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# CRNA [Certified Registered Nurse Anesthetists]: Is the AANA Your Union?

Doris T. Margrabe

# CRNA: IS THE AANA YOUR UNION?

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A Digest Presented to the Faculty of the Graduate School
of the Lindenwood Colleges in Partial Fulfillment of
the Requirements for the Degree of
Master of Science

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# DIGEST

The problem discussed in this paper is whether the Certified Registered Nurse Anesthetists (CRNAs) will need to unionize as a direct result of the activities of the Registered Nurse (RN) in order to insure financial solvency? If unionization is the answer to the CRNAs financial security, then what kind of a bargaining unit should the CRNA be associated with?

The methodology utilized in this paper was: an extensive reading of the history of the nursing profession and its professional organization; the history of nurse anesthetists and the functions of their professional organization; a review of the development of labor legislation and its appropriateness in health care facilities; and an analysis of the judicial decisions affecting the CRNAs personal financial security. To demonstrate the validity of my findings with the nurse professionals, an exploratory survey was conducted and some conclusions are offered.

Through my research, I found there are some obvious differences between the CRNA and the RN. These differences include such things as differences in their education; job responsibilities are unlike; there is a ratio disparity between these professionals in any hospital situation; they are members of different professional organizations; there is a variance in the method of procuring adequate financial renumeration; and who serves

as their representative in labor negotiations. There have been instances when the National Labor Relations Board (NLRB) has acknowledged these differences between these professionals; but in a large majority of the judicial rulings, the Board has continued to group these health professionals into one collective bargaining unit.

The final answer from my research is not clear. Each group of CRNAs and each individual nurse anesthetist will need to face this problem and decide what is best for themselves. The problem is sure to present itself in the next decade if the economic picture stays the same.

# CRNA: IS THE AANA YOUR UNION?

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A Culminating Project Presented to the Faculty of the Graduate School
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This project is dedicated to Happy Face.

I wish to acknowledge and thank Helen Ogle, my instructors, co-workers, and respondents who have aided me in many ways during the completion of this project.

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# CHAPTER I

## INTRODUCTION

Will the Certified Registered Nurse Anesthetist (CRNA) be required to unionize in the future to establish or maintain their economic security? If they unionize, will the collective bargaining unit be composed entirely of CRNAs, or will it be a conglomerate of many health professionals?

A CRNA has as her basic health education a license to practice as a Registered Nurse (RN). From this point, the CRNA must take advanced training in the art and science of anesthesia, graduate from an accredited school of anesthesia, and petition to take and pass a national qualifying exam. In addition, this person must be recertified every two years by participating in 40 hours of continuing education activities. Once this training is successfully completed, the CRNA accepts an expanded nursing role where duties and responsibilities place him/her in a position in which he/she is identified with the medical rather than the nursing staff. These distinctly different duties and responsibilities demonstrate the educational and functional differences between a CRNA and a RN.

The professional organization for the RN is the American Nurses Association (ANA). The professional organization for

CRNAs is the American Association of Nurse Anesthetists (AANA). These two organizations serve some of the same purposes for their members such as developing educational standards and a code of professional ethics but differ greatly in the manner of securing for their members financial stability. The ANA has been the prime impetus for collective bargaining activities for the nurses. The AANA has never attempted to serve any such function for the CRNA. But the CRNA has been involved in the nurse's collective bargaining activity as a result of her basic education. The CRNAs are more critically involved today in labor negotiations because of some recent decisions by the National Labor Relations Board (NLRB) which has grouped all RNs, regardless of their speciality, into one collective bargaining group. This is an unacceptable position for most CRNAs who realize that a union for all RNs or all professional health employees will not recognize the distinguishing characteristics of the CRNAs and will not represent their distinct differences adequately or meet their financial needs.

Therefore, the CRNA of the future may seek a third-party external organization to assist them in mobilizing for the purpose of maintaining their economic security and professional status. It is, however, likely to be an organization that gives them separate and distinct treatment by the NLRB in the matter of establishing bargaining units. If this situation does occur, it will be a matter of choice and not a necessity

arising out of the activities of the nurses.

The purpose of this paper is to demonstrate the precarious position of the professional nurse anesthetist in labor relations because of his/her educational association with the RN. This study will deal only with the economic security of the CRNA if the RNs actively continue to seek their economic security and representation to management through unionization. By tracing the similarities in the professions and the purposes for which these professionals join into associations, it can be seen how their goals might be similar. I plan to show how legislation has hampered CRNAs in their independent pursuit of adequate financial reimbursement.

This study is limited to the establishment of collective bargaining units of the professional employees within the health care facility. The primary input will be a literature review of the existing traditional associations of RNs and CRNAs; the current position and actions of the professional organizations representing the CRNAs and RNs; the legal problems in Missouri for the CRNA; as well as current laws regarding the unionization of the professional health employee. In addition, the root cause for unionization in the health field industry will be explored thoroughly. A conclusion will be drawn about the desirability of union membership by CRNAs through researching by random survey the present feelings of these professionals in Missouri and analyzing the benefits of some health employee unions.

The research design of this study includes a descriptive analysis of existing data as well as an exploratory survey of the current feelings of CRNAs and RNs. There will be a listing, derived from current literature, of the reasons nurses have unionized and what the trend has been in the 1970's.

## CHAPTER II

## THEORETICAL ORIENTATION

Will the Certified Registered Nurse Anesthetists (CRNAs) be coerced into joing a union to insure their financial solvency as a result of the activities of the Registered Nurse (RN)? Up to the present time, because of the similarity in the entry education level of the CRNA and the RN, the trend has been to think of these two different professionals as likes. I intend to show that through additional education, further testing, and being awarded the status of certified the CRNA is not educationally the same as an RN.

Furthermore, the job responsibilities and moral obligation of the CRNA are distinctly different from those of an RN. Because of these job responsibilities, the CRNA is frequently identified with the medical staff of an institution rather than being associated with the department of nursing. This long term voluntary association through duties and responsibilities has not strengthened the association of CRNAs and RNs, but rather, has isolated the CRNAs from their peers, the nurses. The consequences have been that CRNAs are employed within an institution and medical practice groups in special job categories, with different salary scales and benefits, causing them to have

different professional organizations.

A new problem has now arisen that is going to effect the financial solvency of the CRNA. There have been two major legislative changes affecting health care institutions where most CRNAs are employed. The changes I am referring to are the passage of the PL 93-360 which makes all professional medical employees subject to the same labor statutes that affect any worker in the industrial workplace. The law requires employers in health care facilities to allow employees to select a representative of their choosing to present their demands to management. The RNs, who previously had been represented by their professional organization, are turning more and more to unions as their third-party representative.

Prior to this time, representation of the nurses to management had not directly affected the CRNA who has held a special employment status in the institution. Now with the enactment of PL 93-360, the National Labor Relations Board (NLRB) determines what is an appropriate bargaining unit. The Board, having been directed by Congress to prevent the proliferation of bargaining units within an institution, have been grouping all professional nursing personnel, regardless of their expertise into one bargaining unit. This will have a direct negative affect upon the financial solvency, positional status, and the utilization of CRNAs within a hospital. By reviewing the current literature and court

decisions, I feel I can show this has been financially detrimental to the CRNA; that the NLRB does not always place CRNAs in bargaining units if a need for a separate bargaining unit can be demonstrated; and with the American Association of Nurse Anesthetists being unable to represent CRNAs in their labor negotiations, the only practical solution will be for CRNAs to seek separate bargaining units. I see no way the nurses or their activities can force CRNAs into unionizing.

Through an in depth study of labor legislation, it can be shown why unions came into existence in the industrial workplace. Some of these same causes, such as poor salaries and working conditions, are the same reasons that professional health care employees have soughtunionization. But the content of the labor legislation has been to group employees in units that have the same skills, job responsibilities, working conditions, and the like. The problem to explore then is why have they not done the same kind of grouping within hospitals. If it can be demonstrated that there is an educational, functional, and positional difference between CRNAs and RNs, then it can be assumed that CRNAs and RNs have a need for separate bargaining units.

Will the CRNA, out of necessity then, be forced to join unions because the nurses for a variety of reasons have turned to unions to represent them to management. I do not think so. I feel the CRNAs will continue to hold a distinct position in the

hierarchy of hospital structure; the anesthetists will do his/her own labor negotiations; and the anesthetists will realize that they have more to lose by joining a union than they can possibly gain.

# CHAPTER III

## RESEARCH METHODS

Through my research I want to demonstrate that the Certified Registered Nurse Anesthetist (CRNA) will not be forced to join a union to insure financial solvency and to show that if the CRNA does unionize, the only practical strategy will be to group only nurse anesthetists in the bargaining unit.

The first method I will use will be a content analysis of the secondary data. This is a technique of systematic examination of secondary or supporting data that isolates units or indicators of phenomena in which I have an interest. This systematic process will first define the phenomena and units of investigation that are important to my study and will lead me to specifications of those operational indicators in these categories. When such indicators are thus identified, they can be counted. The most preferred indicators are words (Forcese, 1973, p. 186).

The advantage of content analysis is that it provides a systematic examination of material that is usually ladened with the author's biases but guards against any inadvertent biases. The disadvantage of this method is that the researcher may not always pick material which is the most representative of the hypothesis he/she is trying to prove. Many times this occurs

because the researcher is not in a position to determine which sources of material are the most representative; and at other times, it is because no specific source of material is directed specifically to the point in question. If the researcher attempts to score the material, he/she must eliminate any arbitrary elements in order to be effective (Babbie, 1973, pp. 34-35).

I will use the content analysis method of research on existing legislative actions regarding unions in general, and specifically unions in the health care industry, in exploring articles in periodicals and in the decisions of the National Labor Relations Board (NLRB) and in analyzing the historical data to determine the historical development of a correlation between the concept of unionization and health care professionals. The indicators used will be words such as arbitration, collective bargaining, bargaining units, benefits of unionization when coupled with nurses or nurse anesthetists. These will not be scored, but rather used to determine the direction the activities of the Registered Nurses (RNs) and CRNAs are taking.

Another method I will use will be a literature review of the development of nursing and the expansion of nurses into speciality roles. This type of research has the advantage of being financially inexpensive, but has the disadvantage of including some of the author's biases. Therefore, I will limit my review to data which is found in the bylaws of the professional organizations and the licensing laws of the state. In this way, biases should be avoided.

I will also conduct a random survey of the present situation and feelings regarding health professionals in the state of Missouri. Survey research has three objectives: to make descriptive assertions about some population; to make explanatory assertions about the population; or to provide a "search" devised when a particular topic is beginning to be studied (Babbie, 1973, pp. 57-59).

A survey can be taken on any topic that a researcher chooses to look into. The topic to be studied is called the unit of analysis, and it must be described in advance so that no matter what the researcher does the design of the survey and the collection of data does not deter the making of an appropriate analysis (Babbie, 1973, p. 60-61). The unit of analysis in my paper will be the RNs, the CRNAs, and the collective bargaining unit.

There are two basic survey designs that I intend to use. The first is the cross sectional survey. Here the data collected is to be representative of some larger population at that time. It will be descriptive of the two types of speciality nurses, but it will also demonstrate the relationship between these two groups at the time the study is being done (Babbie, 1973, p. 62). I plan to do this with my survey utilizing three groups of nurses—the operating room nurse, the supervisory nurse who holds the position of Director of Nursing, and the CRNA. By using these three groups, I will be able to explore the feelings

towards unionization and who they feel can best represent them in their goal to achieve financial security. By using these parallel types, I can compare the results and perhaps be able to foresee the future status of the CRNA in labor negotiations. These are good parallel groups because they all have the same basic educational background. They are all represented by a different professional organization, and they all have a vested interest in their economic stability in their chosen field.

Before I undertake conducting a survey, I will choose a population sample. A sample is selected, rather than the entire group, because it is less expensive and less time consuming (Babbie, 1973, p. 73). The reasoning behind using a sample is for the purpose of making estimated assertions about the nature of the total population from the samples that have been selected. It is possible that a sample could misrepresent the population from which it is drawn, but established sampling procedures over time can reduce the danger. The accuracy of a sample survey has been proven over time to be a reflection of the state of affairs of whole populations as has been proven in such things as elections (Forcese, 1973, pp. 121-122).

In the use of sampling, there are two basic types: probability and nonprobability (Babbie, 1973, p. 76). I have chosen to use the probability sampling in my research. In this method, every member in the population in question (types of

nurses) has a known probability of being selected. I will then do a random sample, meaning that each individual in the separate list of speciality nurses has an equal chance of being selected in the sample (Forcese, 1973, p. 123). The chance that this method will be absolutely representative of the groups is not guaranteed, but it will be more representative than other types because the biases have been removed. After I have conducted my survey, I should be able to estimate the accuracy of my sample (Babbie, 1973, p. 78).

The population used will be Missouri nurses. To represent the RN without additional training, I will utilize the operating room nurses; to represent the supervisory nurse, I will use Director's of Nursing at Missouri hospitals that are members of the Missouri Hospital Association; and to represent speciality nurses, I will use the CRNAs who are members of the Missouri Association of Nurse Anesthetists. I plan to obtain a present membership list from the Association of Operating Room Nurses, the Missouri Hospital Association, and the Missouri Association of Nurse Anesthetists. I will use a systematic sampling method in which the kth element is picked for the sample. To prevent biases on my part I will pick the first name at random. Babbie calls this the systematic sample with a random start (Babbie, 1973, p. 92). To do this, I place numbers from one to ten in a bowl, and draw my starting number for each list. Since I plan to survey 10% of each population, I will choose every

10th number after my random number.

To achieve success with a self-administered questionnaire the construction of the questions is very important. Questions may be either open ended, unstructured, or closed ended, structured. In a close ended question, all possible answers are given for the population to choose from. Utilizing these types of questions will provide for greater uniformity of responses and make it easier for the researcher to process (Babbie, 1973, p. 140).

The disadvantage of the closed ended questions is that the responses may not cover all the answers the respondent may want to give. The researcher should attempt to allow for all possible answers, and the answers should be such that the respondent can choose only one answer (Babbie, 1973, p. 141). I will use a structured question with only two possible answers—yes and no. My questions hopefully will be clear and without hidden meanings, negative viewpoints, and biased terms (Babbie, 1973, pp. 143-144).

The general format of the questionnaire is as important as the nature and wording of the questions. As a general rule, the questions should be spread out and uncluttered. Squeezed together questionnaires could give disastrous results (Babbie, 1973, p. 150). Questions in like categories should be grouped together. Questions should be short and limited to high quality data. A criteria for each question must be that the researcher can justify its relevance to the concepts that he/she is

interested in obtaining. Efforts should be made to see that it takes respondents no longer than 30 minutes to complete the questionnaire or he/she will lose interest (Forcese, 1973, p. 164). A striking, noteworthy question should be used first for this will catch the respondents interest, and will stimulate him/her to answer the questionnaire (Babbie, 1973, p. 150).

If the researcher really wants a good response to the questionnaire, a self-addressed stamped envelope should be sent with the questionnaire. It has been shown that the longer the respondent puts off answering the questionnaire the less likely he/she will return it. An acceptable rate of returns on questionnaires is 50% and anything above this is considered very good (Babbie, 1973, pp. 160-165).

Any questionnaire used should be reliable and valid. Reliability is defined as the extent to which any other surveyor could duplicate your study and achieve the same results as you. Validity is a measure of your study with reference to did it produce what you wanted it to produce. The administration of a pretest of your questionnaire can measure both the reliability and validity (Forcese, 1973, pp. 165-166). To conduct a pretest, you take your questionnaire and administer it to a small group of subjects which are representative of your population in question. When it is returned, the questions should be checked for clarity, ability to be answered, multiple answers, and direct comments (Babbie, 1973, p. 214). I will administer a

pretest to a small group of each of my sample populations.

In an attempt to use an alternative method of data collection, I will interview by phone local officials in the three health service unions in the city of St. Louis. In this method of research, the researcher asks the questions verbally and records the respondent's answers. The advantages of this method include: a higher response rate than most surveys; less unanswered questions; items on the questionnaire are not as confusing to the respondent; and, finally, the interviewer can note the respondent's voice to determine the quality of the answer given (Babbie, 1973, pp. 171-172).

I will use this type of research to see if I can ascertain any advantages for the CRNA if he/she becomes a member of a bargaining unit that is dominated by any group other than CRNAs.

# CHAPTER IV

# RESEARCH FINDINGS

## Analysis of Historical Data

Since the 1800's, the health care field has grown from a purely philanthropic endeavor carried out by a few people to a highly complex technological industry which employs the services of many varied skilled professionals as well as some unskilled people. The basic reason for this growth is the developing idea by a large number of people that every citizen is entitled to health services as a basic right—not a privilege (Bean, 1977, p. 1). Table I, page 18, portrays the increase in the number of health care professionals from the years 1960 to 1975.

It is within the hospital setting that the majority of the public's health needs are met, especially the major health needs. Hospitals serve a variety of multifaceted purposes; but the principle ones include, though are not limited to, caring for the sick, promoting public and professional education, conducting medical research, and practicing preventive medicine. The work flow in a hospital is, of necessity, variable and irregular; and does not lend itself to mechanical standardization. If indeed, hospitals are to accomplish the primary reason for their existence—namely the care of patients, they must utilize many

TABLE I

NATIONAL NONAGRICULTURAL EMPLOYMENT BY SELECTED INDUSTRY, 1960, 1965, 1975

| Industry | Employment (in thousands) | | | Percent Increase 1960-1975 |
|---|---|---|---|---|
| | 1960 | 1965 | Projected 1975 | |
| Total Nonagricultural Employment | 54,234.0 | 63,932.0 | 76,030.0 | 40.1 |
| Manufacturing | 16,796.0 | 19,186.0 | 19,720.0 | 17.4 |
| Services | 7,423.0 | 9,545.0 | 12,915.0 | 74.0 |
| Medical and Other Health Services | 1,547.6 | 2,206.5 | 3,400.0 | 119.7 |
| Hospitals | 1,030.0 | 1,418.5 | 2,200.0 | 113.6 |

Source: U. S. Department of Labor, Tomorrow's Manpower Needs, Bulletin No. 1606, Vol. 4 (Washington, D.C.: Bureau of Labor Statistics, 1975), p. 88.

human health professionals, two of which are the Registered Nurse (RN) and the Certified Registered Nurse Anesthetist (CRNA) (Bean, 1977, pp. 1-3).

Nursing as an occupation has been in existence since the days of the Crusades when it was carried out by male religious orders. The earliest written nursing records are from the Knights of Malta. The origin of nursing as a profession is attributed to Florence Nightingale; who in the 1840's, with funds from the British public, established institutions for the training, sustenance, and protection of nurses and hospital attendants. From this point, knowledge was collected in books and systematic teaching of nurses began. It is also during this time that the profession began to be pursued by more females than males due to the availability of many spinster females. The duties of the 1840 professional nurse were restricted to the sphere of attendance, cleanliness, the provision of food, as well as any other duties the medical authorities felt they could reasonably provide. From this restricted start has evolved a profession that is an adjunct to medical-surgical treatment (Thatcher, 1953, p. 33).

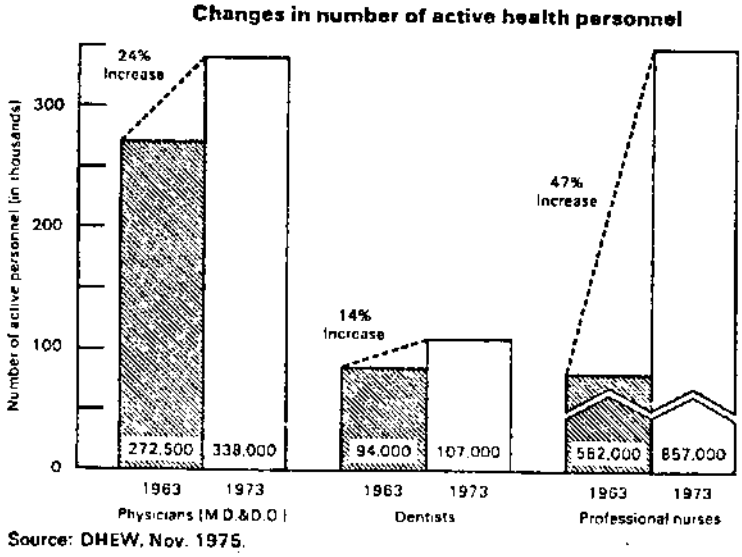
Nursing today is far more encompassing than Ms. Nightingale ever dreamed. It has a much broader base due primarily to the persistent efforts of nurses to make nursing a science and to achieve the status of a professional for its practitioners. With this expanded role, nurses are required to have a broader

educational background and to accept more legal and moral obligations and responsibilities. The number of nurses has increased dramatically as shown in Figure I, page 21.

To become a RN, a person must be in good physical and mental health; attain a high school education or its equivalent; complete the basic curriculum in an approved school of nursing; and have been awarded a diploma from this school. There are three preparatory types of nursing educational programs: first, a diploma school of nursing which is generally a hospital based program where nurses are trained and engage in patient care; second, a college or university program which leads to a Bachelor's Degree; and, third, the junior college Associate Degree program. These last two types of programs generally stress the educational foundations of nursing more than the clinical application of that knowledge (Academy of Medicine, 1977, pp. 491-492). The basic educational requirements of all aspiring nurses include knowledge and application of principles derived from the biological, physical, social, and nursing sciences (Missouri Practice Act, 1981, p. 2).

Upon completion of an approved nursing educational program, the applicant desiring to be an RN must submit to their State Board of Nursing a written application affirmed by oath that they have met the requirements to become a nurse and have reached the age of 19. If the Board approves their application, the person is eligible to take a written examination in such subjects

FIGURE I




Source: DHEW, Nov. 1975.

the Board may approve. Upon successfully passing the examination, the Board of Nursing shall issue the person a license to practice as a RN (Missouri Nurse Practice Act, 1981, p. 7). This license must be renewed annually or at specific intervals for a set fee. Some states such as Kentucky have as a prerequisite for license renewal a specific number of "contact" or "continuing education hours" that have been offered which have had the Board's approved sponsorship (Kentucky Nursing Law, 1978, p. 11).

The American Nurses Association (ANA), the professional organization for nurses of all types, defines the practice of professional nursing traditionally as:

> ...the performance, for compensation, of any acts in the observation, care and counsel of the ill, injured or infirmed or in the maintenance of health or prevention of illness of others, or in the supervision and treatments as prescribed by a licensed physician or dentist requiring substantial specialized judgement and skill and based on knowledge and application of the principles of biological, physical and social science. The foregoing shall not be deemed to include acts of diagnosis or prescription of therapeutic or corrective measures (Annas, 1981, p. 39).

The more modern nurse practice acts or the amended nursing acts have a very broad definition of nursing to allow today's health professionals to advance and expand their practice into other areas of health care. According to the Missouri Nurse Practice Act approved on 28 September, 1981, nursing is the traditional kind of occupation as defined by the nurses association but it specifically defines duties as:

> ...the performance for compensation the above acts including, but not limited to:
>
> a. responsibility for the teaching of health care and the prevention of illness...,
> b. assessment, nursing diagnosis, nursing care and counsel of persons who are ill, injured or experiencing alterations in normal health processes,
> c. the administration of medications and treatment as prescribed by a person licensed in the state to prescribe...,
> d. coordination and assistance in the delivery of a plan of health care with all members of the health team,
> e. the teaching and supervision of other persons in the performance of any of the foregoing (Missouri Practice Act, 1981, p. 2).

Other states such as Kentucky have modernized their Nurse Practice Acts to include some specialities. In Kentucky's Revised Statutes 319.011 (6), there is defined the Advanced Registered Nurse Practitioner as "...someone who is certified to engage in advanced registered nursing practices including but not limited to the nurse anesthetist, nurse midwife and the nurse practitioner" (Kentucky Nursing Law, 1978, p. 9).

Therefore, while there is a standard process to become a RN, the purpose and scope of nursing has been defined but not universally limited to specific criteria.

## The Certified Registered Nurse Anesthetist

A Certified Registered Nurse Anesthetist (CRNA) is a nurse practitioner who performs an expanded nursing role. Their basic education is the same as the Registered Nurse, and can be acquired in any of the three preparatory settings.

The only license that the CRNA holds is that of a registered nurse, but the CRNA does have advanced training in the art and science of anesthesia. The nurse anesthetist will have undertaken and completed two years of anesthesia studies in addition to the general nursing studies. Upon graduation from an accredited school of nurse anesthesia, this applicant can apply to the American Association of Nurse Anesthetists (AANA), the certifying agency for CRNAs, to take the national qualifying exam. The nurse anesthetist becomes certified upon successfully passing this examination. The AANA also extends accreditation to educational institutions offering anesthesia instructional programs. The educational process for the CRNA is longer than other speciality RNsreceive; for example, the nurse practitioner is only required to have 12 additional months of training in his/her respective field. Further, nurse anesthetists are required to complete 40 hours of continuing education every two years to achieve recertification (Weisgerber, 1980, p. 84). As a matter of clarification, the term continuing education for the CRNA means participation in an approved educational program beyond the basic nurse anesthesia programs that presents specific content, planned and evaluated to meet competency levels based on behavioral objectives to develop new skills and upgrade knowledge (Kentucky Nursing Law, 1978, p. 5).

Missouri does not define the advanced registered nurse practitioner in its Nurse Practice Act, but CRNAs do work in the state as such. A nurse practitioner's role can be defined as:

> ...the performance of additional acts by RNs who have gained added knowledge and skills through an organized post-basic program of study and clinical experience approved by the organization or agency which has the authority to certify the advanced registered nurse practitioner. In the performance of those duties which are normally construed as the practice of medicine, the nurses will conform to the standards of medical practice act and established medical protocol (Kentucky Revised Statutes, 1978, p. 4).

This definition is an example of the legal authority under which CRNAs practice in those states which have delineated between nurses and the nurse practitioners.

As many as 30 states have recognized the nurse practitioner including, in many cases, the CRNA specifically. The nurse practitioner operates beyond the typical nursing spectrum, and is perhaps closer to the role of a physician than a nurse clinician. For a variety of reasons, nurse practitioners are performing duties traditionally considered solely in the physician's realm. These updated Nurse Practice Acts allow for the full implementation of the nursing professionals (Weisgerber, 1980, pp. 83-98).

There are other recognizable differences between the RN and the CRNA besides education such as job responsibilities and the CRNA's status in the health care industry. These differences will be demonstrated more fully later.

Professional organizations are formed to represent the interests of their members. In times of prosperity, professional people are rarely concerned about the principles of their groups

survival and have only tenuous bands with like professionals. It is only when common problems become too big for individual solutions that the average professional person becomes conscious of the protection afforded by actively belonging to their specific organizations (Thatcher, 1953, p. 181).

The RNs have as their professional organization the American Nurses Association while the CRNAs are represented by the American Association of Nurse Anesthetists. Each of these organizations are divided into three levels—national, state, and district. At the national level, the association has three primary functions: first, political activity whereby legislation can be lobbied for; second, to be a resource body for information needed by the state and local associations; and last, any other activity which will further the interests of all the affiliated state bodies. The national body maintains standing committees to research and handle major professional problems that affect members nationwide; it divides the membership into divisions of professional practice to deal individually with its unique problems; it maintains liaison with other related interest groups; and conducts occupational forums (Werther, 1976, p. 22).

State associations serve as the primary source of assistance for the local association—not the national body. The state association provides legal counsel for the local associations as well as these services: provides representatives to assist with organizing, negotiating, research, law making, lobbying and

other pertinent services the local association may need. Most of the legislation affecting health care professionals is state enacted so it is appropriate that the evolution of professional health care organizations concentrated most of their power in their state associations (Werther, 1976, p. 22).

At the district level, professional organizations focus on meetings and activities which are designed to further their professionalism. The district level may also represent its members in dealings with management in such things as negotiating contracts. Thus, the district associations have two divisions: a professional division that concentrates exclusively on improving professional competency and reputation; and another division which conducts labor-management relations which attempt to meet the needs of both the staff nurses and administrators of the health care facility (Werther, 1976, p. 23).

The membership of the ANA is composed exclusively of RNs, regardless of speciality, and is open to all graduates of state accredited schools of professional nursing. This association was founded in 1896 by a group of nurse delegates from 10 separate training school alumnae as a result of a meeting in New York to discuss a merger into a national association for the purpose of sharing information, resolving problems, advancing research and establishing a standard for the training of nurses (Christy, 1971, p. 1778). Today, the ANA has 162, 790 members belonging to 50 constituent state nurses associations and Puerto Rico, Guam, and

Virgin Islands and includes 800 district nurse associations (The American Nurse, September 1981, p. 5).

The ANA has as its major objectives the advancement of the professional nurse and the improvement of the health care services for the public. In the ANA handbook which is given to every member the ANA lists their purpose as:

> ...to work for the improvement of health standards and the availability of health care services for people; foster high standards of nursing; stimulate and promote the professional development of nurses and advance their economic and general welfare (Bylaws of American Nurses Association, 1980, p. 2).

The ANA has many functions. The majority of these functions are concerned with the education of the professional nurse. The association has established a standard of nursing practice for nurses and a code of ethics. It stimulates and promotes research in nursing. The association will, at all levels, provide continuing education in the form of seminars, written material, and personalized help if needed. The association also lists as one of its functions the promotion of the economic and general welfare of the nurse. This is the basis for the association serving as the collective bargaining agent at the local level.

Other functions of the ANA include: assuming an active role as a consumer advocate; attempting to predict, analyze and influence new dimensions of health practice and delivery of health care; speaking for the nursing profession in regards to legislation, government programs and national health policy; and representing and speaking for the nursing profession with allied health and

other organizations and the government. The ANA does sponsor an association for the student nurse (Bylaws of American Nurses Association, 1980, p. 1).

The ANA is not the credentialing agent for the schools of nursing nor the licensing agent for nurses. The State Board of Nursing, whose members are political appointees, accredit the schools of nursing, make up and administer the state board examination, and award applicants their license if they pass the State Board Examination and pay the fees (Missouri Nurse Practice Act, 1981, pp. 3-10).

Because there had been a need for a trained individual to administer anesthesia who was not in training to become a surgeon, the occupation of nurse anesthetist was created. Since anesthesia in its infancy was considered as a means to the end of surgery, the person giving the anesthesia was traditionally assigned a subservient role. Due to the number of fatalities under anesthesia, as early as the 1840's the physician, hospital and the government have been attempting to legislate who performs anesthesia, how the anesthetizer is educated and what anesthesia may be used. Because special nurses were the people giving anesthesia in this era, they decided to band together for the protection of their jobs and to pool their knowledge. This small group with Agatha Hodgins as President developed a plan for a national organization of nurse anesthetists and a tentative constitution and a set of bylaws were drawn up (Thatcher, 1953, p. 181).

As a result of the internal dissension among the physicians within their professional organization, the American Medical Association (AMA), the government was eventually involved in the determination of the legitimacy of nurses administering anesthesia. The only court trial to test the legality of nurse anesthesia was in 1934—Dagmar Nelson vs. the State of California (Nelson v California, California, 1934). The court based its decision upon several other court cases and the already established Medical Practice Act. The first case used for precedent was Frank vs. South (Frank v South, 194 S.W. 375, 1928). In this Kentucky Supreme Court case, the judge ruled that nurses who complied with statutes relative to their education, did not purport to engage in the practice of medicine, and did not advertize their readiness to treat the injured or prescribe were acting within the confines of the law. The judge further noted the analogy between the right of the nurse to administer medicine prescribed by the physician even though its administration necessitated the use of the nurse's judgement and the right of the nurse anesthetist to give anesthesia pursuant to the supervision and direction of the surgeon. As a supporting fact, the judge pointed out that at Mayo Clinic 100,000 operations were performed with nurses giving the anesthesia. By 1917, physicians, surgeons, and other respective organizations had approved of nurses delivering anesthesia (Frank v South, 194 S.W. 375, 1928).

The second case utilized in this decision was Yates vs. International Travelers Association (Yates v International Travelers Association,S.W., 1910, p. 301). In this judgement, the Court of Civil Appeals of Texas pointed out that physicians did not regard the administration of anesthetics as a part of the surgery or treatment. Even in adverse reactions in which the patient dies, the court ruled that the giving of anesthesia was not a treatment to be utilized in the cure of any person. In Beck vs. Travelers Protective Association (Beck v Travelers Protective Association, Mo., 1911, p. 112), the court ruled

> ...It (anesthesia) was administered as preparation to the surgical operation, but so might have been his bath and if he had died in his bath it would not be seriously contended that he died as a result of the surgical treatment.

The law further strengthened and established the legitimacy of nurses administering anesthesia in the case of Spain vs. Burch (Spain v Burch,S.W., 1911, p. 172). The court said:

> ...the skill and proficiency by which a physician administering an anesthetic is to be judged is not measured by the usual and ordinary skills possessed by other physicians only, but extends to that possessed by other persons, whose occupation and study given them an equal or better knowledge of the right method or its (anesthesia) use than is possessed by a general practitioner of medicine.

In Dagmar Nelson vs. the State of California (Nelson v California, California, 1934), Judge Campbell upheld the previous court decision that Ms. Nelson was not practicing medicine without a license and anesthesia could be legally given by nurses. The case was appealed and the decision was upheld (Thatcher, 1953,

pp. 147-149).

The challenge of the physicians to deny the nurse anesthetist the right to administer anesthesia served to bring the nurse anesthetists together. By 1933 when the ANA (the only recognized national nurses association) decided to set the wheels in motion for the creation of a section in their organization for "Office Nurses and Nurse Anesthetists", the anesthetists rebelled under the leadership of Agatha Hodgins. Ms. Hodgins was adamant about her desire to preserve anesthesia as a separate hospital service under the guidance of surgeons rather than submit to control by the department of nursing. She had spoken to the ANA at its convention in 1909 and to the National League of Nursing in 1921 and received a very cold response to her ideas of a national association of only nurse anesthetists. The end result was that the ANA would not allow a separate association of nurse anesthetists and the National Association of Nurse Anesthetists was born (Thatcher, 1953, pp. 180-182). The goals of the association were:

> ...if the work is to be properly safeguarded and hoped for progress attained...certain remedies must be taken; namely, development of constructive leadership,...self organization as a special division of hospital service. In such an organization emphasis must be placed on the establishment of educational standards; post graduate Schools of Anesthesia required to conform to an accepted criteria of education; state registration allowing the nurse to practice her vocation beyond criticism; constant effort toward improving the quality of work by means of study and research to afford

> patients greater protection; and dissemination of information gained through proper channels (Hodgins, 1930, p. 863).

From these goals were formulated the six objectives which, although expanded, are still utilized. There are nine objectives, and they all deal with the education of student anesthetists, the curriculum of the schools, and educational and professional advancement.

In analyzing the similarities in these organizations, one can note that the great emphasis has been placed by both groups on educational preparation of their members, the setting of standards for the profession, and the continuing education of the members. Although the associations differ in beliefs on many things, the most prominent difference is on how to secure economic stability of the members. In the 1940's, the ANA became concerned with the deplorable working conditions of nurses. By this time, many of the unskilled workers such as those in the laundry and dietary had been organized into unions by the American Federation of Labor (Annas, 1981, p. 328). In 1946, the ANA decided to help nurses by adopting a program which they called the Economic Security Program. The essence of this economic program was that it set forth guidelines for nurses' collective action. The objectives of the Economic Security Program were two-fold:

> 1. To secure for nurses through their professional association protection and improvement of their economic security—reasonable and satisfactory conditions of employment, and

2. To assure the public that high quality professional nursing service would be available for the sick of the country (American Nurses Association, 1974, pp. 60-71).

As a point of interest, in the original Economic Security Program there was a no strike clause which remained in effect until 1968. However, other than doing some political lobbying on a national scale, the ANA advocated that all true collective bargaining activity be done on one of its 800 district levels. The state and district nurses associations had to act as the exclusive agent of their respective members in the fields of economic security and collective bargaining (American Nurses Association, 1974, p. 1).

During this period (1946-1970), there is nothing in the literature to indicate that the nurse anesthetists were included in any collective bargaining action initiated by the nurses or any nursing speciality. The AANA issued no statements in support of or to recognize the Economic Security Program. The cause for this is probably because of the lack of any interassociation activities.

In this interim the AANA concentrated on development of standards of practice, the enactment of nursing practice acts to include the nurse with expanded roles, building solid curriculum for their schools, and building their professional status. The outcome of this was that as the 1970's were issued in the CRNAs were prepared for the challenges presented in the courtroom as to

their special function.

The nurse anesthetist is basically a nurse who has had additional training in the art and science of anesthesia. This specialized nurse or nurse practitioner performs the same duties as the physician anesthesiologist. The degree of autonomy the nurse anesthetist has depends on the medical practice acts and nurse practice acts of the state in question; for example, nurse anesthetists in the state of Arizona must work only in the physical presence of their supervisory physician (Cazalas, 1978, p. 105). While other places such as Kentucky nurse anesthetists are legally responsible for their own actions and are required to conform to the standards of medical practices and established medical protocol of the state (Kentucky Nursing Law, 1978, p. 4-5).

The job responsibilities of the CRNA are a blending of professional nursing skills with the science of anesthesia. The CRNA administers intravenous, spinal and general anesthesia to render a patient insensible to pain during surgical operations, deliveries, or other medical or dental procedures. His/her duties include positioning patients; administering the anesthesia in accordance with standardized procedures; regulating gas flows, injection of medication in amounts needed, and observation of the patient's reaction to anesthesia and modification of anesthesia as the need is demonstrated; treatment of shock, asphyxiation, or other adverse reactions to anesthesia; keeping the surgeon informed of the patient's condition throughout surgery; making a legal record of the patient's

pre-operative, operative, and post-operative condition and related data; and directing or giving the patient post-operative care as directed by the standards of practice or hospital policy of the place of employment (Rowland, 1978, pp. 65-66).

In the practice of anesthesia, 67% of nurse anesthetists are employed by hospitals in the special category status of staff anesthetist. Of the remainder, 25% are employed in groups and 8% have freelance practices. Of those nurse anesthetists who practice in groups, 88% practice in groups composed of both nurse anesthetists and physician anesthesiologists (Rowland, 1978, p. 66).

According to statistics provided by the AANA in 1978, anesthesia was administered according to the pattern illustrated in Table II, page 37. As can be seen, the physician anesthesiologistsare more often located in urban areas, larger hospitals, and university settings. The CRNA functions in all types of settings with or without the supervision of an anesthesiologist. The CRNA provides proportionally more of the anesthesia in smaller hospitals and rural areas.

There are currently (as of 1976) in the United States about 1.4 million nurses (Bean, 1977, p. 1-2). Of these, 14,000 are professionally qualified anesthetists (Rowland, 1978, p. 66. From this reference, it can easily be noted the disparity of any ratio between the number of RNs and the number of CRNAs that are employed in any institution.

TABLE II

Who Administers Anesthetics
(In percent)

| Personnel category | Hospital Beds 0 to 49 | 50 to 99 | 100 to 249 | Over 250 |
|---|---|---|---|---|
| C.R.N.A. | 67.0 | 65.0 | 50.4 | 42.5 |
| Anesthesiologist | 11.0 | 16.6 | 35.0 | 47.5 |
| Medical doctor | 16.0 | 14.0 | 11.0 | 7.3 |
| Registered nurse | 5.0 | 4.0 | 3.0 | 2.0 |
| Others | .57 | .5 | .6 | .7 |

Source: Rowland, J.S., The Nurses' Almanac. Germantown, Maryland: Aspens Systems, 1978, p. 66.

The inferences that can be drawn between the RN and CRNA in numbers, education, and working conditions are obvious. In 1970, as the RNs began to take more positive steps to unionize, the CRNAs became involved in their collective bargaining activity because of the working of the labor laws. A demonstration of how this occurs will be shown by tracing the origins of the labor laws, the composite of unions and the special outcomes in the health field from Public Law 93-306.

## Analysis of Judicial and Legislative Actions

The genesis of labor law is not distinct. As feudalism demised, the first system of labor laws was born. The first labor case was tried in 1806. It was called Common Wealth vs. Pullis, and dealt with workers who gained work freedoms through group activity. This combination of special workers was prevalent throughout the 1800's. In the 1890's, unions were born when the Sherman Antitrust Act was passed. The purpose was to prevent monopolies, thereby hampering the union's activities (Pointer, 1975, p. 9). By the close of the 19th century, only a few trade unions had been formed, but the American Federation of Labor represented a number of skilled crafts. The pattern of union membership outside the skilled crafts had been unstable—in times of prosperity the unskilled laborers joined unions and then abandoned them in hard times (Strauss, 1972, p. 94).

In 1914, the Clayton Antitrust Act was passed. It was designed to eliminate the abusers of the injunction (a court order requiring employees to do or not do a certain act such as to return to work or stop picketing) by removing unions from coverage under the Sherman Antitrust Act. Injunctions had been used as a power tool against labor unions to hamper workers in their pursuit of their rights under the law. The abuse of labor caused widespread criticism (Pointer, 1975, p. 12).

The Great Depression of the 1930's changed employee-employer relations. The unfair practices of American businesses had resulted in an erosion of workers' confidence in management. Workers realized that to survive and better their positions, they must organize. Unions, which previously were considered un-American, began to thrive (Strauss, 1972, p. 93). Another factor which helped unions thrive was a change in political and legislative attitudes. The federal and state government no longer handicapped unions, and the courts began to be more liberal in their rulings in labor-related cases.

The first favorable piece of labor legislation by the United States Congress was the passage of the Norris LaGuardia Act in 1932. By this Act, Congress demanded that labor unions be allowed to grow and develop without employer interferences. The act also devested the federal courts of jurisdiction to grant injunctions in labor disputes except under certain circumstances. Some previous labor policies such as "yellow-dog contracts" (a

contract by which a new employee is made to agree that he will join no labor union) were restricted (Strieff, 1975, p. 72).

The Clayton Act was passed in the middle of an economic depression. President Roosevelt's economic advisors were advocating the implementation of a national wage policy to establish a floor income for the workers. But Congress, hesitant to enter the labor market directly, perceived that the encouragement of union organization and subsequent collective bargaining efforts could positively affect wage stability and stimulate a sagging national income. Therefore, Congress passed the National Industrial Recovery Act (NIRA) of 1933 which stated:

> ...employees shall have the right to organize and bargain collectively through representatives of their own choosing, and shall be free from the interference, restraints or coercion of employers of labor or their agents, in designation of such representatives or in self-organization or in other certain activities for the purpose of collective bargaining or other mutual aid or protection...(National Industrial Recovery Act, 1933, p. 2).

This gave a broad segment of American labor the right to organize for the first time. This Act was declared unconstitutional in 1935 by the Supreme Court because the court questioned the authority of Congress to initiate legislation regulating labor-management relations. Thus, the path for unionization of most workers was established (Pointer, 1975, p. 12).

The Wagner Act of 1935, also referred to as the National Labor Relations Act (NLRA), stands as the foundation of the United States Labor Code. Passed as a reaction to the Supreme Court decision to

declare the NIRA unconstitutional, it is multifaceted. The NLRA spells out a method of regulatory relationships between employees and employers with respect to union recognition and collective bargaining issues. The law guarantees: the right of labor to organize; the relations between employees and employers; restricts certain behaviors; makes available certain remedies; and establishes certain mechanisms to carry out the intent of the act (Barbash, 1956, p. 18).

The NLRA also created the National Labor Relations Board (NLRB) which interprets various labor situations in light of constantly changing circumstances. It has two major areas of concern: namely, the delineation and design of the various collective bargaining units and the conduction of the election of the employee representative. These Board decisions then form a body of administrative law which is written, certified, and used as a frame of reference to establish precedents for future cases (Barbash, 1956, p. 16). Although the NLRB has the power to make rulings and interpretations regarding the NLRA, it cannot enforce them. Only the Federal courts which review all rulings by the NLRB have complete jurisdiction over the NLRB and enforce the Board's rulings (Barbash, 1956, p. 16).

The NLRA specifically defines what constitutes a collective bargaining agreement. This then is the law for employer and employee relationships. A negotiated collective bargaining agreement specifies both the responsibility and relationship of the

employee, through their selected representative, and the employer. Arbitration is the machinery of any collective bargaining action. Chief Justice William A. Douglas gives the best definition of arbitration:

> ...it is the means of solving the unforeseeable by molding a system of private law for all the problems which may arise and to provide for their solution in a way which is generally in accord with the variant needs and desires of the party...(Barbash, 1956, p. 24).

The NLRA is very comprehensive in nature, but only certain aspects of the Act pertain to health care facilities—specifically Sections 7 and 8 which spell out employee rights and certain unfair management behavior. The unfair practices of Section 8 include: interferences with the right to organize and collective bargain; domination of the labor organization as to its management and control; discrimination with regard to hiring and tenure because of union activity; discrimination for filing charges under the Act; and refusing to bargain in good faith (Pointer, 1975, p. 15).

Although the Wagner Act was designed to protect the rights of workers to organize and elect representatives to collective bargain, it failed to specifically define the status of workers in charitable, religious, or educational institutions. As a result, the judicial system was destined to resolve the problem. The prevalent feeling among the public was fear—fear that if nonprofit hospitals were required to collective bargain the cost of health care would be prohibitive (Metzger, 1972, p. 46).

The first court precedent was established in the case titled Jewish Hospital of Brooklyn vs. Doe (Jewish Hospital of Brooklyn v Doe, 252 Appelate Division 581 @ 584, 1938, p. 4). Here the court decided that the same doctrines that exempt the state and its political subdivisions from the statutes of the Wagner Act required that a charitable institution such as a voluntary hospital also be excluded (Jewish Hospital of Brooklyn v Doe, 252 Appelate Division 581 @ 584, 1938, p. 4).

A second landmark decision was made in the case titled Central Dispensary and Emergency Hospital vs. NLRB (Central Dispensary and Emergency Hospital v NLRB, 145 F 2nd 852 D.C. Circuit, 1949). In this decision, the court said they found no implied exemption for the proprietary hospital in the Wagner Act even though these hospitals engaged in interstate commerce. Hospitals should be subject to the same labor statutes as any other industry. In reality, the court ruled that making voluntary hospitals subject to the provisions of labor statutes was not in the public interest. Therefore, the court excluded those who delivered health care from labor law (Central Dispensary and Emergency Hospital v NLRB, 145 F 2nd 852 D.C. Circuit, 1949). This supports an often quoted statement regarding labor laws — "it can best be understood if one thinks of the courts as an instrument of society adjusting to change in social conditions" (Chamberlain, 1965, p. 223).

After the enactment of the NLRA, several states enacted labor legislation that incorporated provisions similar to this Act. This

resulted in the expansion of union membership, and gave rise to a number of problems regarding the unions and management relations. These problems included: jurisdictional strikes (disputes over which union should do what); abuses of secondary boycotts; and the refusal of some unions to bargain in good faith. The public became aroused and begain to demand remedial action. In this environment, Congress passed the Labor-Management Relations Act (LMRA) of 1947, also called the Taft-Hartley Act (Pointer, 1975, p. 16). The LMRA created regulations relative to unfair labor practices of the unions and served to effectively moderate the NLRA of 1935. Today, this piece of legislation stands as the nation's major piece of labor legislation.

The LMRA amended the NLRA by spelling out the labor practices by the union which Congress deemed unfair. Provisions of this Act included:

1. Unions were forbidden to coerce employees in the execution of their rights,
2. Unions could not refuse to bargain in good faith,
3. The employer could not discriminate against union employees,
4. Unions were prohibited from engaging in certain strikes and boycotts deemed unlawful in their objective,
5. Unions could not require payment of excessive or discriminatory fees to the union security plan, and
6. Unions were not to engage in "feather-bedding" practices.

This piece of legislation expanded management's rights of free speech, excluded supervisors from the provisions of the Act, and also gave the President of the United States the power to enjoin

a strike if it would imperil the national health or safety of the country (Bean, 1977, p. 18).

Of special interest in this act to health care facilities was Section 2 which delineated those employers considered to be exempt from the legislative provisions. This section reads:

> ...shall not include the United States or any wholly owned government corporation... or any state or political subdivision thereof, or any corporation or association operating a hospital, if no part of the net earnings answers to the benefit of any private stockholder or individual...(Labor-Management Relations Act, 1947, Section 2).

Section 2 of the NLRA also defined the professional employee as:

> (a) any employee engaged in work (i) predominately intellectual and varied in character as opposed to routine mental, manual, mechanical or physical work; (ii) involving the consistent exercise of discretion and judgement on its performances (iii) of such a character that the output produced or the result accomplished cannot be standardized in relation to a given period of time (iv) requiring knowledge of an advanced type in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction and study in an institution of higher learning or a hospital, as distinguished from a general academic education or from an apprenticeship or from training in the performance of routine mental, manual, mechanical or physical process, or
> (b) any employee, who (i) has completed the course of specialized intellectual instruction described in clause (iv) in paragraph (a) and (ii) is performing related work under the supervision of a professional person to qualify

> himself to become a professional employee as defined in paragraph (a) (Werther, 1976, p. 79-81).

Through this, non-profit hospitals were specifically excluded from the provisions of this legislation as were all federal, state, and municipal government hospitals. Proprietary hospitals and nursing homes were not specifically excluded. Some analysts felt that hospitals were not included in this legislation because of their non-profit status and that it might further the development of more public dissension. The Act also exempted hospitals because it would further increase health care costs and disrupt hospital services (Bean, 1977, p. 19-20).

One of the consequences of the 1947 LMRA was the effect it had on hospital employers. The LMRA made it clear that non-profit hospitals had no legal obligation to recognize or bargain with their employees. Hospitals, therefore, made it a common practice to discharge union organizers or any employee sympathetic to the union cause. The government employees were protected by some federal executive orders which made provisions for federal labor laws, but non-profit hospitals continued to be subject to the jurisdiction of conflicting state labor laws. Hospital employees and the union lobbied in Washington to have the rights and privileges of hospital employees defined. They wanted hospital employees to have the same recognition as that granted to employees of any private industry. As a result, on June 26 the Labor Management Relations Act of 1974 was passed. It is now

commonly referred to as Public Law 93-306 (Chancy, 1976, p. 13-15).

The LMRA of 1974 is a composite of the NLRA of 1935, the LMRA of 1947, and the Labor Management Reporting and Disclosure Act of 1959. It is comprehensive effecting all proprietary hospitals with a gross revenue of $250,000 and all health care facilities under non-public ownership and control. It extends the NLRA to a broad spectrum of institutions in the health care industry; it changes certain specific provisions of the NLRA; and certain other existing acts were added to better accommodate the labor relation needs of the health industry. The administration and interpretation of the law was done by the NLRB and the law was enforced through the court system (Strieff, 1975, p. 70).

The major features of the 1974 LMRA dealt with the election of a representative for the hospital employee, the unfair labor practices within the hospitals, and the management of labor disputes within the health care industry. This Act particularly set forth the procedure by which employees may solicit a labor organization as their collective bargaining representative to negotiate with the hospital over employment and contract matters. It should be noted that a hospital could voluntarily elect to recognize and deal with a union without resorting to a formal LMRA procedure. The Act also prevents hospitals from engaging in certain conduct which is specifically classed as unfair. The Act further stipulated that employers must bargain in good faith with the representative of the union. For the first time, all

non-governmental hospitals, nursing homes, clinics, Health Maintenance Organizations, homes for the aged, and other institutions devoted to the care of the infirmed or aged person were brought under the nation's labor laws (Chancy, 1976, p. 15).

Labor-Management disputes within the health care industry could have very deleterious affects upon the public. For this reason, the LMRA of 1974 had a new section added that contained special provisions regarding strikes or special action which had to be taken prior to any last-resort confrontation between a union and a health care facility. The law requires a health care facility to provide the other party with a 90-day notice prior to any modification or termination of the existing collective bargaining agreement and to notify the Federal Mediation and Conciliation Services. During this period, the status quo had to be maintained—meaning no lock-outs or strikes. Employees of any health care facility were required to provide a 10-day notice prior to striking in order to allow management to arrange for continuity of patient care. Any labor dispute in a health care facility received priority handling by the Federal Mediation-Conciliation Board. This Act also specifically excludes supervisors from the provisions of the NLRA (Pointer, 1975, p. 58-60).

Although there are many other provisions in this Act, the only other area related to the current research is the provision for the formation of collective bargaining units. Congress was

cognizant of the number and variety of employees concentrated in the health industry. They also realized that if the number of units which administrators had to deal with was increased, the efficiency of the health care facility could be decreased. Therefore, Congress included in the Act a statement directing the NLRB to give due consideration to prevent the proliferation of bargaining units within the health care industry. This particular guideline has caused numerous disputes among professionals in hospitals (Metzger, 1978, p. 109).

In summary, the LMRA of 1974 was designed to bring the provisions of the industrial labor law to the health care industry. Its amendment provisions are designed to insure that every possible approach to a peaceful settlement is fully explored before a strike is called in a health care facility.

## Missouri Labor Laws

The LMRA does not cover hospitals operated by the state or its political subdivisions. Labor management relations in state health care facilities are subject to the state's laws which vary considerably. Most states have no labor-relation statutes unless their state constitution guarantees the right of employees to organize and imposes the duty of collective bargaining on the employer. If this is not the case, most hospitals would not bargain collectively with their employees. Even when a state has a Labor Relations Act, it still may specifically prohibit

strikes, lock-outs, and have provisions for compulsory arbitration even if they have no collective bargaining doctrine. In most cases, the federal doctrine of preemption displaces state jurisdiction. But the United States Supreme Court has ruled that the states can regulate labor relations activity that also falls within the jurisdiction of the NLRB where deeply rooted feelings and responsibilities are affected such as violence, mass picketing, etc. (Strieff, 1976, p. 74).

The Missouri Constitution does contain labor laws. Article I, Section 29, states that employees have the right to organize and to bargain collectively through representation of their own choosing. In the same Article, Section 9, the citizens are noted to have the right to peaceably assemble for their common good and to apply to those invested with the power of government for redress of their grievances by petitions or remonstrance (Missouri Annotated Revision Statutes, 1978, p. 415).

The government of Missouri also recognizes professional labor organizations. Missouri defines a labor organization as any organization which exists for the purpose, in whole or part, of collective bargaining or of dealing with employers concerning grievances, items or conditions of employment or for other mutual aid or protection in relation to employment (Missouri Annotated Revision Statutes, 1978, p. 437). These constitutional provisions do entitle all Missourians employed in the health care field to the full privileges of the NLRA and the LMRA of 1974.

In the first 10 months of the inclusion of health care employees in the NLRA (July 1974 - April 1975), health care unions won 59.7% of elections as compared with a win record of 47.4% in all non-health related industries. This can be taken as proof that the health care industry was more vulnerable to unionization than other industries at this time. From May 1975 to April 1976, health care unions won 58% of their elections to industry's 47.2%; and from April 1976 to January 1977, the health care unions won 47% (Metzger, 1978, p. 101).

## Root Causes of Nurse Unionization

Many theories have been advanced as to why nurses organize—some say internal failures such as poor hospital administrative policies and the organization's work structure, and others claim external factors such as public opinion and legislative happenings. Writers like Bean and Pointer in the field of health care agree that internal factors are of prime importance.

To understand what factors most affect nurses, RN Magazine did a survey of nurses asking them to list factors in their jobs which would cause them to seek an external third party to represent them to management. The 10 most worrisome issues included: no input in matters concerning nurses; low patient care standards; excessive staffing demands; inadequate salaries; not enough say in patient care; too much paper work; no chance for advancement; limited educational opportunities; insufficient challenges; and

lack of recognition (Donnovan, 1980, p. 22-24). These factors can be grouped into supervisory failures, management failures, and organizational failures.

A supervisor is the first in the chain of command in hospitals. Through this person all information is communicated. If the nurses feel that they are kept abreast of happenings concerning them, they are secure. Nurses have not always been treated equitably by supervisors—maybe not intentionally but their needs have not been met on a one-to-one basis. This can lead to frustration; and if this same supervisor has not been trained to deal with the employees grievances, this simple lack of understanding can sow the seeds of unionism (Bean, 1977, p. 26). Other supervisory inadequacies which have been written about include insufficient inservice, being "pulled" to other divisions, rotating shifts unevenly distributed, and inability to have input into patient care (Elliot, 1981, p. 99).

Management also has its failures. The most prevalent one is probably dissatisfaction with wages and economic benefits. If the nurses feel there is great disparity between the salary and benefits they receive and those of other local employees of the same class, management has not kept abreast (Elliot, 1981, p. 94). For many years, while the cost of living soared, the nurses have retained a low salary far behind the major protion of the United States work force. Still the nurses served without complaintand accepted much of the public criticism directed toward

the hospitals over which they have no control. The inadequacies of hospital administration has caused nurses to seek someone to help them to be acknowledged and accepted as a major contributor to the patient's care (Bean, 1977, p. 26).

All hospitals have a common problem. The line of authority in hospitals is shared by a Board of Trustees, the Director of Nursing, the doctors, and the Executive Director. Anyone working in a health care facility can receive mandates from any of these four major centers of power (Bean, 1977, p. 8). Conflicting directives from more than one source of power in the hospital again leads to nurse frustration. If the immediate supervisor does not see the problems through the eyes of the workers and translate them to management who will pass it on to the Board, nothing will change. The nurse will never succeed in being allowed to help formulate policy decisions that are realistic and satisfactory to both administration and the professional nurse. All this will drive the employee into the arms of the union (Metzger, 1978, p. 96).

Some very basic deficiencies are found in administrative personnel. They forget to meet some of the basic needs or desires of employees—namely, the desire to "feel in on things", "acknowledgement for work well done", and providing sympathetic help on personal problems. If the employee does not find himself/herself part of the things occurring, is not informed of those things effecting his daily work life and cannot count on his

supervisor's empathy, then they will look elsewhere; and the nurses have done that (Metzger, 1978, p. 96). A survey in 1976 showing how nurses feel about unions, and why they feel the way they do is illustrated in Figure II, page 55.

## Nursing Unions

The American Nurses Association (ANA) spearheaded the organization of professional nurses in the health field. It mobilized its members to deal with employers on not only wages but on general working conditions even to changing the employee-employer relationship. The ANA had solidly committed itself to procuring for its members these rights: the freedom to bargain collectively in order to produce contracts which have a no-strike clause; state and federal labor laws for hospital employees; elevation of standards of nursing schools; elevation of the status of the nursing profession to attract people to the profession; use of the state nursing associations as a bargaining agent for the individual nurse; and development of a program and philosophy of employee representation among nurses. In situations where the state ANA has been a representative for nurses, they have been successful; for example, as early as 1967, the Iowa State Nurses Association was granted exclusive bargaining rights for nurses in the Veteran's Center in Des Moines (Boyer, 1975, p. 175).

The ANA, then, has performed all the functions of a labor union for nurses such as they are directly concerned with wages,

FIGURE II

**Survey of Union Sentiment Among Nurses***

Only 4% of the nurses participating in the *Nursing '76* survey said they were union members, and for most, this meant being represented by their state nurses' association.

| | Staff Nurses | Directors |
|---|---|---|
| Very much in favor of nurses' unions | 28% | 9% |
| Someone should represent nurses but not unions | 56 | 50 |
| Unions are acceptable for nonprofessionals but not for nurses | 7 | 6 |
| Very much opposed to nurses' unions | 9 | 35 |

**Pro-union**

Those in favor of unions listed these benefits:

- power to make management listen, participation in decision making;
- improved wages and fringe benefits for everyone, including part-time nurses;
- influence over working conditions, including improved staffing;
- a grievance procedure;
- job security and a seniority system;
- more control over their own profession and

*Source. Marjorie Godfrey "Someone Should Represent Nurses" *Nursing '76*, June 1976.

hours and other employment conditions, and engaging in collective bargaining (Strieff, 1975, p. 69). The outcome of this action has been greater security for nurses, not only economically, but in many ways. The nurse as an individual is now a part of a large nurse group and thus has a sense of support that has emerged from the encouragement, technical help, and formal representation by this larger nurse group (Schult, 1958, p. 20).

However, the ANA was not sufficiently successful that nurses did not look to unions as a faster method or, for some, the only method for achieving their personal advancement. Certain state nurses associations were very successful as in California or New York while other states did not push to organize. In 1969, only 30,000 Registered Nurses (RNs) were organized under their state associations. By the 1970's, the number had increased to 70-75,000 and still remains there. Nevertheless, unions have also dramatically increased in their white collar (nurse and doctor) membership. In 1978-1979, the Service Employees International Union (SEIU) gained bargaining rights for more health care employees in the white collar classification than any other union. In health care elections, they had a success scale of 55%. The National Union of Hospital and Health Care Employees, District 1199, won 56% of its health care elections. More and more unions are clamoring to represent nurses and other health care professionals. In 1979, the American Federation of Teachers formed a new division, the Federation of Nurses and Health

Professionals; they claim that they will have 100,000 health care employees under contract; a goal they have not yet met (Elliot, 1981, pp. 55-59).

There has arrived then a time for nurses to unite. Nurses have turned to unions, not necessarily for an answer, but just as an alternative to what they perceived as the institutions' indifference or unwillingness to recognize their problems. The public, the associations, and the Nurse Practice Acts have supported the nurses movement toward an autonomous independent practice. In this kind of practice, nurses would be responsible for making decisions about nursing care and carrying out physicians orders and institutional policies. The problem with this kind of practice is that monetary reimbursement does not match the responsibility the nurses now have. Nurses still feel thwarted by the downward communication patterns and authoritarian management within hospitals (Taylor, 1981, p. 51-52). See Table III, page 58, for the trend of nurse unionization.

The nurses had three options in forming a union. First, they might attempt to get the hospital to voluntarily recognize a specific union as their representative agent, but this was not likely to occur. Secondly, if the nurses could prove a specific unfair labor practice, they could receive a directive from the NLRB ordering the hospital to recognize their representative, but this was not the path they chose. The last route and the most frequently used route by the nurses is to attempt to hold a

TABLE III

**Collective Bargaining Agreements—Hospital R.N.s**

| | Size (beds) | | | | | | Census area | | | | Ownership | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | All hospitals | Under 50 | 50 to 99 | 100 to 199 | 200 to 399 | 400 and over | North-east | North Central | South | West | Non-profit | Govern-ment | Proprie-tary |
| % R.N. collective bargaining agreements | 11.5 | 9.0 | 5.9 | 11.9 | 16.2 | 22.5 | 12.1 | 10.7 | 5.0 | 22.1 | 9.8 | 14.6 | 8.8 |

Source: DHEW, 1975.

National Labor Relations Board (NLRB) election (Shannon, 1980, p. 109).

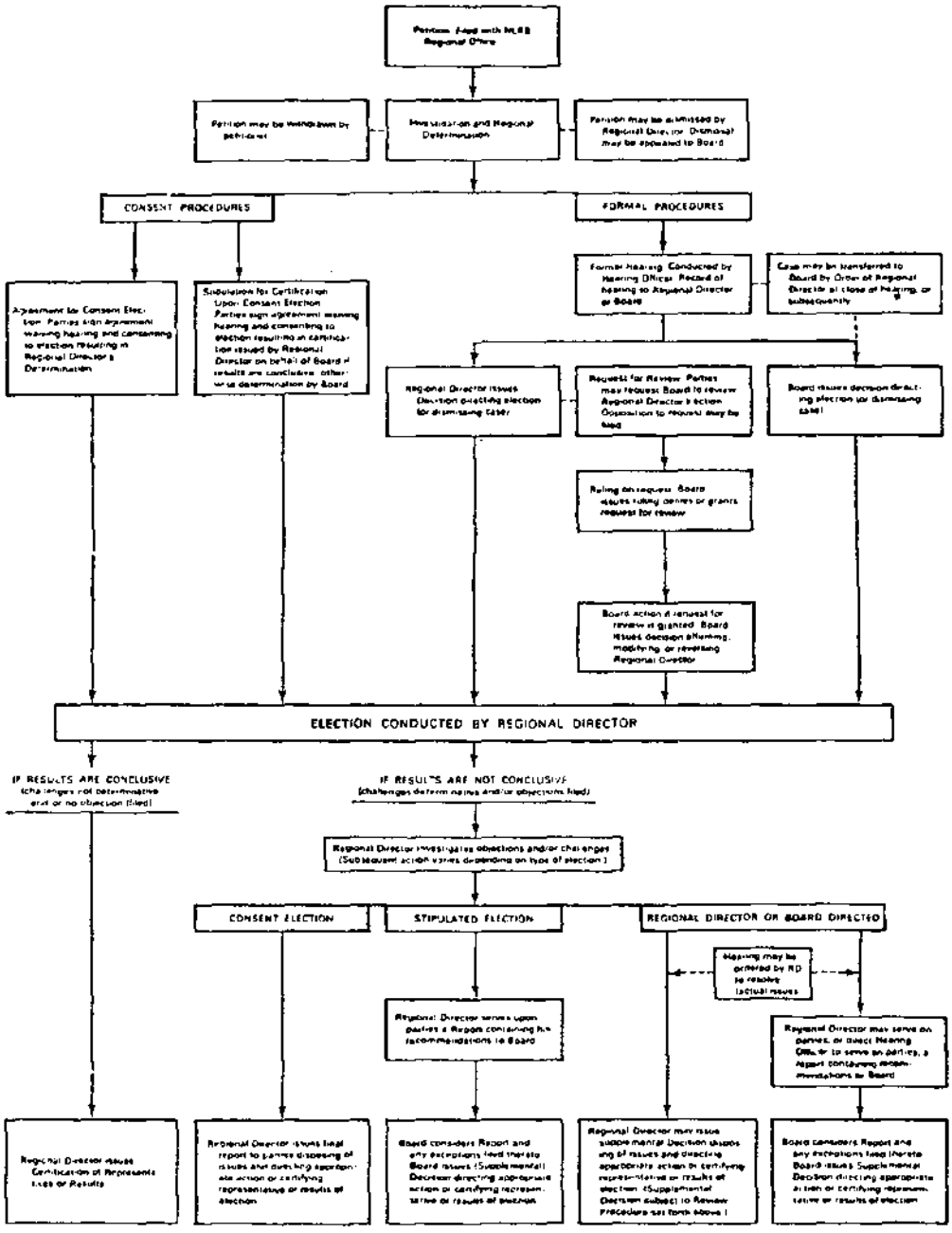
The first step to unionize is to present a petition for certification to the NLRB. This petition states the bargaining unit they are seeking, the nature of their employer's business, and the number of employees that possibly could be included in their bargaining unit. To show genuine interest, the NLRB will ask 30% of the interested members to sign authorization cards petitioning for an election. The NLRB then investigates such things as questions of jurisdiction, appropriate bargaining units, and the like. If the Board finds all in order, a formal hearing is set up and they sign a consent to election agreement. The Regional Director, who has the final authority, decides when the election will be held. If the union wins, management must accept and recognize this union as the representative of the nurses (Warren, 1978, pp. 248-250). See Fiqure III, page 60, for the NLRB Petitioning Process.

The NLRB, in the summer of 1975, established what they consider appropriate bargaining units within a health care facility. Their guidelines are:

1. RNs—entitled to separate bargaining units
2. Professionals—such as physical therapists
3. Technicians—such technical employees as x-ray technicians
4. Business office personal or clerical workers
5. Service and Maintenance—includes all other craftsmen.

The appropriateness of a unit depends to a large extent on the duties actually performed by the employee (Lewis, 1975, pp. 51-54).

FIGURE III




Source: Rowland, J.S., The Nurses' Almanac. Germantown, Maryland: Aspens Systems, 1978, p. 66.

It has now become common for the nurse anesthetist to be included in bargaining units consisting mainly of RNs in the hospital setting. The NLRB feels this is just, as the more and separate units there are in the hospital setting, the more difficult it is for hospital administration to cope with labor issues. It is conceivable that a hospital could face a strike every week or be forced to deal with multiple contract talks (Cazalas, 1978, pp. 111-112).

Unionization of CRNAs

There have been a number of allied health professionals who have continued to reject unionization. The Certified Registered Nurse Anesthetists (CRNAs) have been some of these individuals. There could be many reasons cited for this rejection such as professional loyalty, lack of backing by their professional association, or the desire to maintain professional status. A potent factor to any such professional is their concept of professional status, and it may offset the attractiveness of higher pay and benefits in some groups for a while (Boyer, 1975, p. 175).

An equally important factor which has deterred CRNAs from unionizing is their position in the hospital management structure. CRNAs are not hired as Registered Nurses (RNs) but as a special entity; and hospital administration has given them liberal personnel policies, educational leaves, and other benefits in excess of what RNs achieve. Because of these privileges and payment scale, CRNAs

working in hospitals are considered management professionals. This does not eliminate CRNAs from being eligible to join a union, but they stand to lose more than they gain by union membership (Brown, 1976, p. 54). See Table IV, page 63.

A hospital's staff will have many more RNs than CRNAs. If the CRNAs join with the RNs in a bargaining unit, the CRNA stands to lose anyway the bargaining action occurs. Mr. L. Todd, a CRNA and Director of the New York Association of Nurse Anesthetists, in 1975 reported that he joined a RN dominated bargaining unit. The unit's representative secured for the RNs a 20% raise while only a 9% raise for the anesthetists was obtained. When he evaluated actual dollar amounts of the anesthetist's raise, it represented only 25-50% of the RNs raise (Brown, 1976, p. 56). Many such examples are found in professional literature and have produced a reluctance on the part of the CRNAs to join the ranks of RNs in collective bargaining action.

Because the CRNA performs an expanded nursing role, some CRNAs have advocated joining bargaining units dominated by physician house staff, salaried physicians who provide anesthesia, or other medical staff. These CRNAs clearly identify with physicians. However, the anesthesiologists have not taken kindly to this. In a presentation at the California Association of Nurse Anesthetists, Mr. D. Laube reported the adverse reaction of anesthesiologists to a proposal by Ms. B. Baum, Executive Director of the AANA, that CRNAs should receive 80% of the rate

TABLE IV

**Nursing personnel employed in U.S. hospitals by position, 1972.**

| Position | Total | Full-time (FT) | Part-time (PT) |
|---|---|---|---|
| Totals | | | |
| Registered nurses | 529,677 | 386,846 | 142,831 |
| Licensed practical nurses | 237,346 | 198,771 | 38,575 |
| Aides, orderlies, attendants | 543,871 | 475,092 | 68,779 |
| Department of nursing service | | | |
| Director and assistant | 13,295 | 12,453 | 842 |
| Inservice education personnel | 8,398 | 6,899 | 1,499 |
| All other administrative personnel | 9,697 | 7,205 | 2,492 |
| Supervisor and assistant | 37,872 | 32,118 | 5,754 |
| Head nurse and assistant | 71,497 | 65,920 | 5,577 |
| Staff nurse: R.N. | 357,113 | 235,486 | 121,627 |
| Licensed practical nurse | 231,585 | 193,671 | 37,914 |
| Aide, orderly, attendant | 506,238 | 441,521 | 64,717 |
| Other departments | | | |
| Administrator and assistant | 1,449 | 1,359 | 90 |
| Nurse anesthetist | 10,802 | 8,738 | 2,064 |
| Nursing school faculty | 10,714 | 9,249 | 1,465 |
| Research nurse | 592 | 500 | 92 |
| Central service: R.N. | 2,534 | 2,143 | 391 |
| All other areas: R.N. | 5,714 | 4,776 | 938 |
| Licensed practical nurse | 5,761 | 5,100 | 661 |
| Aide, orderly, attendant | 37,633 | 33,571 | 4,062 |

Source: Division of Nursing, DHEW, 1974.

of reimbursement received by the anesthesiologists. Here he reported, CRNAs would be hurting the doctors in the one area they found most unacceptable—the pocketbook (Laube, 1973, p. 3).

Therefore, because unions were thought to be unprofessional, or because of loss of their position in the hospital hierarchy, or because they are outnumber CRNAs have expended little effort or time in union activities. In 1975, a group of CRNAs were successful in opposing their inclusion in a collective bargaining unit comprised of RNs (Reimer, April 1975, pp. 170-171). The action taken to achieve their exclusion was done during the union's campaign and before the bargaining unit was formed. These CRNAs also voted against the union in the election. They based their objection to inclusion on the differences in the duties of the CRNAs and the RNs (Reimer, June 1975, p. 301).

The American Association of Nurse Anesthetists (AANA) has never followed the American Nurses Association (ANA) in portraying itself as willing to be the bargaining agent for its members. In 1975, when requested by the Washington Association of Nurse Anesthetists to go with them to the National Labor Relations Board (NLRB), Ms. B. Baum, the Executive Director of AANA, expressed the past and the present philosophy of the AANA very concisely by saying:

> ...because the AANA is an accrediting agent for schools of anesthesia, the national association cannot be involved in labor questions. Furthermore, individual states will have to make their own decisions on the labor questions (Paulos, 1975, p. 619).

Further evidence has been presented that a professional association may not be the right organization to fulfill the role of a collective bargaining unit. Professional associations are composed of members who are employed in both staff and supervisory positions. In the case of Annapolis Emergency Hospital Association vs. Anna Arundel General Hospital (Annapolis Emergency Hospital Association v Anna Arundel General Hospital, 217 NLRB 848, 1975, p. 5), the NLRB and the Appelate Court disapproved of the Maryland Nurses Association involvement in collective bargaining activities on the grounds that the association was dominated by supervisory personnel whom the Board considered part of management. But this and other NLRB's decisions have not resolved the conflict of interest (professional vs. labor) for the state nurses association which has served dual roles. This is a growing concern that has led some state nurses associations to discontinue any function that may make them appear to be a labor union. In January 1979, the Wisconsin Nurses Association became the first ANA affiliate to cease its labor management relations role and concentrate its efforts entirely on the professional educational concerns of its members (Kucera, 1979, p. 448).

If the ANA does not represent the RNs in their drive for organization to achieve better working conditions, the RNs will turn to unions for help. If the nurses unionize, with the present feelings of the NLRB, CRNAs will need to actively work

for non-inclusion in the bargaining units of the RNs.

Exploratory Survey

To discover if my perception of the Certified Registered Nurse Anesthetists (CRNAs) and the Registered Nurses (RNs) was correct, I conducted an exploratory survey. In this exploratory survey, I planned to contact members of the American Association of Operating Room Nurses (AORN) to represent the RN with basic nursing training, Directors of Nursing Service in Missouri Hospitals to represent the administrative nurse, and the CRNA to represent the nurse practitioner. I sent letters to the regional and district AORN and contacted both by telephone. I received assurances that a Missouri membership list was being mailed to me, but I was never able to procure the list. Therefore, I eliminated the AORN from my study and used only the two speciality nurses.

In 1980, there were, according to statistics, 1.5 million nurses in the United States. Of these nurses, an undetermined amount are employed in supervisory or management positions. To ensure contacting the administrative nurse, I contacted Directors of Nursing Service in Hospitals belonging to the Missouri Hospital Association (MHA). The MHA has 203 members. In the United States at this time,there are 18,000 CRNAs of which 575 actively practice in Missouri according to the membership list of the Missouri Association of Nurse Anesthetists (Supply, Need, Distribution, 1980, pp. 2-3).

To test the validity and reliability of my questionnaire, I conducted a pretest on five members of each of the three sample groups. This was done to check if the questions were answerable, understandable, and produced a response. When this sample group had no problem with the questionnaire, I mailed the questionnaire to the selected individuals. A copy of these questionnaires is provided in Appendix I, pages 83-84.

The questionnaire was composed of 12 questions of which nine asked for a Yes or No response. There were two questions asking the respondent to express his perceived advantages or disadvantages of unions on three items. One question asked the respondent to name whom he/she felt was his bargaining agent in labor negotiations. Utilizing 10% of these associations' members randomly selected, 20 questionnaires were mailed to Directors of Nursing Service out of 203 members, and 58 questionnaires were mailed to CRNAs out of a possible 575 members. Figure IV, page 68, shows a graph of the daily returns over a two week period.

Of the 78 questionnaires, I had 41 responses—31 CRNAs and 10 Directors of Nurses. Therefore, I had 53% return from the CRNAs and 50% from Directors of Nurses. Appendix II and III, pages 85-86, show the results of these questionnaires which will be discussed in research conclusions.

FIGURE IV

RETURNS

1981

| | | |
|---|---|---|
| December | 4 | — Mailed |
| | 5 | — None |
| | 6 | — Sunday |
| | 7 | — 3 |
| | 8 | — 2 |
| | 9 | — 8 |
| | 10 | — 8 |
| | 11 | — 3 |
| | 12 | — 4 |
| | 13 | — Sunday |
| | 14 | — 3 |
| | 15 | — 5 |
| | 16 | — 4 |
| | 17 | — 1 |
| | 18 | — 0 |
| | 19 | — 1 |

1982

| | | |
|---|---|---|
| January | 3 | — 1 |

# CHAPTER V

## RESEARCH CONCLUSIONS

There are few definite conclusions to be drawn from my research. Certainly the development of nursing has followed a definite path. From the days of Florence Nightingale to the present, nurses, individually and in groups, have strived to advance the art and science of nursing. An equally important goal has been the securing of better working conditions and salaries commissurant with the duties and responsibilities nurses have assumed (Thatcher, 1953, pp. 32-33). When the American Nurses Association (ANA), the nurses professional organization, was formed, it adopted objectives to demonstrate this (Nursing-A Social Policy Statement, 1980, pp. 9-20.

The acceptance of some nurses of additional responsibilities after adequate training to administer anesthesia started in the late 1800's and is the grass roots of the nurse anesthetist. The profession of nurse anesthetist has only two professional goals: first, to be involved in activities which assure the continued existence of high quality, professionally competent schools of nurse anesthesia; and secondly, to enhance the further development of the clinical skills of the individual nurse anesthetist to assure the rendering of excellent anesthesia care by its members (Standards for Nurse Anesthesia Practice, 1974, p. 3). The

American Association of Nurse Anesthetists (AANA), the Certified Registered Nurse Anesthetists (CRNAs) professional organization, has always pursued these goals as shown in its objectives (Standards for Nurse Anesthesia Practice, 1974, p. 3).

The similarities between the Registered Nurses (RNs) and the CRNAs are really only two: first, all RNs and CRNAs start with the basic nursing education; and second, both professional organizations have continuously strived to maintain their professional schools in a competent manner according to published standards which require their graduates to take and pass a qualifying exam.

The differences in the two nursing professions are many. The RN is required to be licensed to practice in his/her individual state. To be licensed, the RN takes a qualifying exam which is constructed by a State Board of Nursing and renewed at specific periods for a fee. There are some states which have additional requirements for license renewal such as participation in a specified number of hours of continuing education. The CRNA must complete all the requirements to be a RN, initially and at the specified intervals. In addition, the CRNA must: have two additional years of education in the art and science of anesthesia at an accredited school of nurse anesthesia; graduate; take a national qualifying exam prepared by the AANA; and be certified by the AANA to practice anesthesia. Every two years the CRNA must be recertified. This is accomplished by participation in 40

hours of continuing education. The CRNA also pays an annual fee to his/her professional association which is used to advance the science of nurse anesthesia.

Another difference in the two nursing organizations pertinent to this paper is one of the major goals of the ANA. In 1946, the ANA House of Delegates adopted the position that state and local associations are qualified to act and should act as the exclusive agent of their respective membership in the fields of economic security and collective bargaining (American Nurses Association Economic and General Welfare Program, 1981, p. 2). History has shown that the ANA membership is united still in its determination that nurses should represent nurses, not only in developing standards of practice and professional ethics, but in developing uncompromising working conditions and above average compensation. The ANA feels that if it abandoned this task the nurses control over their own profession would be jeopardized. Currently, the ANA represents 63% of all organized nurses (McCarty, September 1981, p. 1). The AANA has stood firm in its position that as a professional association which serves as the accrediting body for schools of nurse anesthesia and the certifying agent of its members it cannot become involved in labor negotiations (Paulos, 1975, p. 619).

Nursing is an essential part of the society out of which it grew and with which it has been evolving. Nursing serves society's interest in the area of health. The authority for

nursing is based on social contact. No one has challenged the educationally qualified nurse's right to practice his/her profession (Lane, 1980, pp. 3-8). The right of the CRNA to legally practice his/her profession has been challenged only once, in 1934. The Supreme Court of California ruled that nurses could administer anesthesia because it was not the practice of medicine. The nurse anesthetist has not attempted to diagnose or treat any illness, but rather administer medications as directed or in accordance with accepted standards.

I traced the origins of labor law in the United States with emphasis upon the major pieces of legislation for both trade and health unions. I found that the trade and health employees both sought to organize in their labor status through personal contact and discussion with administration. This has and still does produce the most beneficial changes in CRNAs economics as opposed to unions.

But it remains that CRNAs will more and more be included in bargaining units consisting of many types of health care professionals and not just those composed of RNs. The guidelines of the National Labor Relations Board (NLRB) has consistently placed more and more health professionals together, and I cannot see any indication of a change in this trend.

The responses to my questionnaire were thought provoking. In Question 1, the fact in question was whether nurses could secure adequate financial reimbursement through actions of

their professional associations. Although they were supervisory personnel, 70% of the Directors of Nursing Service said yes, and 42% of the CRNAs agreed. This is interesting as my research showed that it is impossible for either group to utilize their professional associations for financial betterment.

In Question 2, I asked these 2 groups if a health care union would do a better job than their professional organization of representing them to management. Of the CRNAs, 62% said yes, indicating they are not as anti-union as they traditionally have appeared to be. As expected from management personnel, 80% of the Directors said a union would not do a better job than the organization.

Both the CRNAs and the Directors were certain, as indicated in Question 3, that if nurses unionized and the field was more financially attractive there would be no greater supply of nurses. It can be assumed then that lack of financial security for the nurses is not the major reason an individual does not choose nursing for a career.

Question 4 asked if the professional associations were utilized effectively, would there then be no need for unions in the health care field. Although the 2 responding groups were not financially aided by their associations, they both positively agreed—the Directors 100% and the CRNAs 79%. This demonstrates that these two speciality nurses recognize the importance of their associations for personal advancement, not only financial security.

The majority of CRNAs, through their responses to Question 5,

demonstrated that communication with management can be successfully conducted without union help, but it was also noted that 48% said they could not. To me, this indicates that CRNAs are losing their special status in the hospital structure. More surprising, 80% of the Directors felt nurses cannot reach management without the help of an external representative agent. This shows that more nurses of all types will seek organizing help.

In Question 6, both Directors (44%) and CRNAs (63%) felt the unionization of nurses was not a significant factor in the escalation of hospital costs. The slogan that unionization will harm patients in the pocketbook is, therefore, not valid.

Both CRNAs (97%) and Directors (100%) are cognizant that management can prevent unionization, as shown by their response to Question 7, by meeting the demands of the employees. This demonstrates that the mere threat of union organization may make management more sympathetic to the employees demands.

In Question 8, I asked if nurses were unionizing in order to have more input into patient care. The Directors (66%) said no, and many commented that unionization was for mercenary goals only. Of the CRNAs, 50% felt that unionization would allow more input into patient care and this would probably be an issue in the CRNAs decision to unionize.

Questions 9 and 10 were to see how nurses felt unions benefited them. The CRNAs felt unions helped nurses financially and in their labor relations, but not in their professional status. They answered Question 10 by saying unions were detrimental to their

professional status. The Directors definitely did not feel unions helped nurses at all; and in question 10, they answered that unions were detrimental in all respects.

I asked in question 11 if health supervisors were adequately trained or were sufficiently knowledgeable in labor relations to deal with union organizers. The Directors (80%) said yes, and the CRNAs (60%) said no. I think this shows that past dealings with union organizers have made Directors aware of their lack of knowledge in this area and that Directors have pursued educational studies to remedy this deficit while the CRNAs have not yet faced this situation.

As a way to make my respondents think seriously about their situations, in question 12, I asked if these nurses knew who was their bargaining agent. The CRNAs (50%) said no one represented them, and 50% said they represented themselves. Of the Directors, 50% said no one represented them and only 40% felt that their association was their bargaining agent. This points out that most RNs feel they have no bargaining agent.

My hypothesis was that future CRNAs would not be forced to join unions because of the activities of the nurses. This hypothesis has not been proven. My second research question asked if the unionization of CRNAs did occur would the collective bargaining unit be composed of only CRNAs or would it be a conglomerate of many health care professionals. My research indicated the CRNA will be allowed to form separate bargaining

units only in special circumstances determined individually by the NLRB, and there will not be a precedent that provides separate bargaining units for the CRNAs.

Will the CRNA be required to unionize to establish and maintain economic security? The literature suggests that CRNAs have not had, nor can they expect, their professional association to serve as a collective bargaining agent at local or state levels. The national AANA will serve as an accrediting body for schools of anesthesia, and this obviates their participation in labor negotiations (Paulos, 1975, p. 610). The AANA, therefore, is not the answer for the CRNAs economic stability.

The unionization of the RN has not helped the CRNA in the pursuit of financial security. As reported by Brown, CRNAs who have become members of RN dominated bargaining units have fared poorly in getting their needs met (Brown, 1976, pp. 5-6). In a time when the injured feelings which originally split the AANA into a national group separate from the ANA are beginiing to heal, actions such as these will again force the associations apart.

Some CRNAs have understandably wanted to gamble on joining bargaining units dominated by salaried medical doctors who provide anesthesia service. This is an outcome of the CRNA identifying with the medical staff because of their job responsibilities. Anesthesiologists, salaried or otherwise, have not taken kindly to this attempt to restrict or share their income. Many anesthe-

siologists view this as an infringement of their professional autonomy. As reported in Anesthesiology by Dr. Brown, President of American Society of Anesthesiologists, the medical doctors giving anesthesia want to subjugate CRNAs not seek to make them more professionally autonomous (Brown, 1980, p. 1). The rights of the CRNA to control the anesthetist's training, conduct peer reviews, help define client's needs and secure what is considered an acceptable level of reimbursement are not really rights. They are the foundation of professional autonomy, the right to control (ones) work. This is what most sociologists say makes professionals different from non-professionals (Friedson, 1972, pp. 71-72). Therefore, bargaining units have not been the method of choice for the CRNA either.

What is the answer? Through my research, I feel the CRNA is going to find it very difficult to escape unionization on the grounds that the nursing group is an inappropriate bargaining unit. The NLRB does not require that all members of the bargaining unit have an absolute community of interest—that is, working conditions, skills, duties and the like—but rather that they should be grouped together because they are members of a unit in the health care sector. The NLRB merely requires that the members of a bargaining unit be generally appropriate to the representational needs of that particular group. It has been the general trend of the Board's decisions especially to this point that the nursing group as a whole is an appropriate bargaining

unit for the nurse anesthetists. Although they have greater responsibilities than other nurses, they are still subject to the physician's direction.

The NLRB, in some recent decisions, has defined the duties of the CRNA. The primary duty of the nurse anesthetist is to administer anesthesia to hospital patients during surgery. This is similar to that performed by the physician anesthesiologists. In some instances, the nurse anesthetist performs his/her duties under the general supervision of an anesthesiologist; but in a large majority of cases, the anesthesiologist is not present during the performance of the nurse anesthetist. Another arrangement for supervising of the CRNA may be the presence of a floating supervisory anesthesiologist who may or may not monitor the progress in a given operation depending on the circumstances and the experience of the anesthetist. If the hospital setting is in a rural area or in a smaller city, the nurse anesthetist may be giving anesthesia without the supervision of any anesthesiologist (Group Health Co-operative of Puget, 19-UC-126 or 19-RC-7314, 1975 p.3). The nurse anesthetist will also teach students of nurse anesthesia these same skills. The CRNA performs no traditional nursing duties outside the Department of Surgery (Minnesota Federation of Certified Anesthetists, 18-RC-12152, 1979, p. 3).

There are many other duties assigned to the CRNA which will vary from locale to locale depending on the standards of practice

in that area. These duties are accepted by the nurse anesthetist as long as they follow the professional standards of practice.

In a few states, there have been certain circumstances which have led to recognition of the nurse anesthetist as a distinct bargaining unit. These circumstances have included:

1. The definition by hospital regulations of separate working conditions and situations between the RN and the CRNA
2. Specific state licensure requirements for the nurse anesthetist
3. Evidence of specific responsibilities establishing the independent professional status of the nurse anesthetist beyond that of merely a specialized RN
4. Evidence that a bargaining unit composed of RNs would be inadequate to represent the specific concerns of the nurse anesthetist
5. Past bargaining practices between the hospital and the nurse anesthetists.

Even after showing evidence of all of these things, there is still no quarantee that the NLRB will recognize the nurse anesthetist groups as a separate unit. The Regional Directors of the NLRB have a wide degree of discretion in deciding the appropriateness of the bargaining unit.

There have been in the last six years some landmark decisions by the NLRB that suggest why these conclusions were drawn. In 1975, a formal hearing of the NLRB between the Group Health Co-Operation of Puget Sound, the employer, and the Group Health CRNA Employees in Washington State found that a CRNA group was appropriate as a bargaining unit in the light of the fact that formal and informal bargaining between the employer and the CRNA employees had existed

for over 10 years. Other factors influencing this decision included: the history of the state nursing association which had excluded the nurse anesthetist in its bargaining unit; the duties and responsibilities of the CRNA and the RN were demonstrated to be substantially dissimilar; there was a lack of interchange between the RN and the CRNA; and the nurse anesthetists were under separate supervision (19-UC-126, 19-RC-7314). Thus, there are decisions that favor separate bargaining units for CRNAs.

There have been decisions that have been exactly the opposite. In a hearing concerning the Minnesota Federation of Certified Anesthetists, the CRNA bargaining unit was denied on the grounds of the sameness of the professions. This Board determined that CRNAs are RNs and hold identical statutory license; that RNs can and do pursue the numerous nursing specialities and nurse anesthetists are merely a speciality which RNs can and do pursue; that nurses duties and objectives are to provide patient care; and that both RNs and CRNAs do engage in professional intercourse in the provision of the patient's care. Therefore, the NLRB felt the RNs and CRNAs shared sufficient common benefits and working conditions that they should be in the same bargaining units (18-RC-12152-12156, 1979, p. 4).

The biggest deterrent from CRNAs having separate bargaining units is Congressional directions to the NLRB to keep at a minimum the proliferation of bargaining units or the fragmentation of bargaining units within the health care facilities. This has

necessitated the NLRB being heavily influenced by the merits of each individual hearing as opposed to setting any specific precedents. This will be the area in the future on which CRNAs will need to concentrate their activities if they do not want to unionize.

One other fact should be pointed out to professional employees when they begin to entertain the idea of joining a union. Each person individually and then as a member of an organization should first look at the advantages and then the disadvantages of unionization. Unions may not help your financial security at all—first, unions have an initiation fee and then charge annual dues which are collected directly from compensation paid to union members. These dues are subject to change periodically and can be expected to increase at regular intervals. There is also the possibility of special assessments from time to time. This is the first question which must be asked any union organizer (Reimer, April 1975, p. 171).

The most pertinent question to ask oneself when other employees are advocating a union is, "What are my benefits?" If a strike must be called, the union does pay benefits to those whose regular benefit compensation is interrupted. The union will negotiate for retirement benefits, wage and hour terms, conditions under which services are performed, work rules and the like. The union will represent an employee in a grievance procedure and assist an employee in finding other employment should one lose one's job.

What is not provided is any guarantees. Unions can guarantee nothing. All of the benefits which are obtained are negotiated and depend upon the willingness of the employers to make concessions (Reimer, April 1975, p. 172).

It can then be said that one may lose by joining a union. It has been found that many of the items which unions could bargain for are already benefits for the CRNA due to the hiring procedures of hospitals. If the CRNA joins a union, he/she could encounter certain administrative retaliations such as loss of special benefits they have enjoyed (Flanders, 1977, pp. 9-11).

Each group of CRNAs and each individual CRNA will have to face this problem and decide what is best. It is sure to present itself in the next decade if the economic picture continues.

# APPENDIX I

Dear CRNA:

I am involved in research for my Master degree thesis. I am researching the possibility of the need for the unionization of health care professional employees. You have been chosen at random to receive this questionaire. Would you please answer each question by marking an "x" in the appropriate space and then return it in the enclosed, self addressed, stamped envelope. Of course, anonymity is guaranteed. I appreciate your help in this project. Thank you.

Doris T. Margrabe

QUESTIONAIRE

| | | yes | no |
|---|---|---|---|
| 1. | Can nurses secure protection, improvement of their economic security and satisfactory conditions of employment through their respective professional association? | ( ) | ( ) |
| 2. | Would a professional health care union be better qualified to act as the exclusive agent to it's members in the area of economic security and collective bargaining? | ( ) | ( ) |
| 3. | Will the general public be assured of a constant supply of high quality professional nursing service if the nurse unionize? | ( ) | ( ) |
| 4. | Would the effective use of your existing nursing organization be a possible alternative to outright nurse unionization? | ( ) | ( ) |
| 5. | Do nurses need the intervention of a third party, such as a union, to achieve employee representation to management? | ( ) | ( ) |
| 6. | Is the unionization of health care employees a major contributor to the inflation of hospital costs? | ( ) | ( ) |
| 7. | Can management avoid nurse unionization through "meeting employee needs" such as competitive salaries, good working conditions, etc.? | ( ) | ( ) |
| 8. | Is the desire of nurses to achieve greater control and imput into the organization of medical care a contributing factor to the continual spread of union activity? | ( ) | ( ) |
| 9. | Do you think belonging to a union would be advantageous in: | | |
| | economic security | ( ) | ( ) |
| | labor relations | ( ) | ( ) |
| | maintaining professional status | ( ) | ( ) |
| 10. | Are unions detrimental to nurses in: | | |
| | financially | ( ) | ( ) |
| | in labor relations | ( ) | ( ) |
| | professional status | ( ) | ( ) |
| 11. | Do you feel administrative nursing personnel have the maturity and sophistication to cope in the labor relations field? | ( ) | ( ) |

12. Who is your collective bargaining agent? Please check only one.

| | |
|---|---|
| yourself | ( ) |
| ANA | ( ) |
| AANA | ( ) |
| AORN | ( ) |
| No One | ( ) |

## APPENDIX I continued

Dear Director of Nursing:

I am involved in research for my Master degree thesis. I am researching the possibility of the need for the unionization of health care professional employees. You have been chosen at random to receive this questionaire. Would you please answer each question by marking an "x" in the appropriate space and then return it in the enclosed, self addressed, stamped envelope. Of course, anonymity is guaranteed. I appreciate your help in this project. Thank you.

Doris T. Margrabe

QUESTIONAIRE

| | | yes | no |
|---|---|---|---|
| 1. | Can nurses secure protection, improvement of their economic security and satisfactory conditions of employment through their respective professional association? | ( ) | ( ) |
| 2. | Would a professional health care union be better qualified to act as the exclusive agent to it's members in the area of economic security and collective bargaining? | ( ) | ( ) |
| 3. | Will the general public be assured of a constant supply of high quality professional nursing service if the nurse unionize? | ( ) | ( ) |
| 4. | Would the effective use of your existing nursing organization be a possible alternative to outright nurse unionization? | ( ) | ( ) |
| 5. | Do nurses need the intervention of a third party, such as a union, to achieve employee representation to management? | ( ) | ( ) |
| 6. | Is the unionization of health care employees a major contributor to the inflation of hospital costs? | ( ) | ( ) |
| 7. | Can management avoid nurse unionization through "meeting employee needs" such as competitive salaries, good working conditions, etc.? | ( ) | ( ) |
| 8. | Is the desire of nurses to achieve greater control and imput into the organization of medical care a contributing factor to the continual spread of union activity? | ( ) | ( ) |
| 9. | Do you think belonging to a union would be advantageous in: | | |
| | economic security | ( ) | ( ) |
| | labor relations | ( ) | ( ) |
| | maintaining professional status | ( ) | ( ) |
| 10. | Are unions detrimental to nurses in: | | |
| | financially | ( ) | ( ) |
| | in labor relations | ( ) | ( ) |
| | professional status | ( ) | ( ) |
| 11. | Do you feel administrative nursing personnel have the maturity and sophistication to cope in the labor relations field? | ( ) | ( ) |

12. Who is your collective bargaining agent? Please check only one.

| | |
|---|---|
| yourself | ( ) |
| ANA | ( ) |
| AANA | ( ) |
| ACRN | ( ) |
| No One | ( ) |

# APPENDIX II

Dear CRNA:

I am involved in research for my Master degree thesis. I am researching the possibility of the need for the unionization of health care professional employees. You have been chosen at random to receive this questionaire. Would you please answer each question by marking an "x" in the appropriate space and then return it in the enclosed, self addressed, stamped envelope. Of course, anonymity is guaranteed. I appreciate your help in this project. Thank you.

Doris T. Margrabe

QUESTIONAIRE

| | | yes | no |
|---|---|---|---|
| 1. | Can nurses secure protection, improvement of their economic security and satisfactory conditions of employment through their respective professional association? | (13) | (18) |
| 2. | Would a professional health care union be better qualified to act as the exclusive agent to it's members in the area of economic security and collective bargaining? | (18) | (11) |
| 3. | Will the general public be assured of a constant supply of high quality professional nursing service if the nurse unionize? | ( 8) | (20) |
| 4. | Would the effective use of your existing nursing organization be a possible alternative to outright nurse unionization? | (23) | ( 6) |
| 5. | Do nurses need the intervention of a third party, such as a union, to achieve employee representation to management? | (15) | (16) |
| 6. | Is the unionization of health care employees a major contributor to the inflation of hospital costs? | (11) | (19) |
| 7. | Can management avoid nurse unionization through "meeting employee needs" such as competitive salaries, good working conditions, etc.? | (30) | ( 1) |
| 8. | Is the desire of nurses to achieve greater control and imput into the organization of medical care a contributing factor to the continual spread of union activity? | (17) | (13) |
| 9. | Do you think belonging to a union would be advantageous in: | | |
| | economic security | (18) | (12) |
| | labor relations | (15) | (14) |
| | maintaining professional status | ( 6) | (23) |
| 10. | Are unions detrimental to nurses in: | | |
| | financially | ( 8) | (21) |
| | in labor relations | (11) | (18) |
| | professional status | (20) | (10) |
| 11. | Do you feel administrative nursing personnel have the maturity and sophistication to cope in the labor relations field? | (11) | (20) |

12. Who is your collective bargaining agent? Please check only one.

| | |
|---|---|
| yourself | (15) |
| ANA | ( ) |
| AANA | ( ) |
| ACRN | ( ) |
| No One | (15) |
| AVANA | ( 1) |

# APPENDIX III

Dear Director of Nursing:

I am involved in research for my Master degree thesis. I am researching the possibility of the need for the unionization of health care professional employees. You have been chosen at random to receive this questionaire. Would you please answer each question by marking an "x" in the appropriate space and then return it in the enclosed, self addressed, stamped envelope. Of course, anonymity is guaranteed. I appreciate your help in this project. Thank you.

Doris T. Margrabe

QUESTIONAIRE

| | | yes | no |
|---|---|---|---|
| 1. | Can nurses secure protection, improvement of their economic security and satisfactory conditions of employment through their respective professional association? | ( 7) | ( 3) |
| 2. | Would a professional health care union be better qualified to act as the exclusive agent to it's members in the area of economic security and collective bargaining? | ( 2) | (8 ) |
| 3. | Will the general public be assured of a constant supply of high quality professional nursing service if the nurse unionize? | ( ) | (10) |
| 4. | Would the effective use of your existing nursing organization be a possible alternative to outright nurse unionization? | (10) | ( ) |
| 5. | Do nurses need the intervention of a third party, such as a union, to achieve employee representation to management? | ( 2) | ( 8) |
| 6. | Is the unionization of health care employees a major contributor to the inflation of hospital costs? | ( 5) | (4 ) |
| 7. | Can management avoid nurse unionization through "meeting employee needs" such as competitive salaries, good working conditions, etc.? | (10) | ( ) |
| 8. | Is the desire of nurses to achieve greater control and imput into the organization of medical care a contributing factor to the continual spread of union activity? | ( 3) | (6 ) |
| 9. | Do you think belonging to a union would be advantageous in: | | |
| | economic security | ( 3) | (7 ) |
| | labor relations | ( 2) | (8 ) |
| | maintaining professional status | ( ) | (10) |
| 10. | Are unions detrimental to nurses in: | | |
| | financially | ( 6) | ( 3) |
| | in labor relations | ( 7) | ( 2) |
| | professional status | ( 8) | ( 2) |
| 11. | Do you feel administrative nursing personnel have the maturity and sophistication to cope in the labor relations field? | ( 8) | ( 2) |

12. Who is your collective bargaining agent? Please check only one.

| | |
|---|---|
| yourself | (4 ) |
| ANA | ( 1 ) |
| AANA | ( ) |
| AORN | ( ) |
| No One | (5 ) |

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