-point into career advancement and a couple even looked down upon those who did not want to advance. I only spoke to four ADN prepared nurses and four diploma nurses, but they seemed to be content with the progress they had made and were not hoping to be promoted or get more certifications, with the exception of one young, diploma-prepared nurse who was going to begin a bridge program this fall and one ADN who was leaving nursing altogether. Doris, a nurse practitioner who started with a diploma, then went on to get a BSN, MSN and post-graduate certificate claimed that ADN nurses are not prepared for the future of nursing.
because their skills are very technical. “There is so much to learn in those 2 years that there is not enough time for them to learn how to read research and how to apply it to their practice. It is up to the BSNs to understand it and teach the ADNs how to execute it.” Then later she added:

I really would love to see the four-year degree be the entry level into the RN. But I think as long as health care costs are rising and there's basically a shortage in nursing. We have to depend on the community college system to turn nurses out. Part of it is because the physical therapists have moved into a clinical doctorate for their practice, and you're seeing pharmacists are getting their doctorates and we’re looking at getting nursing up to that speed to be more respected because nurses are the only ones that have so many points of entry.

Her sentiments were prevalent among younger, BSN–prepared nurses, and other advanced practice nurses. The overwhelming sentiment among these nurses was that in order for nursing to be treated and compensated appropriately, they must be held to a higher educational standard. There are some problems with its execution however, which is why this is a contentious topic. As Doris mentioned, there is a problem with a nursing shortage, which makes the two-year programs a necessity. Another issue is the fact that in the different levels of education, there are different emphases on technical proficiency. As she illustrated, Associate’s-degree preparation is highly technical with less of an emphasis on theory, while bachelor's degree preparation is heavier on theory and some have argued, turns out less technically proficient nurses. Monica, the young diploma prepared nurse told me, “My boss told me that she would prefer a graduate from [my program] over graduate from [a BSN program] any day of the week. They come in here and they don't know how to do anything.” Susan agreed. "Just because you're good student does not make you a good nurse, and just because you're not a good student doesn't mean you're not a good nurse.” So although the different levels of education may
affect the public perception of nursing, they serve an important purpose in getting the
nursing job done.

These educational differences cause more problems within the nursing field and
lead to different status designations for different job roles. Several of the more educated
nurses used the phrase “just a staff nurse”. Some of the dedicated staff nurses used the
equally derogatory term "clipboard nurse" to refer to advance practice nurses and
managers. Annmarie expressed frustration with nurses who did not want to advance their
careers and choose to stay at the bedside:

I am surprised at the amount of older nurses that have not gone back and gotten
certain certifications in other areas - they have not gone back and gotten Master’s
degrees and that sort of thing because I think, you know as I said before, nursing
is hard work and hard on the body and I'm just trying to wrap my mind around
why anyone would want to do staff nursing for 20 or 30 years. It’s just insane…. I
don't know how you mentor an older person about that. You want to tell them to
some degree, especially the ones that are like, they complain a lot and they are
just unhappy with life, and it's like you want to say, well, maybe if you apply
yourself a little more then you wouldn't have to deal with these things.

Gabrielle further illustrated this division with this answer about challenges to
nursing professionalism. “I personally do not feel my professionalism being anything but
appreciated. I hang out with all other advanced-practice nurses and I think we all feel
really good about our roles and it’s not like I am sitting around the lunch table with
regular staff nurses so I really don't know how they feel”. When I asked Doris about how
a unionization attempt at her hospital would affect her job personally, she said "it
wouldn't at all. I'm one of them,” emphasizing the difference between staff nursing and
advanced practice nursing in terms of the utility of collective action. These advanced
practice nurses clearly experienced themselves as being very separate from staff nurses in
their hospitals. Yet both at other points expressed a strong commitment to the nursing profession, which clearly would not exist without the work of staff nurses.

Many of the staff nurses complained about the management being out of touch with patient care needs. There was a lot of discussion about those nurses forgetting what it is like to be on the floor, since their ambition led them into the management path. Here there were also accusations of diminished patient care, and looking out for the hospital’s bottom line, instead of patient care and the health and safety of the nursing staff. Lillie, a BSN-prepared nurse and self-described “feisty old broad” who was very involved in Valiant’s unionization attempt, summed it up like this:

Valiant has a lot of nursing governance type stuff now and they do do that and I am even on the Nursing Governance Council which I thought was Valiant's answer to the union but I think it's just a horse and pony show. I think it's a chance for – well, most of the members are managers and executives and not many of us are staff nurses and it's an opportunity for the administration to tell us how wonderful things are and how hard they are working to make sure that things will work wonderful. I don't think they have a committee on nurse governance for staffing. They are talking about giving the night nurses five couplets because they don't do much at night anyway which is a joke because that's when you can get a lot of breast-feeding work done because there aren't a lot of visitors around and a lot of stuff goes on at night that needs to be taken care of and they have emergencies just like the day people… Our productivity is crazy because it's linked to deliveries which is crazy because that's not everything that's done but I think you can say that with most jobs.

Around the hospitals, people complain about the structure of their work but they do not see protest as a solution to their problems. The most common structural complaints were about overwhelming workloads, not getting lunch breaks – paid or unpaid, 12-hour shifts and the way that nurses are scheduled. For one thing, South East University Hospital is a state-run, therefore, the employees are not allowed to collectively bargain – rendering striking useless and potentially illegal. However, every single staff
nurse that I talked to from Southeast talked about having to go to extreme lengths to eat their meals, like doing it while entering data into a patient’s chart or sneaking out to the restroom to eat wolf down a Power Bar. But the real issue is the nature of nursing extreme discomfort about leaving one’s patients to take care of one’s own needs. The overwhelming sentiment is that the patient comes first, and as such, ratios and mandated breaks are useless, because if the patient needs care, that need is primary. Beth, a supervisor in a non-nursing department who desperately misses staff nursing said about nurse staffing ratios: “I don't know how you can legislate that.... The ICU has 1/2 nurse/patient ratios and I think that is great, but sometimes that has to change, because, you know, someone has to take care of the patients.” While acknowledging that there are problems with the nursing job, the nature of the job is that it is always changing and there is another human counting on the nurse for care. Protest does not have the ability to change that, especially not protest in the form of striking, which many nurses find distasteful because it leaves patients without care.

The idea of striking or making too many waves and upsetting management is a cause for anxiety. When I asked Kimberly about what nurses in her hospital thought about unions she replied, “I don't dare bring it up - I would be worried for my job… You cannot talk about it in this property, maybe at a bar across the street, but I wouldn't even talk about it there.” She felt strongly that her hospital needed a union because of many injustices perpetrated on staff nurses but feared retaliation. Maria, a Filipino nurse, thought it would be particularly helpful to have a union but was convinced that she would lose her job for even talking about it. And yet she was instrumental in helping new Filipino nurses find their way and their voices in the hospital, providing advice about
surviving confrontations. In fact, most of the nurses talked about working collectively with their coworkers to get their work done by navigating the various barriers put in place by “clueless” nurse managers, “arrogant” doctors and strange hospital policies. While the nurses value the state’s Nursing Practice Act, and would not do anything illegal or unsafe, some of the tactics they would use were forms of resistance. Candace, a young woman who hated nursing and had quit her job to get a degree in public health giggled when she recounted teaching newer nurses how to manipulate residents and interns. She needed them to give her all of the orders that she needed for the rest of her shift, because she knew that a more difficult physician was coming in later. When it worked, she passed the knowledge on to others. These “quiet” ways of developing support at work were perfectly acceptable, but organized dissent was especially troubling.
CHAPTER 5: CONCLUSION

While there is a collective identity which encompasses what it means to be a nurse, the differences in the perceived utility of unionization may be explained by differences in positions held in the workplace and level of educational attainment. My findings indicate that it is not actually the present organizational membership that is most important to feelings about collective actions, but their nursing education which socialized them to the profession and began the formation of their identities. The level of education that they attained prepares them for their future occupational rank, and socializes them into a way of thinking about their professionalism, autonomy and by extension, formulating their ideas about unions. In this way, nursing schools are like business schools – sites for socialization and identity work or “Identity workspaces” (Petriglieri and Petriglieri 2010).

Just as organizations typically develop relationships with stakeholders, giving them more access to organizational culture and influence on identity, so have changes in healthcare allowed patients more access to decisions about their own health. These institutional changes at have transformed the healthcare system and the job structure of the nursing profession. This, combined with the history of the profession, has created a situation in which many nurses feel the need to defend their professional status. Some successful unions have created an actual solution to this problem, by catering the nurses’ needs to be viewed as a professional while also having a venue in which they
can advocate for their patients needs. Other unions have fallen short in this regard, failing to recognize the delicate situation that accompanies unionizing professionals. In this context, nurses will more than likely develop opinions on the utility of unions, professional associations other forms of collective action, and these views are the focus of this study. The state of the labor movement, how nursing jobs are changing, and the socialization of the professional nurse should color the way that the nurse views his or her own place in the profession and the most effective way to overcome obstacles to patient care.

Many studies have noted the tension between nurse professionalism and unionism (see Fantasia 1988, Glazer 2001, Clark et al 2001 for examples), but we lack studies examining the consequences of this tension for social movement mobilization, examined through in-depth, qualitative study. Many qualitative studies are more concerned with other aspects of the nursing profession, such as the intersections of race, class and gender in nurse’s unions (Johnston 1994, Apesoa and Apesoa-Verano 2003). None that I have encountered use social movement theory to examine aspects of mobilization. Doing so provides us with the opportunity to examine how the professional status of these workers affects their understanding of the movement and barriers and opportunities for their own participation. Healthcare is one industry that is becoming more unionized, because of the rapid industry-wide changes, as other industries are seeing a decline in unionization (BNA Plus 2000). With this case scholars have the opportunity to study a growing movement that is experiencing some success, so individual perceptions of the factors that lead to mobilization and participation can help us to understand more about how social movements form and reach other constituents.
The professional/unionist tension previously mentioned is just one factor that may affect the way that nurses view their own desire to participate in unions. Nursing jobs are changing with improvements in technology, and while older nurses may resent these changes, new nurses may view these changes positively, thereby rendering a union unnecessary to some proportion of the staff. A hospital grievance process or a professional association may suffice to answer workplace dissatisfaction. Changes over the years have affected union density in the private sector and have caused difficulties for unions that are trying to maintain themselves or revitalize. The most successful unions are those that diversify their tactics, however, only a very small proportion of unions have begun to change their strategies (Bronfenbrenner and Hickey 2004). If nurses do not articulate a need for a union and unions cannot convince nurses that they would be better equipped to do their jobs with union representation, then nurses will not be motivated to join—just as any organization would have difficulty mobilizing constituents that they could not convince needed their help. Movement participation is affected by a person’s biographical availability, the organizations to which they belong, and their beliefs and sentiments. All of these factors present simultaneous barriers and opportunities for nurses to participate in unions due their ideological commitment to the profession and their patients, long, odd work hours, hospital hierarchy and workplace socialization which begins in nursing school. This study illuminates these factors and others that explain differential participation and professional perceptions of union activities.
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