HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Joan S. Guy

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In First Person: An Oral History

Lewis E. Weeks
Editor

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CHRONOLOGY

1945-1948	Presbyterian Hospital, Chicago, Diploma, Nursing
1948-1952	Municipal Hospital, Two Rivers, WI, Staff Nurse
1949-1952	Carroll College, B.A. Psychology
1949-1951	Carroll College, Student Health Service, Staff and Head Nurse
1951-1952	Municipal Hospital, Waukesa, WI, Staff Nurse
1956-1957	Sparrow Hospital, Lansing, MI, Staff Nurse
1957-1960	Dr. Hyman Shapiro, Office and Surgical Nurse
1960-1962	Sparrow Hospital, Head Nurse (E.R.)
1962-1968	Michigan Nurse's Association, Assistant Executive Director
1962-1967	Michigan State University, Graduate Work, Adult Education
1968-1979	Michigan Nurse's Association, Executive Director
1968-1979	Michigan Nurse, Editor
1979-1983	Michigan Nurse's Association, Associate Executive Director
1983-	Michigan State University, College of Nursing, Adjunct Instructor
1983-	Consultant & Lecturer in Nursing

MEMBERSHIPS & AFFILIATIONS

Administration Program, Wayne State University, College of Nursing. Advisory Committee, Member (past)

American Nurse's Association, Member. Bylaws committee (past)

American Nurse's Association/National Student Nursing Association, Committee on Common Interests and Goals, Member 1978-1984

American Nurse's Foundation, Honorary Trustee 1981- ; Board of Trustees Member and Vice Chairperson (past)

Citizens for Better Care, Board of Directors, 1983-

Concern for Dying

Family Nurse Clinician Graduate Program, Michigan State University College of Nursing, Liaison Group, Member (past)

Michigan Department of Public Health, Nursing Advisory Committee to the Director, Member (past)

Michigan Department of Social Services, Adult and Family Services Advisory Committee, Member 1978-

Michigan Diabetes Research and Training Center, University of Michigan, Advisory Committee, Member (past)

Michigan Heart Association, Project Advisory Committee for Coronary Care Education, Member (past)

Michigan Long Term Care Council (past)

Michigan Nurse's Association, Member

Michigan Nursing Home Coalition (past)

Michigan Public Health Association, Member

Michigan Women's Commission (past)

National Commission for Study of Nursing and Nursing Education, Member (past)

National Student Nurse's Association, Sustaining Member; Consultant 1978-1984

Nursing Project, University of Michigan, Regional Nursing Advisory Committee, Member (past)

MEMBERSHIPS & AFFILIATIONS

(Continued)

Sigma Theta Tau, Alpha Psi Chapter, Public Policy Chairman, 1983-

Task Force on Credentialing in Nursing (past)

Task Force to Study Sexism in Schools, Michigan Board of Education, Member (past)

AWARDS AND HONORS

Carroll College	Magna Cum Laude Delta Sigma Nu (Academic Honorary Fraternity) Who's Who Among Students in American Colleges & Universities	1951 - 1952
Michigan Nurse's Association	Resolutions of Appreciation and/or for Outstanding Service	1973 1978 1979 1983
Michigan Association of School Nurses	Distinguished Service Award	1981
Sigma Theta Tau (Alpha Psi Chapter)	Humanitarian Service Award	1982
National Student Nurse's Association	Honorary Membership Award	1983
Michigan Student Nurse's Association	Honorary Membership Award (First accorded)	1983
Mayor, City of Lansing	Proclamation - Joan Guy Day	1983

WEEKS:

I would like to have you talk about the history of labor negotiations particularly in the Michigan area. Possibly you could fill me in on the picture of labor relations generally in the nursing profession.

GUY:

The movement toward a labor relations program in nursing (formal program) at the national level really began in California. There was a leader known as Shirley Titus who was the Executive Director of the California Nurses' Association back in the '40s. They believed very strongly that nurses not only required improved employment standards and salary compensation but that until that happened, we were going to continue to have a high turnover in nursing and difficulty recruiting bright, young people into the profession.

They were able to influence the American Nurses' Association, which is our national counterpart, to adopt a program in the middle and late '40s. Through the national effort then state nurses' associations were stimulated to develop

programs and could seek the assistance of the ANA in their endeavors.

The Michigan Nurses' Association adopted what we called an economic security program in about 1958-59. This was done by our governing body which is a representative House of Delegates.

The first five years of the program (after we employed a staff person for that purpose) had three primary goals. One was to participate in a public education campaign to raise the awareness of the financial plight of professional nurses in the state. This was done, as I recall -- although I was not here at the time -- through sending letters to a hundred or two hundred influential citizens. Some of them were in business, industry, government, education. It was also accomplished by doing surveys of the employment standards in health agencies, not just hospitals, but public health agencies, nursing homes, etc. throughout the state.

We then worked with groups of nurses in individual employment settings who recognized a need and had an interest, and who were collectively together to do something about their standards. Although at that time we really did not negotiate formal contracts, we did prepare documents that were very much like a contract, laying out the case of the needs of the nurses in that agency.

We also participated with the steering committee or with whatever organizational structure those nurses adopted locally in meeting with their employer and presenting the case through their recommendations.

We did see some improvements begin to be made in those first five years. I would say they were not dramatic but they were consistent.

Now, in 1965, as you know, the labor laws in this state were changed. At that time, at least the nonprofit voluntary hospitals were not covered by the

federal law. And so we relied on the two labor laws in Michigan -- the one covering public employment and the one covering private employment. The Hutcheson Act which changed, as I believe, the public act, in effect opened up the door to increased unionization by public employees.

Now we saw an influx, (into collective bargaining) not only in the field of education, which has grown to be an extremely strong movement, but also in municipalities by both county and city employees. I think our real stimulus into moving into collective bargaining on a formal basis came as a result of nurses -- they might be public health nurses, they might be nurses in county long-term care facilities -- calling us and saying that they had just learned that an election was going to be held in two weeks. They found themselves caught in a bargaining unit with maybe the garbage collectors or the dog catcher or a wide variety of skilled and unskilled occupations. They objected to, first of all, being in a conglomerate group and secondly, in some cases, they didn't want to be in a bargaining group at all. But mostly they objected to not having any choice and any control over their own situation.

So, in a sense, we sort of fell into the program, that is, the collective bargaining program, because of the expressed need of nurses who needed assistance.

In those early days, we assisted some nurses just to be excluded from the conglomerate unit. In others, the nurses decided that if the other employees were going to be unionized then they had better be too and so there would be an effort to put us on the ballot as their bargaining representative.

Between 1967 and 1970, we probably had our fastest growth. We grew from three bargaining units in 1966 to probably close to fifty, I would guess, in

the early 1970s.

We had continued growth through the middle of the 1970s but things, I think, have slowed down somewhat, both for us and for some of the other groups now trying to organize nurses. Each year there may be a few groups added but it is not a strong movement.

At the present time, we represent nurses in about 60 different employment settings. These include small and large hospitals, acute care hospitals. It includes nursing homes and medical care facilities. We have a fair number of public health nurses whom we represent and we have a few small groups. We've had some in the hospital schools of nursing, and visiting nurse associations -- we represent several of them. We represent one of the area chapters of the Red Cross. We have a diversity of nurses.

As you know, the National Labor Relations Act was amended in the '70s to permit, or to require, the inclusion of the nonprofit voluntary hospitals. Although this did not have an appreciable effect, I don't think, in our state because we had already been covered by law, it did again raise some of the controversies. (I'll get into the controversy within the profession about the program.) But I don't think it stimulated any particularly new movement in the state.

We do, however, now work either under the public law in Michigan or under the federal law. The chief difference for us is that the public law in Michigan does permit supervisors to be organized into a bargaining unit of their own. And so we have some units, separate units, of head nurses on up to directors of nursing in some of our public agencies.

In the private agencies, our units are primarily staff nurses although we

have had some head nurses in bargaining units when the board has determined that they are really not fulfilling the traditional management function.

I might say that one of the controversies within nursing, as a collective bargain approach affects us is, the issue of people who are called head nurses, or in some cases clinical managers. Within the profession at the patient unit level of an agency there is a real question about whether these persons called head nurses primarily function as managers of the clinical care for patients or whether they function primarily as managers of staff. In some cases it has been determined that they really are there as a coordinator of the clinical care for patients. In providing and assuring that coordination, they obviously have to work with the direct staff but they do not spend the preponderance of their time in a traditional management or administrative function. It's sort of a mixture.

One of the other interesting things I think we have in nursing collective bargaining is we have, first of all, high turnover of staff in many health agencies. Turnover can be anywhere from 30 to 70% per year of the staff nurse level. As a result of the turnover, we have not only many of the people in the bargaining unit leaving the agency and therefore the bargaining unit, but we have, because of turnover in other positions, a fairly rapid upward mobility of the staff nurses into other positions in nursing which are not normally a part of the bargaining unit. You have a high turnover of the leadership within bargaining units as well as within the rank and file.

We also have a phenomenon of interchangability of nurses in positions. A nurse may work as a staff nurse three days a week and as an assistant head nurse two days a week. Or because of shift rotation, an individual may be a

staff nurse on the day shift but then if she is transferred to the evening or the night shift, she may find herself as a charge nurse. So one of the difficulties which the organization, the employer and the labor relations board have is how do you recognize the composition of a bargaining unit? And how do you sort this out? Is someone indeed in supervision and what is the nature of that supervision?

We have found, less I think today but certainly in the day when collective bargaining was moving very rapidly, a lot of manipulation by employers to try to exclude people from bargaining units by changing their title -- that kind of thing. Fortunately the labor board has said, we will look at what people do and not what they are called. I remember one agency where overnight there were suddenly something like forty-one assistant directors of nursing. They had taken everybody except a staff nurse and given them that title and said, "See, we don't have any of these other people that are kind of in that gray area." I don't think that kind of game playing goes on quite as much as it did.

The other thing you find in our bargaining units that may be different is that the rank and file will include not only the beginning and continuing staff nurse, which would be the first level of the registered nurse position, but you can also find nurses who have advanced education and practice as specialists within nursing -- what we call clinical specialists or nurse practitioners. But because they are not supervisors, they will also be included into that bargaining unit. This may include nurse-anesthetists and other people who command a greater salary, and who have broader responsibilities in patient care but what they are doing is clinically focused

and not managerially focused so that within the bargaining unit we have a mixture of people. The same thing is true in some cases in public health departments.

What we do then is negotiate what you might call a master contract but there may be some variations within that contract to accommodate the different roles, functions and, in some cases, employment standards.

The program that we have conducted in our state for many years has not been a highly aggressive, militant program. Our program is one of a variety of services and responsibilities which a professional association normally carries. We are what we call a multipurpose organization. The economic and general welfare program, as it is now called, is just one piece of the total program of the organization.

We think that there is an advantage to that because we can interrelate all of our activities with the collective bargaining program. One of the primary differences, for example, in the services we offer is that we have on our staff nurses who are prepared at the master's degree level in nursing practice. These people are brought into working with the bargaining unit on matters that pertain to practice. This may involve preparation of language for the contract but mostly it involves problems that have to do with implementation of practice including grievances that are related to patient care or other problems that arise. We have that cross-fertilization of the very important component of nursing practice and service with the efforts of the local bargaining unit.

We also can draw similarly on our public relations program, on our educational program, on our government relations program. In working with a

county like Wayne County (Detroit Metropolitan area), for example, there are times when you have to get into the political process as much as you do into the traditional labor relations process. And we have in the past been able to give assistance in terms of developing political strategies at the local level. If we work with civil service nurses then obviously we are very much into the political government arena in trying to make changes there.

So, I think we have a strength in being a multipurpose organization in terms of operating the collective bargaining program. Probably the disadvantage of that multipurpose nature is that we cannot funnel our total resources into the collective bargaining program. We also continue to have some controversy because we have almost 50% of our membership who are not in bargaining units.

There are nurses who either are not eligible under labor laws to be represented in collective bargaining or they are nurses who choose not to be, or they are nurses who may be represented by another union. These include faculty in our community and senior colleges. They may be covered under collective bargaining by the MEA or the AAUP. But they look to us for something totally separate from that piece (collective bargaining) of their needs. They join us because we are their professional organization and they are interested in our government relations program, our concerns about practice, et cetera.

So we have 50% of the membership contributing to maintenance of that program, although there is a slight differential (in dues for those under our contracts). And not all of our members are particularly fascinated or intrigued by collective bargaining.

I think that if you are in a traditional labor union, although you do certain things in lobbying and in education, they are all focused on collective bargaining process or on the financial or employment needs of the worker.

Probably another difference in our approach is we do not ascribe to the policy that the employee is always right and the employer is always wrong. We feel that we cannot take that stance because, first of all, registered nurses are licensed by the state in the performance of their nursing practice and they have both an ethical and a legal standard and responsibility which they must adhere to.

That license means several things. First of all, it means that the individual nurse is independently liable for her acts and actions. But secondly it means that if we are representing these people we must also support the legal as well as the ethical professional standards of practice.

What we do in cases where a problem arises -- and it may well result in a grievance or an arbitration, where the nurse was clearly incompetent or clearly practiced in violation of those standards -- is to provide that nurse with every assistance in using due process and in utilizing the grievance and the arbitration clause. We may indeed represent that nurse through that process but we may at the same time counsel the nurse in terms of improper practice or in some instances, if it occurs, for example, as a result of alcohol or drug abuse, we may encourage the nurse to voluntarily give up her license and go through a program of rehabilitation. And we will help design that program. We will help insure her rights with the employer so that she may come back to work after she or he has successfully completed it.

But we will not take the position that that nurse should be put back into the employment setting if the person is clearly a danger or a threat to patients. That becomes a fine line sometimes, as you might guess. We represent the nurse through collective bargaining agreement and also try to adhere and encourage the nurse or the group of nurses to adhere to what this association stands for. I don't think a trade union has that dilemma.

There are some differences in what we negotiate. I would say that the majority of the content of our contracts would be similar to the traditional contracts that other groups subscribe to. But we do have some portions that we think are fairly unique. We negotiate, for example, or try to negotiate, recognition by the employer of the right of the nurse to adhere to the ethical code of practice. (We do have a code for nurses which has been for many years evolved by the American Nurse's Association which we regard as the ethical standards which nurses should subscribe.)

We believe that if we can, in the contract, recognize the right of the nurse to refuse to become involved in improper activities, to refuse to practice in situations knowing that the patient's welfare will not be protected, that that will in fact protect the nurse from improper harassment or suspension or even termination. And it gives us a handle through the grievance process to respond to situations like that.

We also try to negotiate recognition by the employer as well as the nurses to the use of professional and legal standards of practice. We negotiate what we call the "role of the nurse." This outlines some of these various factors such as: What is the responsibility of the registered nurse under law as well as under the policies of the employer? What kinds of avenues should be

utilized by the employer and the nurse if these kinds of issues become the focus of any kind of constraint or disagreement?

We negotiate educational opportunities. These would include the right for released time and perhaps some reimbursement for continuing education activities, release time for other professional activities in which the individual might be involved either within the organization's efforts, with community health planning bodies, or with other volunteer health groups in which the nurse is contributing to the health and well-being of people in the community.

In some contracts, we negotiate reimbursement for nurses who continue their formal education toward the next degree. Sometimes this is actually tuition; sometimes it is just the release time; sometimes it is a mutual agreement that the employer will try to accommodate the nurse's schedule to permit the nurse to attend class. That kind of thing. There may be some variations relative to education.

We do negotiate a differential and salary based on education. But usually only when there is also a clear differentiation in the duties and the requirements of that particular position. We are very much aware of the potential inequities that can result under equal opportunity if there is just a blind compensation for a degree but no significant difference in the job that's expected.

We also negotiate a mechanism in addition to the grievance process that we call "special conference." This is an effort for the nurses in the bargaining unit to sit down with nurses and sometime people from other disciplines or other departments to discuss problems that are related to patient care, to do

it in what we would call a round-table setting rather than across-the-table setting. These conferences permit the various groups or committees or individuals within the staff council to meet with the director of nursing service or the director of in-service education or the director of medical education or with the director of pharmacy to discuss problems, to present data and documentation and to present recommendations to resolve these problems. The hope is that the resolution of the problems, particularly those related to professional standards and to patient care, can be resolved in other than the grievance process.

We think this is a more professional way of handling that kind of issue. But we also think there is a danger in taking something directly related to clinical care, or clinical judgments, through grievance and arbitration process where a non-nurse, perhaps someone totally unfamiliar with health care in general and nursing in specific, ends up making a decision about did this or did this nurse not make the right clinical judgment or is this or is this not an appropriate standard for nursing practice.

The special conferences have facilitated problem solving and tried to put nurses on a peer or colleageal basis rather than on an adversarial basis. As a part of that process, we sometimes negotiate special kinds of committees that the bargaining unit has the right to form. The most common one is the professional nursing practice or sometimes called the patient care committee or nursing care committee. This would be a committee of the bargaining unit to look at some issues, to collect their data, to formulate their recommendations and then take them through either the special conference avenue or any other avenue to seek resolution with other members of the health

team and with management within the institution.

There is variation on the degree of this type of activity and effectiveness. Sometimes they are effective when there is a particular issue. We encourage them to have an ongoing commitment to continually look at the quality of patient care in the institution and to try to resolve problems before they occur; to predict problems, rather than just act after the fact.

We have handled some very interesting situations and had some good results from that. We have found that hospitals sometimes violate their own requirements under their license.

One interesting one was nurses on a particular unit found out that a patient was receiving research drugs which a physician was bringing in from outside the hospital. No one knew about it, there was no consent form on the patient's record. Although the research had been approved through the hospital committee, we found out that the composition of the committee did not meet federal requirements. So we were able not only to resolve that problem internally with a little pushing and tugging but also ended up with development by our research council of some guidelines for nurses in all kinds of health agencies to be able to use when research is being conducted either on their unit or within their institution. So we have had some very productive results come out of the practice concerns in our bargaining unit.

Collective bargaining is still an issue within the nursing profession. I mean, it is not an issue only with nurses in management but it is an issue across the board. There are still nurses who do not view collective bargaining as professional, who have real problems with the concept of nurses striking, withholding their services. We have members who do not like their

money going into the program just as we have people paying taxes who don't want their money going into certain government activities. Some of those nurses have dropped their membership. Some of them are still members because the other components of the organization are sufficiently important enough to them.

I would say, however, that that controversy is gradually abating within the profession. You still find it and you still find people who feel strongly about it. I think one of the reasons for some of the controversy is that the directors of nursing service and some of the other nurses in management have been strongly influenced and intimidated by hospital administrators or other people in management. They have been, if you will, brainwashed to believe that because once every other year they sit on the employers' side of the table or must administer a contract that somehow that produces an adversarial situation with their nursing staff on all matters.

We believe that that is an inappropriate and improper philosophy. We see, first of all, that there is nothing wrong with people sitting down and deciding how they are going to carve up the economic pie. And why that makes people adversaries of each other, particularly in a nonprofit institution, we find as a curious philosophy.

We also find in most situations, nursing administrators themselves are only middle management. In many institutions, even the director of nursing has relatively little influence on the final positions and policies determined within the agency. It's a rare director of nursing who ever gets to attend the board of trustees meeting, for example.

I know directors of nursing who have to make appointments with hospital

administrators to sit down and talk with them. Or situations such as a public agency, where not only can the hospital administrator or the medical director overturn the policy and decision of the director of nursing but then the labor relations and civil service and finally the county board of supervisors can overturn those policies. So the director of nursing himself or herself is not even a top administrator in many settings. So to suggest that they then become adversaries of their staff nurses or that they should not belong to their own professional organization because we happen to come in and represent those nurses, I think really is a perversion of not only some principles of labor relations which are supposed to lead to a constructive program but I think it also is a gross interference with the civil rights of those nurses.

Even if the employer says you may not do anything with the state association on the employer's time, they have no right to say you cannot be a member or do what you want on your own time. There has been a great deal of downright harassment of nurses who have been told they must drop their membership, they must do this, they must do that.

At the same time, those same hospital administrators will pay for the dues out of patient monies for their own professional organization or for the organizations of other management people in their department. But they will say to the director of nursing, "You not only will not get your dues paid -- we don't want them to get their dues paid by the way." We think that is conflict of interest -- but they will say that as long as you work here you may not be a member of that association.

So that intimidation has influenced some of the controversy I think, within the profession. It is my observation that the director of nursing and

the other nurse managers who are self-confident in their own competency, in their own abilities and who understand the situation do not let themselves be intimidated this way.

On the other hand, nurse administrators who are weak in their position are more easily threatened. Often those people end up having so little control over their department as a whole that they become very ineffective.

I believe that if you give in to intimidation once then that will continue in everything you do. It certainly does exist in some of our health agencies.

In the past, very bizarre things were done to prevent employees from organizing for collective bargaining. I remember one situation in which the director of nursing brought in a shopping cart from a grocery store, had it filled with groceries, and it had a sign on it which said, "This is what your MNA dues can buy for you." And she wheeled it around the hospital. We know that institutions spend hundreds of thousands of dollars to fight unionization of hospital employees. At the current time, that is now a no-no in terms of the federal requirements that Medicaid and Medicare will not pay for those activities. We also know, however, that it can be buried under the guise of consultants and what-have-you.

We have had figures -- I don't have them now -- but we have had figures in some of the smaller hospitals where the amount of money paid to these union busters far exceeded all of the proposals that were received by the institution from the employee group. So it really is not a matter of cost; it is a matter of management philosophy, I think.

One thing I might move on to and that is overall unionization of registered nurses. As you have pointed out, there has been growth of

unionization of workers in the service professions across the country and certainly hospitals have been a prime target of many unions. I am sure that has resulted from the slow-down of unionization in other fields and the decline of the union population as technology has taken over some of the jobs. So some of it, I think, is a matter of survival of unions.

But the other is that hospital workers have traditionally been underpaid and although we have made strides in the past 10 years, there is still a real catch-up factor. You still find a lot of inequity between both salaries and fringe benefits of all classes of workers, I would say, within a hospital setting. Certainly the nursing homes are even worse.

Now, in the beginning, most of the trade unions went after the more traditional worker -- the dietary, the laundry, and some of the technical workers, maintenance, those. Some of them did include the licensed practical nurse in their union. That was partly because there had been a policy statement on the part of the national labor relations board that has stood for a number of years (although it has been challenged) that it is appropriate that registered nurses have their own bargaining unit because they have a common interest that far surpasses them being mixed in with conglomerate units.

Because a licensed practical nurse legally, through his/her license, must practice under the direction of a registered nurse, that really puts the registered nurse almost automatically as a supervisor of that licensed practical nurse. Now that has changed over the past few years and we see increasing number of unions that are trying to either include registered nurses in a conglomerate unit or in some cases include nursing aides, LPNs and RNs in a single unit, saying that these are all nursing personnel therefore

they have an appropriate community of interest.

It has been very interesting to watch the movement of the trade unions into representation of registered nurses because, for the most part, they have predominantly gone after the bargaining units that were started and were represented by the state nurse's associations, even though the number of agencies in which registered nurses are represented are still in the minority of all agencies, it is a relatively small number of hospitals that have a bargaining unit for registered nurses. Although you would think that the trade union would, in their belief in organizing people, would go after the unorganized people, they have not. They have gone after the units that have already been organized by what we call the SNAs -- State Nurse's Associations.

Now, I can understand that. It is cheaper that way. You have an organized group. You have a channel of communications. You don't have to worry about going through getting the initial certification, you may have to get the authorization forms but you don't have to go through the throes of stimulating interest of the group to begin with to look at collective bargaining as a mechanism. Because of the high turnover in these bargaining units -- and I mentioned leadership -- I think the groups are more vulnerable to being raided. The frustrations are so very high and nurses are very naive about bargaining contracts. Many nurses can't understand why you can't get everything they want in the first contract or the first two contracts. They are not tuned in as are many other occupations that one of the values of the contract is that you build on it every year. The UAW didn't get their current contract in two or three sessions, you know.

But many nurses, I think, do look at the bargaining process because they

are not familiar with it, as something that is going to solve all their problems overnight. When it does not, then I think some of them ask either why do we have this thing or is the agent representing us effectively.

The other thing that has been, I think, a difficulty with many of the unions is that it is not easy to get widespread participation of nurses in a bargaining unit in the leadership activities -- in the work that has to be done. Nursing is very hard work, physically and emotionally. Most nurses -- 98% are women -- have families they have to go home to and take care of. The kind of work that has to be put into developing proposals, negotiating a contract, handling grievances, educating the members to understand how to use the contract, all the things which, while they are in part done by the representative group or the bargaining agent, must come from the local leadership. Many women just do not have that kind of time and energy.

So what you have is a high turnover of leadership to begin with, a chronic problem of how you educate even the leaders to understand their responsibilities and a lack of information about the members as a whole about how to use the contract effectively, what's needed to make a good contract and to understand the continuity, if you will, of the contract and building on it to make it a strong contract.

The other thing I think that has persuaded some bargaining units to leave state nurse's association is that we have a state program. The services flow from the state association in all directions. We don't have paid local representatives or paid stewards. Some of the nurses feel that the rank and file do not see the visibility of the organization on a regular basis. We may be doing all kinds of things with the leadership. We may be handling

grievances and arbitrations and a variety of problems--having meetings with employers--but, if the nurses on that bargaining unit or on that nursing care committee do not communicate those activities with the rank and file, the average nurse may think, "What is MNA doing? We never see them around. We never hear from them." That can be a problem in terms of how they identify with a bargaining agent.

I think the other thing that sometimes happens is that, again, the same nurses, in fact, the majority of the nurses, under two year contract will not be present when the next contract is opened. You have new people who have no history or understanding of what happened in the last negotiations. What were the issues? What was won, and what was lost? They have no means of comparing one contract with another. A trade union may come in and say, "Well you should have this in your contract. This is ridiculous. You certainly ought to have this." They will say to the nurses that this isn't the greatest contract, we can do a much better job for you.

Those nurses probably will never ask to see one of the union contracts and actually do a comparison. Secondly, they may well believe that this union can in fact do what they promise. They may be sold a bill of goods. They may buy that new package without ever making a comparison to begin with or ever finding out where were they or where the nurses in their position were when we started the past contract. What were our goals and what do we think we can achieve?

As I say, there is a certain naivete and certainly a lack of a problem-solving approach in some of these situations. But I think what happens again is that the level of frustration is so high because there

continues to be significant problems in health agencies that are going to take a long time to overcome. A lot of it has to do with attitudes. A lot of it has to do with unfair treatment. A lot of it has to do with inadequate resources, personnel. Some of those problems are not going to be solved by anybody in a one or two year period.

So I think that creates one of the reasons why nurses may shift from one union to another. I think that is not unique only to nurses.

Another factor is (and this is a personal viewpoint only) that we still have a lot of nurses in the profession who were educated in a very rigid, dependent-oriented kind of atmosphere in which nurses pretty much did what they were told. We are products of the socialization of women in our society. It hasn't been all that long that women have begun to stand up and say, "We don't really need to lean on men and we really ought to be able to have some control over our destiny."

I believe that many nurses buy into the traditional trade union because they are male dominated and because those women believe that a male group can come in and deal with a male administrator more effectively than a women's group can. I've had nurses say to me, "We don't have any quarrel with your service. We really believe in the concept of the professional association representing us. But, you know, we think it just takes a man to come in to the bargaining table and pound the table and shake his fist and say to the employer, "Now, you are not going to treat these nice ladies that way."

There is very much a sex component to this decision. We think it is highly unfortunate. We think that if there is an honest case for a trade union doing a better job than we do across the board, then nurses should have

the right to choose that. As Lee Iacocca says, "If you can find a better car, buy it."

But our concern is that what they have done is merely transfer from one situation in which the problem is often directly related to the sex component into another situation in which exactly the same thing is going to happen. There is no question that sex discrimination is a strong factor in health agencies, particularly in terms of nursing.

Nursing is predominantly women. Most directors of nursing are women. Most hospital administrators are men. Most medical directors are men. Most of the members of boards of trustees are men. So we have, first of all, that interaction at the administrative level at which women are often disadvantaged.

I know hospitals for example--and I won't name them--large hospitals where there are certain kinds of perks for the top administrator and that would include the hospital administrator, his immediate assistants, the comptroller of the hospital, perhaps the purchasing agent--memberships in social or health clubs, cars, etc. The director of nursing, who may have equal and sometimes higher education, the largest department, the largest budget, the most personnel, and not only that, she is the only department director that has both an administrative responsibility and a clinical responsibility which none of the other departments have, and yet she is usually paid less, and she gets few of those perks, she does not have access, in many instances, to the top policy-making level.

I think this is all directly related to sex discrimination. That, then, filters down into how all of these policy decisions are made, and how this treatment affects the nursing staff. The nurses are in the one department

providing 24 hour a day, seven days a week coverage. After 5 or 7 in the evening, they are suddenly competent to take on the responsibilities of all the other departments in addition to their own. The nurse is, in effect, the assistant hospital administrator on evenings and nights because that evening and night nursing supervisor is really the administrator of the entire hospital. They have formidable responsibility. And yet, if you look at the salaries, they will get paid less than other occupations in the same institution that have a preponderance of men. Those statistics have been borne out by the US Department of Labor. They have shown that within the health occupations, the higher the percentage of women, the less is their average salary as compared to other occupations with similar responsibility and education who have more men. There is a direct correlation to sex in the salary between occupations that is not based on either responsibility or educational preparation. So, we have that group of disadvantaged nurses within the formal setting who could, through using the collective bargaining tools, begin to correct some inequities but who now transfer their allegiance to a trade union in which they are going to have as little opportunity to affect the top policy making. Trade unions have very few women on the staff, if any, and men who do not understand nursing or health care. They will negotiate a traditional contract, but cannot provide assistance on nursing practice, and who, I think, are greaty disadvantaged if their arbitrations involve nursing or clinical judgment.

In addition, many of these nurses cut themselves off from the profession as a whole because financially they do not feel they can both pay a trade union and a professional association. Our concern about the introduction of

the trade unions really is a pretty broad one. It doesn't deal with just a contract here or there.

One other thing that the trade unions have done which has helped them become effective is they have used some of the issues within nursing that are controversial to their own advantage. We are going through the throes, and have been for some time, of identifying within the profession what the appropriate level of education should be for the future and trying to improve the standards of nursing education. This has been misused greatly by the trade unions to make nurses feel threatened, feel that they are losing professional status, that the professional association is out to get them and cannot represent them. They also use our uniqueness in saying that we believe we can conduct a labor relations program, a strong aggressive program, and at the same time serve the functions of a professional association. Which means, then, that we have members who are teachers, administrators, supervisors, nurses in private practice, nurses who are outside of the collective bargaining realm; that we can have an association that can bring all nurses together in common endeavors. Many of the trade unions say that can't be done; that if you don't kick out all your supervisors and administrators, you can never have a collective bargaining program that is effective.

Many nurses, particularly in our state, are married to men who are in the traditional unions or whose parents were in the union and they have difficulty sorting that issue out. And many times, again, they will buy into the philosophy that you cannot do a good job unless only the staff nurses are within the organization.

Now I am intrigued to see that some of the trade unions that started out

with that approach are changing it because they now want to get some of those same groups into their collective bargaining realm. So they use the argument when it is convenient, but don't necessarily carry it out in their every day activity.

We also try to suggest to nurses that since the professional association has only registered nurses as members that this gives them full and complete control over the organization itself. No one else sets their policies except nurses. No one else speaks for us. No one else makes decisions about practice. They can have control over the level of the dues; over the positions and statements that the organization takes. They can kick out their leaders if they don't like them. They do not have that kind of influence in the traditional trade union. I think in many trade unions, for example, they would never be able to see a complete financial report...much less question it.

We try to suggest to nurses that that's all part of having control over your own destiny. You don't need to be dependent on another union whose primary focus in society is not health care, in order to have an attractive contract. We also think it is a disadvantage to nurses in terms of their public image because the UAW is associated with cars and with mechanical and technical kinds of products. They are not associated in the public minds with expertise in health care. The same thing is true of the service employees or of the bartender's union or the stonecutter's union or the engineer's union. All of those unions have at one time or another tried to represent nurses. Some of them have succeeded and some have not.

WEEKS:

The retail clerks' too.

GUY:

Oh, yes. You name it. We are a ripe group for unionization. But, you see, that is still all part of socializing women and socializing nurses as professionals to believe they are competent to control their own destiny.

WEEKS:

I think that probably nurses have a little trouble with their own self-image right now. Unionism and, if I can use the word, violence, threatens violence, so often associated with unionism is abhorrent to women who consider themselves professionals--which they are of course. But it seems to me today one or two things that you have said have brought things to my mind. One, the nurse today is not quite sure...she would like to be a professional; she thinks of herself as a professional and yet--you didn't mention the word physician, you mentioned the word male, but it's the physician who makes her feel inferior in most cases.

One word that has been interesting in my mind is that recently in reading about nursing studies or reading about nursing practice, you see the word diagnosis come in which never, never, never was in twenty years ago.

GUY:

Oh, it was used twenty years ago but it was not highly touted. It was mostly within the professional terminology.

WEEKS:

But now a nurse who is competently trained should be able to diagnose nursing needs and should be able to work as a colleague of the physician. And if she knows the general type of nursing that he requires, she should be the one who should be able to diagnose what is needed to fulfill the orders of the

physician. But the physician hasn't entirely accepted that picture yet, as we both know. So it would seem to me that here the nurse is faced with the fact of, "I need unionization but where should I go for it. Should I go to my professional organization? Can a professional organization represent me in the rough and tumble, as you indicated?" If she gets into the rough and tumble side of it this is abhorrent to her as a professional.

Now, you mentioned education too. There is quite a difference in two, three and four year courses. Should a RN be any one or should it be, as it is now--all of them? Or in the future can you combine the two and three year? Can you do something that will bring you out with a product that is fairly consistent with the RN and that will be professional -- that will be representative?

There are so many of these things that enter into it but it would seem to me that it would be normal for a person—a professional person, such as a nurse--to turn to a professional organization to represent her in any negotiations with her employer. Now, this brings up the point that I would like to ask you.

We talked about negotiations but we haven't talked about what you negotiate for. I'm sure it isn't all wages.

GUY:

No. Earlier I talked about negotiating the role of the nurse and negotiating continuing education and negotiating standards of practice. That those are things we actually negotiate in the contract that are fairly unique. Now some of the unions have piggy-backed on us and when they have gone in, particularly if they have raided us, and they have gone in and they

have found those in their contract, they may continue them. But if you look at some other contracts that have been negotiated where the union was the first representative of those nurses, you will find a very traditional industrial model of a contract--wages and benefits and that is pretty much it. But we certainly do negotiate other kinds of provisions that get into the professional realm.

Let me comment on two of the things you said, if you don't mind.

I think there are several factors that have resulted in this lack of self-esteem of nurses. Certainly the attitude of medicine is a primary one, but it is not the only one. The low economic reward itself has perpetuated the lack of self-worth. You can't live in a society like ours that is very much economically attuned and say that people get paid what they are worth but then turn around and have the nurse look at the fact that the checkout clerk at Meijer's Thrifty Acres earns more than she does.

So some of it comes from the continued economic suppression. And I think that one of the reasons that we have had in the past--it is not quite as bad now, I think, with the economic depression--one of the reasons we have had this high turnover is that nurses move in and out of the field, they retire for a while and they come back working part-time, retire and come back. The economic reward was not sufficient to enable them to provide adequate child care. It was not sufficient to compensate for the disruption of family and personal life if they have to work weekends, holidays, evenings and nights. So the economics are another one of the things that have added to that feeling of low esteem.

The third thing I think it is that society through the governmental

process has significantly contributed to that problem of image. Professional nurses are the only major health professional group that are not recognized by state or federal government under government health programs as providers of health care, even though it is the nurse who provides the bulk of those services.

The hospital association, for example, has estimated that nurses provide 90% of the direct patient services in hospitals. It is obviously even higher than that in nursing homes. In ambulatory care settings nurses increasingly are providing a significant portion of the services. Public health departments, public health nurses, provide the majority of services in the agency. So even though health care gets delivered primarily by nurses, the federal and state government through Medicare and Medicaid have refused to recognize nurses for purposes of reimbursement.

That does several things. It says to the consumer--you cannot go directly to a nurse practitioner, for example, and receive the kind of care you need because we won't pay either you or the provider for that service. It has perpetuated the concept that all care in this country is medical care. We have a medical model in this country. It is focused on illness. It is focused on the restoration of people who are sick and dealing with pathology. People glibly talk about a health care system, but we don't have a health care system. Medicine doesn't want a health care system because as long as they can keep the medical care model, they can keep their finger on all of the economics of health care.

No one can admit a patient to a hospital except a physician. Nobody can get reimbursed unless there is a physician's signature on that paper, in other

words, physician authorization. It doesn't matter what the service is. They say under Medicaid that everything has to be "medically needy."

WEEKS:

Would this even include midwives?

GUY:

Absolutely, absolutely. Now there are some changes coming. We have finally, through the federal Medicare/Medicaid program, accomplished reimbursement for nurse midwives. Our State Department of Social Services is refusing right now to implement that but it will come.

WEEKS:

Is this under the new law that just went into effect?

GUY:

No. This is under the law that was passed in 1980 but it has taken HHS two years to come up with the regulations to move it ahead. And as I say, even now our state is dragging its feet, not wanting to reimburse them.

There are a few states in the country that have passed laws that have said to insurance companies--you must reimburse nurse practitioners, and nurse midwives for services which other kinds of providers are reimbursed for and which are within the legal scope of practice for nurses.

Current policies really say that society does not recognize you or the work of your services if everything has to be approved or somehow be routed through the physician. Now that is obviously to the physician's financial advantage and they are going to hang on to it.

For example, I remember meeting with a bargaining unit in one of our hospital units. The administrator met with us on a problem and the nurses

were protesting some policies and some edicts that had come down, which in effect seem to negate their right not only to carry out their own nursing practice but in some cases to protect the patient. The administrator said to those nurses in my presence, "Your primary role in this hospital is to keep the doctors happy. Because if the doctor is not happy, he will take his business to the other hospital across town."

I said to him, "I find that a very interesting statement. I always thought the primary responsibility of the hospital and of these nurses was to provide competent care to the patients. You are saying that the patient is not your client but the doctor is your client."

He said, "Yes, because we don't get the patient unless we've got the doctor."

So now you see the self-esteem of nurses then who view themselves as nursemaids to the physician rather than as professional people providing a unique service to patients which is further undermined by the attitude of the administrators. I recognize the bind hospitals are in to keep their beds filled but that attitude certainly reinforces the low status feeling of nurses.

Nurses win very few battles with hospital administrators when it comes to any kind of constraint between a physician and a nurse. Although the literature and the studies are full of evidence that we are losing competent nurses because they are just not going to be treated as subservients. Nurses are not trying to be equals to the doctor. What they are trying to say is that we have a service that is different than yours. It is a service that is needed by society. We are the ones who are competent in the provision of that service and we will have control over providing that service. We will work

with you, collaborate with you, but you don't run our destiny.

Some physicians are very upset by that. Some of them are angry with it. Some of them are bewildered by what is happening. So the educational process needs to spill over to them as well as society.

But you see, in effect, society condones this because they don't say, "I want the right to go to this midwife directly and have my insurance company cover that." It doesn't occur to them to do that because they don't think about it. It doesn't occur to them to say this is the kind of health problem I have and a nurse practitioner can provide better care to me than a physician because this is not the physician's area of expertise. We have a long way to go to educate the public relative to such choices.

The business of self-esteem, self-worth and the reasons why nurses go into collective bargaining are certainly all tied together and I think they are related to their choice of a collective bargaining agent.

WEEKS:

I have a few short questions. One, how many strikes have there been in Michigan by nurses in the past few years? Have there been many?

GUY:

I cannot give you an exact number. I would say there have not been more than eight in the last eight years.

WEEKS:

Has there been any indication that patients have really suffered because of these strikes?

GUY:

No. No.

WEEKS:

Another thing I was wondering is, when you represent a hospital in negotiations, have they come to you for help rather than you seeking them out to represent them?

GUY:

Do you mean the nurses?

WEEKS:

Yes.

GUY:

In every instance, the first contact has been made by the nurse with us.

WEEKS:

In other words, you are not like the unions out trying to organize. Another thing I was wondering. You spoke of the unions trying to raid the hospitals organized by the state associations. One reason was that it was all organized so it was easy enough to take it over. But were these usually hospitals in which the union was already taking care of the service employees or some other branch, or do they come in anyway?

GUY:

Both. We have had both kinds of situations, including some situations where we had fairly good evidence that there were payoffs by the union to the leadership of the bargaining unit. Obviously we didn't have the cancelled checks but we were very much aware that the individual who was the chair of our staff council was paid and, after the election was won, that person went on the staff of the union that sought the representation.

We know another union in which several people who were recognized as

leaders were offered bribes by the union--financial payments. Those may be isolated instances, I don't know, but I think certain kinds of deals are struck sometimes with the leadership. It has been interesting--we have found in some instances that the leadership in wanting to decertify and be represented by the trade union, had husbands in that same union. That family identification is hard to fight.

WEEKS:

Yes, that would be very difficult. It is like women voting like their husbands or at least up until this year they were supposed to have done that.

Just as an aside. I once belonged to a union in a department store in Detroit. I had sort of a supervisory position but they wanted me in the union. The union official wanted everybody in the union. So I paid my dues and was in. But I caused trouble because I could see no reason why we couldn't have secret ballots when we had a vote on something important. This didn't work out well with the union because they wanted the man at the front to intimidate you to the point that you would be afraid to hold your hand up and vote against something that the man directing the meeting was in favor of.

So I think this is the same case that would probably happen in many of the nurse's unions. If they joined a traditional union they might have this dominant practice.

GUY:

One of the reasons that that might or might not create a problem is that I don't know how many nurses would bother to challenge either the policies or the practices of a union. Again, because of the time factor and the risk factor. I know we had a member of our staff--not a nurse--who in another

position was a member of one of the trade unions. He said in one of his early involvements, he went to a membership meeting and after the treasurer's report, he asked to see a copy of the finance report, or asked the question, would he have the right? He said that a little while later, when there was a break, two gentlemen hustled him out of the hall and let him know that under no circumstances was he ever to raise that or make a request of that kind again. They made it appear that he was questioning the integrity of the officers by even asking for it.

Now you see we publish our auditor's report every year in our journal.

But those are questions I don't know how many nurses would even ask. Some of the unions--Council 1199 is one--will tell nurses that you will have complete control over what you do in collective bargaining. We may say to them, well, now do you know where your money goes when it goes to the union? Do you ever have an accounting? Do you know what it is used for? Who makes the decision how that money is used? Do you have any input on political or legislative activities of that union?

If you ask them the questions, they would say, "No." Then some of them will say, "But I don't care. All I want is a good contract."

So, some of those questions are not going to influence everyone who is voting.

WEEKS:

It is interesting. I have been trying to make appointments with some of these people. One of the appointments I have made is with Mr. Nicholas, who is the new head of 1199. He has been in Philadelphia--wasn't there a big strike in some hospital in Philadelphia?

GUY:

There may have been.

The arguments that we pick up from the unions. Many of them will say, "We're larger than the State Nurse's Association, we have more resources, we have a longer history of bargaining and we have clout because society clearly views us in terms of our ability to be aggressive." Some of the unions are selling the nurses that their dues are cheaper. And they may be. Some are more expensive and some are cheaper.

In some cases they don't add that there are other kinds of assessments or initiation fees. But on the surface, it may appear that it could be $60 or $80 a year cheaper than our dues.

Another thing that they sell them on is the point I commented that any group with supervisors and administrators is not going to be able to be effective. You need a group that is sticking for and stands up for the rank and file only.

And then the issue that 1199 has used in this state is the education issue. They try to portray us as not supporting the professional status of the two year nurse and of doing all kinds of horrid things when we say that more nurses should be educated at the baccalaureate level and that the system of education needs to be changed for the future.

I think those are the primary arguments. Now, if you do meet with them, that is what you may pick up. There may be others that I am not aware of.

WEEKS:

If I come across anything revolutionary, I'll let you know.

What benefits do they say--outside of the strength and the experience and

this sort of thing? Do they try to sell the idea that they will be able to get more money for the nurses, or better working conditions?

GUY:

Some of them do. Some of them say that--some of them actually say, we'll be able to get you this kind of a raise. You know, they often don't. Some of them will just make a general statement, "Oh, we can do better for you." And they may hold out a contract of one of their factories. Well, it may be a contract that they have been working on for twenty years but they don't tell the nurses that. But they will say, "See, these are the kinds of benefits that you should have."

Many of those unions, particularly those that have gotten in recently, know absolutely nothing about the health care field which includes the structure of the hospital. They don't realize that labor relations and collective bargaining has been an accepted part of industrial life for many years. I know there are still efforts to undermine it. But generally speaking, it is a fact of life. In hospitals, it is not yet. And so even the toughest union person, if they get in with a private, nonprofit hospital and start throwing their weight around, chances are they are not going to succeed with the same techniques that they were able to use in the factory. And they are not going to find nurses amenable to some of the kinds of tactics that they have used in other settings to achieve their end.

So when we look at the gains they make, they are often not as good as we make. Certainly, they are no better.

One of the promises that they make in some instances is that, "We will have someone here at your beck and call whenever you need it and we will

handle all your grievances and you won't have to wait for two days for someone to come like you do with MNA."

Now in some cases, if they have local stewards in other work settings, they may try to use those stewards as the first line of the system. In some cases that doesn't work at all. In some cases, they can help with the technical aspects of writing a grievance for example. So some of them will sell their organization on the ability of union representatives to be immediately available to help the nurses.

We have had no way to evaluate whether that has in fact come true or whether it has made a difference because the groups that we have that have been raided haven't been represented by unions that long and we haven't been able to get access to their experience. We hear second-hand or we hear random kinds of comments.

WEEKS:

I think you have probably answered this question. Does MNA have a position on unionization? Do you favor it? Do you recommend it? Or do you just react to requests for help?

GUY:

We have what we call a philosophy of economic and general welfare. We not only support the right of nurses to engage in collective bargaining but we also believe that in some settings that will be the only way that they will be able to control conditions of employment and to have injustice corrected and to achieve an equitable salary compensation.

We don't go so far, in terms of the total organization, to say that every employment agency should have their nurses under contract. We try to educate

nurses to understand our service as well as their rights. And we do support, for example, we support nurses striking and exercising the rights which they have under law -- to do so free of harassment.

At the same time, however, we don't condone wildcat strikes under any circumstances. We believe that the preparation and the notice for a strike must provide for the protection of patients.

Now, in some strikes that is difficult because the employer has refused to take seriously the notice of intent to strike. What they do is keep the hospital beds full until the night before the strike, thinking they can intimidate and pressure the nurses into feeling guilty about going on strike because the hospital is full. In our role, we try to educate them to say, "That's the employer's responsibility." It became his responsibility when you filed a ten day strike intent. There was absolutely nothing to prevent that hospital from discharging patients, refusing to admit elective surgery. There should be no patients left in that hospital except a handful of the acutely ill who cannot be moved and in those circumstances we organize a mechanism whereby nurses will donate their services to those acutely ill patients to make sure that they are protected. But we are not going to carry guilt because the employer refused to do the right thing in the event of a strike.

WEEKS:

Ten days would normally be within the turnover time of the average patient.

GUY:

Oh, that should be no problem at all. But you find in a lot of these hospitals that they are still admitting patients through their emergency room the day before a strike.

WEEKS:

This, of course, is a tactic that I can see administration might use.

By the way, just as a little input here -- it may be that the situation you mentioned about the male dominance of some of these professions. When I was at Michigan with the Program of Hospital Administration, at that time our classes were composed of about 98%-99% males. I was talking with the Director not long ago and he said that last year -- I was remarking you have a great increase of women in your classes and he said, "Yes, it's about 50-50 now. If we really could take all of the competent applicants among women, we could have 90%, but we have an obligation. We have promised to place all of these people after they have completed and we can't place that many women at present. But ten years ago, we couldn't have placed as many as we have now,...the picture is changing gradually."

Pharmacy is the same way, medicine, especially in the newer schools -- many of them are more than 50% women. So maybe in ten or fifteen years things will have changed.

GUY:

If the women don't get coopted by the system, things will change.

WEEKS:

I was interested in your talking about continuing education. I'm not familiar with the state law. Is continuing education required of nurses now for continuing registration?

GUY:

Not in this state. But it is in sixteen other states. And we do have in this state within the Public Health Code which includes all of the licensing

provisions for health occupations, that by 1984 each licensing board must have adopted a system whereby they can assess the competency of people who will continue to be licensed. This must be done every four years.

No one knows for sure what the boards will adopt. There are five or six boards now that have had continuing education requirements from five to twenty years. But nursing was not one of those groups.

WEEKS:

I know pharmacy does.

GUY:

Not under the law, I don't think. They have a voluntary program. I don't know whether it is required for licensing. Is it?

WEEKS:

Yes, every two years.

GUY:

I know that medicine does and optometrists do.

WEEKS:

Osteopaths do too.

GUY:

The MDs had that requirement put on them back in the middle '70s when we were going through a big flurry over malpractice problems and they created the fund for this purpose. At the time the legislature said, well, if we are going to do this for you as physicians, we are going to require that you have some evidence that you are keeping up to date. So against medicine's wishes they got slapped with a continuing ed requirement.

WEEKS:

I think the osteopaths had one within their own profession for some years.

The thing that is amazing to me -- I used to have two or three osteopath friends that would go through this -- I don't know whether it was annual or every two years, but anyway -- they would tell me -- they were in the Detroit area -- they would go to Grand Rapids or Traverse City or some place where there could be sort of retreat. They would attend meetings and then play golf in between. But, they would go into a meeting and, if it was dry or dull, they would be likely to walk out. But they had registered when they went in so they would get credit for it. It seemed to me that was a great waste of effort.

The same thing is true for some of these other programs. The only programs that I can see that really pay off are those that have a written examination at the end of the period. Either home study or some kind of evidence that the applicant has absorbed a certain amount of knowledge.

GUY:

Our voluntary program is structured on encouraging people who sponsor continuing education offerings to voluntarily submit them to us for review and approval. They offer so many contact hours and attest to the fact that they have met the standards of the profession. This is part of the national system in nursing but it is all voluntary.

Anybody attending a program that is approved by us or sponsored by us does not get their certificate of attendance or the contact hours granted until the end of the program. You have to complete an evaluation form, or, in some cases, there is a pre- and a post-course test. I suppose a nurse could slip

away for a short period of time, but they are pretty well monitored.

We have heard that in medicine some of them just register and never even go in. Ours are much more tightly controlled.

The problem is you still don't have at this point a really good measure of whether or not that continuing education experience changes the quality of the service of that individual.

WEEKS:

This is true. The only thing you could say in favor of it is that it might keep the nurse up-to-date on new developments and things of this sort.

You have another hurdle there, too, in that when you have levels of education within the same degree that you have to pitch your instruction for the lowest level.

GUY:

Or else you have to make it clear that it's pitched to a certain level. We have tried to experiment, and it is far from perfect, in that we not only state the objectives of the program but we state the audience that it is intended for. In some cases it will say that this is intended for nurses in advanced practice or this is intended for nurses who have had a previous course or something of that kind.

But probably the bulk of them do have to aim at a middle ground. You lose a few people on the underneath side and you bore a few people on the upper side. It is a problem with a mixed audience.

WEEKS:

This whole thing of programmed learning is in its early stages, I'm sure, right now. But it is interesting what some of these people can do and teach.

I've looked at several of them and I think they are going in the right direction. Maybe they haven't arrived yet but they are going in the right direction.

GUY:

We have a national professional journal called the American Journal of Nursing and you may have looked at it.

WEEKS:

Yes. I am familiar with it.

GUY:

If you are interested in that, they have programmed instruction -- a home study programmed instruction that offers contact hours in almost every issue of their journal now. It is approved within this system that we call CEARP - Continuing Education Approval and Recognition Program. And it is entirely home study.

So I think the movement into independent study is becoming an interesting one, although it has some weaknesses. Particularly when it is used in combination with a formal classroom setting and then the home study or the independent learning building on that, and then perhaps coming back for another formal setting. I think you would get the best of all possible worlds in that.

WEEKS:

I think this is good and I think the professional associations should be in the leadership in this. There are a lot of commercial outfits getting into this.

GUY:

And making a lot of money.

WEEKS:

We had, in a little thing that I wrote, a chart which was a financial chart on the stepdown method of cost apportionment which is very complicated but it had to be explained. We had a request from Teachem -- that is one of the commercial outfits -- and they wanted to use that for somebody, I've forgotten what the profession was, but so far removed from financial management. I couldn't understand why they wanted it. We asked them why would you want to do this?

I think it was for pharmacies. Well pharmacists wouldn't be financial managers in a hospital, as an example. And there is no reason why they should have to know how pharmacy enters into the stepdown method. There is no benefit at all that I could see and yet they were putting this into one of their Teachem programs. And they said oh, well we probably won't sell many of them anyway.

George Bugbee who was the head of AHA years ago said that a professional association should have three objectives: one was representation, represent the group, the profession, before anyone including the federal government, or be official witnesses in court, or whatever. Another thing should be to promote education such as continuing education and any other kind. The other was research.

Does your state association do any research? I know the old American Nurse's Foundation did.

GUY:

It is not old. It's still there. In fact I am on their board. Yes, we still have the Foundation and it is beginning to be revived again. We have undertaken a major fund-raising campaign and increasing the number of small grants and the number of studies that are being done.

On the state level, we have a Council for Nursing Research. This is comprised of nurses who may be doing research, and also is comprised of members who believe that nursing needs to expand its research base and want to promote and support research.

One of the major efforts that came out of that council was a five year project that was based at the University of Michigan and also involving MSU. MNA was the sponsor and fiscal agent. We took a look at the dissemination and utilization of research knowledge in nursing. That project was carried out by Dr. Jo Horsley, who was the project director, through the school of nursing. From that have come some major publications and new studies are being spun-off throughout the country as a result of that project.

We have started a grant award now, a small one, for nurses who want to do research in clinical practice. We also collect information on what research is going on in the state and we disseminate this. We also do the same with trying to identify nurse-researchers who might be consultants for practitioners in institutions where they want to undertake a small research project.

So we become a facilitator, if you will, as well as trying to educate nurses by putting information in our journals, our literature.

At the American Nurse's Association level, they have several vehicles

where they are involved with research. They sponsor a cabinet on research in which they look at research across the country, try to set priorities, and interact with federal government as well as with private foundations encouraging increased support for nursing research. They look at the dissemination of research knowledge and how they can encourage nurses to utilize research in their everyday practice.

There is also a council for nurse researchers so that nurse researchers, and there aren't that many of them, many of them may be the only one in her particular agency, can get together as a support system. They provide continuing education for each other and also address some of their problems. And then the Foundation, which is in a sense the research arm of the ANA, serves as a funding source for individuals and groups who want to undertake research. It also serves to fund or to stimulate studies that the ANA or other professional groups believe are important. They hope to do a project on taxonomy in nursing, for example. They have done studies on international nursing.

In addition to those, all of the various what we call structural units or divisions of practice, have as one of their responsibilities to encourage research in their particular clinical area of practice and to utilize their research. So, some of them, at our convention for example, have as their program a report on a research study undertaken in their particular field so that nurses in attendance can find out about and learn about it.

WEEKS:

One time when I was in New York before the Foundation moved to Kansas City, I interviewed the woman who was the head of the Foundation at that

time. She had a very ambitious program proposal that she was going to get the Kellogg Foundation to support. It was a little ambitious, I guess, and they didn't fund it but I had the opportunity of meeting and talking with her. At that time I was editor at the University of Abstracts of Hospital Management Studies. We were trying to encourage the nursing school master's degree programs to send their theses to us so we could abstract them. Then we in turn had an arrangement with the University Microfilms Co. that they would film them so there was a permanent record the same as there is with a Ph.D. thesis. So I got to know quite a few nurses.

To be selfish, I want to ask you a question that leads up to this. I might tell you that among the several things that I do in my spare time is I edit Inquiry. I don't know whether you are familiar with it. It is a so-called scholarly journal which is supported by Blue Cross Association, the national association in Chicago. It has been in existence about 15 years. We publish papers written by persons who have done research or persons who have examined a policy question, this sort of thing.

Occasionally, we have nursing papers. At present we have two nurses on our editorial board. One is Faye Abdellah, the other is Dr. Rozella Schlotfeldt. Barbara Horn has been, but we have a rotating board.

The point I am coming up to is if I do get a paper, could I call you or ask you for someone who might be able to read the paper?

GUY:

We would have nurses that I'm sure could evaluate papers.

WEEKS:

Most of these papers are not written by nurses. They are written by

people on the administrative side or just research people who look into such things as team nursing versus some other kind of nursing.

GUY:

They study nursing.

I just wrote a comment about a Blue Cross publication recently and I was curious to see whether it's the one that could be the publication you referred to. No, this is Perspectives.

WEEKS:

I am familiar with it. Is that Ohio or is that Chicago?

GUY:

It's Ohio.

WEEKS:

They have been talking about moving it to Chicago to the national office. The Blue Cross Association, as you well know, I'm sure, is just sort of an association of all of the separate plans and the plans sometimes don't always agree with the national office or in this case -- I think this publication has to be subsidized -- and Blue Cross was wondering whether they should take over supplying that subsidy.

I realize the nursing shortage is probably due to many things, competition from other professions now, women find it easier to go into something where they don't have to work weekends and nights. What other reasons are there for nursing shortages, shortage of nurses I mean?

GUY:

There have been a number of national studies recently that have gotten at that and you might want to look at some of them. Some of them have been

reported in the American Journal of Nursing. There was one by Mabel Wandelt in Texas. Dr. Virginia Cleland at Wayne State University has done a couple of studies of geographical areas of this state. One she did recently was on the western part of the state.

The Commission on Nursing that the ANA set up has had hearings and has volumes of data. They all say fairly similar things.

The economics is one part. It may not be the most important part but the level of compensation and whether or not that is sufficient to offset some of these other personal costs is certainly a factor.

The rigidity of the schedules, the hours, the work schedule is another factor. That's probably one area that has more experimentation going on than in some of the other areas. They are trying 12 hour/3 day weeks; being paid for forty hours, working thirty-six; they are trying four and forty; they are trying mixtures of part-time people.

The lack of control over the decision making that affects what the nurse does at whatever her level of practice is, is a significant one. The feeling that nurses are just pawns and they can't influence policy or procedures is a significant factor.

The attitude and the atmosphere is important. Are nurses treated and regarded as professionals whether in their interaction with physicians or their interaction with other department people or administration?

Inadequate staffing, inadequate resources: the dreadful frustration of knowing what has to be done and not having enough people to be able to provide a level of care and in some cases recognizing almost dangerous conditions in staffing.

I talked to a nurse the other day, for example, who told me she was going to quit a nursing home job. One of her quarrels was that sometimes there wasn't enough food for patients. She talked about having 19 hotdogs for 29 patients. Things like that. So, the environment including resources, staffing patterns, etc. is important.

There are some hazards in some of our institutions. I think nurses are just now becoming conscious of the nurse who works with x-ray equipment. I read about an arbitration judgment that was awarded to a nurse out East because on a routine basis she had to hold infants in her arms to be x-rayed and that even though she wore a lead apron she felt that that was still dangerous. The judgment came down against the hospital and in her favor because the judgment said that there are other ways or kinds of techniques which could be carried out without jeopardizing the nurse. Working in the operating room around some of the anesthetic gases is another example of possible hazards. So the environment does play a role.

I'm sure that another factor is the nature of the rotating shifts and the weekends work within the institutional setting. Many nurses believe, particularly the better educated ones, that the staff positions in nursing for the most part are paid at the lowest common denominator. So the nurse who does have different skills finds that she cannot use them because the system prohibits it. They put everybody into the same mold.

One of the reasons that you find many of the nurses prepared at the baccalaureate level leaving the hospital setting is because they say that the employer wants everybody to practice at the practical nurse level; that they discourage people from being innovative and creative in wanting to change

things.

So it is a variety of problems focused on the economics of care, the reward system in terms of professional behavior and development, on the right to determine what nursing practice is and how it should be carried out. And then some of these relationships with some of the other providers.

WEEKS:

I think that one of your big problems as a profession is to determine what is a nurse and what degree of education is necessary to become a nurse.

GUY:

But, you see, within the organization we have settled that issue. What you are reflecting, however, is that there is still a portion of the profession that doesn't accept it. And not only that, there are portions of management and medicine that do not accept it. I think that these members from the profession would be more likely to understand and accept it if they weren't constantly intimidated and constantly getting the wrong information from people outside the profession.

It is to the disadvantage of the employer to have the profession of nursing upgrade its standards because what they say now is, for example, at the staff nurse level -- we ought to pay you all the same thing and a large number of you only have two years of education, therefore, the salary scale has to be pegged at the two year level.

At the same time, they will not provide career mobility for the other nurses. They say we'd go broke if we had to have all nurses with baccalaureate degrees.

Well, of course, our position doesn't say that, first of all. But they

twist it. I know nurses who have been told by their employer that if they didn't have a baccalaureate degree by 1985, they would lose their job, or they would lose their license, or they would lose their professional status.

Physicians don't want well-educated nurses, not really. They want competent nurses on the one hand but they don't want uppity nurses who have all of this education which the doctor sees as irrelevant to carrying bedpans. What the doctors don't understand is that that nurse often is the one that keeps that patient alive or doesn't keep that patient alive. So you have a real dichotomy on the part of physicians and administrators. They recognize that care is getting much more complex and requires a different kind of preparation and skill level. But on the other hand, they really don't want to pay for it and they sure don't want those women to start behaving like professional people.

WEEKS:

There are two kinds of administration or management as I see it, if you could separate them broadly. One is the kind where authoritarian force is used and the other where you try to get cooperation. It would seem to me that this is another case where if administrators were really smart when they are dealing with a group of women who are 90% of their employees, when they are dealing with a group of women who are more intelligent than the average employee would be, that they should try to get that person working with them instead of trying to direct them and force them to do something. To me it just doesn't make sense the way this works out.

GUY:

I think there are some -- I don't want to castigate all administrators --

I think there are some that try that. I think they face two problems. First of all, the system has been so rigid and so bureaucratic and so autocratic, if you will, for so long that a lot of nurses are not willing to trust this new administrator who comes in and changes the climate. It is going to take a while for them to build trust and to see that in fact their participation is going to be relevant, and meaningful and they are not going to get slapped down again.

I think the second thing is that it is going to take a long time to change some of those systems. I think the philosophy about labor relations in general, not pulling out the expectations, is twenty years behind -- not only industry but general education.

The other thing that interferes with this is that it has become a vicious cycle. The problems have perpetuated the shortages and the turnover. The turnover, then and the shortages perpetuate inadequate staffing. Many managers in hospitals including the directors of nursing and hospital administrators are so bogged down with having enough bodies here tomorrow to take care of this many patients that they can never institute reform because something has got to start at that point in order to change. There has got to be time for people to implement change. They just can't ever get out of that cycle of the short term goal to achieve the long term goal.

WEEKS:

Half the day is filled with scheduling the next day.

GUY:

Or filling in the gaps, because many of them are scheduled so tightly that one person being sick can throw the whole schedule into jeopardy. I am very

empathetic to that problem but neither will they ever consider, for example, for three months limiting the admissions to the hospital.

Now there are hospitals that have whole units that never opened because they don't have enough nurses. The hardest thing to do is to say to a hospital: If you don't have adequate staff to safeguard these patients, then you had better put the number of patients and the number of staff into some kind of congruity or somebody is going to suffer.

The answer we get is that as long as people aren't dying, why should they do it?

WEEKS:

We know we are over-bedded, generally speaking, and we know that many hospitals are operating at 60% occupancy and they really should have 80% to do a good financial job. I don't know what we can do about it except some day we have got to face facts. The trouble, as you say, we have no system, which I agree with. There is no way of getting together as a whole non-system and working out these problems. Each hospital is competing with the other. Much of the competition is status competition -- can you do this kind of operation or do you have this kind of equipment? We are in a heck of a mess when you stop to think about it. We are not really very efficient in providing health care.

GUY:

We are not really all that efficient either in really analyzing how we utilize the staff we have. There are some trends. I see some hospitals that have done good studies of the acuity level of patients, the mix of patients and have tied it to the nursing diagnosis and the requirements for nursing

services who have, for example, deleted the position of the nursing aide. In some instances, particularly in the acute care setting, have deleted the LPN level because they have found that it is more cost-effective to have the registered nurse with the broader set of skills to take care of at least certain groups of patients.

But they aren't looking carefully enough. For example, very few institutions look at the nursing budget in terms of carving out those things which are really not nursing. So sometimes nursing gets accused of not only having the biggest budget but -- well that's where we've got to cut -- when that budget may reflect the messenger service, certain dietary and certain housekeeping functions. The real analysis of how do we use the resources in this institution to their optimum effect and begin to look at some hard date and look at some research is not something that is being done in very many institutions. It certainly is not an industry-wide effort. There is some attention. I don't want to sound that pessimistic. There is some attention being given to it. But it hasn't yet really benefitted nursing.

WEEKS:

Some of this has come about through accounting methods by apportioning costs, overhead costs, to departments. So nursing is charged with its share, however that is arrived at -- its share of housekeeping, its share of this and its share of that -- which really has nothing to do with nursing per se other than it helps provide the space and so forth. This is one reason these inequities have come in.

Maybe one last question. What is the future of the LPN do you think? What could be done? Are LPNs here to stay, do you think?

GUY:

No, I don't think so. I think what is here to stay is what we in the past have referred to as a technical level of care. I think that we will always need highly competent, skilled technicians to provide physical care and to assist in coordinating some of the other activities within nursing units. I do not believe that even today a one year level of education is sufficient for those kinds of nurses. That is the primary reason for our position which says there should be two levels of nurses. One prepared at the two year level and one at the four year level.

I think that LPNs will be with us for some time because there are many LPNs practicing today that have acquired skills and are competent. I think we still have settings such as some of the basic nursing homes where we still have people who primarily need to have the kind of physical care that results from physical deterioration. But I don't think we are going to need the same percentage of people.

The state health plan which is under consideration now, for example, is predicting an oversupply of LPNs -- a dramatic oversupply by 1990 -- and they are already recommending that we should cut back on admissions, have no more new schools, etc.

Whether we call the person an LPN, whether we call a person a first level RN, I'm not sure. But my contention is that one year level of education is not sufficient even today for the responsibilites that some of these people are being asked to take.

I was interested that the LPN association is not opposing the reduction of admissions because they recognize that the need is abating now, that there are

beginning to be LPNs who are having difficulty finding jobs, that many LPNs themselves are going back to school to complete their ADN degrees.

WEEKS:

There really isn't a ladder there though, is there?

GUY:

Oh yes. There is a ladder. We have at least seven community colleges that have specifically designed ladders.

WEEKS:

I didn't realize that.

GUY:

We have an endeavor underway in Michigan that we call MCANE, Michigan Coalition for Articulated Nursing Education. We are a member of that. Their primary thrust is to develop a smooth articulation between different kinds of nursing education programs so that as long as we have an LPN program that it will be articulated with an ADN. So an individual will not suffer going back. It can't be perfectly articulated because each program has always been designed as a terminal program. But it's becoming very helpful.

And a lot is going on with challenge exams and testing people out on their level of knowledge, giving credit for people who pass the challenge exams. That is true of both the LPN and the RN who wants to go on in baccalaureate education.

WEEKS:

It would seem to me that the LPN would feel better if she or he knew that there was a chance of working up the ladder and that it wasn't a dead end job, in other words.

GUY:

I think a lot of the LPNs today -- now I'm not going to say that it's going to be true for all of the twenty year olds -- but many of the LPNs practicing today, the need is going to be there long enough that if they keep competent there are going to be jobs for them for another several decades I would guess.

WEEKS:

Most of these schools were taking people up to fifty years of age, weren't they?

GUY:

Oh, fifty-five. In fact, I don't know whether they actually have age limits in some of the schools.

WEEKS:

I know that somewhere I read that there were older, particularly older women in that.

GUY:

Yes. Now I asked a couple of community college people whether they think that isn't lessening now. Whether with the first fifteen years of the community college movement, they didn't get a lot of people from the community who were older and who had never had a chance to go to school and whether now they were getting a younger population.

A couple people thought that yes the population was on an average getting a little bit younger but they are still very mixed and they still have a lot of mature people coming into the programs.

WEEKS:

One last observation. It would seem to me that if we look at -- I am very hopeful about this -- look at the number of women who are going into medicine and of course the women who are in nursing, that maybe in time we will get better care. It seems to me that women are more suited to caring for the ill. This has been a traditional family thing that the mother takes care of the family. I'm just wondering what a difference there will be, if there is going to be a difference by having more and more female physicians? If they will work well with nurses? If they will work better with nurses than male physicians?

GUY:

I have not gotten any reports that that is true at this point in time but it certainly is nothing that we have ever tried to assess. What has happened up until the present time that may change as greater numbers come up is that the women physicians not only were coopted by the system but in order to be competitive with their male counterpart, they have to pattern their behavior. They can't give in and, for example, recognize that the clinical nurse specialist is as much an expert in her area as the woman physician in her area.

Until the system of medicine changes both the educational preparation and the system within which those women practice, I don't know that we are going to see any startling difference.

WEEKS:

She may follow the role model.

GUY:

Right now that is the sense we get. There are individual exceptions on

both sexes. It is amazing to us how those young physicians get graduated and just fit into the mold.

I agree that I think that if the nurturing component that women have traditionally played could be transferred into medicine, it would be very helpful. But until they change their focus of dealing primarily with pathology and disease, the likelihood of their treating individuals as individuals is probably going to become very difficult.

I listened to a nurse-midwife, in fact the first nurse-midwife in this state to be employed in the hospital. She set up the nurse-midwifery program at Hutzel. I heard her tell a group of people at a community meeting the difference between how a nurse-midwife works with a pregnant woman and a physician works with a pregnant woman and I almost felt like weeping at the end because the kind of approach and service she described, which is a part of nurse-midwifery, was so beautiful and so complete and I thought about how women have been treated by obstetricians for years and years, and I thought it shouldn't just be a handful of women that have a right for this type of service. She said, for example, that one of the primary differences is that a nurse-midwife assists a woman in giving birth to a child, a physician delivers a woman of a child.

Now, I think she is an unusual woman anyway and not every nurse-midwife is going to be exactly that way but the whole underpining of the approach within nursing, particularly these nurses that are coming out with the advanced preparation, is so focused on the totality of the human being that they don't take just a piece of this and a piece of this and treat it and then say go home. Whether society will pay for that I don't know.

WEEKS:

There are so many exciting things happening now. I have talked to so many persons who have been in favor of national health insurance or a national health service. I've talked to people who say we can't do it, and I believe that we can't afford it right now. We haven't found a way to do it. At least we haven't been able to afford Medicare, we haven't been able to afford Medicaid, really.

GUY:

I've got the figures of a maternity center in New York City in which they differentiated between the costs of the care to a mother and then a child on an ambulatory care basis although the mother was delivered in the hospital and the cost of traditional obstetrical care. If that cost saving on ambulatory care were translated into the Medicaid program over a period of time hundreds of millions of dollars would have been saved through greater use of nurse-midwives. I think of the cost savings to society of that one service alone using nurse-midwives and maternal and child health specialists in nursing, providing the care on an ambulatory care basis, making it total care of the woman from conception through until six weeks or three months after childbirth. If that one service can save that much money, then I'm not convinced that we couldn't afford if not a national health insurance program at least expanded coverage for people who need to have assistance through a federally funded program.

WEEKS:

Maybe I should qualify it and say we can't afford it the way we are running things now.

GUY:

Oh, you can't afford two systems going at the same time, that is for sure.

WEEKS:

There's no question many things can be saved. I am very much in favor of home care, of visiting nurses. I can't see why we haven't done more with it. But physicians, I guess, don't--maybe I shouldn't talk so much about physicians, but I can't help it because I think sometimes they have been the biggest obstruction we have had...fee-for service...

GUY:

Even for home health care, Medicare and Medicaid, Medicaid particularly, will not reimburse any services say to a visiting nurse association unless there is authorization by a physician on that patient's record.

Now they are trying this program--our legislature is trying this program in cooperation the Department of Social Services which will take Medicaid recipients in Wayne County and lock them into a single designated physician provider. The theory is that many Medicaid patients shop around and go to a variety of physicians, get multiple medication orders, and cost a lot of money.

However, this program that is going to lock a patient into a physician is going to cost an additional amount of money that is not insignificant because they are going to have to pay the physicians--I think it's three dollars just to have each one of these people on their rolls. Then, if the patient comes in and receives a service, the physician will charge his normal fee.

The same with that designation for home health agencies. In trying to facilitate care and not put up a lot of obstacles, DDS has said we won't

require that a patient be seen by a physician like every three months, we'll let the physician just sign a form on the basis of the evaluation of the nurses in the home health agency so the service can be continued. Now what they do is they pay the doctors, I think it's five dollars, to sign a form on a patient a physician hasn't seen, or hasn't seen recently.

I figured out that it would cost the state something like $80,000 just to have those forms signed when it is the nurse making the evaluation and providing the service anyway. But you see we keep perpetuating the expenditures of money to keep that medical system locked in.

Now I know the government is very nervous about adding any more new people to the fee-for-service system. What they say to us is well, adding nurse specialists or nurse practitioners, nurse-midwives will just increase the number of providers. It won't save us costs. Of course, that is ridiculous because if you can save 50% by a Medicaid woman being cared for by a nurse-midwife compared with a physician, that may add one more provider but it is going to cut the cost in half.

WEEKS:

As long as the services aren't duplicated. I can believe this idea of locking in and I can believe in the idea of the primary care physician but then we should go to the British system and pay them on a per-capita basis -- we can't get away with that.

GUY:

I'm sympathetic to the problem but I think when you lock a patient to one kind of provider, not only does it deny them certain freedom of choice but it also locks out other providers.

One of the reasons that we were told that DSS would not approve nurse-midwifery or nurse practitioner services to be reimbursed by the Wayne County area is they said, we're trying this other program and that doesn't permit us to do anything flexible with other providers. Again, what they are doing is locking in those recipients.

You may have a recipient who needs mental health services that would be much better served by a psychiatric nurse specialist. Or someone who has a developmental disability...much better going to a nurse specialist in mental health and probably at less money.

WEEKS:

But we have to have some kind of referral there.

GUY:

Well, the physician won't refer.

WEEKS:

No, I know they won't.

GUY:

But I am saying that the patient has the right to seek that service himself.

WEEKS:

But then you have to assume that the patient knows how to. There should be some mechanism outside the physician where a person could go and ask for referral....I have this condition or that and where can I go? I'm afraid we won't get that away from the physician. He wants to be the referral agent.

GUY:

No. A patient can go directly to a nurse right now. The patient doesn't

need to be referred.

WEEKS:

But does the patient know that?

GUY:

Sure. The patients are discovering that. The problem is that the insurance companies won't reimburse.

WEEKS:

Oh, I see.

GUY:

The patient has freedom to go to a nurse-midwife but if the nurse-midwife is not going to be reimbursed and the patient has insurance, they are not going to want to pay out of their pocket for obstetrical service if it is already covered by their insurance company. So what they will say is, gee, we'd like to have you provide our services, this is what we believe in, but we can't afford you because this insurance company won't pay you.

WEEKS:

I can see where the patient would learn about the midwife but some of these other more complicated kinds of choices might be beyond the patient. How do you get around the physician? I think that is our big problem today -- how to get around the physician.

I talked with Dr. Falk, a Ph.D. at Yale who is very much concerned with this National Committee for Health Insurance, the Walter Reuther Committee of One Hundred. Senator Kennedy is very much interested in this now. Kennedy has taken the attitude that we can set up a certain amount of money for the physician's payments in an area, a defined region. Once that money is

dissipated or gets below a certain point then they can reduce the physician's fees. Can you imagine that?

I tried to find out somebody who could prove to me how this would happen. Who could show that physicians would agree to that.

GUY:

They won't.

WEEKS:

They won't.

GUY:

I think the economic control is probably the primary obstacle. In our state the legal obstacles are not significant any more.

I think, for example, there are some futuristic looking hospitals using clinical nurse specialists in their outpatient departments; we have three now that have set up nurse-midwifery services; we have Mt. Carmel Mercy in Detroit that has a large psychiatric service run by nurses, including outpatient and inpatient. We have some mental health clinics that were using clinical nurse specialists and psychiatric nursing until Blue Cross refused to pay them for it. So we have these pockets. We have some HMOs that use nurses in advanced practice. But for the most part, those nurses have to be salaried people then the institution uses the physician designator number in order to get reimbursed. So we play these games. But it is the nurse providing the service.

Now, some of those patients have become very much oriented to the nurse as their primary provider. These nurses in outpatient clinics or in the psychiatric setting carry their own caseload of patients just as the physician

does. The nurse makes the decision, of including the patient in the decision-making of whether, if a medical problem arises, the patient should be referred to the physician. Or if a dental problem arises, to be referred to the dentist or what-have-you.

So there is some beginning growth in this area but it's those economic barriers that continue to inhibit any further growth or any further utilization.

WEEKS:

Do these nurse practitioners or nurse specialists have to keep a medical record which is referred to the physician? They have this independent of him? They just use his number?

GUY:

The institution uses his number. Now you see, a nurse-midwife, in practice, almost always has a physician contact, a physician relationship.

WEEKS:

Sort of a backup.

GUY:

That's right. And most of the nurse-midwives will require that the patient initially be screened by a physician. Then, once that screening is over and the pregnancy is deemed to be a normal pregnancy, then the nurse-midwife carries the rest of it. The only thing she may do is, if again a problem seems to be arising that appears to be a medical problem, she will consult with the physician and in some cases, she will refer the patient back to the physician.

The same thing will be true with some of the other specialists in

practice. Nurses who are caring for and working with chronic hypertensives, monitor their medications, they help the patients adjust their diet, their exercise, their emotional problems, the whole business. If there are any symptoms, however, that the hypertensives are getting out of control or that they need a different kind of medical intervention, then the nurse refers to the physician and the physician takes care of it, and the physician refers the patient back to the nurse again.

Those relationships do exist between physicians and nurses. It is what we refer to sometimes as joint practice.

I have even heard of teams. I heard of one at Montefiore Hospital in New York where they had a true team effort. These again were patients who had, I think, psychiatric problems. But a psychiatric social worker, psychiatric nurse, psychologist, and physician, with some assistance from other providers as needed would sit down, for example, and take a look at a new patient and they would jointly determine whether that patient's condition warranted patient assignment to the nurse, the doctor, the psychologist, or the social worker. Then most people would use the other team members on a consultant basis. But the patient's direct relationship would be with that person as the primary care provider.

WEEKS:

They use the team approach in long-term care quite often too, don't they?

GUY:

I don't know of any team approach in long-term care. In most long-term care settings, most physicians see the patients only as much as the law requires, Medicaid requires, which is thirty to -- I don't know if that has

been extended or not, it used to be thirty days for someone in a skilled facility and sixty or ninety days for someone in a basic facility. They come in and that is all they see. The nurses carry the rest of it.

WEEKS:

I was thinking more or less of the long-term care unit of an acute hospital. Those terms don't go well together but...nursing home care -- I can remember when my father was in a nursing home in Ann Arbor and we had a regular physician who called on him usually every two weeks. He came in on Sundays and made the rounds. Normally, there was nothing wrong. Once or twice my father became ill and he took care of him and everything went along fine. That is a whole other field...I must start interviewing some of the people.

Do you know Mr. Johnson who runs the Whitehall Homes?

GUY:

I don't know whether I know him or not.

WEEKS:

I've talked with him only two or three times for a few minutes. He is a very kind man and I think he has his patient's welfare at heart. He is a very conservative Republican and he writes what he calls the Philosopher. It is like a little newsletter. We still get it although my father has been gone several years. In the newsletter he talks about everything that is going on in the health field that might be interesting to the readers. Then he brings in a little bit about Mr. Nixon. He was one of those who raised money for Mr. Nixon's defense fund and all of that.

GUY:

Oh, my. He really was a conservative...

WEEKS:

He really is. I think he is more convervative than Nixon, even Goldwater probably. Although I don't know if he is a Moral Majoritan.

May I take this and then in a few weeks I'll send you a transcript and you can review it and do what you wish with it and if you are agreeable that I can use it and put it among the other documents, I would appreciate that very much.

GUY:

You may want to, if you are interested making contact with some of the other national units, you may want to contact the American Nurse's Association. Judy Yates is the Executive Director.

WEEKS:

Fine. I'm sure I will. What other union organizations are coming in now besides the 1199 and this service?

GUY:

In our state, we've seen the UAW, who have three or four units now, I think; the SEIU which is the service employees; Council 1199. There was an attempt by one of the engineer's group at an election in Jackson which they lost. AFSCME has had at least one or two units. In terms of the state government, there are some of their nurses who are in the human services unit and some of them then are in MSEA groups and some of them are in AFSCME. Some of the school nurses have been represented by the MEA but that is a small group. There have been attempts by the bartender's union, the stonecutter's union.

In other states, Teamsters represent nurses. I don't think we have any Teamsters in this state that represent registered nurses. There are also nurses that are represented by the county employees' association. I know in Jackson, for example, and here in Ingham County, registered nurses are represented by the independent county group.

Nationally, I think, Judy or whomever she might refer you to could give you some flavor because in some states, New York and California for example, there has been a much more aggressive push even than I think in our state. Even though we are unionized, and we have these efforts, 1199 is probably the most active group right now in Michigan. They could give you a breakdown on all the various units that are trying to represent nurses. AFT, you know, represents nurses in some states. (The American Federation of Teachers.) You name it. They are out there.

WEEKS:

This is going to be interesting. If I compile all of these findings, would you care to read them?

GUY:

Oh, I would love to. The other thing that would be interesting to me if you talk with more people on the management side, I really would be interested in knowing whether anybody is looking at whether or not there is a difference in dealing with the professional association in the representation of nurses -- and the unions. Because we have had mixed, mixed responses. We have had some employers that have said to us, "We don't like collective bargaining but it is a pleasure to deal with MNA after we deal with some of these others." We have then had some administrators that have said to us, "If you want to be

union, you are going to be treated exactly the same way we treat all of the other unions in this facility, no better, no worse." And we have had some in which we think they have in fact given concessions to the registered nurses whom we represent as compared with their other employee groups. They have said to us, "We think we have to treat you differently -- these nurses are professional."

So there are many variations. It would be interesting to know whether there is any kind of pattern or whether AHA, for example, or the state association has ever studied -- are there more strikes where trade unions represent RNs, for example? That may not be a good or bad indication. Is it harder or easier to settle contracts? What are the differences in contracts?

Someone, I think it was one of the RN magazines, claimed to have done a study to show that salaries were higher under union negotiated contracts than under state nurse's association negotiated contracts. Because this magazine has such a poor reputation on the lack of validity on studies they do, I haven't taken it too much at face value.

Is there a difference in the components of contracts? We find that it is easier to settle the economics than it is to settle the professional issues.

WEEKS:

This is a good indicator of what the nurses want. They are more interested in their professional standing, interested in many ways in their work conditions.

GUY:

See, all of those might make very interesting studies someday.

WEEKS:

I've got to find somebody on the management side. I'm going to try to find a hospital that has had a strike, or a hospital that has negotiated and has had an election in which the union has not been favored. To find out what the attitude is. There is a new book out which I have ordered but haven't received yet by Rothman, Mr. William Rothman.

GUY:

Who worked at Metropolitan?

WEEKS

Yes.

GUY:

That is interesting.

WEEKS:

I called him on the phone - he is out in Connecticut now, he has just recently moved -- to try to find out what he had in his book. But he is more concerned with strikes rather than with contract negotiations, I think.

GUY:

We represented the nurses in his hospital for I'll bet you more than ten years, 10-12 years. Then they decertified to the UAW. They were the first UAW group.

WEEKS:

It's almost natural with this...

GUY:

But I think he may have left before or at that time. I would really be fascinated to note the difference from management's perspective on dealing

with the SNA and dealing with the union. Not just in terms of across the table relationship but in terms of the end result of the contract. Did they feel, for example, it was easier to settle for fewer benefits or fewer concessions with the SNA than the union? What was the difference in the focus of the negotiations?

Now, I don't know how much you could tell the first time around because when a union takes our contract and builds on it, they have already gotten a lot of those issues incorporated. But the UAW does have I think two units now in hospitals that have never been unionized. It would be interesting to see how they do on those.

WEEKS:

Have you ever been able to set minimun standards for the state? Recommended minimums?

GUY:

We used to always. We used to have an annual publication with minimum standards for the different positions in nursing. That was the approach we took during the early, oh, about the first seven years of our program. But we found, after we really went into collective bargaining, that those would be used against us.

WEEKS:

Yes. This would be the maximum.

GUY:

Yes. So we discontinued doing that.

WEEKS:

The old rule of thumb that I can remember from a few years back was that

if you took a registered nurse at 100, a licensed practical nurse would be 75% and an aide would be 50%. That was about staff nurse and so on. I don't know whether that still holds true.

GUY:

It used to be 75 or 80 and I've forgotten where the aide would fall. That may still be apparent but I don't think it's done with that intent any more.

WEEKS:

It just kind of works out that way.

GUY:

I think that there can be variations. I think there are some agencies where there is as little as 15% differential. I think there may be other agencies in which there is 25 or 30%.

WEEKS:

I suppose a whole lot depends on the supply and demand and all of this sort of thing.

GUY:

You see, we have hospitals in which the majority of the nurses are either LPNs or ADN. When you have only a year's difference between those two categories and they are almost used interchangeably, it becomes a much harder case to say, well, the registered nurse should have 25% differential.

That says something probably for the level of nursing care and for the understanding of the managers more than it does to the collective bargaining process itself.

WEEKS:

We have even heard of the University of Michigan hospital on night duty

having an LPN in charge of a unit.

GUY:

It really is illegal but they do it. Nursing homes are run on aids and LPNs.

WEEKS:

Sure they are.

GUY:

There are basic nursing homes that have LPNs that are Directors of Nursing. What the law says and what happens are sometimes quite different.

WEEKS:

I have enjoyed this interview. Thank you very much for your interest and time.

Interview in East Lansing, MI

November 11, 1982

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