

DETERMINANTS OF REGISTERED NURSE ATTITUDES
TOWARD COLLECTIVE BARGAINING

by

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CHAPTER I

INTRODUCTION

Overview of the Topic

In the literature of industrial relations there are many studies examining the determinants of an individual's attitudes toward unions. Two classes of variables have typically been examined as factors which influence pro- or anti-union views, (a) those which may be considered to be role-related outcomes, e.g., economic rewards and job satisfaction,^{1,2,3} and (b) those concerned with certain demographic and personality variables which are held to predispose employees for or against unions.^{4,5}

¹E. Wright Bakke, "Why Workers Join Unions," Personnel 22 (July 1945):37-46.

²Joseph A. Alutto and James A. Belasco, "Determinants of Attitudinal Militancy Among Nurses and Teachers," Industrial and Labor Relations Review 27 (January 1974):216-27.

³William J. Bigoness, "Correlates of Faculty Attitudes Toward Collective Bargaining," Journal of Applied Psychology 63 (June 1978):228-33.

⁴W. H. Uphoff and M. D. Dunnette, Understanding the Union Member (Minneapolis: University of Minnesota Press, 1956).

⁵J. P. Cangemic, L. Clark, and M. E. Harryman, "Differences Between Pro-Union and Pro-Company Employees," Personnel Journal 55 (September 1976):451-453.

In addition to the distinction between these two classes of variables, scholars have typically assumed that the attitudes across different occupational groups are shaped by different concerns. Blue collar and other non-professional workers are usually held to approach unionism from a utilitarian perspective. What economic and job security benefits does the union offer?^{1,2} In contrast to this group, the attitudes of professional and semi-professional workers are assumed to be influenced by a higher level of concerns. Will unionization provide opportunities for more job autonomy, participation in decision making, and professional recognition?^{3,4} This dicotomization of the workforce into non-professional and professional categories has contributed much to the inconsistency which permeates the literature. So great has this inconsistency been that some researchers have felt it necessary to construct discrete theories of unionization for individual professions.⁵

¹Joel Siedman, Jack London, and Bernard Karsch, "Why Workers Join Unions," The Annals of the American Academy of Political and Social Science 274 (March 1951):75-84.

²Arther Kornhauser, Mental Health of the Industrial Worker: A Detroit Study (New York: John Wiley and Sons, 1965).

³Don Hellriegel, Wendell French, and Richard B. Peterson, "Collective Negotiations and Teachers: A Behavioral Analysis," Industrial and Labor Relations Review 23 (April 1970):380-96.

⁴Ronald G. Corwin, "Professional Persons in Public Organizations," Educational Administration Quarterly 1 (Autumn 1965):4-5.

⁵T. L. Guyton, Unionization: The Viewpoint of Librarians (Chicago: American Library Association, 1965).

One approach to reconciling this problem has been to seek out new explanatory variables which are unaffected by occupational status. Among those suggested have been: employee perceptions of their own ability to modify conditions, the role of organization context, and the effects of the immediate work group.^{1,2} While this approach may eventually prove productive, it fails to address the dicotomization problem directly.

Yet there may be a way to confront this problem and simultaneously evaluate the utility of the non-professional vs. professional categorization. By evaluating the individual's level of professionalism, the attitudes toward unions, and potential determinants of those attitudes, it should be possible to reconcile some of the problems which have plagued researchers thus far.

However, a simple clarification of the determinants of attitudes toward unions across these two classes of employees may be of little utility in explaining an individual's decision whether or not to join a union.³ That is, it is entirely conceivable that a professional employee may hold unions in high esteem but nonetheless consistently choose not to join. On the other hand, it is possible to envision

¹Bigoness, pp. 228-233.

²Peter Blau and William Scott, Formal Organizations (San Francisco: Chandler Publishing Co., 1962).

³J. LeLouarn, "Predicting Union Vote from Worker Attitudes and Perceptions," Industrial Relations Research Association, Proceedings of the 32nd Annual Meeting (Madison, Wis.: n.p., 1979), pp. 72-82.

the employee who believes union membership to be incompatible with professionalism, and yet will vote in favor of unionization.

Studies dealing with professionalism which have been reported thus far share two common weaknesses. First, definitions of professionalism have been uniformly weak. There is an extensive body of sociological literature which has attempted to define precisely what it means to be a professional. While some researchers marginally tapped this literature base, an empirically acceptable measure of professionalism has heretofore not been employed, calling into question some of the conclusions reported.

A second weakness arises when attitudes are generally used as a proxy measure for actual behavior. It is true that data relating an individual's decision to join a union is extremely difficult to obtain given the atmosphere surrounding collective bargaining decisions. However, recent work by Ajzen and Fishbein¹ demonstrates that it is possible to improve the reliability of the link between attitudes and behavior through use of the concept of behavioral intention. A study addressing these two weaknesses has the potential of making a significant contribution to the literature, since it would both build upon the past efforts of others and make an original contribution of its own.

¹Icek Ajzen and Martin Fishbein, Understanding Attitudes and Predicting Social Behavior: Illustration of Applied Social Research (Englewood Cliffs, N.J.: Prentice-Hall, 1980).

Purpose of the Study

Individuals join or decide not to join unions for a wide range of reasons. And while researchers have been able to identify some factors which may predispose certain occupational groups to join unions, the influences of several major determinants remain clouded. It is the purpose of this study to examine empirically the relationships between attitudes toward collective bargaining and some potential antecedents of those attitudes. Specifically, the study is designed to explore the relationship between attitudes toward collective bargaining and professionalism, job satisfaction, age, level of education, and work-related stress.

In addition to this primary purpose, the study has a supplemental objective. Since the relationship between attitudes toward collective bargaining and the behavior of actually joining a union may not be highly correlated, the survey instrument includes an item designed to measure behavioral intention. Behavioral intention is intended to provide a closer approximation to actual behavior.

Organization of the Study

Chapter I

Chapter I is an introduction to the dissertation. It presents a brief overview of the topic and identifies the purpose and significance of the study. In addition, key terms are defined and an outline of the study provided.

Chapter II

Chapter II consists of a review of the literature with concentration on these subject areas: (1) the current state of the unions; (2) a general review of why people join unions; (3) the relationship between professionalism and unionism; and (5) registered nurses on the question of professionalism and unionism.

Chapter III

In Chapter III, the research hypotheses are stated along with a detailed consideration of the theoretical and research foundations of each. Hypotheses to be tested concern the issues of attitudes toward unions, behavioral intention, job satisfaction, work-related stress, professionalism, level of education, and age.

Chapter IV

This chapter contains an introduction of the research methodology. The methodology is discussed in terms of its relationship to the objectives of the study. The appropriate statistical tools are also employed in this chapter to address the research questions presented earlier in the dissertation. In light of the theoretical framework provided and the results of these statistical procedures, the key conclusions of the study are developed.

Chapter V

Chapter V summarizes the findings of the study and states the conclusions drawn with respect to the stated purpose of the dissertation. In addition, discussed in this chapter are the implications of this research for the discipline, its inherent limitations, and suggestions for future research.

Significance of the Study

Labor relations experts have long recognized the shifting structure of the U.S. economy. In past years the term white collar workers emerged to describe the members of the new occupations developing as a result of the change from a manufacturing to service economy.^{1,2} Popular were reports on the status of white collar unions, their problems, and their prospects.^{3,4}

¹"New Union Frontier: White Collar Workers," Harvard Business Review 40 (Jan.-Feb. 1962):65.

²C. Wright Mills, White Collar: The American Middle Class (New York: Oxford Press, 1951).

³Everett M. Kassalow, "Organization of White-Collar Workers," Monthly Labor Review 84 (March 1961):234-238.

⁴Adolf F. Struranthal, ed., White-Collar Trade Unions (Urbana, Ill.: University of Illinois Press, 1966).

As these analyses of the white collar workforce progressed, a split emerged. In the literature there appeared an increasing tendency to adopt the position that the term white-collar-worker was too broad to capture the diverse interests of the groups traditionally included. Growing numbers of authors adopted the position that white collar occupations could be distinguished on the basis of the criterion of professionalism. Examples of non-professional white collar workers included clerks, secretaries, technicians, bookkeepers, etc. Examples of professional white collar workers included engineers, nurses, and airline pilots.

Union gains in this latter professional group were typically explained with reference to the occupations' status. For example, infringements on the professional status of engineers was identified as a source of dissatisfaction leading to the emergence of unionism among engineers following World War II.¹ Likewise, nursing unionism was seen as an attempt to protect professional status.²

In the more than twenty years since the white collar shift was popularized, the workforce has continued its progression away from blue collar jobs. Observers are still pursuing their examinations of

¹Richard E. Walton, The Impact of the Professional Engineering Union: A Study of Collective Bargaining Among Engineers and Scientists and its Significance for Management (Cambridge: Harvard University Press, 1961).

²S. M. Miller, "Professionalization, Organization, and Economic Advance in the Nursing Profession, " New York State Nurse (March 1961):10-12.

the effects of this shift on the labor movement. This study is a continuation of that line of research. However, it is significant and distinguishable because it attempts to integrate the large body of sociological work on professionalism with the work of industrial relations. The use of an empirical measure of professionalism will provide an objective standard against which various occupational groups can be compared with respect to the impact of professionalism on unionization trends.

Beyond its contributions to academic pursuits this study should be of value to audiences outside the academic community. Since the sample consists of registered nurses, the professional associations representing them should find insights as to how they might better meet the needs of their members. Health care managers will be interested because they are currently facing severe nurse staffing difficulties. The factors shaping nurse perspectives on unions may well be the same factors influencing other work related problems such as absenteeism and turnover. Additional groups that will benefit from the information obtained from this research are the unions. It is common knowledge that union membership as a percentage of the workforce has been in a long term decline. This study will cast light on why unions have generally been unable to organize nurses and related para-professional occupations.

Definitions of Terms

Attitude: attitudes are predispositions to respond in a particular manner to some stimulus. They are distinguishable from other such states of readiness in that they predispose toward an evaluative response.¹

Ideology: a set of ideas and beliefs commonly held by the actors that helps to bind or integrate the system together as an entity.²

Behavioral Intention: a measure of the likelihood that a person will engage in a given behavior.³ In this study it is applied in the context of Ajzen's and Fishbein's theory of reasoned action. According to this theory, intention is the immediate determinant of behavior, and when an appropriate measure of intention is obtained, it will provide the closest approximation of actual behavior.

¹C. E. Osgood, G. J. Suci, and P. H. Tannenbaum, The Measurement of Meaning (Urbana, Ill.: University of Illinois Press, 1957).

²Reinhard Bendix, Work and Authority in Industry: Ideologies of Management in the Course of Industrialization (New York: John Wiley & Sons, 1956), p. xxii.

³Ajzen, p. 42.

Profession: a particular form of occupational organization. Unlike unions and guilds which are designed to control how work will be done, who shall do the work, and for what pay, professions go further; they decide what shall be done and for whom.¹

Friedson has defined a profession in a similar manner. He suggests that a profession be thought of as an occupation which has assumed a dominant position in a division of labor, so that it gains control over the determination of the substance of its own work. Unlike most occupations, it is autonomous or self-directing.²

Professional: an individual holding a unique set of attitudes.

Individuals are considered to be more or less professional according to the degree to which they approach or depart from a set of attitudes with respect to the ideal professional type.

¹Ivan Illich, "The Need-Makers," in The Professions and Public Policy, ed. Philip Slayton and Michael J. Trebilcock (Toronto: University of Toronto Press, 1978):342.

²Elliot Friedson, The Profession of Medicine (New York: Dodd, Mead, 1970).

These attitudes are measured with respect to five professional standards: commitment to calling, ethics, autonomy, identification with profession and fellow professionals, and collegial maintenance of standards.¹

Professional Demands: collective bargaining demands made by occupational groups claiming professional status. They are demands designed to further the interests of the profession or to increase the opportunities for its members to pursue their work, as contrasted to demands which improve the economic position or off-the-job status of members of the profession.²

Work-Related Stress: a condition arising from the interaction of people and their jobs, characterized by changes within people that force them to deviate from their normal functioning.³

Implicit in this definition is the notion that an individual's attitudes and behavior are influenced by his/her perceived level of stress.

¹Steven Kerr, Mary Ann VanGilnow, and Janet Schriesheim, "Issues in the Study of 'Professionals' in Organizations: The Case of Scientists and Engineers," Organizational Behavior and Human Performance 18 (April 1977):331-332.

²George Strauss, "Professional and Occupational Associations," Industrial Relations 2 (May 1963):105.

³David C. McClelland, The Achieving Society (Princeton, N.J.: D. VanNostrand Co., Inc., 1961).

CHAPTER II

A REVIEW OF SELECTED LITERATURE

Introduction

In this chapter a review of selected literature is presented. A discussion of the current state of unionism in the United States begins the review in order to provide a rationale for the position that unions continue to play an important role in the development of labor policy both at the governmental and institutional levels. The point is made that unions are being forced by both economic and social realities to recruit the currently unorganized white collar/professional employees.

Having established both the readiness of unions to organize and the potential receptiveness of employees to respond to their appeals, the review turns to a general discussion of why people join unions. Both macro- and micro-sociological explanations are explored.

A frequently cited reason for declining union membership by a large segment of the white collar workforce is the perceived conflict between professionalism and unionism. Therefore, the concept of professionalism is given extensive treatment in order to demonstrate the difficulty of defining what it means to be a professional.

The inability to define professionalism and therefore its relationship to unionism is explored in the discussion of professionals

in unions. While it is true that large segments of the professional workforce tend to view the ideologies of professionalism and unionism as conflicting, there is evidence that many have successfully reconciled this potential conflict.

The final portion of the review is directed at a single occupational group--registered nurses. As an aspiring profession with a long history of collective action, the nurses provide a unique sub-population in which to test hypotheses concerning unions and white collar employees.

The State of the Unions

Collective bargaining in the United States has a long, and often times not so glorious history. Yet in spite of its problem-plagued beginnings, the labor movement has become an accepted part of the social milieu and workers continue to demonstrate their willingness to join unions. In the six-month period between April and September 1980, the National Labor Relations Board conducted 3,362 collective bargaining elections. Unions won majority designation in 1,533 (45.6 percent). This represented a gain of 71,622 new members.¹

These statistics demonstrate that unions continue to remain attractive to large numbers of American workers but they are also consistent with a trend toward lower representation levels, apparent

¹NLRB Statistical Summary for the Three-Month Period April through June 1980, (Washington, D.C.: NLRB, 1981), p. 3.

since the mid-1950's. In the decade of the seventies, for example, membership trends in labor unions were in a positive direction. Membership actually increased from 21,248,000 in 1970 to 22,366,000 in 1980. But an important long term trend is masked by these raw statistics. In 1980, labor unions represented 20.9 percent of the total United States labor force and 24.7 percent of employees in non-agricultural employment. Corresponding proportions in 1970 were 24.7 and 30 percent respectively. (Table 2-1)

The apparent inconsistency between real membership gains and declining proportional representation can be explained by reference to disproportionate growth rates between labor force and union growth. The total labor force grew by 24.3 percent in the decade while total union membership increased by 5.3 percent. (Table 2-1)

Depending upon one's predilections, these statistics either indicate continued slow demise of the labor movement or signal opportunities for renewed vigor. Pessimists are fond of pointing out reasons why the long term process of decline will continue. They look to continued structural changes in the economy, where unionized industries are being replaced by industries with non-union traditions.¹ They also point to more sophisticated management practices, changing work force demographics, the abundance of Federal

¹Leo Troy, "Trade Union Growth in a Changing Economy," Monthly Labor Review 92 (September 1969):3-5.

TABLE 2-1

U.S. LABOR ORGANIZATION MEMBERSHIP 1970-80
(Numbers in thousands)

Year	Member- ship	Total labor force		Employees in nonagri- cultural establishments	
		Number	Percent members	Number	Percent members
1970	21,248	85,903	24.7	70,880	30.0
1971	21,327	86,929	24.5	71,214	29.9
1972	21,657	88,991	24.3	73,675	29.4
1973	22,276	91,040	24.5	76,790	29.0
1974	22,809	93,240	24.5	78,265	29.1
1975	22,361	94,793	23.6	77,364	28.9
1976	22,662	96,917	23.4	80,048	28.3
1977	22,456	99,534	22.6	82,423	27.2
1978	r 22,757	102,537	r 22.2	86,697	r 26.2
1979	r 22,579	104,996	r 21.5	89,886	r 25.1
1980	r 22,366	106,821	r 20.9	90,657	r 24.7

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, News, (Washington, D.C.: Government Printing Office, September 18, 1981):p. 1, table 1.

NOTES: Totals include members of locals directly affiliated with the AFL-CIO, but exclude Canadian members and members of single-firm labor organizations.

r=revised.

legislation dealing with on-the-job issues¹ and weakened ability of labor unions to marshal political support for their causes.²

Optimists on the other hand look at these same trends and draw a different set of conclusions. They contend that while it is true unions are in decline, there is reason to suspect change in the relatively near future. A recent study by Kochan³ lends some qualified support to this position. He discovered that the widely held view that unions will have more difficulty organizing in the future because of demographic, industrial, occupational, and regional changes in the characteristics of the work force may not necessarily be correct. Analysis of his data revealed that no specific population sub-groups could be identified that were consistently unwilling to join a union if their conditions warranted unionization. In fact, he reported that one-third of the presently unorganized work force would actually prefer to unionize. Were all the potential members successfully enlisted into the ranks of labor, the size of

¹Myron Roomkin and Hervey A. Juris, "Unions in the Traditional Sectors: The Mid-Life Passage of the Labor Movement," Proceedings of the Thirty-first Annual Meeting: Industrial Relations Research Association, (Madison, Wis.: n.p., 1978), pp. 213-22.

²Everett M. Kassalow, "Collective Bargaining: In the Grip of Structural Change," Proceedings of the Thirty-third Annual Meeting: Industrial Relations Research Association, (Madison, Wis: n.p., 1978), p. 126.

³Thomas A. Kochan, "How American Workers View Labor Unions," Monthly Labor Review 12 (April 1979):23-31.

the unionized work force could almost double. If such were true, the relationship shown earlier between the growth of the labor force and union membership would be quite different.

Why People Join Unions

Perhaps the most reasonable conclusion to be drawn from the studies of union membership trends in the United States is this: given the right set of circumstances the potential exists for significant gains in union growth. But this conclusion in turn, generates even more difficult questions: Why do unions exist?; and what motivates an individual to join a union?

The literature of industrial relations is rich in potential explanations for union growth. Historically the search for answers to these questions has taken various forms. One way to approach an analysis of these questions is to classify the various theoretical perspectives of union growth on the basis of their macro-sociological versus micro-sociological orientation.

The macro-sociological explanations of unionism generally treat unions as an adjustment mechanism to a changing society. Proponents of this approach tend to see unions as a consequence of the historical shift from an agricultural to an industrial society. The micro-sociological or individualist type theories on the other hand tend to emphasize the study of occupational, organizational or individual characteristics. Both these perspectives have something

to offer to the study of how registered nurses view collective bargaining and therefore warrant a brief review.

Macro-Sociological Explanations

Because labor unions have been so successfully integrated into advanced industrial societies, macro-sociological explanations of the labor movement are not currently popular topics of scholarly debate. This situation, however, did not exist in an earlier phase of our economic development. During and preceding what labor historian Irving Bernstein¹ has called the "Turbulent Years" of the 1930's, macro-sociological theories of the labor movement were widely discussed.

Few authors have attempted to classify the various theories of the labor movement and no generally accepted organizational scheme is available. Perhaps the best comprehensive summary of early labor theorists is provided by Mark Perlman in his book, Labor Union Theories in America.² Perlman classifies the theories in five categories based upon their "natural theoretical groupings". The five are: (1) the Protestant Christian Socialist and the Roman Catholic Christian social movements, (2) the Marxian Socialist

¹Irving Bernstein, Turbulent Years (Boston: Houghton Mifflin Co., 1970).

²Mark Perlman, Labor Union Theories in America (Evanston: Row, Peterson and Co., 1958; reprint ed., Westport, Conn.: Greenwood Press, 1976), p. xi.

movements, (3) the environmental psychology discipline, (4) the neo-classical economics discipline, and (5) the legal or jurisprudential history discipline.

Employing a similar but different perspective, Johnson also developed a classification scheme for unionization theories. He identifies two broad categories and eight sub-categories. The broad categories are Sociological Causation Factors and Psychological Causation Factors. (Table 2-2) These divisions closely parallel the macro- vs. micro-sociological scheme employed in this discussion.

By macro-sociological we mean theories that treat unionism as a mass sociological phenomenon. Unions are thought to emerge from an ill-defined sense of dissatisfaction and express themselves in what appears to be a spontaneous and relatively uncoordinated challenge to the status quo. An example of a macrosociological theory applicable to this discussion is the power elite theory developed by Kerr, et al. It holds that unions emerge because an elite group has "captured control" of the economic system; unions exist to help alleviate dissatisfaction within the industrial workforce by providing workers with an opportunity to influence the "web of rules" that directs work behavior.¹ According to the model, large scale dissatisfaction with the distribution of power and authority is the fuel that feeds union growth.

¹Clark Kerr et al., Industrialism and Industrial Man (Cambridge, Mass.: Harvard University Press, 1960), p. 31.

TABLE 2-2
LABOR THEORY CLASSIFICATION

Theorists	Sociological Causation Factors (Social-System)				Psychological Causation Factors (Self-System)			
	1	2	3	4	5	6	7	8
	Class Struggle	Power Elite	Institutional Pressures	Competitive Forces	Economic Insecurity	Scarcity Consciousness	Psychological Frustration	Anomie
Karl Marx	X	X	X	X	X			
John R. Commons	X		X	X				
The Webbs	X			X				
G. D. H. Cole	X							
Kerr, Dunlop Harbison, Myers		X						
Robert F. Hoxie			X					
Selig Perlman		X				X		
Frank Tannenbaum			X					X
John Mitchell					X			
Carlton Parker							X	

SOURCE: Charles H. Johnson, "A Causal Taxonomy of Theories of Unionization," The Journal of Business (May 1977):6, table 1.

TABLE 2-2 (cont.)

NOTES:

¹Class Struggle. An inherent conflict between groups or classes, most generally differentiated by the amount of personal wealth.

²Power Elite. Groups of people distinguished by some attribute (wealth, knowledge, expertise) which imparts to them the power to influence the course of social development.

³Institutional Pressures. Forces which are more specific than those of Class Struggle or Power Elites and stem from such sources as mechanization, management prerogatives, political institutions, governmental policy, etc.

⁴Competitive Forces. The economic pressures originating in the market place and reflected through the chain of distribution and production to the worker, causing downward pressure on wages and competition among workers.

⁵Economic Insecurity. Individual anxiety over present or future economic status.

⁶Scarcity Consciousness. A fixation on perceived scarcity of material wealth.

⁷Psychological Frustration. The thwarting of basic (common) psychological traits causing a frustration.

⁸Anomie. Personal alienation or disorganization resulting from social change.

Interestingly enough this maldistribution of power is a striking characteristic of the health care system and the nursing profession in particular. Medical sociologists have long noted that physicians dominate the division of labor involving medical and medically-related tasks. And further, that this dominance has persisted despite evidence that the quality of nursing care may be the single most important factor affecting successful patient care in the hospital.¹ Of course, as sociologist Hans Mauksch has noted,² the history of nursing is closely interwoven with the history of women in general. Physicians, who are primarily male, have tended to view the nurse as having the attributes of wife and mother, doing whatever home and family require, allowing others to define their tasks. But nursing is in a state of ferment, reflecting not only changes in the nature of the health care delivery system, but also larger changes in society. As the nursing profession responds to these changes, the power elite theory of union emergence offers a potentially useful guide for an understanding of the emergence of nursing unionism.

¹Basil S. Georgopoulos and Floyd C. Mann, The Community General Hospital (New York: MacMillan, 1962).

²Hans O. Mauksch, "Nursing: Churning for Change?" in Handbook of Medical Sociology, 2nd ed., ed. Howard E. Freeman, Sol Levine, and Leo G. Reeder (Englewood Cliffs, N.J.: Prentice Hall, 1972) pp. 206-30.

Despite their potential, however, the power elite theories, like their macro-sociological counterparts suffer a major weakness. The macro-sociological theories inquire into the antecedents to union growth based on deductive reasoning rather than empirical research. This means there is no way to empirically demonstrate the validity of the theories.

Micro-Sociological Explanations

In contrast with the macro-sociological theories there has emerged since the 1960's a body of literature which treats unionism as the consequence of individual behaviors. The distinguishing characteristic of these approaches is their emphasis on the interaction of the individual in his/her environment, and the use of empirical methods to analyze the consequences of this interaction. The primary question is not why unions exist as social institutions, but rather why individuals choose to participate or not participate in the institution of unionism. A primary motivation of this shift in approach may be attributed to the emergence of organizational behavior as an accepted discipline and attempts to integrate organizational behavior concepts into the structure of traditional labor relations.¹

¹George Strauss, "Can Social Psychology Contribute to Industrial Relations?" in Industrial Relations: A Social Psychological Approach, eds. G. M. Stephenson and C. J. Brotherton (London: John Wiley & Sons, 1979), pp. 131-57.

The majority of researchers employing this approach have tended to retain the economic orientation of early labor relations practitioners, but they have recast the theories to meet the needs of the micro-sociological framework. This recasting has taken the form of explaining unionism behavior in terms of fulfillment of extrinsic and intrinsic needs. Extrinsic needs tend to encompass traditional economic concerns, intrinsic needs capturing the more obscure psychological needs.

Extrinsic needs refer to the so called "bread and butter" issues. Using this framework, the decision process leading to pro- or anti-union behavior is dependent upon some sort of cost/benefit analysis, with focus on aspects of the employment exchange closely related to the worker's economic security (wages, benefits, and job security). The critical role of these factors has been demonstrated in a number of studies over the past three decades, they have been found to be of primary importance across all occupational groups whether they be blue-collar, white-collar,¹ or professional employees.²

In addition to the extrinsic or bread and butter issues, another class of variables has been explored in the literature--intrinsic

¹Edward R. Curtin, "The Facts About White Collar Unionization," Conference Board Record 6 (June 1969):17.

²Dennis Chamot, "Scientists and Unions: The New Reality," American Federationist 81 (September 1974):8-12.

needs. Vroom's¹ recognition that employees differ as individuals, having different expectations with respect to their jobs, helped stimulate this line of research. Examples of intrinsic needs include the desire for job autonomy and the need to achieve. There are some people who want jobs that provide them with the right and privilege to make decisions and operate without being closely supervised. Likewise, the work of McClelland² has demonstrated that individuals tend to differ in striving for achievement. Some seek challenging goals, while others are satisfied to accomplish moderate or low goals.

This emphasis on micro-sociological variables has led to the development of a new approach to the study of the unionization process.^{3,4} Accepting the premise that individuals make rational decisions and that most decisions are made on the basis of whether a particular need will or will not be met, this approach stresses the importance of the perceived instrumentality of the union. As

¹Victor H. Vroom, Work and Motivation, (New York: Wiley, 1964).

²McClelland, p. 5.

³T. A. DeCotiis and J. LeLouarn, "A Predictive Study of Voting Behavior in a Representation Election Using Union Instrumentality and Work Perceptions," Organizational Behavior and Human Performance 27 (February 1981):103-118.

⁴T. A. Kochan, Contemporary Views of American Workers Toward Trade Unions (Washington, D.C.: Department of Labor, 1978).

expressed by Kochan,¹ this model holds that a person will vote for a union to the extent to which he/she perceives the union to be instrumental to the satisfaction of his or her needs. Employing this individualist multi-factor approach to predicting unionization votes in a group of registered nurses, LeLouarn² was able to correctly predict 83 percent of the votes, knowing only the age of the respondent, his or her job-related psychological stress, perceived role ambiguity at work, and perception concerning the instrumentality of a union for the attainment of relevant outcomes.

The shift in emphasis from macro- to micro-sociological explanations of union related behavior has only recently begun to pay dividends in the form of an enhanced understanding of individual behavior, yet the potential returns on research of this nature are substantial. The decision to join a union is clearly multi-faceted; the challenge is to discover which factors are most salient for significant subgroups of the workforce population

Professionalism and Unionism

As the previous discussion indicates, we have a generally good idea of why people join unions. We know considerably less however, about why people do not join unions. What is it that motivates an individual to refrain from union membership? The most obvious answer

¹Ibid.

²LeLouarn, p. 81.

is simple; people do not join unions because they are satisfied with their present terms and conditions of employment. Indeed, some large and very successful employers have been able to avoid unions in large part because they have recognized the link between dissatisfaction and unionization.¹

Yet, if Kochan's² observation, that approximately one-third of the non-union labor force would actually prefer to organize is correct, it is safe to assume that there are large numbers of workers who remain both dissatisfied and non-unionized. Possible explanations are many and include: the failure of unions to organize aggressively, strong employer resistance, out-dated labor laws, etc. All of these arguments are no doubt valid but there is one that is particularly germane to this study. Many individuals choose not to join unions because it is inconsistent with their self-concept as professionals. For large segments of the white collar work force an irreconcilable conflict exists between unionism and professionalism. This portion of the study explores what professionalism is and its potential influences on unionization decisions.

¹Fred K. Foulkes, "Large Nonunionized Employers," in U.S. Industrial Relations 1950-1980: A Critical Assessment, ed. Jack Stieber, Robert B. McKersie, and D. Quinn Mills (Madison, WI: Industrial Relations Research Association, 1981), pp. 129-158.

²Kochan, p. 25.

Defining Professionalism

One of the functions of a science is to develop a common language to provide a means for the dissemination of knowledge. Some disciplines have been extremely successful at this task. Physicists know exactly what the term "meter" means when they discuss measurements of length. Likewise, chemists know exactly how much of a certain liquid is contained in a one "liter" flask. Unlike practitioners of the physical sciences, social scientists have a much more difficult task in precisely defining all the elements of their language. An excellent example of this problem is provided by the concept of "professionalism." Exactly what does it mean when an individual is defined as a professional? At what point does an occupation cease to be just an occupation and transform itself into a profession?

Failure to define professionalism precisely, and the parallel concepts of profession and professionalization, has not been for want of trying. The literature is replete with attempts to define each of these concepts once and for all. Unfortunately the goal remains elusive. Yet the terminology persists and an understanding of the concept is vital to the study of occupations in society.

For purposes of this review the concept of professionalism will be examined from two different perspectives. First, from the moral or evaluative approach of defining professionalism. And second, from an attributional approach. Finally, these definitional attempts will be summarized within the framework of professionalism as an ideology.

Moral Definitions

Serious sociological investigation of the professions is a relatively new phenomenon. Much of the pioneering work in this area can be credited to Carr-Saunders. His was one of the earliest attempts to both distinguish the professional from the non-professional and develop paradigms for investigating the role of professional associations in a free society.

One of Carr-Saunders' important contributions was his identification of the historical relationship between professionalism and Western Christian traditions. As a distinct occupational group, the professions emerged in the Middle Ages, coincident with their training and accrediting institutions, i.e., the universities. But as Carr-Saunders pointed out, the Church governed the medieval university. The faculty of arts and the schools of medicine, law, and theology all granted ecclesiastical degrees.¹ Thus, the members of the professions were by definition also churchmen. And as churchmen they were accorded higher status than those occupations not affiliated with the then all-powerful Church.

In the medieval Christian cosmological order, every man had been "called" (vocatus) to fulfill a specific task: "Unusquisque maneat in ea

¹A. M. Carr-Saunders, "Professionalization in Historical Perspective," in Professionalization, ed. H. M. Vollmer and D. L. Mills (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1966), pp. 3-9.

vocatione in qua dignoscitur vocatus."¹ ("Everyone should abide in that calling to which he is known to have been called.")² Some were called to positions of higher status and prestige than others. And with this calling came not only rights, but responsibilities. Each individual by virtue of his/her vocation was responsible to serve God, the priests directly, the professionals through their clients, and the serfs through their Lords.

The implications of this historical link between the professions and the Church is apparent in the definitions of professionalism which emerged in the mid-twentieth century. Perhaps the best example of this link is mirrored in the definition provided by Cogan after his extensive review of the literature on professions. Attempting to distinguish a profession from other lesser occupations he stated:

A profession is a vocation whose practice is founded upon an understanding of the theoretical structure of some department of learning or science, and upon the abilities accompanying such understanding. This understanding and these abilities are applied to the vital practical affairs of man. The profession, serving the vital need of man, considers its first ethical imperative to be altruistic service to the client.³

If, in fact, professions are distinguishable on the basis of this definition, the professions clearly operate on a higher moral

¹I Cor. 7:20.

²Walter Ullmann, The Individual and Society in the Middle Ages (Baltimore: Johns Hopkins Press, 1966), p. 42.

³M. L. Cogan, "Toward a Definition of Profession," Harvard Educational Review 23 (1953):43.

plane than the majority of other occupations. After all, what occupational groups other than religious orders can legitimately claim to be motivated by an "ethical imperative" to provide "altruistic service"?

But discovery of the existence and origins of the moral component of professionalism does not explain its persistence. In order to support the claim that morality continues to exert an influence on contemporary definitions of professionalism, it is necessary to explain why it has continued despite the secularization of the professions in post-medieval history.

Perhaps the best explanation is found in an examination of the symbolic function of professionalism. The image of the professional serves the symbolic function of providing a standard of reference against which other occupations can be compared. In this capacity, professionalism simultaneously serves to legitimate status differentials between occupations and provide a model for the upward mobility of aspiring professions. Hall, a leading student of the professionalization process agrees with this observation. He holds that the professional model is useful in large part because its elements "provide the imagery that occupations aspiring to professionalism observe in their attempts to gain recognition."¹

¹R. Hall, Occupations and the Social Structure (Englewood Cliffs, N.J.: Prentice Hall, 1975), p. 80.

In other words, the professional model provides a yardstick of social value. To some, what is symbolized is the ideal of altruism, i.e., selfless laboring in the service of mankind. To others, it symbolizes honorable or ethical action in the performance of one's work. And to still others it symbolizes the culmination of a long quest to master a body of theoretical knowledge. Yet, whatever the individual's symbolization, there exists the commonly held belief that to be a professional is to be socially valuable.

The Attributional Approach

While moral elements have tended to persist in more recent definitions of professionalism, they have assumed a secondary role. Rather than simply disappearing, the moral elements have become part of a broader definitional framework aimed at developing a taxonomy of professionalism. This taxonomic approach has yielded a wide spectrum of lists, as theorists have attempted to delineate a consistent set of traits which might successfully distinguish the professional from the non-professional.

Attempts by sociologists to develop a constellation of characteristics has a long history. Carr-Saunders and Wilson, whose joint venture in the study of the professions is still highly regarded, began this trend almost fifty years ago. In lieu of a formal definition of a profession they state that "a typical profession exhibits a complex of characteristics, and that other vocations approach this condition more or less closely, owing to the

possession of some of these characteristics fully or partially developed."¹

The procedure applied to discover which characteristics are part of a correct constellation has been to identify a priori an "ideal" occupation. Thus certain occupations--physicians, lawyers, or ministers, for example--have at various times served as the standard, the reference point against which all other occupational groups are compared. The relative professionalism of other groups is therefore determined on the basis of the extent to which they possess or fail to possess the ascribed attributes.

Beyond the problems associated with correct identification of an "ideal" profession to serve as a standard, critics of this approach have noted the inherent difficulty of arriving at a generally accepted list of attributes. Because most of the taxonomic researchers have worked independently there has emerged a wide array of lists,² often using different language to convey the same concepts. Roth,³ in commenting on the confusion inherent in this approach, has noted that some authors have actually varied their own lists at different times.

¹Alexander M. Carr-Saunders and P. A. Wilson, The Professions (Oxford: Clarendon Press, 1933), p. 3.

²Douglas Klegon, "The Sociology of Professions," Sociology of Work and Occupations 5 (August 1978):259-283.

³J. Roth, "Professionalism: The Sociologist's Decoy," Sociology of Work and Occupations 1 (February 1974):6-23.

Despite the existence of a confusing array of professional attributes, researchers have persisted in their attempts to apply the concept of professionalism in empirical behavioral research. This persistence has resulted in the emergence of a number of professionalism scales. Scales developed to measure professionalism may be differentiated from their predecessors, i.e., the a priori taxonomic approaches, on the basis of their orientation. Rather than concerning themselves with the questions of what occupations are professions, the individual becomes the unit of analysis. The inherent assumption is that there exists a consistent set of attitudes which distinguish the professional from his/her non-professional counterpart. Under this approach an occupational group is considered to be a profession to the extent that it's individual members share a given set of attitudes.

The earliest serious attempts to employ the concept professionalism appear with the application of Merton's¹ distinction between locals and cosmopolitans. This distinction, operationalized by A. W. Gouldner² stimulated a whole stream of

¹Robert K. Merton, Social Theory and Social Structure (New York: Free Press, 1957).

²A. W. Gouldner, "Cosmopolitans and Locals: Toward an Analysis of Latent Social Roles," Administrative Science Quarterly 2 (December 1957):281-306.

literature which tended to equate cosmopolitanism with professionalism, and proceeded to test a number of professionalism hypotheses.^{1,2}

Other researchers also developed their own measures of professional attitudes, with varying degrees of complexity and success. Miller and Wagner³ in their attempt to operationalize professionalism simply included items relating to the use of fellow professionals as referents. At variance with this limited approach is Hall's⁴ frequently cited attempt to develop a comprehensive attitude scale to measure the degree of professionalism among practitioners of various occupations. Using Likert scaling procedures, Hall used ten items to measure each of five attitudes of professionalism:

- use of the professional organization as a major referent
- belief in public service
- belief in self-regulation

¹R. W. Scott, "Professionals in Bureaucracies: Areas of Conflict," in Professionalization, ed. H. M. Vollmer and D. L. Mills (Englewood Cliffs, N.J.: Prentice Hall, 1966), p. 269.

²J. E. Sorenson and T. L. Sorenson, "The Conflict of Professionals in Bureaucratic Organizations," Administrative Science Quarterly 19 (March 1974):98-106.

³Miller & Wagner 1971-Schriesheim

⁴Richard H. Hall, "Professionalization and Bureaucratization," American Sociological Review 33 (February 1968):92-104.

- sense of calling to the field
- feeling of autonomy

Hall's scale is a comprehensive attempt to measure professionalism but it suffers a major weakness beyond those pointed out in Snizek's¹ critique. Schriesheim has identified this weakness. While embracing the direction and methodology of Hall, she nonetheless notes that his instrument includes items:

. . . measuring individual attitudes with items measuring self-reported individual behaviors, perceptions of occupational characteristics, perceptions of occupational colleagues, and perceptions of characteristics of the employing organization. Thus, the scale is confounded, since it is not a pure measure of either attitudes, behaviors, or perceptions.²

Having identified this shortcoming, Schriesheim developed her own extension of the Hall instrument. Supported by extensive statistical procedures to ensure reliability and validity, this instrument consists of 65 items, 13 of each of the five characteristics of professions. Professionals, for purposes of this scale, are treated as individuals holding attitudes which indicate:

- high commitment to their work and occupation

¹William E. Snizek, "Hall's Professionalism Scale: An Empirical Reassessment," American Sociological Review 37 (February 1972):109-114.

²Janet Fulk Schriesheim, "A Psychological Measure of Professionalism in a Public Utility" (Ph.D. dissertation, Ohio State University, 1978), p. 9.

- acceptance of a code of ethics
- desire for autonomy
- identification with the profession and fellow professionals
- perceived commitment to help police the conduct of fellow professionals

Schriesheim's formulation is an attempt to extend Hall's scale, while at the same time emphasizing attitudinal attributes so as not to confuse them with the structural characteristics of an occupation. The practical advantage of this approach rests in its ability to highlight the individual nature of professionalism. Professionalism is treated as being independent of the structural characteristics of an occupation. An example comparing nurses and physicians may clarify the utility of this perspective.

Education is a structural characteristic of professionalism. Most definitions hold that professionals are more highly educated. It follows then, that because physicians have a longer term of formal training than nurses, they are more professional. This may be true but it is not necessarily true, especially if one considers attitudes. Role theory tells us that individuals who aspire to higher social status tend to adopt the behaviors and norms of their reference groups.¹ Individual nurses then, who aspire to higher

¹A. E. Siegel and S. Siegel, "Reference Groups, Membership Groups, and Attitude Change," The Journal of Abnormal and Social Psychology 55 (November 1957):363.

status and prestige may well adopt a "professional" model of behavior, regardless of the length of their training. Adoption of this behavior model is an individual decision and is likely to be reflected on a scale of professional attitudes. A purely attitudinal measure of professionalism, when used in combination with structural characteristics, then has the potential of explaining more precisely the relationship between professionalism and unionism, since it is not confounded, as is Hall's, by built-in definitional biases.

Professionals in Unions

Researchers exploring professional attitudes have generally assumed that professionals are motivated by a unique set of needs, and therefore behave differently than non-professionals. Some investigators even have gone so far as to attempt to use professionalism as a predictor of deviant behavior. Quinney,¹ for example, reported that professionally oriented pharmacists tended to be less frequent violators of prescription control laws.

But the vast majority of applied professionalism research has concentrated on what might generally be labeled "professionals in bureaucracies." A common quest of this line of research is to determine how certain occupations can maintain their professional

¹E. R. Quinney, "Occupational Structure and Criminal Behavior: Prescription Violation by Retail Pharmacists," Social Problems 11 (Fall 1963):179-185.

status within bureaucratic organizations. For example, Kornhauser¹ is concerned with the maintenance of professional autonomy in a setting which emphasizes formal authority structures. Blau and Scott² are interested in potential limitations on professional autonomy that might emerge in a situation where decision making is controlled by non-professionals. Wilensky³ addresses the impact of bureaucratization on the maintenance of the service ideal that has generally been considered a professional attribute. And Scott⁴ expresses reservations about the potential impact on collegial control of performance standards if career advancement takes place through hierarchies, in which control is shared with or dominated by non-professionals.

In the main, these scholars have been motivated by the common concern that bureaucratization is a threat to the professional model: that because of the structures which accompany employment in bureaucratic organizations, society will be deprived of the positive benefits which are held to be a consequence of professional behavior.

¹W. Kornhauser, Scientists in Industry: Conflict and Accomodation (Berkeley: University of California Press, 1962).

²Blau, p. 125.

³Harold L. Wilensky, "The Professionalization of Everyone?" American Journal of Sociology 70 (September 1964):137-158.

⁴Richard Scott, "Reactions to Supervision in a Heteronomous Professional Organization," Administrative Science Quarterly 10 (January 1965):65-81

No definitive answers are yet available with respect to the impact of bureaucracy on professionalism but this line of research has helped spawn a related body of literature. This group of studies takes the question of bureaucratization one step further and is concerned with the relationship between unionism and professionalism.

The link between these lines of research becomes clearer when one considers the relationship between bureaucracies and unions. The roots of modern industrial unionism can be traced to the growth of large bureaucratic manufacturing enterprises. With the growing bureaucratization of the service sector and the resultant employment of increasing numbers of professionals within its confines, unionization trends among the new group of wage employees began to generate serious academic research.

Early studies of union growth in the service sector concentrated on clarifying the distinctions between blue-collar and white-collar workers. White-collar workers, for example, are reported usually to have more education, closer identification with management, and greater interest in change in job design.¹ This line of research in part is motivated by the desire to predict whether unions can expect to make significant organizing gains among the white collar workers. Thus far, for reasons still not totally explained, aggregate gains in the U.S. have not been impressive. In 1974, only

¹Claude Edwards, Some Reflections on White-Collar Collective Bargaining (Kingston, Canada: Queens University, 1977), pp. 1-2.

13 percent of the white-collar workers in the United States were union members, as compared with 24 percent in Germany, 38 percent in Great Britain, 41 percent in Australia, 58 percent in Norway, and 70 percent in Sweden.¹ But these aggregate statistics present a slightly distorted picture of white-collar organizing in the U.S. This is so because there exists both a strong tradition of unionism among some white-collar occupations and the potential for significant gains in other sectors.

Some of the professional white-collar areas where unions are securely established include: musicians, actors and actresses, newspaper reporters, airline pilots, teachers, engineers, and scientists.² Speculating as to why unions appeared in these professional groups and not others, Kassalow³ has posited that unions emerged, in part at least, to advance the professional recognition of these groups. Unions appeared in these occupations because without unionizing they had little power since they lack strong professional associations, formal training requirements, and/or occupational licensing.

¹D. W. Rawson, "A Note on Manual and Nonmanual Union Membership in Australia," Journal of Industrial Relations 16 (December 1974):394-397.

²Chamot, pp. 8-12.

³E. Kassalow, "Prospects for White Collar Union Growth," Industrial Relations 5 (October 1965):43.

The transition to collective bargaining, for many of the occupations which have embraced it, has not always been easy. In fact, in many of the fields where the potential for union growth is most promising, the debate over the conflict between professionalism and unionism rages on. In engineering, for example, it has been almost twenty years since Strauss¹ identified the dilemma faced by engineering professional associations. Should they pursue so-called bread-and-butter issues or should they concentrate on traditional professional issues. Latta,² in a 1981 article updating unionization trends among engineers, demonstrates that the dilemma still is unresolved.

Similar debates have persisted in other occupational groups as well. The single largest occupational group to confront the unionization issue is teachers. At all levels of the educational system the conflict has appeared and continues. In fact, as recently as November, 1982, faculty of Michigan State University held its third election to decide whether or not to enter into collective bargaining contract with the regents.

¹George Strauss, "Professional or Employee-Oriented: Dilemma for Engineering Unions," Industrial and Labor Relations Review 17 (July 1964):519-533.

²Geoffrey W. Latta, "Union Organization Among Engineers: A Current Assessment," Industrial and Labor Relations Review 35 (October 1981):29-42.

After teachers, the next single largest source of potential union members is to be found in the health care industry. For a number of years employment levels in health care have been burgeoning. Total hospital employment grew 194 percent from 1950 to 1976 and by more than 50 percent from 1965 to 1976.¹ In the 15-year period between 1962 and 1977, the hospital labor force expanded at a rate more than three times that of the total U.S. labor force (5.5 vs. 1.7 percent).² More recently this growth rate has continued, from 1975 to 1980 the health care work force expanded by 18 percent, to total 6.7 million workers.³

One of the distinguishing characteristics of the growing health care labor force is the emergence of the allied health professions. As defined in Section 795 of the Public Health Service Act, the allied health professional group includes all "individuals with training and responsibilities for (a) supporting, complementing, or supplementing the professionals in the delivery of health care to patients, or (b) assisting environmental engineers and other personnel in environmental control and preventive medicine

¹David R. Denton, "The Union Movement in American Hospitals 1847-1976" (Ph.D. dissertation, Boston University, 1976).

²Rosemary Stevens, American Medicine and the Public Interest (New Haven: Yale Press, 1971).

³"A Merger that Might Add to Hospital Bills," Business Week, April 12, 1982, p. 39.

activities."¹ Under terms of this broad definition, approximately two-thirds of the total health care labor force, encompassing more than 100 separate occupations and specialties, qualify as the allied health professional group.²

Because health care has traditionally been a low wage industry, the rapid growth of the allied health care workforce initially appeared to be fertile ground for union gains among professional workers, especially so in light of the opportunities provided by the 1974 Health Care Amendments to the NLRA. Due to the perceived threat of trade union growth in hospitals, a number of professional associations in the 1970's seriously debated acting as bargaining agents for their members, in effect transforming their professional associations into unions. Examples of organizations debating the wisdom of this transition include the American Nurses Association (ANA), the American Society of Hospital Pharmacists (ASHP), and the American Society of Medical Technologists (ASMT).³

For the remainder of this review, the special case of nurses will be explored. Nurses receive special treatment for three reasons. First, they hold characteristics in common with numerous

¹Public Health Service Act, Title VII, Subpart II of Part G, Sec. 795.

²U.S. Department of Health, Education, and Welfare, A Report on Allied Health Personnel, DHEW Pubn. No. (HRA) (1979), pp. 20-28.

³Dennis A. Pointer and Lloyd L. Cannedy, "Organizing of Professionals," Hospitals J.A.H.A. 46 (March 1972):70-73.

other white collar occupations. This is especially true with respect to their education requirements, working environments, and career potentials. Second, nurses are the oldest and largest segment of the allied health workforce. The example of the nurse is therefore critical to an examination of unionization trends in the health care industry. And third, nurses warrant special attention because of their long and continuing struggle to raise their status within the health care hierarchy through professionalization. As will be described in the review to follow, organized nursing has, since its emergence, experimented with various programs designed to assist in the transformation for a semi- to full profession.

Nursing: An Aspiring Profession

Every occupation has a history unique unto itself but some are richer and more enlightening than others. Nursing falls into this special group. The history of nursing is explored below in order to demonstrate how historical forces continue to exert their influence. Following this brief historical review, the problems and opportunities of contemporary nursing are examined. This inquiry is aimed at identifying the dilemmas faced by the modern nurse. It is the purpose of the review of the nursing occupation to provide a background for interpreting information gathered with respect to the research variables in this study, i.e., job satisfaction,

work-related stress, attitudes toward unions, professionalism attitudes, and the relationships between the variables.

The Historical Background of Nursing

The emergence of modern nursing closely parallels that of the modern hospital and the rise of scientific medicine. Until well into the Nineteenth Century, nursing as a lay occupation was non-existent. Religious orders dominated the occupation and their dedication was to God and not to the advancement of nursing as a profession. Beyond the nuns and deaconesses, the only other lay practitioners of nursing were paupers or drunkards, persons unfit for any other type of work.

It was in the mid-1800's when nursing embarked upon its march to respectability. Leading the march was Florence Nightingale who, applying scientific, technical, and organizational skills, demonstrated that nurses could make a valuable contribution to patient care. The first major demonstration of her abilities came in the battle field hospitals of the British Crimean War. There, against the opposition of the male medical officers, she organized and directed the nursing services in such a way that the death rate fell markedly, in a war zone where casualty rates of fifty percent or more due to disease were common.

These successes were fully reported in the British press, and Nightingale had the base from which to launch her own campaign to reform nursing. Her books and statistical reports including Notes

on the British Army, Notes on Hospitals, and Notes on Nursing had a major impact on the delivery of both military and civilian health services.

Of particular importance were her contributions to nursing education. In 1859, her fame already secure, she established a training center for a new breed of nurses, the Nightingale School of London. The plan was based on the triad of training of the character, the acquisition of skill and knowledge, and nursing administration and instruction in the hands of nurses. The Nightingale nurses, once trained, were not to accept private work, but to go into other hospitals and public institutions and start similar schemes. The Nightingale nurses were missionaries: they trained to train.¹

The philosophy of Nightingale arrived intact on the American shores in 1873 with the establishment of nurse training schools at three leading hospitals: Bellevue, New Haven, and Massachusetts General. The nurse shortages of the Civil War had paved the way for creation of these schools; the subsequent discovery, that student nurses were better disciplined, performed better service, and were less expensive than untrained hired women, assured their survival.

¹Monica E. Baly, Nursing and Social Change, 2nd ed. (London: William Heinemann Medical Books Ltd., 1980), p. 124.

Nightingale's beliefs about nursing continue to provide the basic foundation on which nursing care is practiced today. A brief review of her approach is necessary to appreciate the continuing influence of her model on the nursing profession.

The core concept of the Nightingale system is an emphasis on the environment. Having witnessed the devastating impact of filth and vermin on the survival rates of soldiers, Nightingale stressed the primary importance of a clean environment to recovery. It is then, the function of nursing to provide and maintain a healing environment.

As expected, given the social milieu in which Nightingale worked, the emphasis in her work is on the control of the physical elements that disturb health, such as dirt, dampness, chills, drafts, smells, and darkness.¹ Yet, as one would expect from a comprehensive theory of nursing, the psychological and social environments are also addressed. But in the Nightingale system these factors come into play only after the patients' basic physical needs are secured. Figure 2-1 provides a visual representation for the interrelationships between the physical, psychological, and social environments.

¹Florence Nightingale, Notes on Nursing (New York: Dover Publications, Inc., 1979).

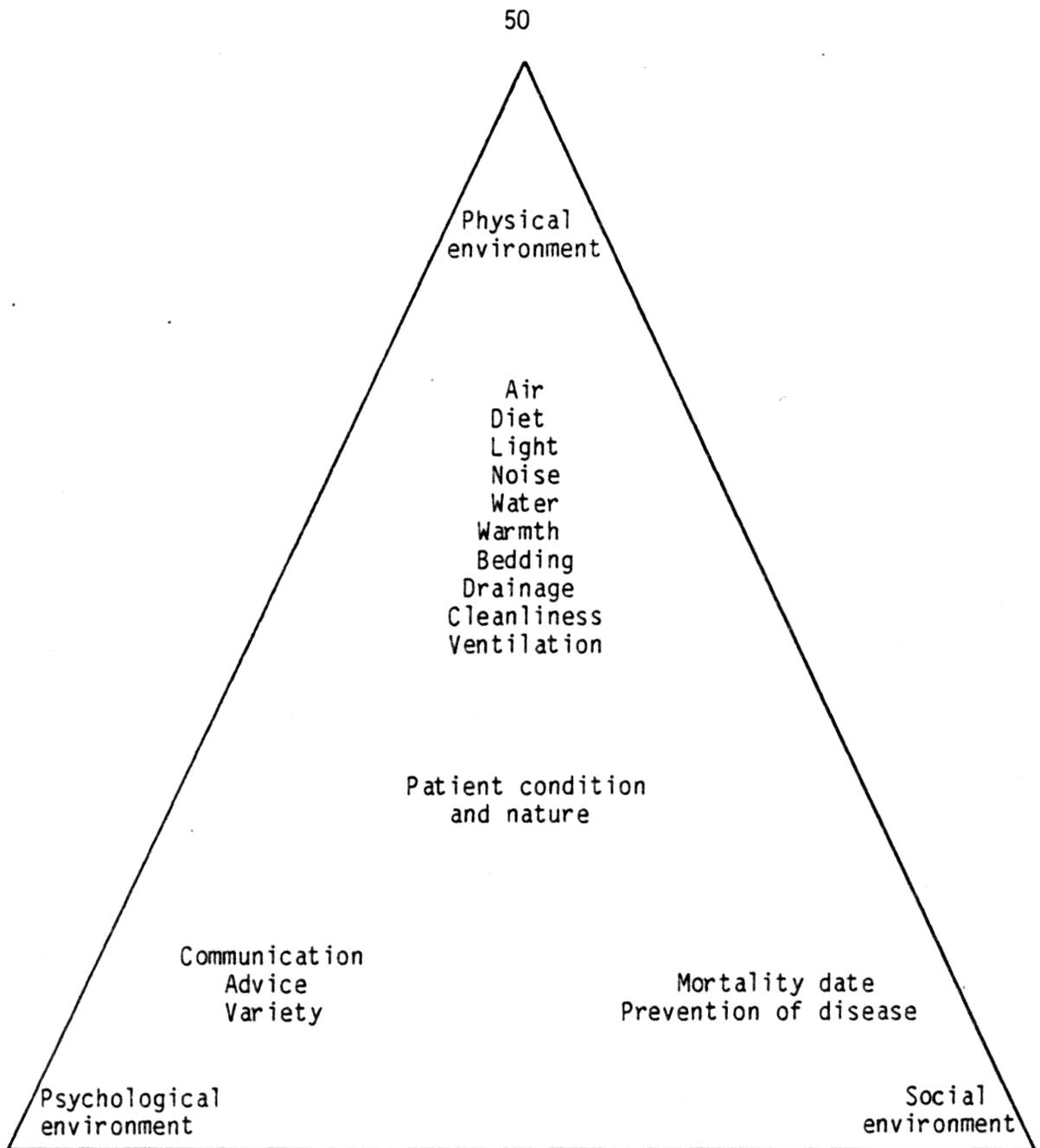


Figure 2-1. Nightingale's theory of nursing

SOURCE: Gertrude Torres, "Florence Nightingale", in Nursing Theories, ed. Julia B. George (Englewood Cliffs, N.J.: Prentice Hall, 1980):p. 31, Figure 3-1.

In addition to identifying its unique function, Nightingale also provided nursing with the opportunity to carve out its own professional niche within the health care system. She did this by defining the nursing role as separate, but no less important, than that of physicians. An example will help clarify this point. Imagine a patient entering the health care system with an inflamed appendix. It is the physician's responsibility to diagnose and treat the disease, in this case through surgery to remove the diseased part. From the Nightingale perspective, once surgery has been completed, the physician begins his progressive withdrawal as primary provider. It is the nurse's role to assume responsibility for providing the curative environment where post-operative patients can regain optimum health.¹

Florence Nightingale thus made two primary contributions to nursing. She was the first to identify the foremost function of nursing--provision and maintenance of an environment where the natural healing process could progress unencumbered by unsanitary and noxious menaces to recovery. Her second contribution was to distinguish the nursing role from the physician's role. While not disparaging the physician, she predated the development of the modern concept of team medicine by treating recovery from disease as a

¹Gertrude Torres, "Florence Nightingale," in Nursing Theories, ed. Julia B. George (Englewood Cliffs, N.J.: Prentice Hall, 1980), p. 29.

process, a process in which nurses have a distinguishable and legitimate role to play. But while laying the foundation for development of modern "professional" nursing, Nightingale also planted the seeds for the dilemmas confronting contemporary nursing.

Contemporary Nursing

The principle reason Florence Nightingale is still held in high regard by the modern nursing establishment was her insistence that nurses are legitimate and independent providers of health care. But even while she lived, an inherent contradiction in this position was obvious. So long as physicians remain the dominant health care providers, claims to both legitimacy and independence are compromised because nursing continues to be defined as a derivative of doctoring.

One need only turn to a popular dictionary to demonstrate the pervasiveness of the physicians' impact upon the nursing occupation. A nurse is defined as "a person trained to care for the sick or disabled under the supervision of a physician."¹ Davies, in her examination of the relationship between nurses and physicians has observed that "Nurses have frequently been seen as somehow 'less professional' than the doctor, as 'borrowing' his prestige and status, as 'complimenting' his curative orientation with a focus on

¹American Heritage Dictionary, rev. ed. (1976), s.v. "nurse."

more personalized care, his specific obligation with a more diffuse one."¹

Further evidence for the proposition that nurse claims for legitimacy and independence are compromised by physician dominance is provided by an observation with respect to the evolution of the nursing role. Even though medical care has witnessed an elaborate stratification of physicians into specialties and subspecialties as knowledge and technology have expanded, the reigning assumption in hospitals is still that nurses are interchangeable and can readily be rotated among tasks and types of units.²

This secondary status has not gone unnoticed in nursing circles and calls for action have frequently arisen. As early as the 1890's nurses began attempts to exercise "professional" control over the development of their occupation. In 1893, 20 superintendents of the leading nursing schools met at the International Congress of Charities, Correction, and Philanthropy in Chicago. The following year they formed the American Society of Superintendents of Training Schools for Nurses of the U.S. and Canada. In 1912 this group was renamed the National League of Nursing Education, the organization

¹C. Davies, "Comparative Occupational Roles in Health Care," Social Science and Medicine 13A (August 1979):516.

²David Mechanic, Medical Sociology, 2nd ed. (New York: The Free Press, 1978), p. 363.

which continues to exercise control over nurse education. One year after the founding of the nurse educators' association another important gathering took place.¹ The Nurses' Associated Alumnae of the United States and Canada was formed to represent the interests of graduate nurses; in 1911 this group was renamed the American Nurses' Association.²

But these organizations and their modern counterparts are primarily organizations of the elite. That is, their members and leadership tends to be dominated by administrators, educators, and nursing activists. The majority of nurses choose not to seek membership in a nursing professional association.³ Various researchers have attempted to explain the wide diversity of views within the occupation. Habenstein and Christ,⁴ for example, look to the traditional women's role for an explanation. They hold that large numbers of nurses, particularly those with non-baccalaureate

¹Kathleen Cannings and William Lazonick, "The Development of the Nursing Labor Force in the United States: A Basic Analysis," in Organization of Health Workers and Labor Conflict, ed. Samuel Wolfe (Farmingdale, N.Y.: Baywood Publishing Co., 1978), p. 92.

²R. Shryock, The History of Nursing (Philadelphia: Saunders, 1959), p. 219.

³Nadine Furlong, "Group Identity: Nursing Political Sleeping Giant," The Michigan Nurse 59 (October 1981):3.

⁴Robert W. Habenstein and Edwin A. Christ, Professionalizer, Traditionalizer, and Utilizer, 2nd ed. (Columbia: University of Missouri, 1963).

degrees, view nursing as an occupation secondary to their primary role as wife and mother. Because of this orientation, these nurses are held to be less likely to join professional associations or engage in other activities designed to advance the occupation.

While this explanation may account for a nurse's reluctance to support a professional association, another factor may be at work. The nursing associations have since their beginning been divided over the means to advance nursing interests. Consider the plight of the American Nurses' Association. The original charter called for the promotion ". . . of the financial and other interests of the nursing profession."¹ But the means to promote financial interests may be at variance with the means to promote professional interests. The nature of this conflict became most obvious in the 1930's. During the Depression many Americans were forced to cut drastically their expenditures on health care. This in turn resulted in hard times for graduate nurses. The ANA was, at first, reluctant to support calling for a sharing of the available work. At the beginning of the depression it resisted the substitution of an 8-hour day for RN's for the usual 12-hour day on the grounds that, as professionals, their workday was dictated by the need of the patients for service.²

¹G. J. Griffin and G. Griffin, Jensen's History and Trends of Professional Nursing, 6th ed. (St. Louis: C. V. Mosby Co., 1969), p. 116.

²V. Bullough and B. Bullough, The Emergence of Modern Nursing, 2nd ed. (New York: MacMillan, 1969), chapter 5.

The ANA eventually came around to supporting an 8-hour day for nurses but by that time the seeds of new activism had already taken root. Growing numbers of nurses were joining unions and, within the ANA organization, there emerged a vocal minority calling for the ANA to adopt the tactics and philosophy of unionism. In 1937, in response to growing pressure, the ANA recommended that nurses not join unions but rather suggested that "in their professional associations nurses have the instruments best fitted and equipped to improve every phase of their working and professional lives."¹

This call to professionalism, however, was falling on deaf ears. In order to adjust itself to the realities of union competition for membership, the ANA in 1946 officially initiated its Economic Security Program with a policy stating:

The American Nurses's Association believes that the several state and district nurses' associations are qualified to act and should act as the exclusive agents of their respective memberships in the important fields of economic security and collective bargaining. The Association urges all state and district nurses' associations to push such a program vigorously and expeditiously.²

¹D. H. Kruger, "Bargaining and the Nursing Profession," Monthly Labor Review 84 (July 1961):699.

²American Nurses' Association, Major Official Policies Relating to the Economic Security Program (New York: The American Nurses' Association, 1965), p. 1.

In the years following adoption of the Economic Security Program the ANA took a number of collective bargaining-related actions:

- 1950 -- adoption of a "no strike" policy
- 1952 -- by this time 29 state nurses' associations had successfully negotiated 87 agreements covering 199 health care institutions
- 1957 -- 43 state associations had officially accepted the responsibility for the ANA "economic security program"; however, only 17 had active programs
- 1966 -- the "no strike" policy was rescinded
- 1968 -- ANA offered technical labor relations staff assistance to states and districts; however, role of "exclusive agent" remained with the states and districts¹
- 1974 -- ANA affiliates have negotiated 475 contracts covering 65,684 nurses, a number of them with federal and state governments, as well as nonprofit facilities²
- 1975 -- adoption of the "1985 plan." The ANA proposed to split registered nursing into professional and technical levels. The professional nurse would have a bachelor's degree, and would be eligible for administration, supervision, and advanced-practice jobs. The technical nurse would stay at the bedside, with limited opportunities for advancement.
- 1982 -- the ANA's House of Delegates adopted a bylaws revision that changed the ANA from an association of individual members to a federation of state nurses' associations.³

¹G. L. Stumpf, "Labor Relations Among Professional Groups," Journal of the American Dietetic Association 65 (August 1974):138.

²U.S. Department of Labor, Labor-Management Services Administration, Impact of the 1974 Health Care Amendments to the N.L.R.A. on Collective Bargaining in the Health Care Industry, 1979, p. 94.

³The American Nurse 14 (July/August 1982):1

Adoption of the Economic Security Program helped maintain ANA dominance as spokesperson for the nation's nurses, but with passage of the 1974 Health Care Amendments to the NLRA, the ANA has faced increased competition from other unions. Competition from such aggressive unions as the Service Employees International Union, National Union of Hospital and Health Care Employees (District 1199), and the Food and Commercial Workers Union, has placed the ANA on the defensive. The basic dilemma confronted by the ANA is whether it wants to be a professional organization or a labor organization. When the 1974 Amendments extended the NLRA to employees in non-profit hospitals, the newer aggressive unions began to challenge ANA control.

These challenges upset the delicate balance between professional and labor union demands the ANA maintained since 1946. The nature of this balance is important to an understanding of the problems of the ANA, nurses as a group, and other aspiring professionals.

The balance centers around two key questions. First, can the ANA expect hospital management to assist it in its drive to professionalize the occupation? For example, prior to labor law coverage, nurses' associations were regarded by hospital administrators to be complementary rather than competitive organizations. Administrators frequently allowed meetings to be held on employer premises, time off to attend meetings, and payment of association dues directly to the association. Where previously these

cooperative arrangements were made on the assumption of shared mutual interest, current interpretations of labor law consider these bargainable issues, which must be negotiated within the traditional adversarial framework.

A second dilemma concerns potential conflicts within the nursing hierarchy. As a professional association, the ANA has encouraged membership by all nurses without regard to their work responsibilities. But under terms of the NLRA there is a clear distinction made between "employees" and "supervisors". Supervisory employees are by definition not employees and are therefore excluded from representation rights by a recognized labor union. This definitional problem has resulted in a considerable amount of litigation,¹ yet it still is an unsettled question as to what nursing personnel can legally be represented by the professional association when it is a certified bargaining agent.

The contemporary nurse, like her predecessors, is still striving to establish a niche within the community of professional occupations. What is unique about the current situation is the presence of a collective bargaining alternative. Prior to 1974, the majority of nurses, i.e., those employed in non-profit hospitals, were not covered by the NLRA. With the passage of the health care

¹NLRB vs. Annapolis Emergency Hospital Assoc., d/b/a Anne Arundel General Hospital, CA4, No. 76-1116, August 31, 1977.

amendments, the stage was set for a major confrontation between the professionalism vs. unionism models to occupation mobility. Since 1946, the ANA has officially maintained that professionalism and unionism are not only compatible but rather they are complementary. It remains to be demonstrated, however, whether the majority of practicing nurses hold a similar view.

Summary

The information presented above supports the three major assumptions that underlie this study. First, the white collar professional workforce provides fertile ground for new unionization initiatives. Second, while researchers have some insights into why people join unions, we do not necessarily know why people do not join them. The concept of professionalism was explored as a potential contribution to this quest. And third, while no two occupational groups are alike, many of the knowledge occupations are seeking the status and prestige that accompany social sanction as a professional group. With this assumption in mind, registered nurses are given special treatment as a representative of this group of aspiring occupations.

CHAPTER III

RESEARCH HYPOTHESES

Introduction

In Chapter III the hypotheses to be tested in this study are presented. It is possible to categorize the six hypotheses into two sub-classes. The first consists of those suggested by previous empirical studies as being related to attitudes toward collective bargaining. Included in this group are the three hypotheses aimed at testing the relationship between attitudes toward collective bargaining and job satisfaction, age, and level of education.

In the second sub-class of hypotheses are those addressed toward previously less explored areas. These include the relationship between attitudes toward collective bargaining and behavioral intention, level of professionalism, and work-related stress. Each of these variables has previously been discussed in the literature but not within the framework suggested by this study.

Professionalism/Unionism Hypotheses

A major objective of this study is to shed light on a persistent question facing potential white collar union members: Is it possible to be both a union member and a professional simultaneously? A review of the literature reveals that there have been attempts to answer this question, with mixed and sometimes conflicting results. Herman and Skinner¹ in their study of university faculty members reported that fifty percent expressed the view that collective bargaining is inconsistent with professionalism. But they also reported wide differences in views across the various colleges. While the faculty of the College of Engineering considered collective bargaining inconsistent with professionalism, no such conflict was reported by faculty in the two-year colleges. Herman and Skinner explained this variation by recognizing that the term "professional" is subject to different interpretation by different groups of faculty.²

This may explain why Corwin³ approaches the conflict between the two ideologies from a completely opposite perspective. In his

¹E. E. Herman and G. S. Skinner, "A Survey of Faculty Attitudes Toward Collective Bargaining," Industrial Relations Research Association, Proceedings of the Twenty-Eighth Annual Meeting (Madison, Wis.: n.p., 1975):pp. 266-77.

²Ibid. p. 272.

³Corwin, pp. 4-5.

view, unionism serves to advance the professionalization process for teachers. Militant professionalism, i.e., joint action through unionization, is interpreted to be a method through which teachers can gain some control over decision making in schools.

As discussed in Chapter II, this definitional problem surrounding the question of professionalism is no doubt real and influences many occupations in addition to teaching. Engineers, for example, have tried to walk the middle road between unionism and professionalism, with some professional societies actually encouraging the formation of independent unions to represent engineers and scientists.¹ Similarly, as if to anticipate passage of the 1974 Health Care Amendments to the N.L.R.A., a number of health care professional associations have looked upon collective bargaining in a favorable light.² Perhaps the professional association most aggressively confronting the unionism-professionalism conflict is the American Nurses Association (ANA). As early as September 1946 the house of delegates of the ANA initiated the Economic Security Program, a master plan addressing many traditional collective bargaining issues. In the more than thirty years since adoption of the security program, the debate as to

¹Herbert R. Northrup, Unionization of Professional Engineers and Chemists (New York: Industrial Relations Counselors, Inc., 1946):pp. 15-20.

²Pointer, pp. 70-73.

how the expressed goals are to be reached continues, with some groups advocating traditional union tactics and others preferring a less militant and adversarial approach.

To address this potential conflict between professionalism and unionism, two hypotheses are tested in this study.

H1: The more positive a nurse's attitude toward collective bargaining, the lower will be her/his level of professionalism.

H2: The higher a nurse's score on the professionalism scale, the less likely will be her/his behavioral intention to enter into collective bargaining.

The first hypothesis addresses itself to the relationship between attitudes toward collective bargaining and professionalism.

Presumably, if professionalism is inconsistent with unionism, those individuals scoring high on an instrument objectively measuring their level of professionalism will tend to hold negative attitudes toward collective bargaining. A statistically significant inverse correlation between the level of professionalism and favorable attitudes toward collective bargaining will be interpreted as evidence leading to rejection of the null hypothesis.

Hypothesis 2 also addresses itself to the relationship between professionalism and collective bargaining, but it carries the investigation one step further. Whereas previous researchers have generally equated favorable attitudes toward collective bargaining with an increased likelihood that an individual would vote to join a union, the link between attitudes and behavior may not be as strong

as generally assumed. Other researchers have also recognized this problem. Getman, Goldberg, and Herman¹, for example, went through a series of long legal battles in order to secure the actual voting behavior of their subjects.

To maximize the validity of this study and yet circumvent potential legal and methodological problems, actual voting behavior will not be determined. As a proxy measure, subjects will be asked their behavioral intention. Behavioral intention will be determined on the basis of responses to a question designed to evaluate the relative strength of their willingness to exhibit behavior in support of collective bargaining. This measure of behavioral intention is incorporated in order to shed light on the relationship between attitudes and collective bargaining voting behavior. Since previous research by a number of researchers^{2,3,4} has demonstrated that there tends to be a highly significant correlation between actual behavior and behavioral intention in a wide variety of situations, its inclusion should enrich our understanding of voting behavior.

¹J. G. Getman, S. B. Goldberg, and J. B. Herman, Union Representation Elections: Law and Reality (New York: Russell Sage Foundation, 1976).

²Ajzen, p. 10.

³E. A. Locke, "Toward a Theory of Task Motivation and Incentives," Organizational Behavior and Human Performance 3 (May 1968):157-189.

⁴W. H. Mobley, "Intermediate Linkages in the Relationship Between Job Satisfaction and Employee Turnover," Journal of Applied Psychology 62 (April 1977):237-40.

Because behavioral intention is a relatively new construct as applied in the context of collective bargaining, it is necessary to explicate its development and potential contribution to the analysis. The original model incorporating behavioral intention was developed by Fishbein¹ as an extension of Dulany's² "theory of propositional control" to social behavior.

The model can be summarized by the following algebraic expression:

$$B \approx BI = [A\text{-act}]w + [NB(Mc)]w$$

where B = overt behavior; BI = behavioral intention; A-act = attitude toward performing a given behavior in a given situation; NB = normative beliefs; Mc = motivation to comply with the norms; and w = empirically determined weights. The model of potential antecedents of actual behavior is important to this analysis for three reasons.

First, it helps clarify the relationship between attitudes and behavior by specifying the conditions under which attitudes can be assumed to be predictive of overt behavior. This is so because Fishbein's formula defines the relevant attitudes in terms of

¹M. Fishbein, "Attitude and Prediction of Behavior," in Readings in Attitude Theory and Measurement, ed. M. Fishbein (New York: Wiley, 1967), pp. 477-492.

²D. E. Dulaney, "Awareness, Rules, and Propositional Control: A Confrontation with S-R Behavioral Theory," in Verbal Behavior and General Behavior Theory, eds. D. Horton and T. Dixon (Englewood Cliffs, N.J.: Prentice-Hall, 1967)

performing a given behavior in a given situation. Thus in a collective bargaining context, attitudes toward the behavior of actually joining a union is the variable of interest, as opposed to attitudes toward unions in general.

Perhaps an example will help clarify the distinction. According to this model, a researcher attempting to assess an individual's potential for union membership would not utilize an attitude scale with statements of this type: "Labor unions help raise wage levels." Instead the attitude statement would read "Joining a labor union would lead to an increase in my wages." Note the difference between the two statements. The initial statement assesses the individual's attitude toward unions in general; the latter is much more specific, it attempts to measure only those attitudes directly associated with the behavior of interest.

A second reason this formulation is important is because it helps point out that behavior is not merely a function of attitudes. By including a normative component, Fishbein successfully incorporates the social context into the model. This is so because normative beliefs are by definition a group phenomenon. And as the human relationists so clearly demonstrated years ago, behavior in the work place is significantly affected by group norms. Thus it is possible to envision a situation where an individual might hold highly favorable attitudes toward union membership but decide to vote no in a certification election out of fear that a yes vote could result in ostracism from the group.

A third and final reason the Fishbein model is important to this study is its introduction to the concept of behavioral intention. Examination of the algebraic model reveals that behavioral intention is an intermediate variable between actual behavior and its attitudinal and normative antecedents. Recognition of this state of affairs is critical because it forces the researcher into an awareness that behavior does not take place in a static environment. New information and social conditions continually impact upon a person's attitudinal and normative beliefs. The concept of behavioral intention demands recognition of the dynamic. Nonetheless, at any given point in time behavioral intention may be highly correlated with actual behavior.

An example related to this research will help clarify its implication. Assume for a moment that a unionization drive is currently taking place among registered nurses at a local hospital. In the initial stages of the drive, labor law requires at least a 30 percent showing of interest in the appropriate unit before an election will be scheduled. This means, at a minimum, 30 percent of the eligible voters have decided that union membership is appropriate since the recognition cards typically state: "I hereby authorize Local XXXX to represent me for the purpose of collective bargaining with my employer." In effect these individuals have by this action expressed their behavioral intention to vote in favor of union representation. And if the election were held on the same day as the

card signing, there no doubt would be a high correlation between the intent as expressed by the card signing and the overt behavior of joining the union, as expressed by the actual vote. However, in the real world, elections are not held for approximately two months after the recognition cards have been submitted to the NLRB for validation.¹ During this interim period both company and union conduct a campaign to influence the behavioral intention of the participants. To the extent these campaigns are successful, the correlation between the original behavioral intention and actual behavior will be influenced.

Beyond the issues addressed in the first two hypotheses, there are further questions surrounding the decision to embrace collective bargaining. Many possible factors influencing an individual's decision to join a union have been explored in the literature. Placing this research in a multiple regression framework, the dependent variable becomes the actual union vote, or attitudes toward unions. Independent variables have been many, including such factors as personality characteristics, demographic characteristics, job satisfaction, economic concerns, role conflict, role ambiguity, job autonomy, etc. In this study three independent variables will be explored, job dissatisfaction, age and level of education, and occupation stress.

¹Bruce Feldacker, Labor Guide to Labor Law, (Reston, VA: Reston Publishing Co., Inc., 1980), p. 35.

JOB DISSATISFACTION HYPOTHESIS

In the section of Chapter II dealing with micro-sociological explanations for union growth, it was proposed that the emergence of organizational behavior encouraged the search for a new group of variables useful in explaining union growth. One of the earliest variables to emerge as a result of the interaction between traditional collective bargaining research and the new discipline of organizational behavior was job satisfaction.

The initial impetus to study the link between job satisfaction and willingness to join a union may have been the consequence of two factors. First, there is the inherent logic which holds that unions exist in order to redress perceived inequities--inequities with respect to basic job conditions such as wages, working conditions, fringe benefits, supervision, and company policies. From this perspective, job satisfaction is defined in terms of the extent to which a job generates a set of personal outcomes that are perceived as being fair.¹

A second reason for the initial and continued interest in job satisfaction may be the result of Herzberg's work on the relationship between satisfaction and motivation. While much of his work has been

¹William W. Rambo, Work and Organizational Behavior (New York: Holt, Rinehart, and Winston, 1982), p. 209.

criticized, (especially by methodology),¹ he did make a powerful argument that the roots of job satisfaction and job dissatisfaction are located within different areas of work. For students of collective bargaining, recognition of this possibility stimulated a new perspective on the unionization issue. Do people join unions out of dissatisfaction with hygiene factors or because they are not satisfied with motivating factors? For example, if people join unions because they are not experiencing job satisfaction, they are joining in an attempt to secure a sense of job achievement, recognition, responsibility and personal growth. On the other hand, if they are joining as the result of job dissatisfaction, they are concerned about the traditional "bread and butter" issues of organization policies, pay, and job security. The condition to be drawn from this observation is similar to Herzberg's position with respect to the link between hygiene factors and motivation. Just as high pay, good working conditions, and job security may not be enough to assure motivated nurses, they also may not be enough to assure non-unionized nurses.

The cross fertilization resulting from the association of collective bargaining and organization behavior perspectives has resulted in a number of interesting studies examining the

¹Robert J. House and Lawrence A. Wignor, "Herzberg's Dual-Factor Theory of Job Satisfaction and Motivation: A Review of the Evidence and a Criticism," Personnel Psychology 20 (Winter 1967):369-89.

relationship between job satisfaction and willingness to support and/or join unions. Although definitional problems with the construct of satisfaction (see Chapter IV for a full discussion) have muddied the waters somewhat, these studies generally conclude that dissatisfied workers are likely to exhibit pro-union attitudes and behaviors.

For example, Allutto and Belasco¹ demonstrated that dissatisfaction with the behaviors and attitudes thought to be necessary for career advancement ranked as a major contributor to the emergence of attitudinal militancy for nurses and teachers. Getman, Goldberg and Herman,² from their intensive study of union election campaigns, reported a substantial and significant ($r = -.5; p < .01$) correlation between voting for a union and an employee's total job satisfaction. Hammer and Smith, in a longitudinal study of 87,740 salaried clericals, sales, and technical employees, concluded ". . . it does appear that job-related attitude items that measure the degree of dissatisfaction employees have with their work setting can predict the degree of success a union will have in gaining the

¹Alutto, pp. 216-27.

²Julius G. Getman, Stephen B. Goldberg, and Jeanne B. Herman, Union Representation Elections: Law and Reality (New York: Russell Sage Foundation, 1976).

support of a majority of a potential bargaining unit."¹ And finally, Schriesheim² in a carefully constructed study where actual voting behavior was known, reported a highly significant correlation ($r = -.65$; $p < .01$) between dissatisfaction and pro-union voting. These finds therefore, suggest Hypothesis 3:

H3: The greater the degree of overall job dissatisfaction, the more favorable will be attitudes toward collective bargaining.

Age and Level of Education Hypotheses

Previous research has also demonstrated that certain demographic variables may be valuable indicators of collective bargaining sentiments. In most cases these have been examined because they act as surrogate measures of pre-work and life experiences. Among the most frequently examined indicators have been employee socio-economic status, skill level, education, and age. In this research, age and education have been selected as the variables of interest.

Age was chosen for two reasons. First, because age is an increasingly important element in the structure of the

¹W. C. Hammer and E. J. Smith, "Work Attitudes as Predictors of Unionization Activity," Journal of Applied Psychology 63 (August 1978):417.

²Chester A. Schriesheim, "Job Satisfaction, Attitudes Toward Unions, and Voting in a Union Representation Election," Journal of Applied Psychology 63 (October 1978):548-52.

para-professional work force as a consequence of the fact that so many of the representative occupations are of relatively recent origin. This is particularly true in health care, where growth of the para-professional workforce was stimulated by a change in public policy and a large expenditure of public funds that accompanied it.

As a direct result of federal interventions, in the six years between 1964 and 1970 the number of college-based programs in allied health more than doubled; from 1970 to 1973 there was a further increase of 70 percent; and between 1973 and 1975, an additional five percent were added.¹ By 1978 there were more than five million workers employed in the health field. Of these, approximately 66 percent, or more than 3.5 million workers, could in the broadest sense be classified as allied health workers. As a consequence of these relatively recent interventions, we can expect a progressive shift toward a more mature population of para-professional workers.

A second reason for selection of age as a variable of interest is that a review of the literature fails to reveal the presence of a consistent relationship between age and propensity to join a union. Much of the literature tends to support the notion that younger workers are more inclined toward unionization. Hellriegel et al.,² for example, reported that younger teachers were more disposed to

¹U.S. Department of Health, Education, and Welfare, A Report on Allied Health Personnel, DHEW Pubn. No. (HRA) 80-28 (1979).

²Hellriegel, et al., p. 394.

striking. The work of Alutto and Belasco¹ supported this conclusion. They discovered age to be the best single predictor of attitudinal militancy among teachers and nurses. Likewise, in studies of university faculty, Feuille and Blandin² found the age-linked factors of both tenure and organization status inversely related to attitudes toward collective bargaining; and Bigoness³ reported a negative correlation between age and attitudes toward unionism in a similar sample. This observed relationship between age and unions is further supported by the work of Odewahn and Spritzer,⁴ where over three-fourths of the college administrators in their survey agreed that the strongest support for unionism was among the younger faculty members of their institutions.

Nonetheless, the generalization that younger workers tend to be more supportive of unionism is not without its critics. Getman, Goldberg and Herman investigated age as part of a broad group of demographic and job experience variables. They reported, "across elections there were only slight tendencies for employees with similar characteristics and experiences to have similar

¹Alutto, p. 223.

²Peter Feuille and James Blandin, "Faculty Job Satisfaction and Bargaining Sentiments: A Case Study," Academy of Management Journal 17 (December 1974):678-92.

³Bigoness, pp. 228-33.

⁴C. A. Odewahn and A. D. Spritzer, "Administrators' Attitudes Toward Faculty Unions," Industrial Relations 15 (May 1976):212.

dispositions."¹ And further, a recent study of professional engineers by Latta² found that the leading organizers of engineering unionism tended to be older, highly skilled, and well respected. This observation was explained in part by reference to fear of skill obsolescence and the diminishing probability of being promoted to managerial work with increasing age. To test these conflicting positions, Hypothesis 4 states:

H4: The older the nurse, the less favorable will be her/his attitudes toward collective bargaining.

In addition to age, level of education is another demographic variable of interest. As stated previously, observations thus far suggest that more highly educated individuals tend to be more anti-union.³ But much of the research reporting this relationship was conducted prior to the organizing success among teachers and other white collar workers during the 1970's.⁴ That is, much of the work took place when the differences between white and blue collar work were more apparent. More recently Arnowitz has observed

¹Getman, et al., p. 66.

²Latta, p. 35.

³Kornhauser, pp. 224-25.

⁴Albert A. Blum, et al., White Collar Workers (New York: Random House, 1971).

that the white collar-blue collar distinction is increasingly invalid as an indicator of union attitudes.¹

The link between education and union attitudes is of particular interest with respect to nurses. It has already been noted that the American Nurses Association openly endorsed unionism more than 35 years ago. But a number of years before that, the organization was lobbying intensively to raise education requirements. As early as 1919, a committee established under the auspices of the Rockefeller Foundation, published the Goldmark Report on nursing education. The report urged greater standardization in nursing education and recommended that the public be educated as to the true definition of the term nurse, i.e., it should be restricted to describing a professional registered nurse.² Thus the Goldmark Report attempted to do for nurses what the Flexner Report did for physicians almost a decade earlier. While its impact was not nearly as great, it did reinforce the power that educational credentials have assumed in the health care community. In nursing as well as all health-related occupations, educational credentials have assumed utmost importance

¹Lucille Knopf, From Student to RN: A Report of the Nurse Career Pattern Study, U.S. Department of Health and Welfare (Washington, D.C.: Government Printing Office, 1972):1.

²Committee for the Study of Nursing Education (Goldmark Report), Nursing and Nursing Education in the United States (New York: MacMillan, 1923):16.

in channeling people into different levels of the hierarchy and in legitimizing the resulting lines of authority and allocation of job functions.^{1,2}

In the past two decades, RN training has moved increasingly out of hospital-based diploma programs into community and four-year colleges,³ a trend that has continued in recent years. Among all RN's in November 1980, about two-thirds obtained their basic nursing education in diploma programs compared to three-quarters in 1977. About 18 percent held associate degrees in 1980 compared to 11 percent in 1977, and about 17 percent held bachelor's degrees compared to 14 percent in 1977.⁴

These statistics, however, tend to underestimate the impact of education. In nursing, the term "graduate" nurse has long been recognized. Typically it has referred to nurses who have returned to school for advance training. When considering not only basic

¹S. Bowles, "The Integration of Higher Education into the Wage Labor System," Review of Radical Political Economics 6 (Spring 1974):100-33.

²S. Bowles and H. Gintis, "IQ in the U.S. Class Structure," Social Policy 4 (January/February 1973):65-96.

³Kathleen Cannings and William Lazonick, "The Development of the Nursing Labor Force in the United States: A Basic Analysis," in Organization of Health Workers and Labor Conflict, ed. Samuel Wolfe (Farmingdale, NY: Baywood Publishing Co., Inc., 1978).

⁴"Nurses Today--A Statistical Profile," American Journal of Nursing 82 (March 1982):451.

education but education obtained after a nurse is licensed, it was estimated that in 1980, about 18 percent of the nurses held associate degrees, 22 percent held bachelor's degrees, and 55 percent held diplomas. In addition, 5 percent held master's or doctoral degrees.¹ Table 3-1 provides a brief summary of education titles and their sources.

Despite the various paths available in nursing education, the term nurse applies to all licensed RN's, and currently the work roles of members of each group are the same.² This is true even though there are separate licensing examinations for diploma, associate, and bachelor degree nurses.

Research investigating the consequences of these parallel education systems has yielded mixed results. Highriter³ and Davis⁴ have reported that education may affect behavior. McLeore and Hill found that degree nurses tended to have a more democratic orientation toward work, a higher functional orientation, a higher level of consideration for subordinates, and a lower willingness to

¹Ibid p. 451.

²Knopf, p. 1.

³M. E. Highriter, "Nurse Characteristics and Patient Progress," Nursing Research 18 (December 1969):484-500.

⁴B. G. Davis, "The Effect of Levels of Nursing Education on Patient Care: A Replication," Nursing Research 23 (March-April 1977):150-55.

TABLE 3-1

LEVELS AND EDUCATIONAL PROGRAMS IN NURSING

Profession	Length of training	Academic structure	Degree	Certifying bodies	Site of training	Basic skills
Registered nurse-master's degree	5-6 academic years	1-2 years academic interspersed with clinical training in a specialty, e.g., pediatrics or psychiatry. Or, nursing administration or education	M.S., nursing	University standards and NLN	University hospital & community health agencies	More independent responsibility for quality of patient care. Responsibility for staff and patient education
Registered nurse-baccalaureate degree	4 years, and summer sessions	Four years academic interspersed with clinical experience, usually in the last two years.	B.S., nursing	State Board of Nursing, University Standards and NLN	University hospital and health agencies	Psychosocially biologically oriented-concern for total patient and family well-being.

TABLE 3-1
LEVELS AND EDUCATIONAL PROGRAMS IN NURSING (cont.)

Profession	Length of training	Academic structure	Degree	Certifying bodies	Site of training	Basic skills
Registered nurse-diploma	27-36 months	1 year academic 2 years clinical courses and experience.	Diploma granted by hospital	State Board of Nursing and NLN	Hospital	More task oriented e.g., catheterization paracentesis, thoracentesis.
Registered nurse-associate degree	Two years	2 years academic interspersed with clinical experience	Associate degree, nursing	State Board of Nursing and NLN State & Local educational rules and regulations	Junior colleges Hospital	More task-oriented e.g., catheterization paracentesis, thoracentesis

SOURCE: Adapted from Avedis Donabedian et al., Medical Care Chart Book, Bureau of Public Health Economics, University of Michigan, Ann Arbor, 1968.

initiate action for others.¹ Alutto, et al., however, found that regardless of the type of nurse training, subjects did not differ in terms of cognitive commitments to professional nursing, employing organization, and clinical specialties.²

And so, as with the demographic variable of age, the effect of education on attitudes toward collective bargaining is difficult to project. However, since the weight of evidence continues to suggest that lower levels of education tend to accompany pro-union attitudes, Hypothesis 5 states:

H5: Diploma nurses will tend to hold more favorable attitudes toward collective bargaining than their degree nurse counterparts.

Work-Related Stress Hypothesis

An issue of increasing concern to students of health, management, and industrial relations is the impact of stress on

¹S. Dale McLemore and Richard J. Hill, "Role Change and Socialization in Nursing," in A Sociological Framework for Patient Care, eds. Jeannette R. Folta and Edith S. Deck (New York: John Wiley, 1966), pp. 111-22.

²Joseph A. Alutto, Lawrence Hrebiniak, and Ramon Alonso, "A Study of Differential Socialization for Members of One Professional Occupation," Journal of Health and Social Behavior 12 (June 1971): 146.

individuals.^{1,2,3,4} Research has clearly demonstrated that stress is the result of a wide range of factors. Caplan, et al.,⁵ for example, has reported that various features of the work setting-- conflicts with authority structures, overlapping areas of responsibility, and interpersonal conflict--tend to promote greater degrees of occupational stress. As a consequence, Greenwood⁶ estimates that the annual cost of executive stress alone in the United States is between \$10 and \$20 billion. He points out that

¹B. L. Margolis, W. M. Kroes, and R. P. Quinn, "Job Stress: An Untested Occupational Hazard," Journal of Occupational Medicine 16 (October 1974):659-661.

²S. Kasl, "Work and Mental Health," in Work and the Quality of Life, ed. James O'Toole (Cambridge, Mass.: MIT Press, 1974), pp. 61-83.

³J. M. Ivancevich and M. T. Matteson, Stress and Work: A Managerial Perspective (Glenview, Ill.: Scott, Foresman, 1980).

⁴H. Selye, "The Stress Concept and Some of Its Implications," in Human Stress and Cognitions, eds. V. Hamilton and D. M. Warburton (New York: John Wiley and Sons, 1979), pp. 150-52.

⁵R. D. Caplan, S. Cobb, J. F. French, R. J. Harnson, and S. R. Pinnean, Job Demands and Worker Health: Main Effects and Occupational Differences (Washington, D.C.: U.S. Government Printing Office, 1975).

⁶J. W. Greenwood, "Management Stressors," in Reducing Occupational Stress, ed. A. McLean (Washington, D.C.: U.S. Dept. of Health, Education, and Welfare, National Institute for Occupational Safety and Health, 1978).

this figure is higher than the gross revenue of most corporations on the Fortune 500 list. Von Wiegand¹ contends that high levels of stress contribute to the six percent of the workforce suffering from alcoholism. And Cooper and Marshall² report growing evidence of the relationship between high levels of stress and increased risk of coronary heart disease and mental ill health.

While the majority of research on the implications of too much stress has centered upon its potential health consequences, more recent research has attempted to assess its impact on work related behavior. Levi has identified two categories of behavior potentially affected by stress: passive behavior (e.g., resignation, low motivation, indifference to product quality, absenteeism) and active behaviors (e.g., grievances, go-slows, strikes, turnover, reluctance to take on certain jobs).³

In addition to the knowledge that stress influences behavior, it is also known that certain occupational groups work under conditions

¹R. A. Von Wiegand, "The Crucial Role of Management and Labor in Employee Alcoholism Programs," in Occupational Health and Safety Symposia, Symposium presented by the U.S. Dept. of Health, Education, and Welfare (Washington, D.C., Government Printing Office, 1976), p. 41.

²C. L. Cooper and J. Marshall, "Occupational Sources of Stress: A Review of the Literature Relating to Coronary Heart Disease and Mental Health," Journal of Occupational Psychology 49 (March 1976):11-28.

³Lennart Levi, Preventing Work Stress (Reading, Mass.: Addison-Wesley Publ. Co., 1981), p. 75.

of greater stress. Health care facilities in general and hospitals in particular are viewed by their members as highly stressful environments.¹ Marshall in her extensive review of stress amongst nurses identified three attributes of nursing which contribute to its stress-producing potential: (1) as a skilled worker, nurse competence (to heal) is on trial on a daily basis; (2) working with the sick and dying reminds the nurse on a daily basis of her own vulnerability to illness; and (3) the nursing role carries with it a strong sanction against showing symptoms of stress. A central requirement of her role is that she show no signs of stress--maintain detached concern with patients and relatives and remain calm even during emergencies.²

Given the growing amount of interest in work-related stress and its implication, this study investigates the potential relationship between stress and attitudes toward collective bargaining. It is assumed that perceived high levels of stress will contribute to more favorable attitudes toward collective bargaining. Thus, Hypothesis 6 states:

H6: The higher a nurse's level of self-reported work-related stress, the more favorable will be her/his attitudes toward collective bargaining.

¹Caplan, et al. p. 35.

²Judi Marshall, "Stress Amongst Nurses," in White Collar and Professional Stress, eds. C. L. Cooper and J. Marshall (New York: John Wiley and Sons, 1980), p. 21.

An Integrated Model

Figure 3-1 provides a graphical representation of the proposed relationships between possible key determinants surrounding the decision to join a union. As stated in the preceding hypotheses, each item in the top most row of variables--professionalism, job satisfaction, age and level of education, and work-related stress--are postulated to be positively and significantly correlated with favorable attitudes toward collective bargaining.

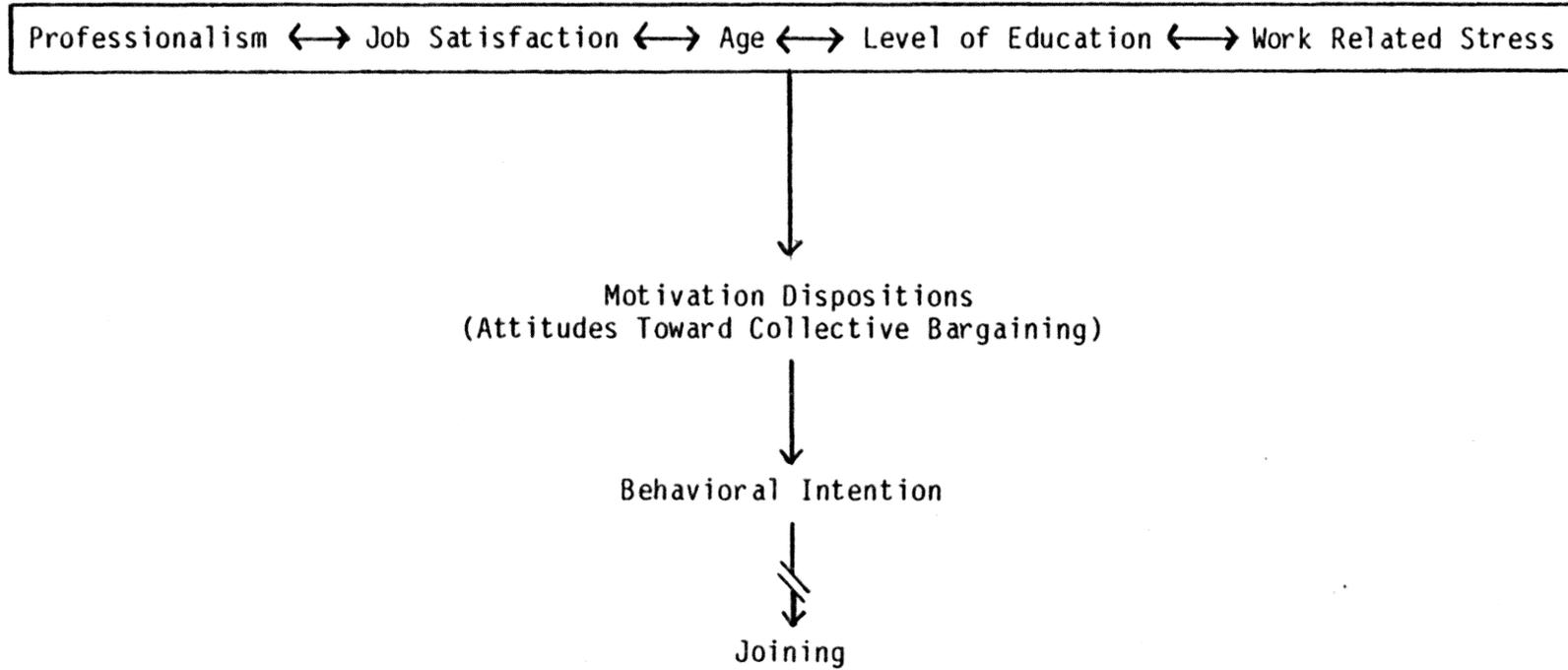
However, as discussed earlier, one of the objectives of this research is to enrich our understanding of actual voting behavior through inclusion of the behavioral intention variable. The broken arrow leading to the actual decision to join is intended to indicate that behavioral intention is, at best, an approximation of actual behavior. It should also be noted that potential intercorrelations exist between the productive variables of interest. Recognition of this possibility is indicated by the dashed lines connecting each variable.

Summary

In this chapter the major hypotheses to be tested in this study are presented. Included with each is a brief discussion of the logic which leads to their development and a graphical representation of their proposed relationship. The hypotheses to be tested can be

FIGURE 3-1

PROPOSED MODEL OF ATTITUDES TOWARD COLLECTIVE BARGAINING AND BEHAVIORAL INTENTION



Paradigm of the factors playing a role in the decision to join a union.

divided into two categories. First, those building directly upon previous research. These include the hypotheses dealing with topics of job satisfaction, age, and level of education. The second category includes those designed to break new ground in the search to explain work-related behaviors. Hypotheses in this group include those dealing with the topics of professionalism, behavioral intention, and work-related stress.

CHAPTER IV

METHODOLOGY

Introduction

The hypotheses developed in the preceding chapter were tested using data collected from a cross-sectional survey distributed to members of a representative para-professional health occupation (registered nurses). The anonymous questionnaire requested self-reports on all variables and was designed to collect primarily attitudinal data. The survey was mailed to the homes of respondents in the states of Virginia and Michigan. Survey responses were variously analyzed by means of Pearson product-moment correlations and multiple regression. Specific details are provided in the following sections.

Data Collection Instrument

The instrument, as originally designed, had three primary divisions, Parts A, B, and C. Part A was divided into two sub-sections: Section 1, the shortened version of the Minnesota Satisfaction Questionnaire (MSQ); and Section 2, a scale designed to measure work-related stress. Part B also consisted of two sub-sections: Section 1, eight items measuring attitudes toward

collective bargaining and a single item to solicit information with respect to behavioral intention; and Section 2, twenty-five items aimed at determining professionalism attitudes. Part C of the instrument was designed to collect a variety of demographic variables including such factors as age, race, work site, and professional association membership status. A complete copy of the original survey can be found in Appendix A.

Pretesting the Instrument

In order to establish the final form of the instrument before the actual data collection phase of the study, a field pre-test of the questionnaire was conducted. Subjects for the pre-test were employed registered nurses in south-western Virginia. Approximately thirty (30) surveys were distributed and eighteen (18) were returned for analysis.

As a direct result of this pre-test various modifications were made to the original questionnaire. In summary they consisted of:

(1) Minor modifications to the work-related stress section of Part A. Five changes were made, examples include: "Unfamiliar situations" changed to "Unfamiliar patient diagnoses" and "Lack of teamwork with other departments" changed to "Lack of teamwork with non-nursing department." All of these changes were intended to clarify wording ambiguities.

(2) A minor change was made in one item in Section 1, Part B, Attitudes Toward Collective Bargaining. Wording of item six (6) of this scale was changed. Originally it read: "Collective bargaining for RN's would serve to encourage the employment of less qualified nursing personnel, eventually resulting in decreased RN job security." Following the words "nursing personnel" an example was inserted in parentheses (e.g., LPN's and nurse aides). This change was made in order to help clarify potential threats to nurse job security.

(3) In Section 2 of Part B there were extensive changes made following the pre-test. Comments by respondents such as "same question", "not clear", and "similar to others mentioned", were frequent enough to indicate a high level of redundancy and confusion. To remedy these problems the original set of 25 items was reduced to 10. It was hoped that this change would reduce confusion and improve response rate. (A complete discussion follows on page 97.)

(4) In Part C of the questionnaire there were also a number of changes. Some items were either dropped or modified in order to both shorten the instrument and react to respondent unwillingness to answer. Items dropped included: spouse's occupation, history of family unionism, and a listing of nurse professional associations. Modifications included the addition of more specific job roles and the deletion of month from tenure questions.

In summary, the final version of the instrument did not change drastically; it remained true to its original intent. As one consequence of these changes it should be noted that the final length dropped from eight to five pages. This change from eight to five pages is felt to have enhanced the response rate of the final sample.

Content of the Instrument

Job Satisfaction

The short form of the Minnesota Satisfaction Questionnaire (MSQ) was used in this study.¹ This instrument is designed to measure satisfaction with more than 20 different job aspects or facets, and has been carefully developed, refined, and validated.^{2,3,4} For

¹D. J. Weiss, R. V. Davis, G. W. England, and L. H. Lofquist, Manual for the Minnesota Satisfaction Questionnaire, Minnesota Studies in Vocational Rehabilitation, no. 22 (Minneapolis: University of Minnesota, 1967).

²E. Betz, D. J. Weiss, R. V. Davis, G. W. England, and L. H. Lafquist, Seven Years of Research on Work Adjustment, Minnesota Studies in Vocational Rehabilitation, no. 20 (Minneapolis: University of Minnesota, 1966).

³B. Gillet and D. P. Schwals, "Convergent and Discriminant Validities of Corresponding Job Descriptive Index and Minnesota Satisfaction Scales," Journal of Applied Psychology 60 (June 1975): 313-317.

⁴R. B. Durham, F. J. Smith, and B. S. Blackburn, "Validation of the Index of Organizational Reactions with the JDI, the MSQ, and Faces Scales," Academy of Management Journal 20 (Fall 1977): 420-32.

this sample the reliability coefficient $\alpha = .867$.¹ Response choices for the MSQ are weighted in the following manner:

<u>Response Choice</u>	<u>Scoring Weight</u>
Very Dissatisfied	1
Dissatisfied	2
Neither	3
Satisfied	4
Very Satisfied	5

Thus, responses are scored 1 through 5 proceeding from left to right on the response form. The short-form actually consists of three scales: Intrinsic, Extrinsic, and General Satisfaction.

Work-Related Stress

To measure work-related stress a slightly modified version of an instrument developed by McKenna and Oritt² was used. It was originally designed for research exploring the relationship between stress and employee turnover in a health care facility. Scales on this instrument reflect the conditions of the working environment (e.g., work load, organization policy, time constraints, adequacy of

¹Cronbach's coefficient alpha is an estimate of test reliability based on item intercorrelations. Alpha can be considered a unique estimate of the expected correlation of one test with an hypothetical alternative form containing the same number of items.

²Jack F. McKenna and Paul L. Oritt, "Occupational Stress as a Predictor of Expected Employee Turnover," Proceedings of the Academy of Management, August 1980.

facilities, etc.) that tend to produce the greatest amount of stress. Test-retest reliability coefficients are reported to range from .72 to .90.

Participating subjects are asked to indicate how stress-producing each of the following conditions are on their job. Responses are indicated on a four point scale ranging from not stress-producing to high stress-producing. Cronbach's alpha for this sample measured .872.

Inadequate Knowledge and Technical Skills

- Unfamiliar patient diagnoses
- Lack of experience and skills
- Lack of knowledge
- Lack of in-service education opportunities
- Unfamiliarity with equipment

Nature of Direct Patient Care

- Decision-making responsibilities
- Routine procedures
- Emergencies
- Uncooperative patients
- Inability to meet patient needs

Interpersonal Conflicts

- Lack of team work with non-nursing departments
- Communication problems
- Staff personality problems
- Unavailability of physicians
- Lack of support from physicians

Physical Working Conditions

- Too many people in workspace provided
- Noisy
- Poor lighting
- Lack of supplies
- Malfunctioning equipment

Management of the Unit

Lack of time
Organization of work (paperwork, interruptions)
Inadequate staffing
Lack of support from nursing administration
Rotating shift scheduling

Attitudes Toward Collective Bargaining

While there has been previous research on attitudes toward collective bargaining for professionals and attitudes toward unions in general, there has been little consistency in instrument design. A generally accepted and rigorously validated instrument is not available. Therefore, an attitude instrument specifically developed for this study was used. The items used in this research were not drawn from any single source. Rather it is an attempt to capture concerns in two areas. The first area taps what might be considered collective bargaining universals, i.e., wages, methods for grievance settlement, impasse resolution, and job security. They are generally labeled blue collar concerns since they are at issue in every collective bargaining relationship.

In addition, a group of so called professional items was included in an attempt to capture what seems to be the special concerns of skilled white collar workers, and in this case nurses in particular. These items were drawn primarily from nursing journal articles where collective bargaining was the topic of interest. These include the desire for autonomy, the desire to provide a public

service, the desire for occupational status and the desire to participate in decision making.

Responses are measured on a five point Likert type scale with "strongly agree" and "strongly disagree" serving as the anchor points.¹ Several items are negatively phrased and reversed scored to reduce response bias. ($\alpha = .822$)

Items on the instrument are:

Blue Collar Concerns

Collective bargaining leads to improved wages for nurses.

An effective and fair grievance procedure is a consequence of collective bargaining for nurses.

Collective bargaining for nurses inevitably leads to strikes.

Collective bargaining for RN's serves to encourage the employment of less qualified nursing personnel (e.g., LPN's and nurse aides), eventually resulting in decreased RN job security.

Professional/Concerns

Collective bargaining is inappropriate for nurses because their work is too unstructured to have employment conditions determined in a collective manner.

Collective bargaining for RN's leads to improved patient care.

¹It should be noted that there is controversy as to whether instruments of this type are actually measuring beliefs or attitudes. Fishbein, for example, argues that attitudes actually have three components, affective (evaluative), cognitive, and conative (action). Further he notes that it is usually only the evaluative or "the affective component" which is measured and treated by researchers as the essence of attitude. Thus the reader should be cognizant of the fact that the attitude scales in this research are open to the criticism that beliefs rather than attitudes are actually being measured.

Collective bargaining is incompatible with the professional status of nursing.

Collective bargaining for registered nurses encourages democratic decision making.

Behavioral Intention

Studies employing measurements of attitudes are confronted with a persistent question: What is the relationship between attitudes and behavior? Recently a number of authors Brannon,¹ Calder & Ross² and Liska³ have addressed this question. Evidence gathered thus far suggests that attitudes are useful for predicting behaviors. Attitudes do in fact tend to produce correspondent behavior. However, this correspondence often does not appear because of other factors that may surround the behavioral situation.

Recognizing this potential inconsistency and the forces that contribute to it, Ajzen & Fishbein⁴ developed the concept of behavioral intention (BI). They hold that a correlation will exist between BI and overt behavior if certain precautions are observed. More precisely, (a) the measure of intention should be specific to a

¹R. Brannon, "Attitudes and the Prediction of Behavior," in Social Psychology: An Introduction, eds. B. Seidenberg and A. Snadowsky (New York: Free Press, 1976), pp. 93-121.

²B. J. Calder and M. Ross, Attitudes and Behavior (Morristown, N.J.: General Learning Press, 1973).

³A. E. Liska, ed., The Consistency Controversy: Readings on the Impact of Attitude on Behavior (New York: John Wiley, 1975).

⁴Ajzen, p. 12.

given behavior and a given situation; and (b) conclusions with respect to the strength of the relationship must be guided by recognition that the greater the time interval between measurement of BI and overt behavior, the weaker the probable correlation.

In this study we are not interested in predicting overt behavior with respect to joining a union. Rather we are interested in evaluating whether union membership is an option to be considered were the opportunity available. Given recognition of this specific purpose, the item intended to measure a nurse's behavioral intention with respect to supporting collective bargaining states:

If a vote were taken tomorrow with the option of voting for collective bargaining representation by a responsible union/association, I would vote in favor of union representation.

Responses are scored on a seven point scale, anchored by the options "extremely likely" and "extremely unlikely".

Professionalism

There is available an extensive amount of literature dealing with the concept of professionalism, but the vast majority of it is either normative or subjective in nature. To date there have been only two serious attempts to derive an empirically based definition of professionalism. The first and best known instrument was

developed by Hall¹ and critiqued and modified by Snizek.² The second, more recent attempt was made by Schriesheim.³ Both approaches share two basic similarities. First, they rely on participant self reports. And second, they treat professionalism as a multi-dimensional construct of similar elements. The single and significant difference is that Schriesheim treats professionalism as a purely attitudinal construct. That is, professionalism is treated as being independent of such structural characteristics as level of education and membership in professional associations.

This need for a purely attitudinal measure of professionalism is particularly important to this study for two reasons. First, there is the heterogeneity of the nursing population. Nurses are likely to work in a wide variety of situations having varying degrees of autonomy. Likewise there is a wide range of educational options and opportunities to enter nursing following careers in unrelated fields. This is in contrast to the more homogeneous populations of traditional professionals like physicians, lawyers, and ministers. And second, we are interested in professionalism in relationship to attitudes toward collective bargaining and behavioral intent. An underlying assumption in this study is that attitudes about

¹Hall, p. 82.

²Snizek, pp. 109-114.

³Schriesheim, p. 9.

professionalism influence attitudes about collective bargaining. Therefore, in order to enhance the validity of the study, measures of like nature should be employed to the extent possible.

Thus the decision was made to use Schriesheim's instrument. However, an immediate problem presented itself. The original scale consisted of 65 items, 13 for each of five dimensions of professionalism. For the initial draft of the survey 25 items from the original Schriesheim scale were selected. The selection was based on both intuitive judgement and statistical guidance. Statistical guidance was available in the form of tables of intercorrelations for each dimension as published in the original study. Those items having the highest intercorrelations were assumed to be most representative of their respective dimension.

Responses of the pretest, however, indicated that even with 25 items the scale was too long. Therefore it was decided to select those items which appeared to have the greatest face validity with respect to the dimension of interest. A total of 10 items representing five dimensions of professionalism appeared on the final form of the instrument. They were:

Commitment

Deciding to work in the occupation I am in was a mistake on my part. (reverse scored)

I would describe myself as having a real dedication to working in my occupation.

Ethics

Codes of ethics are not important for work in my occupation.
(reverse scored)

People in my occupation must never forget that they have a basic duty to do what is best for society.

Autonomy

I would not object to having a supervisor who is not trained in my occupation tell me how to go about my job. (reverse scored)

I should be free to make up my own mind about how to do my job without interference from people who don't have training in my occupation, even if they "outrank" me.

Identification with Profession

I prefer to avoid becoming involved in occupational associations (e.g., ANA).

It is important to me to keep in touch with what is being done by other people in my occupation even if they are not in my organization.

Collegial Maintenance of Standards

No matter what his/her title or position, unless a person is trained in my occupation he is not qualified to evaluate my work performance.

My occupation should be totally responsible for self-control by setting entrance standards and training requirements for persons who wish to practice in the occupation.

Administration

The final form of the survey was mailed to 350 registered nurses in each of two states, Virginia and Michigan. These states were selected in order to enhance the generalizability of the results. The logic behind this rests with the fact that Michigan, as a northern industrialized state has a long tradition of unionism, and

Virginia as a southern border state has a long tradition of general non-support for unionism.

The mailing lists for each state were obtained from their respective licensing boards. From Michigan micro-fiches were available listing the name, address, and license expiration date for every registered nurse in the state. Virginia did not have micro-fiches available and the expensive pre-addressed labels had to be acquired. Cost considerations therefore necessitated pre-selection of specific geographical regions. From Virginia, regions were selected from the eastern and northern sections of the state, in Michigan the south central portion was targeted. An attempt was made to match the two areas on the basis of general economic similarities and the presence of major medical research center, e.g., Richmond in Virginia and Ann Arbor in Michigan. Rural areas were not included because nursing unionism is not an active issue and the skills distribution in the nursing population was thought to be too limited.

Actual mailing began in late November 1982 in Michigan, and approximately two weeks later in Virginia.¹ In an attempt to maximize the return rate, the cover letters for each state carried the logo and return address of a state educational institution. It is impossible to assess the success of this approach but since the opportunity was available, it was considered worth the effort. In

¹See Appendix B and C for samples of actual surveys mailed.

addition to this appeal to state pride, each respondent also received a post card reminder approximately five days after receipt of the survey. With the two assists, from a total of 700 initial surveys, 251 (35.8%) were returned. Of the 251, a total of 191 (76.1%) were usable, yielding a final usable response rate of 27.3%.

This response rate is not exceptional but mailing list quality must be considered. For both states it was impossible to identify active from inactive nurses. In fact, a recent national survey of registered nurses discovered that approximately 25 per cent of licensed nurses are not actively employed.¹ It should also be noted that 32 percent of those who are working, do so on a part time basis. These and other factors no doubt discouraged a higher response rate.

Summary

In this chapter the methodology employed in this research was presented. A brief history of the developmental process leading to creation of the final form of the instrument was furnished. Information concerning pretesting of the instrument was provided along with explanations for the changes from the initial to final

¹"Nurses Today--A Statistical Profile," pp.448-451.

version of the instrument. In addition, each of the various scales used in the survey were discussed in conjunction with the rationale behind their inclusion in the research. The chapter ends with a brief outline of the instrument administration procedures.

CHAPTER V

RESULTS

Introduction

Chapter five reports results obtained from the statistical analysis of the survey data. It begins with an overview of the sample characteristics, providing evidence that the sample can be considered representative of registered nurses nationwide. This evidence is in the form of a comparison of the means and standard deviations of six key demographic variables. Further, it contains both the descriptive and analytical statistics necessary to test the hypotheses developed in chapter three. The principle statistical tools used in the analysis are Pearson product-moment correlations and multiple regression. Correlations are the statistic of choice for examining the research hypotheses. Multiple regression was employed in order to explore the utility of the descriptive model proposed to explain the antecedents of collective bargaining attitudes.

Characteristics of the Sample

Based upon comparison with data published by the American Journal of Nursing, the characteristics of this sample closely parallel those of the general nursing population. Table 5-1 provides

TABLE 5-1
COMPARISON OF SAMPLE TO NATIONAL SURVEY RESULTS

Variable	National Survey (%) ¹	Research Sample (%)
Age Under 25	9.6	6.3
25-29	19.9	18.8
30-34	16.2	17.3
35-39	12.4	15.2
40-44	11.1	17.3
45-49	9.2	6.8
50-54	8.2	7.3
55-59	6.5	8.4
60-64	3.3	2.6
Over 65	1.5	0.0
Marital Status		
Married	70.8	68.3
Single	15.0	18.5
Widowed, divorced, or separated	14.0	12.1
Sex		
Male	97.3	96.3
Female	2.7	3.7
Education		
Diploma	55.0	42.6
Associate	18.0	21.1
Bachelors	22.0	28.9
Graduate	5.0	5.3
Status		
Supervisory/Educational	22.5	31.1
	64.7	68.9
Actively Employed	76.0	76.0

¹Source: "Nurses Today-A Statistical Profile," pp. 448-51.

a summary of some relevant demographic factors. Of those factors for which comparisons are possible, there are no striking departures noted in this sample. It does appear however, that respondents tended to be slightly better educated than the norm (28.9 vs. 22 per cent holding bachelor degrees). Despite this minor variation, these statistics indicate that the sample of nurses examined in this study was representative of registered nurses nationwide. It should also be noted that no significant differences were identified across key variables between sub-samples from the states of Michigan and Virginia. Appendix D presents in table form a comparison of the two states. Failure to discover significant differences across states further enhances claims of representativeness for this sample.

Table 5-2 provides a summary of the means and standard deviations for each of the variables. Examination of these statistics reveals a potential problem with the professionalism scale. The standard deviations both the aggregate professionalism score and each of the sub-scales reveals surprising low levels of variation. For example, approximately 68 percent of the respondents scored between 35.8 and 45.2 out of a potential range of 20 to 50. This clustering of scores at the high end of the scale was apparent in a scattergram analysis and was no doubt a contributing factor to relatively low reliability of the scale. ($\alpha = .579$) Only the

TABLE 5-2
SUMMARY DESCRIPTIVE STATISTICS

Variables	x	S.D.	Valid Cases	Potential Range
Professionalism	40.53	4.66	188	10-50
1. Commitment	8.33	1.59	190	2-10
2. Ethics	8.33	1.62	191	2-10
3. Autonomy	8.12	1.60	191	2-10
4. Identification	7.38	1.70	190	2-10
5. Collegial Maintenance	8.33	1.63	191	2-10
Job Satisfaction	71.68	11.76	180	20-100
Intrinsic	46.94	6.65	188	12-60
Extrinsic	17.93	4.92	183	6-30
Age	38.4	10.32	188	
Education				
1. Diploma	81*			
2. Associate	40			
3. Bachelors	55			
4. Graduate	10			
Work-Related Stress	60.60	12.21	169	25-100
1. Inadequate Knowledge	11.17	3.18	184	5-20
2. Patient Care	12.04	2.64	186	5-20
3. Interpersonal Conflicts	13.12	3.08	184	5-20
4. Physical Working Environment	10.67	3.36	182	5-20
5. Management of Unit	13.41	3.40	179	5-20
Attitude Toward C. B.	24.8	6.58	181	8-40
Professional Component	11.90	3.97	183	4-20
Blue-Collar Component	12.98	3.14	184	4-20
Behavioral Intention	3.82	2.33	189	1-7

*This statistic represents the number of respondents reporting the indicated educational background

professionalism statistics provide cause for concern. The means and standard deviations for each of the other scales indicate no obvious problems and are consistent with expectations.

Hypothesis Testing

In Chapter III the key hypotheses under investigation were developed and stated. Pearsons product moment correlations were used to test these hypotheses. In order to simplify discussion of the finding, the hypotheses along with the appropriate statistics are summarized on Table 5-3.

The decision to accept or reject Hypotheses 1 thru 6 was made on the basis of a significance level of .05. This significance level was selected because of its general acceptability, ease of interpretation, and compatibility with the objectives of this research.¹ In this research the .05 level is utilized as a tool intended to provide a baseline reference point. Consistent with this view the level of significance for each appropriate test is reported. This strategy is consistent with the exploratory nature of this research and has the advantage of permitting statements of acceptance or rejection for the hypotheses of interest. Given this decision

¹J. K. Skipper, Jr., A. L. Genter and Gilbert Nass, "The Sacredness of .05: A Note Concerning the Uses of Statistical Levels of Significance in Social Science," The American Sociologist 1 (February 1967):16-18.

TABLE 5-3

HYPOTHESES

	<u>r</u>	<u>p</u>	<u>Decision</u>	<u>n-size</u>
H1: The more positive a nurse's attitudes toward collective bargaining, the lower will be her/his level of professionalism.	.038	.308	Reject	178
H2: The higher a nurse's score on the professionalism scale, the less likely will be her/his behavioral intention to enter into collective bargaining.	.09	.112	Reject	186
H3: The greater the degree of overall job satisfaction, the less favorable will be attitudes toward collective bargaining.	.042	.294	Reject	172
H4: The older the nurse, the less favorable will be her/his attitudes toward collective bargaining.	-.046	.272	Reject	179
H5: Diploma nurses will tend to hold more favorable attitudes toward collective bargaining than their degree nurse counterparts.	.055	.233	Reject	180
H6: The higher a nurse's level of self-reported work-related stress, the more favorable will be her/his attitudes toward collective bargaining.	.006	.47	Reject	161

criterion, it will be noted that the available evidence will not permit rejection of the null hypotheses for all variable sets of interest.

Stated in another manner, the information collected by this survey suggests that nurse attitudes toward collective bargaining are not significantly related to one's level of professionalism, level of job satisfaction, age, educational background, or perceived level of work-related stress. Further, the rejection of Hypothesis 2 indicates that the level of professionalism has no impact on nurse behavioral intention with respect to union membership. Alternatively stated, there appears to be no significant relationship between one's professional attitudes and willingness to engage in collective bargaining.

These results seem at variance with much of the literature reviewed in Chapters II and III. This is particularly apparent upon closer observation of both the Pearson correlations and their levels of significance. Not only are the correlations exceptionally low (the highest = .09), but the levels of significance are clearly indicative of weak relationships, despite the relatively large sample size.

Viewed in aggregate this set of correlations calls into question many of the generally accepted perceptions with respect to the determinants of attitudes toward collective bargaining, especially in

regards to the para-professional workforce. It would however, be premature to discard variables which have demonstrated their utility in previous research. Rather the next step in the process should attempt to dissect the relevant attributes of each variable and suggest directions for further investigation.

In order to move in this direction two further steps in the analysis are undertaken. First, intercorrelations between all the variables are examined in order to help identify relationships not previously considered. (Table 5-4) Second, correlations are examined between each sub-scale of the key variables, attitudes toward collective bargaining and behavioral intent, in order to investigate the relationship between attitudes and behavioral intent. (Table 5-5) And third, all variables are incorporated into a multiple regression model in an attempt to better describe the precursors of favorable attitudes toward collective bargaining and behavioral intention.

Closer examination of the primary hypotheses reveals that in five of them the dependent variable was attitude toward collective bargaining. In one, Hypothesis 2, the dependent variable was behavioral intention. As part of the literature review the nature of the relationship between attitudes toward collective bargaining and behavioral intention was discussed. It was revealed that according to the model developed by Fishbein, there should be a high but not

TABLE 5-4
MATRIX OF INTERCORRELATIONS

	1	2	3	4	5	6
1. Professionalism						
2. Job Satisfaction	.161 .061 177					
3. Age	.111 .067 185	.181* .008 177				
4. Education	.033 .328 187	-.081 .141 179	-.143* .025 188			
5. Stress	.049 .265 167	-.33*** .001 162	-.193** .006 167	-.051 .256 168		
6. Attitudes toward Collective Bargaining	.038 .308 178	.042 .294 172	-.046 .272 179	.055 .233 180	.006 .47 161	
7. Behavioral Intention	.09 .112 186	-.202** .003 178	-.062 .20 186	.088 .116 180	.177* .011 167	.771*** .001 179

* $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$

TABLE 5-5

CORRELATIONS WITH ATTITUDES TOWARD COLLECTIVE BARGAINING
AND BEHAVIORAL INTENTION

	Attitudes			Behavioral Intention		
	r	p	n	r	p	n
Professionalism						
Total	.038	.308	178	.09	.112	186
Commitment	.014	.429	180	.037	.309	188
Ethics	.068	.182	181	.181**	.006	189
Autonomy	.053	.24	181	.03*	.339	189
Identification	.076	.156	180	.103	.079	180
Collegial Maintenance	.068	.182	181	.181*	.006	189
Satisfaction						
Total	.042	.294	172	-.202**	.003	178
Intrinsic	.059	.216	178	-.134*	.034	186
Extrinsic	.013	.431	175	-.236***	.001	181
Stress						
Total	.006	.47	161	.177*	.011	167
Inadequate Knowledge	.009	.456	174	.167*	.012	182
Patient Care	-.076	.16	176	.033	.33	184
Interpersonal Conflicts	.026	.366	175	.164*	.013	182
Physical Working Environment	.074	.167	172	.2**	.004	180
Management of Unit	.004	.478	170	.153*	.021	177
Collective Bargaining Attitudes						
Total				.711***	.001	179
Professional Issues	.946***	.001	181	.737***	.001	181
Blue Collar Issues	.913***	.001	181	.57***	.001	181

*p ≤ .05; **p ≤ .01; ***p ≤ .001

necessarily perfect correlation between them. For the sample the correlation between attitudes toward collective bargaining and behavioral intention was .711 ($p = .001$, $n = 179$), a correlation of the magnitude expected.

This correlation takes an added significance when the data from a series of correlational runs is examined. In Hypothesis 1 a negative relationship between attitudes toward collective bargaining and professionalism was postulated. Likewise in Hypothesis 2 a negative relationship was posited between behavioral intention and professionalism. In neither case was the correlation significant nor in the direction expected. But closer examination of Table 5-5 reveals an interesting paradox. Fishbein's model proposed that attitudes precede behavior. Thus if one holds negative attitudes one would expect a negative behavioral intention. Taking this one step further, if there is a low correlation between professionalism and attitudes toward collective bargaining, there should be an even lower one with behavioral intention.

Such is not the case here, the direction of the correlations is opposite that expected. While still not statistically significant, the data does seem to indicate that professionalism may act independently on attitudes toward collective bargaining and behavioral intention. This observation is further reinforced when

the five sub-scales comprising professionalism are analyzed separately. Again referring to Table 5-5, it will be noted that no component of professionalism was significantly correlated with attitudes toward collective bargaining. Yet there is a significant correlation between behavioral intention and ethics and collegial maintainence of standards, ($r = .181$, $p = .006$, $n = 189$) in both cases.

Despite some problems arising as a result of the relatively poor reliability of the professionalism scale ($\alpha = .579$), there is some further information in need of consideration. A look at Table 5-5 reveals a stronger correlation between behavioral intention and professional collective bargaining issues ($r = .739$, $p = .001$, $n = 181$) than between behavioral intention and blue collar collective bargaining issues ($r = .570$, $p = .001$, $n = 181$). This observation is consistent with the apparent wrong direction and relative magnitude of the correlation between professionalism and behavioral intent. If professional collective bargaining issues are a proportionately larger contributor to behavioral intention, it is less surprising that nurses scoring higher on the professionalism scale also tend to express a greater willingness to actually join a union.

Hypotheses 3 thru 6 also postulated a relationship between attitudes toward collective bargaining and job satisfaction, age, education and work-related stress. Each of the proposed

relationships proved insignificant but as in the case of Hypotheses 1 and 2 a closer look at the data reveals some surprising insights.

Table 5-5 presents a complete correlation matrix between job satisfaction and its components with attitudes toward collective bargaining and behavioral intent. As one would expect given the conclusion to Hypothesis 3, no significant relationship exists between attitudes toward collective bargaining and either intrinsic or extrinsic satisfaction. Significant negative correlations however, are present between general satisfaction, its two sub-components, and behavioral intention. These results therefore suggest the somewhat contradictory conclusion that dissatisfaction is not related to favorable attitudes toward collective bargaining but is related to a positive behavioral intention. In other words, dissatisfied nurses may hold negative or neutral attitudes toward unions and still be willing to join one.

With respect to the relationship of age to attitudes toward collective bargaining and behavioral intention the results of this study are inconclusive, neither of the correlations are significant. It is important however, to note the direction and relative strength of the correlation. Both carry a negative sign indicating that older nurses are less likely to look favorably upon collective bargaining. This is consistent with most of the literature of the subject. The relative strength of the correlations is also informative in that it

may be that older nurses are more willing to express a negative behavioral intention rather than negative attitudes. This tenuous conclusion is based upon the strength of the correlation between age and attitudes toward collective bargaining ($r = -.046$, $n = 179$, $p = .272$) versus that between age and behavioral intention ($r = -.062$, $n = 186$, $p = .20$). In other words, the relative strength these correlations may indicate that despite only moderately negative or neutral attitudes toward collective bargaining, older nurses are still less likely to join unions than younger nurses holding the same attitudes. Age is positively and significantly related to job satisfaction ($r = .181$, $n = 177$, $p = .008$), level of education ($r = -.143$, $n = 188$, $p = .025$) and work related stress ($r = -.193$, $n = 167$, $p = .006$). Thus we are able to conclude that with age the level of job satisfaction tends to increase, there is a greater probability of holding either a diploma or associates degree, and older nurses experience lower levels of work related stress.

The correlation matrix for education is also informative despite the fact that only one correlation is significant (i.e., age and education). For example, there was not a strong correlation between education and professionalism ($r = .033$, $n = 187$, $p = .328$), calling into question the long held assumption that education can be used as a proxy measure for professionalism. The negative direction of the correlation with job satisfaction while not significant does lend

some support to the notion that for nurses there is a discrepancy between the promises of advanced education and the realities of the work place. And the negative sign on the correlation between education and stress is also worth noting since it suggests that higher levels of education may lead to lower levels of stress.

Examination of the relationships between work related stress and attitudes toward collective bargaining and behavioral intention reveals a repeat of the apparent paradox highlighted earlier. Level of stress had no relationship to attitudes toward collective bargaining ($r = .006$, $n = 161$, $p = .470$) but was significantly related to behavioral intent ($r = .177$, $n = 167$, $p = .011$). Thus the conclusion that a stressful work situation may not necessarily lead to favorable attitudes toward unions, but may well result in a higher propensity toward union membership. Table 5-5 also reveals that existence significant relationship between stress and job satisfaction ($r = -.33$, $n = 162$, $p = .001$). Therefore, it is not surprising that both work related stress and job dissatisfaction are both significantly related to behavioral intention.

Evaluating the Model

The discussion thus far has concentrated on the task of finding out which variables are related to attitudes toward collective bargaining and behavioral intention. Having explored these correlations the analysis now turns toward the task of examining the model developed at the end of Chapter III. The statistical procedure

of choice for this purpose was multiple regression. This technique has the twin advantages of being both a descriptive and inferential tool. Descriptive in that the linear dependence of one variable on others is summarized and decomposed. Inferential in that the relationships in the population can be evaluated from examination of the sample data.¹

The first step in the application of this statistical procedure was the stepwise regression of the key variables in the model--job satisfaction, work related stress, professionalism, education and age. The order of inclusion for the variables was decided a priori with guidance provided by the pattern of correlations determined earlier. Table 5-6 summarizes the results of the regression on attitudes toward collective bargaining. Table 5-7 summarizes the results of the regression on behavioral intention.

Examination of the resultant statistics indicates that the relationships proposed in the model (Figure 5-1) are not supported by this data. None of the variables in either model, i.e., one treating attitudes toward collective bargaining as the dependent variable, the other treating behavioral intention as the dependent proved significant. In fact these variables explained less than two percent

¹E. E. Ghiselli, J. P. Campbell, and Sheldon Zedeck, Measurement Theory for the Behavioral Sciences (San Francisco, CA.: W. H. Freeman, 1981).

TABLE 5-6
 REGRESSION RESULTS WITH ATTITUDES TOWARD COLLECTIVE
 BARGAINING AS THE DEPENDENT VARIABLE

Independent Variable	Partial ¹	F	Significance ²	R ²
Satisfaction	.059	1.21	.272	.007
Stress	-.0003	.000	.996	.007
Professionalism	.036	.091	.763	.007
Education	.273	.263	.609	.010 ³
Age	-.043	.565	.453	.014 ³

¹Unstandardized partial regression coefficient

²Significance of partial regression coefficient

³Significance of R² = .845

TABLE 5-7
 REGRESSION RESULTS WITH BEHAVIORAL INTENTION
 AS THE DEPENDENT VARIABLE

Independent Variable	Partial ¹	F	Significance ²	R ²
Satisfaction	-.025	1.88	.173	.017
Stress	.019	1.29	.257	.024
Professionalism	.043	1.12	.29	.034
Education	.169	.853	.357	.039 ³
Age	.109	.309	.579	.041 ³

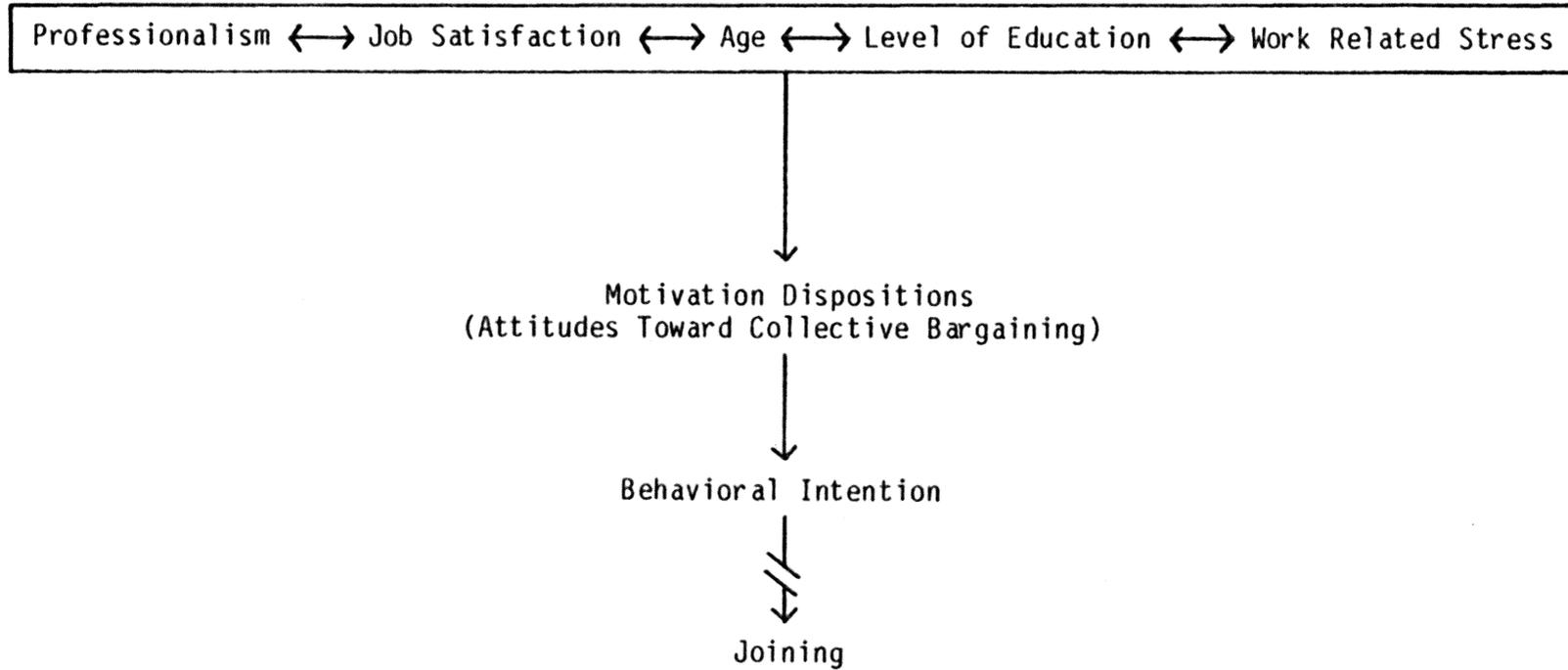
¹Unstandardized partial regression coefficient

²Significance of partial regression coefficient

³Significance of R² = .291

FIGURE 5-1

PROPOSED MODEL OF ATTITUDES TOWARD COLLECTIVE BARGAINING AND BEHAVIORAL INTENTION



Paradigm of the factors playing a role in the decision to join a union.

of the variance ($R^2 = .014$) in the model for attitudes toward collective bargaining and only four percent ($R^2 = .041$) in the model for behavioral intention.

Summary

In this chapter the statistical analysis of the data was presented. Analysis of the data revealed that none of the relationships proposed in the six hypotheses developed in Chapter III were significant. It was, however, revealed that attitudes toward collective bargaining and behavioral intention are two separate and distinct variables.

Further, when multiple regression techniques were used to test the linear relationship of job satisfaction, work related stress, professionalism, education, and age to attitudes toward collective bargaining and behavioral intention only insignificant amounts of the variation in each dependent variable could be explained. This suggests that for registered nurses, and perhaps related occupational groups, new variables will have to be incorporated in future research.

CHAPTER VI

DISCUSSION

Summary

It was the purpose of this study to examine the relationships between collective bargaining, behavioral intention and the variables--level of professionalism, job satisfaction, age, level of education and work related stress. A questionnaire was mailed to a random sample of 700 registered nurses in two states, 191 (27.3%) were suitable for analysis. Comparison of demographic variables from the sample with those of a national study of registered nurses indicated the sample was representative of the population of nurses nation wide.

There were six primary hypotheses to be tested, using Pearson product moment correlations as the test statistic. None of the relationships as proposed in the hypotheses proved significant. That is, favorable attitudes toward collective bargaining were not found to be significantly related to level of professionalism, job dissatisfaction, age, level of reduction and work related stress. Further, no support was found for the hypothesized relationship between level of professionalism and behavioral intent. In other

words, the proposed negative relationship between high levels of professionalism and an expressed unwillingness to join a union was not supported.

Given the ambiguous, yet not unanticipated results, a complete correlation matrix of the key variables in the study was calculated. It was the purpose of this matrix to identify relationships not anticipated in the original design. This matrix identified a set of six significant relationships:

1. a positive correlation between level of professionalism and job satisfaction. ($r = .161$, $n = 177$, $p = .016$)
2. a positive correlation between job satisfaction and age. ($r = .181$, $n = 177$, $p = .008$)
3. a negative correlation between job satisfaction and work related stress. ($r = -.33$, $n = 162$, $p = .001$)
4. a negative relationship between age and level of education. ($r = -.143$, $n = 180$, $p = .025$)
5. a negative correlation between behavioral intent and job satisfaction. ($r = -.202$, $n = 178$, $p = .003$)
6. a positive correlation between work related stress and behavioral intention. ($r = .177$, $n = 167$, $p = .011$)

Unfortunately Pearson correlations do not allow conclusions with respect to causality. As a result it is difficult to draw inferences from the observed relationships. This is especially true regarding finding one and three. In the case of number one, it is just as reasonable to suggest that professionalism leads to higher levels of job satisfaction as it is to propose that job satisfaction leads to higher levels of professionalism. Likewise in finding number three,

in an absence of a well designed longitudinal study it is impossible to say with confidence that satisfaction leads to lower levels of stress or that work related stress results in increased levels of dissatisfaction. Both scenarios are equally legitimate, although the latter seems more plausible.

Such cautious interpretations are not however, as critical with the other observed relationships. For example, number two on the list reports a positive relationship between age and job satisfaction. This clearly indicates that older nurses do tend to be more satisfied than younger nurses. Likewise, the relationship between age and level of education is unambiguous because it is well established that increasing numbers of new nurses are seeking advanced degrees.

Of the observed relationships, numbers five and six on the list are the most interesting. Number five reports a negative correlation between job satisfaction and behavioral intent. Clearly indicating that dissatisfied nurses are more likely to express a willingness to join a union. Likewise, number six demonstrates that higher levels of work related stress are also related to willingness to join a union.

Additionally, these last two correlations are significant for another reason. Neither job satisfaction nor work-related stress are significantly related to favorable attitudes toward collective bargaining. This observation calls into question much of the

research to date, which has used attitudes toward collective bargaining (unions) as a proxy measure for propensity to join unions. This research suggest that when it comes to collective bargaining, decisions attitudes may not be sound predictors of intention with respect to union membership.

Conclusions

It was not the objective of this research to explore uncharted terrain. Rather it was an attempt to re-examine some previous research perspectives and challenge, some long held, but poorly tested assumptions. Modest goals necessarily lead to modest implications and this study is no exception to that rule. Following is a brief summary of the implications in list form.

Professionalism is not related to either attitudes toward collective bargaining or behavioral intent. The results of this research indicate that the long held assumption of professionalism as a major determinant of negative attitudes toward collective bargaining and behavioral intention is of questionable validity. Not only was professionalism found to be unrelated to either attitudes or behavioral intention, it also was to be unrelated to any variable examined in the study. This is not to suggest that professionalism does not influence behavior. Rather it suggests that the approach

used in this study to measure it, one based upon traditional definitions of professionalism, may be inappropriate.

Behavioral intention is a useful construct in collective bargaining research. Unlike attitudes toward collective bargaining, behavioral intention was found to be significantly related to both job dissatisfaction and work related stress. This suggests that researchers be wary of over interpreting favorable attitudes toward collective bargaining as being indicative of a higher propensity toward joining unions. This is not to suggest that actual behavior and attitudes are unrelated. It merely suggests that the psychological distance between attitudes and actual behavior may be greater than previously recognized by industrial relations researchers.

Professionalism, job satisfaction, age, education, and stress are not in aggregate, significantly related to either attitudes toward collective bargaining or behavioral intention. That is, when placed in a multiple regression model these variables explain an insignificant proportion of the variance in measures of both attitudes and behavioral intention. This suggests that future models of this process will have to identify new variables, better capable of explaining collective bargaining sentiments.

Registered nurses may represent a unique and relatively homogenous occupational sub-population with respect to collective

bargaining issues. The failure to find significant relationships for any of the hypotheses tested may be a consequence of the unique occupational culture experienced by registered nurses. A culture shared regardless of their educational or geographic backgrounds. This is so because the hypotheses tested in this study were developed in response to work done with primarily male dominated, production oriented occupations. Nursing, as a uniquely female dominated aspiring profession may possess attributes, heretofore, unrecognized in the literature.

Limitations

Beyond the obvious limitations inherent in the interpretation of any research of this nature, there are some additional points the reader should be appraised of. These limitations can be organized into two broad categories. First, those concerning research design. Second, those concerning the theoretical perspectives which guided its development.

With respect to the design of the study, there were some oversights which had they been recognized earlier, would have enriched the study. They include: (1) The survey instrument did not elicit information on the part-time vs. full-time work status of the respondents. A small number (approximately 10-15) voluntarily indicated their part-time status, but other research indicates that

approximately 32 percent of employed registered nurses work part time. Had it been possible to control for full-time vs. part-time status further analysis of the data would have been possible;

(2) Related to the failure to elicit work status was also the failure to identify the work site. Substantial numbers of nurses work in a variety of non-hospital employment situations, including--public health agencies, physician and dentist offices, student health services, occupational health services, and nursing homes. Just over one-third of all employed registered nurses work in non-hospital sites. Again, had this information been collected the potential for further interpretation of the data would have been enhanced; and

(3) Nurses were probably treated as a too homogenous group with respect to their relative skill levels. Not only is the type of nursing degree important in indicating relative skill level, but work experience, on site training, and personal initiative are also important factors. As with most occupations, within nursing there exists an internal, at times informal, hierarchy which may be a better indicator of actual skill levels. And (4), the response rate of 27% was disappointingly low where compared to other research using nurses as subjects. This low rate is partially excusable due the nature of the mailing list used. Nurses have a tendency to maintain their licenses regardless of their working status and reporting changes of address to the state boards appears to be a relatively low priority item.

The theoretical perspective of this research was biased to the extent that it treated attitudes and behavioral intention as solely the consequences of individual decision making. That is, it failed to consider the social component of the Ajzen and Fishbein's model of reasoned action. The research would have been improved had it contained some measure of group influence.

Inherent in any research relying extensively on attitudinal data is the potential charge that attitudes are unreliable due to their inherent volatility. Had the study collected more hard data on work related issues such as--wage level, hours worked, and conditions of employment--greater confidence could be placed in the final results.

Some of these limitations were relatively minor and could have been corrected without major modification of the survey instrument and research design; others could only have been eliminated through a total restructuring of the research. Nonetheless, it remains that this research has raised some interesting points about the unionization process for a unique occupational group, and should provide the basis for improved research in the future.

Implications

As suggested in the discussion outlining the significance of this research, there are four audiences with potential interest in

the results of this research--academic researchers, health care administrators, labor union organizers, and leaders of professional nursing associations. Perhaps the single most important implication of this research is that nurses do in fact appear to be a unique occupation sub-population. This finding is based both upon the fact that none of the proposed hypotheses proved significant and the relative homogeneity of the sample across geographic regions. The hypotheses tested in this study were developed from a review of the literature where the subjects were primarily male, semi-skilled and working in industries culturally distant from health care. The conclusions reported here suggest that we need to develop new models of collective bargaining behavior; models capable of capturing the unique experiences and concerns of nursing personnel.

More specifically, each of the audiences can individually benefit from consideration of these findings. Academic researchers will be responsible for developing the new theoretical models required. They will need to accept the fact that even the best researched predictor of favorable attitudes toward collective bargaining, job satisfaction, failed when tested with this sample of registered nurses. Academics will also benefit from the introduction of the behavioral intention construct. Behavioral intention will eventually prove to be a consistent component of research of this nature because of its potential for giving a better approximation of actual behavior.

Health care administrators might find particularly useful the findings with respect to work-related stress and education. High levels of work-related stress were found to be associated with increased levels of dissatisfaction, and dissatisfaction was shown to be related to positive behavioral intent with respect to collective bargaining. The fact that level of education was significantly correlated only with age should dispel administrator bias with respect to the stereotyping of nurses based upon their education background. It appears that less educated nurses are no more likely to engage in collective bargaining than their better educated co-workers.

The observation with respect to education is also of importance to labor union and professional association leaders. Organizing campaigns directed at nurses with particular education background are unlikely to yield substantive results. Both labor organizations and professional associations should also note the relative apathy of this audience with respect to collective bargaining. There appears to be no significant tendency toward either pro- or anti-union sentiments. And lastly, leaders of these two groups should be cognizant of the failure of the professionalism scale to demonstrate a significant relationship with any other variable in the study. This research suggests that the concept of professionalism, at least in a collective bargaining context, has no demonstrable effect on

collective bargaining sentiments. Thus appeals to professionalism may be inappropriate when associated with collective bargaining issues.

Future Research

The results of this research indicate that fertile ground remains for studies of like nature in the future. Discussed in the limitations section of this chapter are some changes that would enhance a repeat of the same study. But beyond a simple remodeling of the same study, there are opportunities made apparent as a result of this research. They can be summarized thusly:

(1) As suggested in the literature review, registered nurses are but one occupational group in the process of attempting to enhance their status and prestige. Other health industry occupations experiencing similar pressures include: medical technologists, x-ray technologists, dieticians, and inhalation therapists. The lessons learned in this research could be applied to studies of these additional occupational groups; comparisons between groups would enrich our understanding of the workings of various interest groups within a single industry.

(2) Within nursing and like occupations there is a continuing controversy surrounding the separation of managerial and line

personnel. It would be interesting to explore the consequences of these blurred lines of authority on the potential for unionization.

(3) Because of the difficulty of defining professionalism, as demonstrated by this study, future research should approach professionalism from a less tradition bound perspective. Where previously researchers were primarily interested in examining occupational hierarchies, the emphasis in industrial relations research is to discover the consequences of professionalism on the propensity to join and participate in unions. Future research should approach professionalism from a functionalist perspective; does the individual believe herself/himself to be a professional? If so, what are the consequences of these beliefs.

(4) More research needs to be conducted on the actual consequences of collective bargaining by nurses and related occupations. Ponak in his recent article, "Unionized Professionals and the Scope of Bargaining: A Study of Nurses,"¹ provides a sound beginning for this line of research. The primary question being, to what extent is the rhetoric of professionalism incorporated into contractual outcomes.

¹Allen M. Ponak, "Unionized Professionals and the Scope of Bargaining: A Study of Nurses," Industrial and Labor Relations Review 34 (April 1981):396-407.

(5) Finally, serious research needs to be conducted on the boundary conditions imposed by labor law on the attainment of professional goals through collective bargaining. Because of the difficulties surrounding separation of employee, professional and managerial responsibilities current labor laws may act as a barrier to professionalization through unionization.

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Appendix A
A SURVEY FOR REGISTERED NURSES

PART A

SECTION 1

JOB SATISFACTION

The purpose of this section is to give you a chance to tell how you feel about your present job, what things you are satisfied with and what things you are not satisfied with. On the basis of your answers we hope to get a better understanding of the things individual nurses like and dislike about their jobs.

INSTRUCTIONS: First, READ each statement carefully. Then, THINK about how satisfied you feel about the aspect of your job described by the statement. Next, DECIDE whether you feel (1) Very dissatisfied, (2) Dissatisfied, (3) Undecided or neutral, (4) Satisfied, or (5) Very satisfied with the aspect. Finally, next to the statement circle the number that best reflects your feelings.

- | | |
|--------------------------|--------------------|
| 1 = Very Dissatisfied | 4 = Satisfied |
| 2 = Dissatisfied | 5 = Very Satisfied |
| 3 = Undecided or Neutral | |

BE SURE to answer every statement (do not skip any). Also, do NOT mark more than one answer for any statement. The statements begin below. Please answer each honestly and frankly, to give a true picture of your feelings about your job.

		Very Dissatisfied				Very Satisfied
1. Being able to keep busy all the time	1	2	3	4	5	
2. The chance to work alone on the job	1	2	3	4	5	
3. The chance to do different things from time to time	1	2	3	4	5	
4. The chance to be "somebody" in the community	1	2	3	4	5	
5. The way my boss handles her/his people	1	2	3	4	5	
6. The competence of my supervisor in making decisions	1	2	3	4	5	
7. Being able to do things that don't go against my conscience	1	2	3	4	5	
8. The way my job provides for steady employment	1	2	3	4	5	
9. The chance to do things for other people	1	2	3	4	5	
10. The chance to tell people what to do	1	2	3	4	5	
11. The chance to do something that makes use of my abilities	1	2	3	4	5	
12. The way hospital policies are put into practice	1	2	3	4	5	
13. My pay and the amount of work I do	1	2	3	4	5	
14. The chances for advancement on this job.	1	2	3	4	5	
15. The freedom to use my own judgement	1	2	3	4	5	
16. The chance to try my own methods of doing the job	1	2	3	4	5	
17. The working conditions	1	2	3	4	5	
18. The way my co-workers get along with each other	1	2	3	4	5	
19. The praise I get for doing a good job	1	2	3	4	5	
20. The feeling of accomplishment I get from the job	1	2	3	4	5	

SECTION 2

WORK-RELATED STRESS

This portion of the questionnaire seeks to identify those aspects of your job which cause you to feel stressed. For each of the following phrases ask yourself the question: HOW STRESS-PRODUCING IS THIS CONDITION ON MY JOB? Then, circle the letter which best captures your feelings.

- A = Not stress-producing
 B = Low stress-producing
 C = Medium stress-producing
 D = High stress-producing

	Not	Low	Medium	High
1. Lack of orientation	A	B	C	D
2. Emergencies	A	B	C	D
3. Communication problems	A	B	C	D
4. Routine procedures	A	B	C	D
5. Decision-making responsibilities	A	B	C	D
6. Staff personality conflicts	A	B	C	D
7. Unavailability of physicians	A	B	C	D
8. Inability to meet patient needs	A	B	C	D
9. My Lack of experience and skill	A	B	C	D
10. Unfamiliar situations	A	B	C	D
11. Inadequate workspace	A	B	C	D
12. Organization of work (paperwork, interruptions)	A	B	C	D
13. Lack of support from physicians	A	B	C	D
14. Lack of supplies	A	B	C	D
15. Lack of teamwork with other departments	A	B	C	D
16. Uncooperative patients	A	B	C	D
17. Unfamiliarity with equipment	A	B	C	D
18. Noisy	A	B	C	D
19. Inadequate staffing	A	B	C	D
20. Shift scheduling	A	B	C	D
21. Malfunctioning equipment	A	B	C	D
22. Too many people in workspace provided	A	B	C	D
23. Lack of time	A	B	C	D
24. Poor lighting	A	B	C	D
25. My Lack of knowledge	A	B	C	D

PART 3

SECTION 1

ATTITUDES TOWARD COLLECTIVE BARGAINING

The following questions explore your attitudes toward collective bargaining for registered nurses. Collective bargaining refers to a situation in which the employees join a union for the purpose of representing them in negotiations with the employer over wages, hours and other terms and conditions of employment.

For each statement, circle the number which most closely indicates your feelings. Circle only one number for each statement.

1	2	3	4	5
Strongly Disagree	Disagree Somewhat	Neither Agree Nor Disagree	Agree Somewhat	Strongly Agree

1. Collective bargaining would lead to improved wages for nurses.

1	2	3	4	5
SD				SA

2. Collective bargaining is inappropriate for nurses because their work is too unstructured to have employment conditions determined in a collective manner.

1	2	3	4	5
SD				SA

3. An effective and fair grievance procedure would be a consequence of collective bargaining for nurses.

1	2	3	4	5
SD				SA

4. Collective bargaining for nurses inevitably leads to strikes.

1	2	3	4	5
SD				SA

5. Collective bargaining for RN's would lead to improved patient care.

1	2	3	4	5
SD				SA

6. Collective bargaining for RN's would serve to encourage the employment of less qualified nursing personnel, eventually resulting in decreased RN job security.

1	2	3	4	5
SD				SA

7. Collective bargaining is incompatible with the professional status of nursing.

1	2	3	4	5
SD				SA

8. Collective bargaining for registered nurses would encourage democratic decision-making.

1	2	3	4	5
SD				SA

	Strongly Disagree			Strongly Agree	
11. The only people who should be allowed to influence how I do my job are people who are trained in my occupation.	1	2	3	4	5
12. I prefer to avoid becoming involved in occupational associations.	1	2	3	4	5
13. Work in my occupation is rewarding in more than just a material sense.	1	2	3	4	5
14. I would not object to having a supervisor who is not trained in my occupation tell me how to go about my job.	1	2	3	4	5
15. It is important to me to keep in touch with what is being done by other people in my occupation even if they are not in my organization.	1	2	3	4	5
16. People in my occupation should be responsible for deciding how our work should be performed, rather than lecturing persons without training in the occupation decide.	1	2	3	4	5
17. People in my occupation have a duty to give time and effort (by reviewing new procedures, participating in standard-setting committees, etc.) to make sure that standards of quality in the occupation are maintained.	1	2	3	4	5
18. If I had the opportunity, I would just as soon change my occupation.	1	2	3	4	5
19. It does not really matter to me how well or poorly other people in my occupation do their work, as long as it doesn't directly affect me.	1	2	3	4	5
20. People in my occupation must never forget that they have a basic duty to do what is best for society.	1	2	3	4	5
21. I should be free to make up my own mind about how to do my job without interference from people who don't have training in my occupation, even if they "outrank" me.	1	2	3	4	5
22. I would like to present papers or participate in other ways in activities at meetings of my occupational associations.	1	2	3	4	5
23. My occupation should be totally responsible for self-control by setting entrance standards and training requirements for persons who wish to practice in the occupation.	1	2	3	4	5
24. It does not really matter to me whether or not my work contributes something of value to society.	1	2	3	4	5
25. Occupational associations are not worth very much to me.	1	2	3	4	5



Saginaw Valley State College

Appendix B

Dear Registered Nurse:

I need your help! I am conducting research to investigate the role of the registered nurse in the modern health care delivery system. Through this research I hope to identify more clearly some of the sources of work pressures and evaluate different strategies for improving conditions. This survey is part of that effort.

Your name has been selected at random from a state-wide listing of registered nurses. The number of individuals receiving the survey however is small and your participation is critical to the success of the project. It will take you approximately 15-20 minutes to complete the survey. Please assist me and your fellow health care providers by responding to the following questions and return it to me in the enclosed envelope.

The survey is designed to solicit information from nurses who are presently employed. In the event you are not now actively employed as a nurse please return the blank questionnaire and indicate your current employment situation.

Because of the nature of some of the questions, I want to assure you that all the information you provide will be treated as strictly confidential. Results will be reported on an aggregate basis only; no participating organizations or individuals will be identified.

Sincerely yours,

Paul M. Swiercz, M.P.H.
Research Coordinator

PMS/smr

University Center, Michigan

Phone

or

A SURVEY FOR REGISTERED NURSES

PART A

SECTION 1

JOB SATISFACTION

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5. Decision-making responsibilities	A	B	C	D
6. Staff personality conflicts	A	B	C	D
7. Unavailability of physicians	A	B	C	D
8. Inability to meet patient needs	A	B	C	D
9. Lack of in-service education opportunities	A	B	C	D
10. Unfamiliar patient diagnoses	A	B	C	D
11. Lack of support from nursing administration	A	B	C	D
12. Organization of work (paperwork, interruptions)	A	B	C	D
13. Lack of support from physicians	A	B	C	D
14. Lack of supplies	A	B	C	D
15. Lack of teamwork with non-nursing departments	A	B	C	D
16. Uncooperative patients	A	B	C	D
17. Unfamiliarity with equipment	A	B	C	D
18. Noisy	A	B	C	D
19. Inadequate staffing	A	B	C	D
20. Rotating shift scheduling	A	B	C	D
21. Malfunctioning equipment	A	B	C	D
22. Too many people in workspace provided	A	B	C	D
23. Lack of time	A	B	C	D
24. Poor lighting	A	B	C	D
25. My lack of knowledge	A	B	C	D

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For each statement, circle the number which most closely indicates your feelings. Circle only one number for each statement.

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1	2	3	4	5
SD				SA
2. Collective bargaining is inappropriate for nurses because their work is too unstructured to have employment conditions determined in a collective manner.				
1	2	3	4	5
SD				SA
3. An effective and fair grievance procedure is a consequence of collective bargaining for nurses.				
1	2	3	4	5
SD				SA
4. Collective bargaining for nurses inevitably leads to strikes.				
1	2	3	4	5
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5. Collective bargaining for RN's leads to improved patient care.				
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6. Collective bargaining for RN's serves to encourage the employment of less qualified nursing personnel (e.g., LPN's and nurses' aides), eventually resulting in decreased RN job security.				
1	2	3	4	5
SD				SA
7. Collective bargaining is incompatible with the professional status of nursing.				
1	2	3	4	5
SD				SA
8. Collective bargaining for registered nurses encourages democratic decision-making.				
1	2	3	4	5
SD				SA

9. If a vote were taken tomorrow with the option of voting for collective bargaining representation by a responsible union/association, I would vote in favor of union representation.

likely extremely quite slightly neither slightly quite extremely unlikely
 likely likely likely unlikely unlikely unlikely

SECTION 2

OCCUPATIONAL ITEMS

Here you are asked to describe your attitudes and opinions about several things related to your occupation. There are no right or wrong answers; you are simply asked to provide your own personal opinions about how you see your own occupation. "Occupation" as used here, means not just your specific job with your current employer but the general type of work you see yourself as doing. For example, a "professor of management at Virginia Tech University" would be a specific job, but "college professor" would be an occupation. Similarly, "staff nurse at Riverside Hospital" would be a job, but "nurse" would be an occupation. Please indicate your opinions by circling the number from one to five according to how much you agree or disagree with each statement. Please use the following categories for your answers:

- 1 = Strongly disagree
- 2 = Disagree
- 3 = Neither disagree nor agree
- 4 = Agree
- 5 = Strongly agree

	Strongly Disagree				Strongly Agree
1. Deciding to work in the occupation I am in was a mistake on my part.	1	2	3	4	5
2. No matter what his/her title or position, unless a person is trained in my occupation he is not qualified to evaluate my work performance.	1	2	3	4	5
3. Codes of ethics are not important for work in my occupation.	1	2	3	4	5
4. I would describe myself as having a real dedication to working in my occupation.	1	2	3	4	5
5. I prefer to avoid becoming involved in occupational associations (e.g., AIA).	1	2	3	4	5
6. I would not object to having a supervisor who is not trained in my occupation tell me how to go about my job.	1	2	3	4	5
7. It is important to me to keep in touch with what is being done by other people in my occupation even if they are not in my organization.	1	2	3	4	5
8. People in my occupation must never forget that they have a basic duty to do what is best for society.	1	2	3	4	5
9. I should be free to make up my own mind about how to do my job without interference from people who don't have training in my occupation, even if they "outrank" me.	1	2	3	4	5
10. My occupation should be totally responsible for self-control by setting entrance standards and training requirements for persons who wish to practice in the occupation.	1	2	3	4	5

PART C
GENERAL INFORMATION

This final group of questions does not relate directly to the previous sections, but it provides us information needed to compare your answers with the answers of people like yourself who work for other organizations. Please respond to each question below.

1. Your sex: Male Female
2. What is your age? _____
3. Your race: Black Asian White
 Hispanic American Indian Other: _____
4. What is your occupational title? _____
5. In your present job, are your responsibilities primarily supervisory in nature? Yes No
6. What is your nursing education background?
 Associate degree BSN
 Diploma Masters degree
 Other (please specify; include non-nursing degrees): _____
7. How long have you been employed at your current work site? Years _____
8. How long have you been employed as a registered nurse? Years _____
9. Is your work site: Unionized Non-Unionized
10. Marital Status: Single Married Divorced Widowed
11. Are you a member of a professional nursing association? Yes No
12. Please indicate the type of nursing you currently perform.
 Medical-surgical Operating Room Nursing Educator
 Critical Care Obstetrical Nursing In-service
 Emergency Room Pediatrics Nurse Administrator
 Other: _____
13. What shift do you most frequently work?
 Days _____ Afternoons _____ Nights _____ Rotating _____
14. How long have you been working this schedule?
 Years _____ Months _____
15. Please use the remaining space below for any comments you may have. Thank you for participating in the research project.



Appendix C

COLLEGE OF BUSINESS

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Blacksburg, Virginia 24061

DEPARTMENT OF MANAGEMENT

Dear Registered Nurse:

I need your help! I am conducting research to investigate the role of the registered nurse in the modern health care delivery system. Through this research I hope to identify more clearly some of the sources of work pressures and evaluate different strategies for improving conditions. This survey is part of that effort.

Your name has been selected at random from a state-wide listing of registered nurses. The number of individuals receiving the survey however is small and your participation is critical to the success of the project. It will take you approximately 15-20 minutes to complete the survey. Please assist me and your fellow health care providers by responding to the following questions and return it to me in the enclosed envelope.

The survey is designed to solicit information from nurses who are presently employed. In the event you are not now actively employed as a nurse please return the blank questionnaire and indicate your current employment situation.

Because of the nature of some of the questions, I want to assure you that all the information you provide will be treated as strictly confidential. Results will be reported on an aggregate basis only; no participating organizations or individuals will be identified.

Sincerely yours,

Paul M. Swiercz, M.P.H.
Research Coordinator

PMS/smr

A SURVEY FOR REGISTERED NURSES

PART A

SECTION 1

JOB SATISFACTION

The purpose of this section is to give you a chance to tell how you feel about your present job, what things you are satisfied with and what things you are not satisfied with. On the basis of your answers we hope to get a better understanding of the things individual nurses like and dislike about their jobs.

INSTRUCTIONS: First, READ each statement carefully. Then, THINK about how satisfied you feel about the aspect of your job described by the statement. Next, DECIDE whether you feel (1) Very dissatisfied, (2) Dissatisfied, (3) Undecided or neutral, (4) Satisfied, or (5) Very satisfied with the aspect. Finally, next to the statement circle the number that best reflects your feelings.

- | | |
|--------------------------|--------------------|
| 1 = Very Dissatisfied | 4 = Satisfied |
| 2 = Dissatisfied | 5 = Very Satisfied |
| 3 = Undecided or Neutral | |

BE SURE to answer every statement (do not skip any). Also, do NOT mark more than one answer for any statement. The statements begin below. Please answer each honestly and frankly, to give a true picture of your feelings about your job.

	Very Dissatisfied			Very Satisfied		
	1	2	3	4	5	
1. Being able to keep busy all the time	1	2	3	4	5	
2. The chance to work alone on the job	1	2	3	4	5	
3. The chance to do different things from time to time	1	2	3	4	5	
4. The chance to be "somebody" in the community	1	2	3	4	5	
5. The way my boss handles her/his people	1	2	3	4	5	
6. The competence of my supervisor in making decisions	1	2	3	4	5	
7. Being able to do things that don't go against my conscience	1	2	3	4	5	
8. The way my job provides for steady employment	1	2	3	4	5	
9. The chance to do things for other people	1	2	3	4	5	
10. The chance to tell people what to do	1	2	3	4	5	
11. The chance to do something that makes use of my abilities	1	2	3	4	5	
12. The way hospital policies are put into practice	1	2	3	4	5	
13. My pay and the amount of work I do	1	2	3	4	5	
14. The chances for advancement on this job.	1	2	3	4	5	
15. The freedom to use my own judgement	1	2	3	4	5	
16. The chance to try my own methods of doing the job	1	2	3	4	5	
17. The working conditions	1	2	3	4	5	
18. The way my co-workers get along with each other	1	2	3	4	5	
19. The praise I get for doing a good job	1	2	3	4	5	
20. The feeling of accomplishment I get from the job	1	2	3	4	5	

SECTION 1.

WORK-RELATED STRESS

This portion of the questionnaire seeks to identify those aspects of your job which cause you to feel stressed. For each of the following phrases ask yourself the question: HOW STRESS-PRODUCING IS THIS CONDITION ON MY JOB? Then, circle the letter which best captures your feelings.

- A = Not stress-producing
 B = Low stress-producing
 C = Medium stress-producing
 D = High stress-producing

	Not	Low	Medium	High
1. Lack of orientation	A	B	C	D
2. Emergencies	A	B	C	D
3. Communication problems	A	B	C	D
4. Routine procedures	A	B	C	D
5. Decision-making responsibilities	A	B	C	D
6. Staff personality conflicts	A	B	C	D
7. Unavailability of physicians	A	B	C	D
8. Inability to meet patient needs	A	B	C	D
9. Lack of in-service education opportunities	A	B	C	D
10. Unfamiliar patient diagnoses	A	B	C	D
11. Lack of support from nursing administration	A	B	C	D
12. Organization of work (paperwork, interruptions)	A	B	C	D
13. Lack of support from physicians	A	B	C	D
14. Lack of supplies	A	B	C	D
15. Lack of teamwork with non-nursing departments	A	B	C	D
16. Uncooperative patients	A	B	C	D
17. Unfamiliarity with equipment	A	B	C	D
18. Noisy	A	B	C	D
19. Inadequate staffing	A	B	C	D
20. Rotating shift scheduling	A	B	C	D
21. Malfunctioning equipment	A	B	C	D
22. Too many people in workspace provided	A	B	C	D
23. Lack of time	A	B	C	D
24. Poor lighting	A	B	C	D
25. My lack of knowledge	A	B	C	D

PART 3

SECTION 1

ATTITUDES TOWARD COLLECTIVE BARGAINING

The following questions explore your attitudes toward collective bargaining for registered nurses. Collective bargaining refers to a situation in which the employees join a union for the purpose of representing them in negotiations with the employer over wages, hours and other terms and conditions of employment.

For each statement, circle the number which most closely indicates your feelings. Circle only one number for each statement.

1	2	3	4	5
Strongly Disagree	Disagree Somewhat	Neither Agree Nor Disagree	Agree Somewhat	Strongly Agree

1. Collective bargaining leads to improved wages for nurses.

1	2	3	4	5
SD				SA

2. Collective bargaining is inappropriate for nurses because their work is too unstructured to have employment conditions determined in a collective manner.

1	2	3	4	5
SD				SA

3. An effective and fair grievance procedure is a consequence of collective bargaining for nurses.

1	2	3	4	5
SD				SA

4. Collective bargaining for nurses inevitably leads to strikes.

1	2	3	4	5
SD				SA

5. Collective bargaining for RN's leads to improved patient care.

1	2	3	4	5
SD				SA

6. Collective bargaining for RN's serves to encourage the employment of less qualified nursing personnel (e.g., LPN's and nurses' aides), eventually resulting in decreased RN job security.

1	2	3	4	5
SD				SA

7. Collective bargaining is incompatible with the professional status of nursing.

1	2	3	4	5
SD				SA

8. Collective bargaining for registered nurses encourages democratic decision-making.

1	2	3	4	5
SD				SA

9. If a vote were taken tomorrow with the option of voting for collective bargaining representation by a responsible union/association, I would vote in favor of union representation.

likely extremely quite slightly neither slightly quite extremely unlikely
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SECTION 1

OCCUPATIONAL ITEMS

Here you are asked to describe your attitudes and opinions about several things related to your occupation. There are no right or wrong answers; you are simply asked to provide your own personal opinions about how you see your own occupation. "Occupation" as used here, means not just your specific job with your current employer but the general type of work you see yourself as doing. For example, a "professor of management at Virginia Tech University" would be a specific job, but "college professor" would be an occupation. Similarly, "staff nurse at Riverside Hospital" would be a job, but "nurse" would be an occupation. Please indicate your opinions by circling the number from one to five according to how much you agree or disagree with each statement. Please use the following categories for your answers:

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5. I prefer to avoid becoming involved in occupational associations (e.g., ANA).	1	2	3	4	5
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7. It is important to me to keep in touch with what is being done by other people in my occupation even if they are not in my organization.	1	2	3	4	5
8. People in my occupation must never forget that they have a basic duty to do what is best for society.	1	2	3	4	5
9. I should be free to make up my own mind about how to do my job without interference from people who don't have training in my occupation, even if they "outrank" me.	1	2	3	4	5
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7. How long have you been employed at your current work site? Years _____
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Appendix D

Comparison Across States on Key Variables

	Mean	Std. Dev.	F-Test	Significance	N
Satisfaction					
MI	71.38	12.21	.126	.723	91
VA	71.97	10.01			89
Stress					
MI	59.31	11.81	2.03	.156	88
VA	61.99	12.54			81
Professionalism					
MI	40.35	4.92	.56	.455	93
VA	40.85	4.16			95
Attitudes toward Collective Bargaining					
MI	24.6	6.60	.221	.639	91
VA	25.1	6.61			90
Behavioral Intention					
MI	3.76	2.43	.159	.069	95
VA	3.89	2.23			94
Education					
MI	2.10	1.10	.920	.339	95
VA	1.95	1.01			95
Age					
MI	38.37	9.82	.002	.961	94
VA	38.44	10.85			94

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DETERMINANTS OF REGISTERED NURSE ATTITUDES
TOWARD COLLECTIVE BARGAINING

by

Paul M. Swiercz

(ABSTRACT)

In 1974 Congress amended the National Labor Relations Act to include provisions specifically addressed to labor relations in the health care industry. Early expectations were that rapid union gains would be forthcoming. Those predictions proved incorrect. This study examines some factors which may help explain the unattractiveness of unions for a major segment of the health care para-professional work force i.e., registered nurses. The study was designed to test a number of hypotheses concerning factors which may influence an individual's decision to join a union.

Surveys were mailed to registered nurses in the states of Michigan and Virginia. The final data base consisted of 191 usable responses. Analysis of the data revealed no significant Pearson product moment correlations between attitudes toward collective bargaining and job satisfaction, level of professionalism, degree of work-related stress, and educational background. The survey instrument also included an item designed to measure behavioral

intention. Inclusion of the behavioral intention construct proved valuable, as it provided evidence of the legitimacy of the distinction between attitudes, intention, and actual behavior.

Conclusions of the research suggest that registered nurses may represent a unique occupational group with respect to determinants of their collective bargaining sentiments. And because no discernable differences could be detected between samples from the states of Michigan and Virginia, the research also indicates that these results are applicable to registered nurses nationwide. In addition to determinants of attitudes toward collective bargaining a portion of the study was devoted to analysis of the relationship between professionalism and the work-related outcomes of job satisfaction and stress. Level of professionalism was not found to be significantly related to any of these variables.