DIETITIANS' ATTITUDES TOWARD COLLECTIVE BARGAINING AND UNIONIZATION: AN EMPIRICAL INVESTIGATION

by

Dana Richard Spencer

Dissertation submitted to the Graduate Faculty of the

Virginia Polytechnic Institute and State University

in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

Human Nutrition and Foods

APPROVED:

M. E. Quam, Chairperson

J. A. Phillips

J. W. Robinson

M. R. Bedford

R. E. Webb

July, 1976

Blacksburg, Virginia

DEDICATION

This dissertation is dedicated to my wife, Marilyn, my daughter, Dawn Elizabeth, and my parents, R. Milford and Frances.

ACKNOWLEDGMENTS

The author wishes to express his sincere appreciation to the many individuals who provided encouragement, constructive criticism, and guidance for the production of this dissertation. First, appreciation is expressed to the major professor and chairperson of his advisory committee, Dean Mary E. Quam. Without her personal guidance and encouragement, this study would not have become a reality.

Grateful acknowledgment and appreciation is expressed for the astute suggestions, counsel, and inspiration from Professor Jean A. Phillips. Professors Mary Ruth Bedford, James W. Robinson, and Ryland E. Webb are acknowledged for their efforts as members of the dissertation committee. Appreciative acknowledgment for guidance and constructive criticism in the study is extended to Professors Stephen L. Hayford, Charles Whitman, Robert S. Schulman, and Robert L. King.

Acknowledgment is also extended to Mr. Thomas R. Bowles, Vocational Rehabilitation Specialist, Veterans' Administration, who provided support throughout the study, and Mrs. Marijane Whitescarver for her expert typing.

Finally, but most importantly, I am grateful to my dear wife, Marilyn, for her love and understanding, and especially to my daughter, Dawn Elizabeth, who helped immensely during the mechanical aspects of the study.

TABLE OF CONTENTS

	Page
DEDICATION	ii
ACKNOWLEDGEMENTS	iii
LIST OF TABLES	vi
LIST OF FIGURES	ix
Chapter	
I. INTRODUCTION	1
Background and Significance of the Study	2
Purpose of the Study	3
Definition of Terms	3
II. REVIEW OF LITERATURE	5
Historical Perspectives of Organized Labor	5
Overall Objectives of Organized Labor	8
Federal Labor Legislation	9
Organized Labor: Its Growth and Appeal	12
The Professional	15
Growth of Unions Among Professionals	18
White Collar Professionals	21
College and University Professors	23
Health-Care Professionals	25
Physicians	25
Registered Nurses	26
Professional Dietitians	29
The American Dietetic Association	32
III. PROCEDURE	42
Hypotheses Tested in the Study	42
The Survey Instrument	47
Geographical Areas	50
The Sample Group	50
The Pre-Tested Questionnaire	51
Cover Letter	51
Scoring of the Questionnaire	52
Treatment of Data	53

Page

IV. RESULTS. 54
Survey Response 54
Profile of Respondents. 57
Results of the Tests of Hypotheses 1 through 10 61
Place of Employment. 61
Age. 65
Educational Status 68
Annual Income. 68
Length of ADA Membership 74
Geographical Area. 77
Union Membership 81
Employment Status. 84
Major Job Responsibility 84
Employment Location. 87
Further Tests of Hypotheses. 91
Results of the Tests of Hypotheses 11 through 17. . . . 100
Additional Analysis 103
Sex. 103
Types of Labor Organization Activity 107
Profile of Union Membership. 107
Additional Observations 112

V. SUMMARY AND CONCLUSIONS. 114

VI. RECOMMENDATIONS. 118

LITERATURE CITED. 119

APPENDIX A: DEFINITIONS. 129

APPENDIX B: COVER LETTER AND QUESTIONNAIRE 132

APPENDIX C: GEOGRAPHIC AREAS 140

VITA. 142

LIST OF TABLES

Table		Page
I.	Sample Group Description by State or Location within Six Geographic Areas as Defined by The American Dietetic Association.	55
II.	Profile of Respondents.	58
III.	Frequency Distribution of Respondents Employed Full or Part Time by Major Job Responsibility as Defined Within Place of Employment.	62
IV.	Frequency Distribution of Respondents by Employment Status as Defined Within Their Place of Employment.	63
V.	Mean Collective Bargaining Attitude Scores by Place of Employment	64
VI.	Analysis of Variance for Collective Bargaining Attitude Scores by Place of Employment.	66
VII.	Mean Collective Bargaining Attitude Scores by Age of Respondents.	67
VIII.	Point Multiserial Correlation Coefficient for Collective Bargaining Attitude Scores by Age of Respondents	69
IX.	Mean Collective Bargaining Attitude Scores by Educational Status.	70
X.	Analysis of Variance for Collective Bargaining Attitude Scores by Educational Status	71
XI.	Mean Collective Bargaining Attitude Scores by Present Annual Income	72
XII.	Point Multiserial Correlation Coefficient for Collective Bargaining Attitude Scores by Present Annual Income	73
XIII.	Mean Collective Bargaining Attitude Scores by Length of Membership in The American Dietetic Association	75
XIV.	Point Multiserial Correlation Coefficient for Collective Bargaining Attitude Scores by Length of Membership in The American Dietetic Association.	76

Table		Page
XV.	Mean Collective Bargaining Attitude Scores by Areas and by States or Locations	78
XVI.	Analysis of Variance for Collective Bargaining Attitude Scores by Areas and by States or Locations	80
XVII.	Mean Collective Bargaining Attitude Scores by Union Membership	82
XVIII.	Analysis of Variance for Collective Bargaining Attitude Scores by Union Membership	83
XIX.	Mean Collective Bargaining Attitude Scores by Employment Status	85
XX.	Analysis of Variance for Collective Bargaining Attitude Scores by Employment Status	86
XXI.	Mean Collective Bargaining Attitude Scores by Major Job Responsibility	88
XXII.	Analysis of Variance for Collective Bargaining Attitude Scores by Major Job Responsibility	89
XXIII.	Mean Collective Bargaining Attitude Scores by Employment Location	90
XXIV.	Analysis of Variance for Collective Bargaining Attitude Scores by Employment Location	92
XXV.	Duncan's New Multiple Range Test Applied to Classification Dimensions for Mean Collective Bargaining Attitude Scores	93
XXVI.	t-Test on Statements Regarding Dietitians' Attitudes toward Collective Bargaining	101
XXVII.	Binomial Test on Attitudes of Respondents toward Collective Bargaining	104
XXVIII.	Mean Collective Bargaining Attitude Scores by Sex	105
XXIX.	Analysis of Variance for Collective Bargaining Attitude Scores by Sex	106

Table		Page
XXX.	Participation of Respondents in Labor Organization Activities.	108
XXXI.	Frequency Distribution of Respondents by Union Membership as Defined Within Their Area and State or Location.	109
XXXII.	Profile of Union Members	110

LIST OF FIGURES

Figure		Page
1.	Scatter Diagram for Age of Respondents Plotted Against Grouped Collective Bargaining Attitude Scores.	97
2.	Scatter Diagram for Length of ADA Membership Plotted Against Grouped Collective Bargaining Attitude Scores.	98
3.	Scatter Diagram for Annual Income Plotted Against Grouped Collective Bargaining Attitude Scores.	99

CHAPTER I

INTRODUCTION

Collective bargaining, today, is a well-established facet of contemporary American society. The position that organized labor now enjoys has been earned over a period of time reaching back into United States history. Traditionally, the term "union" was nearly synonymous with unskilled and skilled employees in manufacturing and heavy industry. These individuals had organized together primarily for the purpose of establishing a system of bilateral decision-making with their employers for various job aspects -- wages, hours, and terms and conditions of employment.

Until recently, professionals (including health-care personnel) were not considered or legally able to be potential union members. Professional employees are frustrated with inflation and rising costs coupled with rapid technological and social changes in our society. Today, professionals are in the same position as the mass production employees of the 1930's -- numerous, needed, and often neglected.

Health-care professionals are more receptive to unionization today as a result of the following factors: (1) recent changes in federal and state labor laws, (2) militancy among some health-care professionals, (3) increases in organizational activity by unions and quasi-union organizations, (4) basic changes in the socio-economic conditions of professionals, and (5) acceptance of unions by society in general over the past fifty years (Bunker, 1973). Professional employees are finding increasing levels of bureaucratic control in their

employment, and their career progression is often being controlled by hierarchical levels of non-professionals instead of occurring by a system regulated by their colleagues.

Professional associations which once provided autonomy, unity, and self-regulation in varying degrees for their total membership, are not equipped and sometimes not capable of handling specific individual problems and grievances for their members. Presently, many health-care professionals such as physicians and registered nurses are joining or organizing professional unions or quasi-labor organizations for the purpose of collective action with their employers. Historically, health-care professionals have viewed unionization as unprofessional, relying solely on their individual merit to achieve job-related benefits.

Background and Significance of the Study

Dietitians facing opposing aspirations of other health-care professionals who are employed in the same environment must consider the ramifications of professional unionization to insure growth in status and self-realization for themselves and for other dietitians. Dietitians, who have often been considered more competent in the technical rather than the management and labor relation skills (Miller, 1960), are becoming increasingly aware of their position among other professionals who are considering collective bargaining. A question that is gaining increased importance to The American Dietetic Association membership is whether or not dietitians should adapt the methods of labor organizations as the most efficient means of securing equitable compensation for their services.

There is a dearth of information on dietitians' attitudes toward professional unionization particularly to ascertain the trend and direction professional unionization will take in the future.

A thorough review of literature indicated that there has been limited research regarding the influence of unions upon dietitians in either the public or private sector. This is a crucial issue because changes in the degree of union involvement in professional associations such as The American Dietetic Association can influence the functions of professional groups. It is hoped that this study will add to dietitians' awareness of the impact of unions in the health-care field, thereby assisting The American Dietetic Association in establishing its policies and positions regarding collective bargaining.

Purpose of the Study

The purpose was to investigate the attitudes of professional dietitians toward collective bargaining and unionization and to compare these with the classification and geographic area data. From these data, it was hoped that inferences concerning the dietitian's position regarding professional unionization might be made which would bear substantial implications for all dietitians who are members of The American Dietetic Association.

Definition of Terms

Many of the terms employed in this study are so widely used as not to require redefinition. Selected terms which have specific reference to this study have been defined in Appendix A. In order to promote

ease of reading, two terms have been abbreviated as follows: (1) The American Dietetic Association, ADA; and (2) Collective Bargaining Attitude Scores, CBAS.

CHAPTER II

REVIEW OF LITERATURE

Historical Perspectives of Organized Labor

An historical review of organized labor links many characteristics and techniques of contemporary labor organizations to benevolent societies of carpenters, cordwainers, and printers formed as early as 1771 (BLS, 1964; Robinson and Walker, 1973; Wykstra and Stevens, 1970). Unions were confined at that time to certain geographic areas and therefore exercised limited power and control over regional craftsmen. In upholding the standards within each craft, unions often sought and were credited with supporting higher wages, minimum rates, shorter working hours, enforcement of apprenticeship regulations, and exclusive union hiring policies. The first recorded discussion of workers' demands was between Philadelphia cordwainers and their employers in 1799 (BLS, 1964; Robinson and Walker, 1973; Wykstra and Stevens, 1970).

According to labor historians and researchers (Levy and Sampson, 1962; Robinson and Walker, 1973; Wykstra and Stevens, 1970), trade unions in the United States originated in that period of the eighteenth century cited as the beginning of the Industrial Revolution. However, the full impact of industrialization was not developed until after the Civil War when it became less feasible for proprietors to manufacture products at home. The independent owners of cottage industry products found it increasingly difficult to compete with manufacturers employing manpower in factories with larger productive capabilities.

Levy and Sampson (1962) cited that the industrial workers during the nineteenth century found that they did not have the status, dignity, sense of belonging, and security of others in society. Tannenbaum (1960) described the early industrial employee's plight in the following statement:

> The persistent individualization and isolation of the individual that resulted from the Industrial Revolution made men not merely free, equal, and independent, but by destroying the social texture into which their lives had been woven, made them economically helpless and morally adrift. The element of personal insecurity and isolation lay like pall upon men. . . (Tannenbaum, 1960, p. 55).

In this general background of industrial consolidation and increasing labor discontent, the union movement began to develop. Unions emerged as a means for bringing a measure of individual security into their employment relationships (Beal and Wickersham, 1967). As skilled craftsmen demanded general economic improvements by means of organized unions -- the Knights of Labor (founded in 1869), The National Labor Union (1866), American Federation of Labor (1886), and the Industrial Workers of the World or "Wobblies" (1905) -- the success of anti-union employers, and for that matter the federal government, played a significant role in weakening and disrupting the organization of workers (BLS, 1964; Wykstra and Stevens, 1970). To accomplish this, companies sponsored use of spies, strikebreakers, "yellow-dog" contracts, and even encouraged their own use of counter violence to compensate for the employees' frustrations. Courts were equally as biased against labor and supported the employer's use of injunctions to limit union organization (Wykstra and Stevens, 1970). Hostility of the courts, according to

Wykstra and Stevens (1970), continued through the 1920's resulting in many employees remaining unorganized.

It was not until passage of the Norris-LaGuardia Act in 1932, which limited judicial restriction on strike activity, picketing, and boycotts and forbade the use of "yellow-dog" contracts, that union membership began to increase (Wykstra and Stevens, 1970). Federal and state laws were enacted to provide employees with the right to organize and to bargain collectively free from interference, restraint, and coercion, which Reynolds (1964) cited as unprecedented opportunity in a favorable political and economic climate for union growth.

With the passage of the National Labor Relations Act, the so-called Wagner Act in 1935, and subsequent amendments such as the Taft-Hartley Act passed twelve years later in 1947, a basic code to encourage free collective bargaining was established. The relatively simple contracts of the early twentieth century have evolved into legally elaborate and complex agreements covering such issues as: (1) wages and wage administration; (2) fringe benefits -- holidays, vacations, pensions, and health insurance plans; (3) working conditions, safety, and shop rules; (4) work schedules and transfers; and (5) operative provisions such as grievances and arbitration procedures, seniority, promotion, bargaining units, union security, check off, discipline procedures, and duration of the contract (BLS, 1964; Robinson and Walker, 1973). The above list should not be considered all inclusive as many unions are presently investigating and negotiating many diversified issues and areas such as maternity leave and day-care centers for its members.

Overall Objectives of Organized Labor

Yoder (1970) indicated that the objectives of American Labor unions generally have been:

> (1) to bargain collectively and to expand and increase the scope of the collective bargaining system; (2) to maintain and expand the security and survival capacity of unions; (3) to gain and maintain exclusive control of labor supplies as a means of enforcing union demands; (4) to improve the economic status and welfare of union members; (5) to develop and improve the union's means of controlling the labor environment -- programs, practices, techniques to be used in defense of the organization and in expanding its power; (6) to represent its members in the area of political action, lobbying, and securing political concessions for unions and their members; (7) to maintain strong organization, democratically controlled, however, with enough internal discipline to achieve the forementioned policies; and (8) to facilitate improved understanding of union policies and programs by appropriate educational programs (p. 439).

This greatly elaborated on Beal and Wickersham's (1967) earlier definition of union goals. They found the two basic objectives of American unions to be: (1) to raise their members' standards of living, and (2) to protect members from unilateral arbitrary action by their employers.

Kruger (1964) cited the strongest union goal to be survival, followed by protection of job interests of its members; improvement of wages, hours, and conditions of employment; and lastly, grievance procedures, in this descending order. More recent researchers (Bok and Dunlop, 1970; Robinson and Walker, 1973) ranked grievance procedures and arbitration high on the list of union functions. The decline of strikes, the increasing role of government, and the use of arbitrators have all been factors in the changing functions of unions over the past

thirty years. These factors may well account for the change in priority of union objectives (Tannenbaum, 1965).

Individual bargaining has generally proved ineffective particularly as job changes and working conditions affect others in varying degrees and therefore cannot usually be negotiated by a single individual (Beal and Wickersham, 1967). Chief Justice Charles Evan Hughes, in delivering the opinion of the Supreme Court, NLRB v. Jones and Laughlin Steel Corporation: 1937, stated that unions were essential in creating a bilateral power structure with management. He continued:

> Long ago we stated the reasons for labor organizations. We said that they were organized out of necessities of the situation; that a single employee was helpless in dealing with an employer. . . that the union was essential to give laborers opportunities to deal on equity with their employers.

Federal Labor Legislation

Labor organizations gained strength after the passage of the Norris-LaGuardia Act in 1932. The National Labor Relations Act in 1935, the most significant labor legislation in our nation's history, attempted to equalize both union and management positions under the law. This Act was amended by the Taft-Hartley Act in 1947 and again by the The Labor-Management Reporting and Disclosure (Landrum-Griffin) Act of 1959.

According to Wykstra and Stevens (1970), the National Labor Relations Act is still the basic labor legislation in the United States. Whereas the Norris-LaGuardia Act had removed many of the advantages management held over unions, the National Labor Relations Act specifically ordered employers to stop interferring with union activities,

bargain in good faith, and recognize the union as the sole and exclusive bargaining representative for its employees when so designated by the employees in a specific bargaining unit.

The National Labor Relations Act strengthened the National Labor Relations Board (NLRB) allowing it to investigate, hold hearings, and issue decisions and orders on matters regarding union recognition, unionization of the employment organization, and discrimination by management against union members. Similar policies also applied to unions against employers, and both parties were directed to bargain in good faith (Anderson, 1975; Beal and Wickersham, 1967; Wykstra and Stevens, 1970).

Congress specifically excluded federal employees from the coverage of the Taft-Hartley Act by citing in Section 2(2) that the federal government, any wholly owned government corporation, or any political subdivision was not considered to be an "employer" under the Act (Bunker, 1973). This particular section also excluded non-profit voluntary hospitals by the same provisions of the Act:

> Section 2(2) The term 'employer' includes any person acting as an agent of an employer, directly or indirectly, but shall not include the United States or any wholly owned Government corporation, or any Federal Reserve Bank, or any state or political subdivision thereof, or any corporation or association operating a hospital, if no part of the net earnings inures to the benefit of any private shareholder or individual, or any person subject to the Railway Labor Act, as amended from time to time, or any labor organization (other than when acting as an employer), or anyone acting in the capacity of officer or agent of such labor organization (Wykstra and Stevens, 1970, p. 228).

The NLRB later ruled that it would assert jurisdiction over proprietary

hospitals having gross annual incomes of $250,000 and over proprietary nursing homes having at least $100,000 gross annual incomes (Butte Medical Properties, 1968; University Nursing Home, 1968).

As a result of legislation introduced to Congress between 1949 and 1961, and a task force report in 1961, President John F. Kennedy enacted Executive Order 10988 in 1962. This Executive Order allowed agencies and departments of the federal government to recognize and bargain with their employees. Essentially, the directive provided all federal employees with the right to join or not to join organizations to represent them regarding terms and conditions of employment (Bunker, 1973). In 1969, Executive Order 11491 superceded the 1962 directive, strengthening the original order. In addition, this Order created the Federal Labor Relations Council (FLRC) to administer the government's labor programs and the Federal Impasse Panel to settle deadlocks in public contract negotiations (Bunker, 1973).

By 1971, approximately 23 percent of federal government hospitals had negotiated collective bargaining agreements (Pointer, 1971). In 1974, Hyatt confirmed that almost 50 percent of federal employees belonged to unions; however, nearly one-third of the 3,600 local unions in the federal sector were without bargaining agreements resulting from federal agencies' slowness to negotiate and sometimes refusal to bargain in spite of Executive Orders. Hyatt (1974) predicted a change in this situation as unions place more emphasis on collective bargaining in the public sector area.

In July, 1974, the 1974 Amendment (Public Law 93-360) to the National Labor Relations Act was enacted allowing collective bargaining in health-care institutions (Hallahan, 1974; Stumpf, 1974; Stanton, 1974). The term "health-care institutions" was defined as "...any hospital, convalescent hospital, health maintenance organization, health clinic, nursing home, extended care facility, or other institution devoted to the care of sick, infirm, or aged persons" (Anonymous, 1974c, p. 6).

All nonsupervisory employees including dietitians are presently covered by the National Labor Relations Act in health-care institutions. Professional employees, however, may not be grouped with non-professionals unless, in arriving at the appropriate bargaining unit, a majority of the professionals consent by vote to belong to a non-professional group. During fiscal year 1975, the NLRB received 1,659 representative petitions from the health-care industry with unions winning 62.5 percent of all elections held, a substantial win rate when compared to 50 percent for all other industries (Rosmann, 1975).

Organized Labor: Its Growth and Appeal

Traditionally, management acted unilaterally without consultation with its employees. This often resulted in one-way communication, lack of good faith bargaining, and divergencies between policy and actual practice. Collective bargaining remedied this relationship as it required management to consult with labor, provide impasse procedures, bargain in good faith, and discuss divergencies between policy and practice (Nolte, 1970). The labor-management relationship has become

bilateral, cooperative, and democratic as both parties have come to recognize the need to make the system work to their individual benefit (Nolte, 1970). This labor-management arrangement has significant implications to unorganized employees, whether unskilled or professional, in that it appeals to their individual job-related needs.

As previously cited, employees seek out labor organizations for various reasons. Estey (1967) indicated that union membership has drastically increased since 1930, reaching an all-time high in 1956 of approximately 18 million members. Since 1960, there has been a shift in the labor force from blue-collar to white-collar employee majority. Professional and technical employees, once considered unorganizable by labor organizations, have increased substantially in union membership (Estey, 1967).

Kinney (1969), while not addressing his remarks particularly to health-care professionals, cited the following reasons why individuals investigate and join labor organizations:

> People join unions . . . for many reasons . . . . Voluntary associations with unions come from a desire to improve wages, a desire to have a voice in workplace decisions, a machinery for presenting complaints to management, and to 'belong' to a society of one's peers (p. 11).

In a later study, Demarko (1976) found similar reasons why increasing numbers of individuals join labor organizations, stating that:

> . . . wages are not the only reason why employees turn to collective bargaining. Job security and an effective grievance procedure are two other reasons why employees might seek the help of a union (p. 14).

Studies (Haire, Ghiselli and Gordon, 1967; Lawler and Porter, 1966; Svitlik, Prien and Barrett, 1964) have shown that pay was not related to performance in organizations. Typically, pay related to job level and seniority rather than to performance and merit consideration. Lawler and Porter (1966) discovered negative, and even zero correlations, between pay and supervisory ratings of performance among professional employees when in effect these relationships might be expected to produce higher pay.

Merit consideration, Foster (1961) said, was difficult to define, especially as economic forces substantially increase annually and become perceived by the recipients as a system to maintain pay relationships, and not for individual merit. Employees must first perceive a positive relationship between size of merit provided and their job performance in order to understand the true meaning of merit consideration. For example, Evans (1970) studied members of the Fortune 500 list which included top business and manufacturing firms in the United States. He found that although 93 percent of these organizations claimed to subscribe to merit reward philosophy, the majority did not relate pay to performance.

Douty (1971) stated that professional groups have been concerned with matters such as promotion policies, grievance procedures, and aspects of administration rather than direct compensation. Indirect compensation, sometimes referred to as "fringe benefits", has been classified by Sargent (1963) into the following categories: (1) pay for time not worked; (2) monetary awards and prizes for special activities

and performance; (3) bonuses, contributions, and profit sharing; (4) payments to provide employee security; and (5) practices and services that benefit employees. A partial listing of such benefits might include: (1) overtime and weekend premiums, (2) paid attendance at professional meetings, (3) educational leaves, (4) encouragement and reimbursement for publications in professional journals, (5) disability insurance, (6) retirement pensions, (7) stock purchase plans, (8) flexible working hours, (9) more technical assistance, (10) use of an organizational automobile, and (11) dental care.

Belcher (1974) cited increased industrialization and changes in our modes of living as creating additional risks which are compensated for, perhaps in part, by indirect benefits. Wagner and Bakerman (1960) reported that preferences for either direct or indirect compensation vary widely among employee groups. Some employee groups, including professionals, preferred increases in benefits over wages which indicated to the investigators that preferences may be based on perceived needs rather than on actual monetary increases. Gordon and LeBleu, in 1970, predicted that indirect compensation would reach 50 percent of employer payrolls by 1985 as unions can more readily obtain these benefits for their members than wage increases. Indirect benefits also offer a means of protection against inflation in times of rapidly rising prices (Belcher, 1974).

The Professional

Historically, the professions were limited primarily to physicians, lawyers, and the clergy, who were considered by Cheek (1967) as

"free professions", operating free from bureaucratic and organizational restraints. In recent growing professions such as the sciences, Cheek (1967) found professionals encountering increased organizational control and restraint. Professionals, today, are more apt to identify with their employer rather than a specific occupation; however, according to Cheek, many professionals try to maintain their occupational role as an integral part of their self-conception.

Cheek (1967) indicated that there appears to be little consensus regarding which occupations are "professional". He cited several dimensions between professional occupations based not only on amount and kind of training, but in commitment, status, and working conditions as well. Cogan (1953) offered the following definition of the term "profession":

> 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 practices of the profession are modified by knowledge of a generalized nature and by the accumulated wisdom which serves to correct the errors of specialism. The profession, serving the vital needs of man, considers its first ethical imperative to be altruistic service to the client (p. 48-49).

Thereby, a "professional" is an individual characterized by or conforming to ethical standards of a profession in the service of others.

In accepting this form of fiduciary responsibility toward the client, Garbarino and Aussieker (1975) assumed that the client is incapable of making informed judgments on the qualifications and performance of the professionals. The professionals become the only competent

judges of their members. Professional associations generally certify the competence not only of the individual but often the institution responsible for training. The American Medical Association is an example of this (Garbarino and Aussieker, 1975).

While not all sociologists of occupations agree completely with the listing of characteristics of professionals, Goode (1960) has been recognized as identifying characteristics into basic categories. He suggested that professionals (1) possess knowledge based upon scientific theory, (2) are service oriented, (3) are often legally recognized by some form of licensure, and (4) adhere to norms of practice enforced by the profession (even more stringent than legal controls). In determining the degree of professionalization of an occupation, Seymour (1963) argued that established professions do not always meet all the characteristics; some characteristics are only valid for a few professions. The entrance of technicians who have many characteristics of professionals including a specialized body of knowledge, control over standards and membership, and a code of ethical relationship with others has made the term an exercise in semantics (Seymour, 1963).

In 1945, Hughes identified the factors which contribute to professional solidarity and conscience. These factors were early training in a particular field and the moral unit produced by association with professional societies and organizations. Hughes considered these factors directly antithetical to the bureaucratic concept of strict, vertical, unilateral authority that existed in the marketplace. Professionals were oriented to horizontal collegial authority which provided autonomy and self-regulation to varying degrees (Hughes, 1945). In other

words, professionals gained strength and unity through their collective associations.

Growth of Unions Among Professionals

In the history of the United States, there have been three major periods of union development. The first period, from approximately 1900 to the middle 1930's, reflected unionization of skilled craftsmen; the second period, from the mid-1930's to the 1950's, found semi-and-unskilled employees who were primarily in manufacturing being organized; and the third period starting in the mid-1960's voiced the aspirations of the professional employees (Torrence, 1973; Tyler, 1972). For example, in 1972, Nation's Business reported that many professional employees showed increased interest in either joining unions or converting professional associations into representative units (Anonymous, 1972c).

As many groups became aware of their image as a political force in the latter half of the 1960's, the unionization movement developed for many professional groups. Tyler (1972) stated:

> Equally significant were the millions of employees who belonged to organizations such as the National Education Association, the American Nurses' Association, the various health-care associations, and even those organizations that disclaimed the title of 'union' as these often elect bargaining representatives, negotiate contracts, process grievances, and either strike outright or indulge in the subtle strike known as 'job action' (p. 101).

Mosher (1968) found that there has been a consistent increase in the number of professionals between 1900 and 1960. He stated that while the American labor force increased approximately 123 percent, the number

in professional occupations increased by 485 percent during the same period. Sackley and Gavett (1971) found that among the various factors contributing to the increase in the number of professionals, particularly since 1940, were: (1) a post-war increase in birth rate; (2) increased educational levels and career aspirations; and (3) a prospective increase in the proportion of women and non-whites in professional occupations.

Evans (1964) investigated professionals in the health industry and found the basic conditions present to produce bureaucracy, a factor contributing to growing professional unrest. These conditions were: (1) growth in technology, (2) elaboration of the division of labor, (3) intensification and expansion of types of specialization, and (4) significant increases in the number of individuals in the work setting. Cheek (1967) viewed the emergence of bureaucratic forms of organizations, a reflection of the changes occurring throughout larger society, as tending to tie the professional's role directly to society changes. Etzioni (1964) has aptly characterized the individual's tendency toward a bureaucratic mode of life in the following statement:

> We are born in organizations, educated by organizations and most of us spend much of our lives working for organizations. We spend our leisure time paying, playing, and praying in organizations. Most of us will die in an organization and when the time comes for burial, the largest organization of all, the state must grant official permission (p. 6).

Other researchers (Kelley and Bilek, 1973; Scott, 1965) found employment in bureaucratic organizations to have the effect of decreasing the opportunity of the professional for career progression.

Career progression was viewed as a matter of progressing through hierarchies which were controlled by or shared with non-professional colleagues. Gellerman (1963) indicated that professionals in large bureaucratic organizations band together primarily out of frustration for the following reasons: (1) to reinforce their beliefs and attitudes, (2) to act in common defense against outside pressures, and (3) to share the burden of a dehumanizing institution in order to gain greater self-respect and self-satisfaction.

Garbarino and Aussieker (1975) noted the following:

> Professional associations are organized to deal with conditions affecting an occupation as a whole and have not been concerned with many conditions important to a specific individual who works for a specific employer (p. 45).

While some associations organized their members for reasons of promoting group status in institutional governance, job security, salaries and other economic conditions, individual problems and grievances have not been investigated by professional associations (Garbarino and Aussieker, 1975). Professionalism tends to stress the individualism of the person, leading many professionals to view collective action as unprofessional (Seidman, 1965). Davey (1965) indicated there was nothing unprofessional in improving an individual's economic position if the means of accomplishing this were done in a systematic fashion.

Selden (1969) cited that professional associations were not only responsible for promoting and preserving high standards but also for protecting and fostering the economic, social, and professional status of their members. He warned of the following:

> If an association fails to adequately represent the economic, social, and professional status of its membership, it will ultimately fail to attract members and fail in its attempts to promote high standards of professional conduct and service (p. 7).

White-Collar Professionals

The term "white-collar" includes a wide variety of overlapping occupations ranging from general office and clerical employees to business executives, college faculty members, and physicians. Because of the overlapping nature of this term, white-collar employees will generally refer to executives in business unless otherwise specified in this section.

In 1972, Petersen reported that the fastest growing segment of the labor market was white-collar employees with approximately 39.1 million as compared to 29.6 million blue-collar employees. Between 1960 and 1974, the number of white-collar employees in labor unions, including health-care professionals, increased 56 percent as compared to an approximate 8 percent increase for all other employees in unions (Anonymous, 1974f).

The future and growth of the labor movement, according to an article in Banking Journal (Anonymous, 1974d), rested with the organization of the professional, technical, and white-collar employee. These employees, the article concluded, found that ". . . rationalization, specialization, and computerization have conspired to make large employing organizations separate from employees. . . [with] meaningful participation in the process" (Anonymous, 1974d, p. 12). Loss of

individuality, meaningless job participation, and decline of job participation were factors which encouraged growth of professional white-collar unions (Anonymous, 1974d; Weatherford, 1975). Lipset (1965) cited another reason why professionals organize; standards of accomplishment of professionals may be at odds with the job market and the particular needs of the employer. In other words, the professional is dissatisfied even before he or she enters the job market.

Kelley and Bilek (1974) found that junior and middle level executives have fewer opportunities today to participate in decision- and policy-making processes regardless of their backgrounds in education, job training, or employment experience. As this situation continues to develop, professional dissatisfaction was predicted to turn to either boredom or hostility, referred to by Kelley and Bilek as the four A's: alienation, anomie, anxiety, and apathy. This behavior, the authors concluded, has the ramification of powerlessness, isolation, and meaninglessness among lower level professionals as work tasks appear less satisfying or rewarding or job security decreases. Many tasks have become repetitive and outdated by more efficient technology.

According to the Swedish Confederation of Professional Associations (SCPA, 1959), professional employees often organize as a defensive reaction. They stated:

> It is . . . quite a natural thing in itself that a social group should be compelled to organize in a society in which all other groups are organized. Otherwise it risks being discarded and forgotten. . . (SCPA, 1959, p. 4).

Kassalow (1965) also recognized that as unions grow and expand among professional employees, the prospects of unionism become substantially enhanced for other employee groups who come to accept labor organizations.

College and University Professors

Researchers (Garbarino, 1974; Edmondson and Simon, 1974; Siedman, Kelly and Edge, 1974; Walker, 1974) reported that in institutions of higher learning some faculty members have adapted the methods of trade unions, not only to redress the balance of power between themselves and the administration and trustees, but to give additional weight to their position. Collective bargaining and unionization are becoming increasingly accepted as effective means to settle grievances, as witnessed by union recognition of faculty in states such as New York, Hawaii, and California.

Before 1960, the idea of professional organization in higher education was nearly unthinkable. Until recently, faculty members in two- and four-year institutions were not considered potential union members; however, this has gradually changed as more faculty form and join unions or quasi-unions such as the American Association of University Professors (AAUP), the National Education Association (NEA), and the more militant American Federation of Teachers (AFT). Faculty members, like others in our society, have been frustrated with economic conditions; however, unlike other professionals, they have exerted the least influence to change their economic situation.

Garbarino (1974) found that a total of 326 institutions of higher education had more than 91,000 organized faculty in 1974. About 60 percent of these unionized institutions were two-year community colleges, but the four-year campuses accounted for more than 70 percent of the faculty represented by unions. Aussieker and Garbarino (1973) cited a rapid faculty union growth from 2,600 members in 1966 to 80,000 members in 1973.

According to Robinson (1974), collective bargaining might increase the amount of faculty participation in administrative decision-making. More and more faculty favored collective bargaining because of the following factors: (1) diminished financial status of colleges and universities; (2) stable student enrollment; and (3) an oversupply of professors competing for limited job vacancies. While collective bargaining may introduce some needed reform, Robinson (1974) cautioned that collective bargaining may introduce social costs and a diminution in the quality of higher education. Schramm (1976) reported that faculty resist collective bargaining because of their identification with separate academic disciplines which may not support inter-collective action within a college or university system.

In a survey by Allen (1972), university professors in Kansas were asked to rank their employment compensations. Salaries ranked most important; job tenure and security ranked fourth; reduced teaching loads ranked tenth; and grievance procedures and arbitration ranked sixteenth and seventeenth, respectively. Allen concluded that immediate benefits appeared to be the most important aspect of the surveyed professors' employment.

Health-Care Professionals

Physicians

In the 1960's, physicians' unions were non-existent (Urlich, 1973). By 1975, at least 16,000 physicians belonged to approximately 26 organizations involved in collective bargaining (Bognanno, Dworkin and Omotayo, 1975). In a 1971 survey, three out of five physicians in the United States believed physicians should organize for collective action (Anonymous, 1972c; Marcus, 1975; Paxton, 1972).

Bognanno, Dworkin, and Omotayo (1975) surveyed physicians to determine reasons for joining medical unions. The main reasons cited were: (1) to protect physicians' interests; (2) to support social welfare legislation and various federal, state, and local agencies; and (3) to deal with the socio-economic aspects of their profession not undertaken by the more traditional medical associations. The need for "political clout" and the right to strike was supported by a majority of the respondents to the survey.

As early as 1972, interns and residents, whether independent or affiliated with medical or non-medical unions, were organizing for purposes of collective bargaining (Anonymous, 1972a; Anonymous, 1973). Collective demands of physicians have been varied as witnessed by striking doctors, residents, and interns at Cook County Hospital, Chicago, Illinois (Wiesman, 1975). In the final agreement between the physician's union and The Hospital Governing Commission, the following items were included in the contract: (1) additional interpreters for Spanish-speaking patients, (2) quicker return of X-rays, and (3) better trained personnel for intravenous procedures. Where physician

associations have sought collective bargaining representation, there have been greater successes in increasing salaries and improving hospital care (Anonymous, 1972a).

The American Medical Association, at a 1975 convention in Hawaii, adopted the following policy which opened the way for future collective bargaining among physicians. The policy stated:

> It is appropriate for medical societies to aid, assist, or represent interns and residents and attending physicians individually or collectively in resolving disputes with hospitals and others (Anonymous, 1976a, p. 121).

Registered Nurses

Elementary and secondary school teachers were among the first to accept joining a union, negotiating a contract, dealing through a representative, and striking for wages, hours, and working conditions (Aluto and Belasco, 1974). Nurses have rivaled teachers in collective action and have predominated the health-care field in labor negotiations since the 1950's (Miller, 1971). The American Nurses' Association (ANA), unwilling to assume the complete posture of a labor organization has ". . . donned the trappings of a true labor organization" while fulfilling its professional association obligations (Epstein and Stickler, 1976).

Stumpf (1974), in reviewing the union activities of health-care professionals, cited the following resolution passed at a 1946 convention of the American Nurses' Association:

> ANA believes that the several state and district nurses' associations are qualified to act and should act as exclusive agents of their respective memberships in the

> important fields of economic security and collective bargaining (p. 140).

The American Nurses' Association has had a conflicting history in the area of collective bargaining with the Association passing a "no-strike" policy in 1950 which was rescinded in 1966 (Hershey, 1969). However, by 1968, The Code for Nurses, Article 8, provided for collective negotiations with employers of members over economic conditions and general welfare (Stumpf, 1974). The American Nurses' Association has long recognized its dual-identity problem: (1) providing skills and education to nurses not interested in or participating in collective bargaining; and (2) maintaining the Association's posture and clout in labor negotiations for members desiring recourse against their employers (Epstein and Stickler, 1976).

In the mid-1960's, Kleingartner critically suggested that the majority of nurses were women, and that this factor presented a problem in the drive for collective bargaining. He stated that "women, generally, have not made good collective bargaining material" (Kleingartner, 1967 p. 238). Dewey (1971) acknowledged that women are less inclined to join unions, viewing their work as a temporary phase, either seasonal or supplemental. This has tended to decrease women's interest in some union benefits such as job security, retirement pensions, and representation.

Other researchers have disputed the above (BLS, 1974b; Dewey, 1971; Lyle and Ross, 1973). The Bureau of National Affairs reported that nurses' labor organizations won more representative elections in the first nine months of 1975 than any other unions organizing professional employees (32 wins in 42 elections) (BNA, 1975). Marchak (1973)

surveyed professional employees in British Columbia, Canada, and found that union potential was higher among women than among men. There was a direct relationship between women and union membership as income level and job control increased. In fact, between 1968 and 1970, female union membership in the United States increased 21 percent (Anonymous, 1972d). Kaufman (1970) discovered that in NLRB white-collar representative elections, women did not differ significantly from men in their preference for union representation.

Aluto and Belasco (1974), in a study of professional militancy toward employment, reported that the greater career dissatisfaction of professionals, the more positive attitudes these members had toward professional associations and the more negative attitudes toward strikes and unions. As the professional advanced in age, those that were disenchanted with their career progression turned to their professional associations for relief. The researchers found that the greater the degree of job-related tension experienced by the professionals, the more positive was their evaluation of collective bargaining and unions. These individuals were identified as older, lower seniority employees who were less committed to the organization. Attitudinal militancy among professionals, therefore, suggested three factors: (1) professional occupational characteristics, (2) types of employing institutions, and (3) age (Aluto and Belasco, 1974).

In 1974, the then president of the American Nurses' Association, Rosalund Gabrielson, cited that the most critical issue facing nurses was the growing perception of helplessness and unimportance particularly among general duty nurses (Anonymous, 1974e). Brown (1969) predicted

that the well-established national organization that nurses have developed during the past twenty years would be the foundation for collective bargaining in the future.

Professional Dietitians

Burger (1975) stated that The American Dietetic Association membership was 25,777 members as of December, 1975, an increase of 2,813 members since The Report by the Study Commission on Dietetics (Anonymous, 1972b). In 1971, the Commission (Anonymous, 1972b) determined that dietitians employed by hospitals, public health agencies, and other health-care facilities constituted 70 percent of all employed professional dietitians. Approximately 18 percent were employed by academic institutions either as educators or as food service supervisors, the remainder being employed by governmental agencies (federal, state, and local -- approximately 7 percent); school foodservice (less than 2 percent); and commercial and industrial employers (approximately 3 percent).

The Report of the Study Commission on Dietetics (Anonymous, 1972b) established that of the total American Dietetic Association membership, 71 percent (16,330 members) held bachelor's degrees; 23 percent (4,683 members) master's degrees; and 1.7 percent (383 members) doctorate degrees. Ninety percent (20,714 members) of the Association was "registered" having met the additional requirements of The American Dietetic Association for professional registration. Of the total membership, 73.4 percent (16,808 members) was actively engaged in some type of dietetic activity; the remainder of dietitians were unemployed,

retired, or engaged in employment activities outside of dietetics.

The median annual salary of dietitians having a bachelor's degree was approximately $9,000, with master's degree, $10,000, and for those with a doctorate, $16,000 (Anonymous, 1972b). For twenty-one metropolitan areas, with the exception of New York City, average earnings for dietitians were higher in governmental agencies than in private hospitals (BLS, 1974a). In government hospitals, including federal, state, and local, dietitians averaged 25 percent more earnings than their colleagues in private hospitals in Baltimore; 15 percent more in Chicago; 10 percent more in Washington, D.C., and Philadelphia; and 2 percent more in Atlanta and Seattle (BLS, 1974a). Gosman and Krishnamurty (1971), in a survey of food service personnel, found that the median salary for dietitians was $7,000 annually; however, the researchers noted that some dietitians surveyed were only employed part time.

Recent studies (Anonymous, 1974b; BLS, 1971; Herrick and Quinn, 1971; Plowman, 1975; Oppenheimer, 1970; Simmons, Freedman, Dunkle and Blau, 1975) have indicated that incomes for professional women have been consistently lower than men in the same occupations. Simmons et al. stated that "occupations in which women predominate are often dismissed as unskilled or unimportant, even for men [in the same occupation]" (p. 53). The investigators determined that among professional employees, median earnings of women were 66 percent of median earnings for men. Although difficulty was found in comparing skill levels, particularly in professional occupations, educational attainment provided a rough index of men and women within a number of predominantly female job categories

(Simmons, Freedman, Dunkle and Blau, 1975).

Oppenheimer (1970), in a similar study, compared the level of educational attainment and earnings of men and women employees within predominantly female occupations. While the educational attainment of both men and women was higher than the median for the total male civilian labor force, the median earnings of female employees did not approach either those of the total male labor force or those of their own male colleagues with the same occupations (Oppenheimer, 1970).

In the Manpower Report to the President -- 1975, the median income of full-time professional women was said to be $8,796 in 1972, approximately 68 percent of men's income in comparable occupations (BLS, 1975b). The Occupational Outlook Handbook, 1974-1975 (BLS, 1975a) established that experienced dietitians received annual salaries ranging from $8,400 to $14,000. In 1972, some dietitians with advanced academic degrees and varied work experience averaged as much as $21,000 annually (BLS, 1975a).

Somers (1974) ranked occupations (not considering sex of employees) and determined by earnings that dietitians ranked 324th out of 423 total occupations investigated. For example, dental hygienists ranked 16th; stenographers, 98th; postal clerks, 184th; truckdrivers, 250th; and bakers, 278th -- all ranking above dietitians in occupational earnings. Somers did find that the median earnings of dietitians ranked higher when comparing 391 selected predominantly female occupations. Earnings of dietitians ranked 212th (fifth decile) with 98.5 percent of the reported number of dietitians being women.

Criticism of these findings centered around Somers' (1974) utilization of federal agency statistics which estimated the number of dietitians to be between 30,000 and 37,000. This represented a substantial difference between the number of dietitians as reported by federal bureaus and those actually holding membership in The American Dietetic Association, approximately 17 to 32 percent more than reported by Burger (1975). The explanation might be that some individuals being called "dietitians", who either by choice or by inability to meet membership criteria, are not members of The American Dietetic Association (Anonymous, 1972b; BLS, 1975a). Somers (1974) might also have included dietitians with part-time earnings, tending to lower the reported overall occupational earnings.

In comparing the direct compensation of dietitians to other allied health-care professionals, the Department of Health, Education, and Welfare (HEW, 1970) found that dietitians in government employment received salaries equivalent to other health-care employees with similar academic training. With essentially the same educational accomplishments, dietitians' salaries were practically the same as psychiatric social workers and public health nurses (HEW, 1970).

The American Dietetic Association

Dietetics has had a relatively short history in the medical hierarchy (Cleveland, 1963). Dietetics has developed from that of a cook-teacher status in 1879 to the status of a distinct profession (Barber, 1959). The American Dietetic Association, the national organization, organized in 1917, has developed into a strong, well-integrated

group recognized world-wide for its advancements in the art of dietetics and the science of nutrition (Barber, 1959). Basically, the education of dietitians has been directed toward a broad basic background in home economics with emphasis on the science of nutrition and business management enabling dietitians to assume and accept the challenges of dietetics (Lipscomb and Donaldson, 1964).

Strauss, in 1963, viewed professional associations such as The American Dietetic Association as providing the following functions: (1) increased social fraternization, (2) provision for occupational identification, (3) heightened occupational status through growth within the organization and the community, (4) furtherance of professional objectives, and (5) advancement of the economic interests of its members.

In its role as a professional association, The American Dietetic Association has effectively instigated two methods to advance its members' economic interests. The first method has been salary surveys, under which The American Dietetic Association collects salary data, calculates means for different types and positions of respondents, assigns ratings, and publishes the final results as position papers. This has undoubtedly influenced the salary level by facilitating and encouraging the process of discrimination comparison. The following salaries and employment conditions were recommended as guidelines to attract competent individuals, to improve and insure proper employment conditions and practices, and to maintain salaries commensurate with the academic backgrounds and experience of dietitians:

1. Written objectives of the organization and of the department.
2. Written organization structure.
3. Written position description, defining responsibilities and functions.
4. Budget and facilities that provide for maximum efficiency in fulfilling professional responsibilities, i.e.: (a) adequate professional and supportive positions, (b) adequate clerical assistance, (c) adequate office and conference space for: planning, interviewing, teaching, and counseling functions, (d) adequate production and service facilities.
5. Letter of appointment, confirming position title, beginning date of employment, conditions of employment, and salary.
6. Defined work week.
7. Disability benefits, i.e., sick leave; insurance, for example, group life, health, accident, hospitalization. For professional personnel, the level of benefits provided should be at least: (a) twelve days' sick leave per year cumulative to sixty days, (b) group life insurance equal to annual salary, (c) hospitalization and medical insurance paid for by employer, providing usual and customary hospital and surgical charges plus major medical. (Good plans provide four weeks and at least nine days, respectively.)
8. Policy governing vacation and holidays.
9. Plan for salary increments and opportunities for advancement. The range from minimum to maximum in the same position should be at least 25 percent. Compensation plans should be reviewed annually and minimums, maximums, and intermediate steps adjusted to keep up with trends, in the economy, the industry, and the profession.
10. Retirement plans to supplement Social Security and tax-sheltered annuity in public or non-profit employment.
11. Provisions for professional growth, i.e., for attendance at professional meetings for academic study, and for support of in-service educational programs.
12. Travel allowances (Anonymous, 1974b, p. 188-189).

The ADA position papers presented recommended classifications for dietitians related to responsibilities, qualifications, and minimum salaries (Anonymous, 1974b). Salaries for the five general

classifications of dietitians ranged from $10,000 for entering dietitians with a baccalaureate degree and dietetic internship to $20,000 for a registered dietitian with an advanced degree and varied work experience. Undoubtedly, the ADA will continue to evaluate and to up-date these classifications and salary guidelines as economic conditions change in our society.

The second means utilized by the ADA has been to conduct in-depth job analyses and to formulate job descriptions on various employment responsibilities of dietitians including administrative and consultant positions (Anonymous, 1975a; Anonymous, 1975b; Blaker, 1973). This has tended to establish pre-determined standards which allow members "a genteel form of bargaining" over wages, hours, and terms and conditions of employment with prospective employers (Garbarino and Aussieker, 1975, p. 45).

These two methods have shortcomings in the area of collective bargaining in that a system of representation is shifted from the national level solely to local initiative and the pressure of individual members (Garbarino and Aussieker, 1975). Salary surveys have been found to have the greatest effectiveness and strength when used by national and regional negotiating teams on behalf of the national body for its members.

Pointer and Cannedy (1972) in a survey of twenty-four health-care professional associations including the ADA, discovered a lack of knowledge of labor organizations and collective bargaining by members in the associations. With the exception of the American Nurses' Association, National Association of Social Workers, American Society of Hospital

Pharmacists, and the American Society of Medical Technologists, the remaining associations were indifferent to the prospect of collective actions (Kralewski, 1974; Pointer and Cannedy, 1972).

Dietitians, similar to other health-care professionals, have a horizontal occupational structure usually situated in vertical, multi-level organizational hierarchies, creating a lack of advancement opportunities. Aluto and Belasco (1974) have suggested a differentiated professional hierarchy to remedy this problem. A system might be devised that would allow steps of professional advancement, thereby permitting upward advancement within the various steps. Dietitians under such a system might advance through the various steps as a means of job enrichment and increased satisfaction.

The American Dietetic Association has not engaged in collective bargaining activities. The major effort has been to provide labor relation information by way of its professional journal and newsletters to the membership. The publishing of recommended employment standards has been viewed as an abrupt change from past policies. The ADA's present position is in the initial stage taken by other health-care professional groups and associations who have wished to strengthen their positions among members and the employment community (Bedford, 1976).

Nurses have frequently utilized the publication strategy to influence their employers and to provide local nurses' associations with wage and employment guidelines (Pointer and Cannedy, 1972). For example, in 1966, the New York State Nurses' Association made the following specific proposal to hospital employers in the New York City area:

(1) reclassification of compensation plans, (2) increased shift differentials, (3) pay differentials for academic degrees, (4) elimination of non-nursing duties, and (5) various benefits relating to working conditions. Employers ignored these requests and proposals until nurses finally threatened to enforce their demands through massive resignations and informational picketing (Lewis, 1966). Similar patterns have been reported by other health professional groups since 1966 (Weisman, 1975; Bognanno, Dworkin and Omatoyo, 1976; Selden, 1969).

An article by the Labor Relation Committee of the ADA in the ADA Courier, 1974, recommended that the Association not become involved in collective bargaining on behalf of its members although ". . . the Association does not prohibit state or district associations from acting as a collective bargaining agent" (Anonymous, 1974a, p. 1).

In general, the ADA has continued to investigate labor relation matters of other health-care professions, to support pertinent federal and state labor legislation, and to report periodically to the entire membership supportive or educational labor materials (Anonymous, 1974e). In a Conference of Associations of Allied Health Professionals in 1972, Stumpf (1974) reported that the ADA expressed limited interest in a coordinated health-care professional union since some ADA members were not employed in hospitals, many dietitians were supervisors, and there was a low demand by members for representation.

By 1975, state affiliations of the ADA had made a concerted effort to organize labor relation workshops and committees to keep local dietitians abreast of changing developments in federal and state labor legislation (Bedford, 1976). District associations reported on

professional unionization of members; for example, eight states out of thirty-four indicated some unionization of dietitians either in selected geographic areas or throughout the state. States such as New York, Florida, Iowa (limited), Kentucky (limited), Alabama, Utah (Salt Lake City area), Minnesota (Minneapolis-St. Paul area), and Vermont (Rutland area) have reported some unionization of dietitians (Bedford, 1976).

Since the passage of the 1974 Amendment to the National Labor Relations Act, dietitians in hospitals and other health-care facilities have found profound changes in their status. The 1974 Amendment has made it clear and concise that hospitals and other health-care facilities are the dietitian's "employer", under Sections 2(2) and 2(14); that the dietitian is the hospital's "employee", under Section 2(3); that any representative of dietitians, whether a quasi-association or union is a "Labor Organization", under Section 2(5); that it matters whether a dietitian with supervisory responsibility be included or not, under Section 2(11); and that dietitians received different treatment, under Section 8(a) (Anderson, 1975; Anonymous, 1974c).

Recent NLRB litigation has centered around representation of professionals to determine whether certain classifications of health-care employees were considered as supervisors or non-supervisors. None of the cases involved dietitians. However, implications of the following cases might have an effect on dietitians. In Newton-Wellesley, 219 NLRB No. 80 (1975); St. Mary's Hospital, 220 NLRB No. 92 (1975); Doctors' Hospital, 217 NLRB No. 87 (1975); and Driftwood Convalescent Hospital, 217 NLRB No. 183 (1975); head nurses, charge nurses, and assistant nursing coordinators were included in the bargaining unit as evidence

indicated a lack of authority and supervisory criteria under Section 2(11) of the Act (Epstein and Stickler, 1976).

Solivan (Anonymous, 1976c) stated that only dietitians with bona-fide supervisory responsibilities will be excluded from the National Labor Relations Act. All other dietitians will be covered by the Act and thereby will be allowed to organize in appropriate bargaining units for purposes of collective action. He cited that the bargaining unit may include other health care professionals besides dietitians. More importantly, the appropriateness of the bargaining unit will undoubtedly be decided by the NLRB. The NLRB generally takes the following aspects into consideration when determining the appropriateness of a bargaining unit: (1) the history of collective bargaining, (2) the desires of the employees concerned, (3) the employment interests of the employees involved, and finally, (4) the degree to which employees are organized within the organization (Anonymous, 1976b). Epstein (1975) reported that the NLRB has clarified its position on appropriate units for bargaining in the health-care industry as follows: (1) registered nurses; (2) all other professionals; (3) service and maintenance employees; (4) business office and clerical employees; and (5) technical employees, including licensed practical nurses.

Strauss (1963) reported that professional unions tend to be more conservative than traditional blue-collar labor organizations. However, many quasi-professional labor organizations were criticized as being ". . . halfway houses on the road toward unionism" (p. 10). Some disadvantages of professional unionization besides loss of individuality and forfeiture of individual merit consideration are considered economic

in nature. Examples of this include initiation fees, dues, and other assessments (Anonymous, 1976b). Professionals also experience collective job action or strikes substantive to a contract.

The bargaining power of dietitians might be substantially reduced as a result of a limited number of dietitians in any given health-care facility. Dietitians might well be affiliated with other professionals who may or may not have the majority control in the bargaining unit. Such a position might leave dietitians without a controlling aspect in their institutional environments and with the alternative of either accepting the employment situation or finding employment elsewhere (Pointer and Cannedy, 1972).

Investigators (Hart and Sharp, 1975; HEW, 1971) indicated that the allied health professions, of which dietitians are a component, have received considerable pressure from the public and private sectors for credentialing. Provisions were made in the 1972 Social Security Amendment (Public Law 92-603) to establish the Professional Standards Review Organization (PSRO). This program would require qualifying health-care personnel through proficiency examinations. According to Hart and Sharp (1975), "the meaning and ramification of credentialing . . . have direct and powerful implications for the professional dietitian. . ." (p. 456). Consideration would be given to equivalency or proficiency examinations for both entry level dietitians and for specialties and continued performance (Hart and Sharp, 1975; Kuhli, 1973).

Hepner and Hepner (1973) viewed the trend toward producing credentials in the United States as rewarding individuals for academic

credit, degrees, and licenses rather than being recognized for job performance. This situation poses serious questions to dietitians especially those long established in their profession. Is it possible that licensure and credentialing could become requirements for getting and maintaining the job? Will dietitians have job security if such requirements become established? How will the thinking of dietitians be effected by the vote to permit registration independent of ADA membership? These questions as well as others are being investigated by The American Dietetic Association and researchers (Anonymous, 1976b; Hart and Sharp, 1975; Selden, 1972; Winterfeldt, 1974). Some professional dietitians may choose unionization and collective bargaining as a means to retain their positions in the employment environment.

CHAPTER III

PROCEDURE

The purpose of this study was to elicit the prevailing attitudes of dietitians toward collective bargaining and unionization. Several major questions concerning dietitians' attitudes in relation to classification and geographic area data were developed into hypotheses which could be statistically analyzed.

Hypotheses Tested in the Study

The questions and corresponding hypotheses studied in this investigation are stated below:

Question 1

Is there a significant difference in the CBAS of professional dietitians based on their place of employment such as government agencies, hospitals, health-care facilities, school foodservices, and so forth?

Hypothesis 1

There is a significant difference in the CBAS of professional dietitians based on their place of employment such as government agencies, hospitals, health-care facilities, school foodservices, and so forth.

Question 2

Is there a significant difference in the CBAS of professional dietitians based on their age level classifications?

Hypothesis 2

There is a significant difference in the CBAS of professional dietitians based on their age level classifications.

Question 3

Is there a significant difference in the CBAS of professional dietitians based on their academic degrees?

Hypothesis 3

There is a significant difference in the CBAS of professional dietitians based on their academic degrees.

Question 4

Is there a significant difference in the CBAS of professional dietitians based on their annual income levels?

Hypothesis 4

There is a significant difference in the CBAS of professional dietitians based on their annual income levels.

Question 5

Is there a significant difference in the CBAS of professional dietitians based on length of membership in The American Dietetic Association?

Hypothesis 5

There is a significant difference in the CBAS of professional dietitians based on length of membership in The American Dietetic Association.

Question 6

Is there a significant difference in the CBAS of professional dietitians based on six geographic areas of the United States including the District of Columbia and Puerto Rico?

Hypothesis 6

There is a significant difference in the CBAS of professional dietitians based on six geographic areas of the United States including the District of Columbia and Puerto Rico.

Question 7

Is there a significant difference in the CBAS of professional dietitians based on their representation by professional labor organizations or unions?

Hypothesis 7

There is a significant difference in the CBAS of professional dietitians based on their representation by professional labor organizations or unions.

Question 8

Is there a significant difference in the CBAS of professional dietitians based on their employment status?

Hypothesis 8

There is a significant difference in the CBAS of professional dietitians based on their employment status.

Question 9

Is there a significant difference in the CBAS of professional dietitians based on their major job responsibility?

Hypothesis 9

There is a significant difference in the CBAS of professional dietitians based on their major job responsibility.

Question 10

Is there a significant difference in the CBAS of professional dietitians based on their employment locations?

Hypothesis 10

There is a significant difference in the CBAS of professional dietitians based on their employment locations.

Question 11

Do professional dietitians think that collective bargaining can provide an effective vehicle for dealing with their employers over the issues of wages, hours, and terms and conditions of employment?

Hypothesis 11

Professional dietitians think that collective bargaining is the best means for dealing with their employers over the issues of wages, hours, and terms and conditions of employment.

Question 12

Are the guidelines for recommended salary ranges and employment conditions as published by the ADA realistic with respect to actual practices in employment?

Hypothesis 12

Dietitians find the recommended salary ranges and employment condition guidelines for professional dietitians as recently published by the ADA realistic to practices in employment.

Question 13

Do dietitians' wages, hours, and terms and conditions of employment compare favorably with those in similar professional groups?

Hypothesis 13

Dietitians think their wages, hours, and terms and conditions of employment compare favorably with those in similar professional groups.

Question 14

Are current trends for specialization, increased academic knowledge, and possible changes in The American Dietetic Association membership requirements (i.e. licensure) going to make dietitians more vulnerable to unemployment, underemployment, or discharge?

Hypothesis 14

Dietitians think that current trends for specialization, increased academic knowledge, and possible changes in membership requirements (i.e. licensure) will make dietitians more vulnerable to unemployment, underemployment, or discharge.

Question 15

During the past five years, have the attitudes of professional dietitians toward unionization become more favorable?

Hypothesis 15

During the past five years, dietitians' attitudes have become more favorable toward professional unionization.

Question 16

Do professional dietitians find unionization acceptable for other professions or groups?

Hypothesis 16

Professional dietitians find unionization acceptable for elementary and secondary school teachers, registered nurses, and professional athletes.

Question 17

Should The American Dietetic Association become involved in representation of dietitians in collective bargaining, grievance matters, and labor relations for its members?

Hypothesis 17

Dietitians believe that the ADA should involve the Association in collective bargaining, grievance matters, and labor relations on behalf of its members.

Hypotheses 1, 3, 6, 7, 8, 9, and 10 were tested through use of one-way analysis of variance for unequal sample size employing the F statistic. Hypotheses 2, 4, and 5 were tested through use of point multiserial correlation coefficient employing the $F_{obs.}$ statistic (Hamdan and Schulman, 1975). Hypotheses 11 through 16 were tested by use of a one-tailed one-group t-test statistic. Hypothesis 17 was tested by use of one-tailed binomial test statistic at the 0.01 level.

In the first ten hypotheses, the alpha level value of 0.01 was used for the acceptance or rejection of the hypothesis under investigation. In Hypotheses 11 through 16, the alpha level was 0.05. If the preceding analyses of Hypotheses 1, 3, 6, 7, 8, 9, 10 indicated a significant difference in the Collective Bargaining Attitude Scores of the respondents, the Duncan's New Multiple Range test was used to determine within those hypotheses where significant differences were obtained.

In Hypotheses 2, 4, and 5, the following statistical method was devised to determine where contrast existed between classification levels in relation to mean Collective Bargaining Attitude Scores, (Schulman, 1976). Collective Bargaining Attitude Scores were assigned into eight ordered groups, equally spaced. For example, the number of respondents having mean scores greater than 1 and equal to or less than 1.5, was assigned to group 1.5, according to the respective classification level for each of the above-listed hypotheses. Similar groups, including 1.5, were designated as follows: 1.5, 2.0, 2.5, 3.0, 3.5, 4.0, 4.5, and 5.0, each constituting a grouped Collective Bargaining Attitude Score.

Frequencies for each grouped Collective Bargaining Attitude Score within each classification level were determined by utilizing chi square (χ^2) statistic. This statistical method detected whether there were differences between observed and expected sample frequencies. A scatter diagram was constructed utilizing plus (+) and double-plus (++) signs. Where observed frequencies exceeded expected frequencies, a plus or double-plus sign (+ or ++) was used, depending upon degree of observed frequencies above expected frequencies. A linear trend, either positive or negative, indicated a relationship between Collective Bargaining Attitude Scores and the classification levels.

The Survey Instrument

The questionnaire survey was selected as the appropriate research technique for a compilation of attitudes toward professional unionization. This instrument has been widely used and generally accepted as a means of eliciting opinions of a broad sample (Kerlinger, 1964; Moser

and Kalton, 1972; Selltiz, Jahoda, Deutsch and Cook, 1964). No pre-existing scale concerning dietitians' attitudes toward collective bargaining and unionization was available; therefore, a questionnaire composed of information used by other researchers was developed (Bedford, 1971; Hayford, 1975; Nash, 1972; Wertheimer and Nelson, 1975).

The survey instrument developed was constructed with three basic sections (Appendix B): (I) biographical information for classification and analysis of participant responses to questions in Section two and three; (II) eleven Likert scale (one to five points) statement-response questions aimed at educing the attitudes of dietitians concerning collective bargaining and unionization; and (III) questions to elicit internalized attitudes of dietitians toward (a) union organization of other professionals or groups, (b) The American Dietetic Association's position regarding the role it should undertake in labor relations, and (c) actual labor organization involvement by dietitians, as well as (d) changes in attitude over a period of time. Closed response questions were utilized in all questionnaire sections except where the respondent was asked to indicate a state of residence. This procedure facilitated classification and quantification of response data.

The first section of the questionnaire contained ten questions designed to provide classification data and facilitate attitudinal comparisons along the following classification dimensions: (1) employment status, (2) place of employment, (3) major job responsibility, (4) present annual income, (5) employment location, (6) sex, (7) educational status, (8) date of birth, (9) length of membership in The American Dietetic Association, and (10) a yes or no question concerning

present union or quasi-union membership. The information obtained in Section I concerning classification data was coded numerically to facilitate final analysis. Possible responses within each classification, referred to as levels, were assigned numbers.

All possible responses within the classifications included in Section I were assigned the numbers one through nine depending on the particular level. For example, the possible responses for the variable "Date of Birth" were "before 1920", assigned the number 1; "1920 to 1929", 2; "1930 to 1939", 3; "1940 to 1949", 4; and "1950 or later", 5. This information was utilized to analyze stated hypotheses one through ten in relation to the respondents' Collective Bargaining Attitude Scores.

In Section II of the questionnaire (Appendix B), statement-responses for questions four through eleven were designated as the Collective Bargaining Attitude Scores. Respondents were instructed to circle the number that most accurately indicated the extent of their agreement or disagreement with the statement. An instructional guide, provided at the beginning of this Section, included five response choices (Strongly Disagree -- 1, Disagree -- 2, Undecided -- 3, Agree -- 4, and Strongly Agree -- 5). The corresponding point values (one through five) were arbitrarily assigned to the above options. The means of these questions were utilized in analyzing the data collected.

The five-point response range was selected over other alternative scales because of its unique and unambiguous nature for each response option. It was assumed that this scale would allow an optimal degree

of discrimination by the respondents in the selection of the response that most nearly indicated their agreement or disagreement with the statements.

Geographical Areas

The questionnaire included a request for respondents to indicate their state or area of residence. The Collective Bargaining Attitude Scores were analyzed in relation to six geographical areas of the United States including the District of Columbia and Puerto Rico (Appendix C), as defined by The American Dietetic Association (Anonymous, 1976d).

The Sample Group

The sample was randomly selected from the total membership (25,777 members) of The American Dietetic Association (Burger, 1975). The sample included dietitians from the 50 states within the United States as well as members from the District of Columbia and Puerto Rico. Names and corresponding addresses were obtained from the data processing firm commissioned to handle computer data and records for The American Dietetic Association. The sample group was selected by state, district and territory, alphabetically, for every fifteenth member. A total of 1,910 names (7.41 percent) was selected in this manner. Twenty-nine members living overseas and in Canada and Mexico, including military dietitians, were excluded from the sample group. Questionnaires were sent to 1,881 dietitians which represented 7.29 percent of the total membership.

The Pre-Tested Questionnaire

Prior to starting the actual data collection, a pre-test of the questionnaire was conducted with a group of seventeen randomly selected dietitians in the Roanoke Valley Dietetic Association in Southwestern Virginia. The participants were asked to complete the questionnaire and to make recommendations and constructive criticism as to their perception of the meaning and clarity of each question. There was a 70.5 percent response to the pre-test questionnaire.

The questionnaire was also evaluated at various stages of its development by faculty members from the Departments of Business Administration, Statistics, and Human Nutrition and Foods at Virginia Polytechnic Institute and State University, Blacksburg, Virginia. These periodic examinations focused attention primarily on the content, clarity, and appropriateness of the items which were included in the final form of the questionnaire. The comments made and questions raised were evaluated, and several modifications and deletions were incorporated.

Cover Letter

As recommended by researchers (Rummel and Ballaine, 1963), the cover letter contained the title, purpose, and a brief description of the scope of the study. The cover letter is illustrated in Appendix B. Self-explanatory, clear instructions were included in the cover letter as well as the questionnaire sections. A statement estimating the amount of time required to complete the questionnaire was suggested by only a small number of researchers (Dugdale, 1967; Hillway, 1969), and therefore was not included in the instructions regarding the questionnaire.

A statement to establish the insurance of confidentiality of the participant was included because of the personal nature of attitudinal research.

Selltiz, Jahoda, Deutsch, and Cook (1959) reported that returns would be greater if the respondent was offered inducements to reply. As the study has significant implications for The American Dietetic Association and its members, an appeal to the participant was made to encourage completion and return of the questionnaire as well as an offer made to provide a summary of the findings upon completion of the study. A self-addressed, postage-paid envelope was enclosed to facilitate responses. A follow-up letter with another questionnaire was not utilized in this study, as Borg (1963) found that this generally produces limited results.

Scoring of the Questionnaire

The summated mean point values for combined questions (four through eleven) in Section II were used to determine whether dietitians had favorable or unfavorable attitudes toward collective bargaining and unionization. This Collective Bargaining Attitude Score indicated favorable attitudes toward collective bargaining (mean value above 3) and unfavorable attitudes (mean values below 3). Questions five, nine, and ten in Section II required number order reversals by the computer so that these questions would correspond with direction of either favorable or unfavorable responses. This was accomplished by subtracting the respondent's selected number from the value six to obtain the correct response value for these particular questions.

Treatment of Data

The data were recorded upon IBM cards, cross-checked for accuracy, and processed at the Virginia Polytechnic Institute and State University Computation Center, Blacksburg, Virginia. The Statistical System Analysis (SAS) was employed in the computer analysis of the data. One-way analysis of variance for unequal group size was used to determine whether there were significant differences among the means of the Collective Bargaining Attitude Scores.

The significant overall analyses of variance were further investigated by a multiple comparison procedure, the Duncan's New Multiple Range test for unequal sample size, which tested all pair-wise comparisons among means (Hicks, 1964). In addition, the computer was programmed to provide means, standard deviations, frequency distributions, and percentage data when appropriate to certain areas of the study (Klugh, 1974; Siegal, 1956).

CHAPTER IV

RESULTS

Results of the study will be presented to relate the professional dietitians' profiles to their attitudes toward collective bargaining and unionization.

Survey Response

A detailed description of the number of subjects to whom the survey instrument was mailed and the number and percentage of responses returned is presented in Table I. The overall response rate of 1,114 (59.22 percent) was obtained from a total sample of 1,881 questionnaires mailed. Kerlinger (1964) considered questionnaire response higher than 50 percent as "rare" (p. 414). Because some returned questionnaires had incomplete or conflicting responses, 43 (2.28 percent) were deleted from the sample. Conflicting information occurred when multiple answers were given for single response questions.

An additional 18 (0.96 percent) of the total returned questionnaires did not give the state or location classification but were retained for final analysis since other data from these questionnaires appeared appropriate. Therefore a final total of 1,071 (56.94 percent) questionnaires were returned and tabulated for analysis. Approximately 203 (18.93 percent) respondents were unemployed, retired, or full-time students and thus, did not complete answers to questions concerning major job responsibility, annual income, and place of employment.

Sample group response by state or location within six geographic areas (Table I) ranged from 46.9 percent in Area D to 60.6 percent in Area B. Individual state or location responses varied more widely, from

TABLE I

SAMPLE GROUP DESCRIPTION BY STATE OR LOCATION WITHIN SIX GEOGRAPHIC AREAS AS DEFINED BY THE AMERICAN DIETETIC ASSOCIATION

Area	State or Location		Number of Participants	Number of Responses	Percentage of Responses
A	Alaska		3	3	100.0
	California		218	136	61.5
	Hawaii		11	3	27.3
	Idaho		8	6	75.0
	Montana		7	5	71.4
	Nevada		4	1	25.0
	Oregon		24	11	45.8
	Utah		13	7	53.8
	Washington		43	25	58.1
	Area A	Total	331	197	Mean % Response 59.7
B	Iowa		31	19	61.3
	Kansas		27	18	66.7
	Michigan		70	44	62.9
	Minnesota		49	27	38.6
	Nebraska		20	11	55.0
	North Dakota		8	7	87.5
	South Dakota		5	2	40.0
	Wisconsin		55	31	62.0
	Wyoming		4	4	100.0
	Area B	Total	269	163	Mean % Response 60.6
C	Arizona		22	12	54.5
	Arkansas		12	4	33.3
	Colorado		35	20	57.1
	Illinois		107	61	57.0
	Missouri		45	22	48.9
	New Mexico		10	4	40.0
	Oklahoma		21	12	57.1
	Texas		104	64	61.5
	Area C	Total	356	199	Mean % Response 55.9

TABLE I (Continued)

Area	State or Location		Number of Participants	Number of Responses	Percentage of Responses
D	Alabama		27	11	40.7
	Florida		63	31	49.2
	Georgia		30	16	53.3
	Kentucky		21	8	38.1
	Louisiana		30	12	40.0
	Mississippi		13	7	53.8
	Puerto Rico		15	4	26.7
	South Carolina		12	7	58.3
	Tennessee		32	18	56.3
	Area D	Total	243	114	Mean % Response 46.9
E	Delaware		6	4	66.7
	District of Columbia		11	5	45.5
	Indiana		40	20	50.0
	Maryland		49	26	53.1
	North Carolina		30	16	53.3
	Ohio		108	50	46.3
	Pennsylvania		87	49	56.3
	Virginia		43	30	69.8
	West Virginia		9	5	55.6
	Area E	Total	383	205	Mean % Response 53.5
F	Connecticut		30	17	56.7
	Maine		6	3	50.0
	New Hampshire		7	6	85.7
	Massachusetts		68	45	66.2
	New Jersey		48	23	47.9
	New York		126	70	55.6
	Vermont		5	3	60.0
	Rhode Island		9	8	88.9
	Area F	Total	299	175	Mean % Response 58.5
	No Information			18	
	Grand Total		1881	1071	56.9

a low response return for Hawaii, Nevada, and Puerto Rico (27.3, 25.0, and 26.7 percent, respectively) to a high return for Alaska, Wyoming, and Rhode Island (100.0, 100.0, and 88.9 percent, respectively).

Profile of Respondents

A profile of the sample group responses is presented in Table II. The number and percentage of responses were reported for the classification dimensions of sex, age, educational status, length of ADA membership, annual income, employment status, employment location, place of employment, major job responsibility, and union membership.

Approximately 97 percent of the respondents was female; length of ADA membership was fairly equally divided among the different classification levels of the respondents. The greatest number of respondents over the age classification was reported in the "26 to 35" age level (31.3 percent) with 23.3 percent representing the "46 to 55" age level.

Over two-thirds of the respondents had baccalaureate degrees with only 2.9 percent reporting a doctorate. The greatest percentage of the subjects, over 43 percent, indicated annual income earnings in the "$10,000 to $14,999" level. Earnings of $20,000 or over were reported by approximately ten percent of the subjects. The majority of the respondents to this study were employed full time, and a large percentage (47 percent) lived in a city with 100,000 or over population. Only 0.7 percent reported living in a rural area. The majority of the subjects was employed in a hospital or health-care facility. Major job responsibilities, in descending order, involved therapeutics, general, management, and consultant categories. In this study, approximately 5.3

TABLE II

PROFILE OF RESPONDENTS

Classifications		Number of Responses	Percentage of Responses
Sex:			
Female		1041	97.2
Male		30	2.8
	Total	1071	100.0
Age:			
Over 55		150	14.0
46 to 55		249	23.3
36 to 45		206	19.2
26 to 35		335	31.3
Less than 26		131	12.2
	Total	1071	100.0
Educational Status:			
Baccalaureate		727	67.9
Master's		313	29.2
Doctorate		31	2.9
	Total	1071	100.0
Length of ADA Membership:			
Less than 5 years		278	26.0
5 to 9 years		181	16.9
10 to 19 years		257	24.0
20 to 29 years		219	20.4
30 years or more		136	12.7
	Total	1071	100.0
Annual Income:			
Less than $5,000		125	14.4
$5,000 to $9,999		124	14.3
$10,000 to $14,999		374	43.1
$15,000 to $19,999		158	18.2
$20,000 or more		87	10.0
	Total	868[1]	100.0

[1]Data excluded 203 respondents who were either unemployed, retired, or full-time students.

TABLE II (Continued)

Classifications	Number of Responses	Percentage of Responses
Employment Status:		
Employed full time	631	58.9
Employed less than full time	216	20.2
Full-time student	17	1.5
Part-time student/ Part-time employed	21	2.0
Not employed	141	13.2
Retired	45	4.2
Total	1071	100.0
Employment Location:		
City 100,000 or larger (including suburbs)	504	47.0
City 10,000 to 90,000	273	25.7
Town 2,500 to 9,999	73	6.8
Town 2,499 or less	11	1.0
Rural (farm or open country)	7	0.7
Not employed, retired, or full-time student	203	18.9
Total	1071	100.0
Place of Employment:		
Hospital	428	49.4
Health-care facility	142	16.4
College or university	89	10.3
Government agency	43	5.0
School foodservice	28	3.2
Public health agency	30	3.5
Self-employed	37	4.3
Employed in field other than dietetics	29	3.3
Other	42	4.6
Total	868[2]	100.0

[2]Data excluded 203 respondents who were either unemployed, retired, or full-time students.

TABLE II (Continued)

Classifications	Number of Responses	Percentage of Responses
Major Job Responsibility:		
Teaching	110	12.7
Food service	57	6.6
Therapeutic	212	24.4
General (administrative, therapeutic, and teaching)	156	18.2
Management	122	13.9
Public Health	30	6.4
Consultant	135	13.7
Other	46	4.1
Total	868[3]	100.0
Union Membership:		
Belong to union	57	5.3
Do not belong to union	811	75.7
Not employed, retired, or full-time student	203	19.0
Total	1071	100.0

[3]Data excluded 203 respondents who were either unemployed, retired, or full-time students.

percent of the respondents belonged to a professional union or labor organization.

Frequency distributions of place of employment with (1) major job responsibility (Table III) and (2) employment status (Table IV) were developed. Data in both tables excluded respondents who were unemployed, retired, or full-time students. In general, the respondents were similar to the distribution of a 1972 ADA manpower survey as related to their place of employment. Over seventy-two percent was employed full time (Table IV). A total of 97.6 percent of the subjects was employed either full time or part time.

Results of the Tests of Hypotheses 1 Through 10

The first ten hypotheses were concerned with the attitudes of the respondents in relation to demographic characteristics. The test of the ten hypotheses was formulated to determine whether significant differences existed in the subject's attitudes as measured by the Collective Bargaining Attitude Scores as related to place of employment, age, educational status, annual income, length of membership in The American Dietetic Association, geographical area and state or location, representation in a professional union or labor organization, employment status, major job responsibility, and employment location.

Place of Employment

As indicated in Table V, the mean Collective Bargaining Attitude Scores of respondents for government agency and public health agency were 3.22 and 3.06, respectively, representing means that were high as compared to self-employed subjects (mean 2.31) or subjects employed in

TABLE III

FREQUENCY DISTRIBUTION OF RESPONDENTS EMPLOYED FULL OR PART TIME BY MAJOR JOB RESPONSIBILITY AS DEFINED WITHIN THEIR PLACE OF EMPLOYMENT

Place of Employment	Major Job Responsibility — Number of Respondents								Total		ADA[1]
	Teaching	Food Service	Therapeutic	General	Management	Public Health	Consultant	Other	Number	Percent	Percent
Hospital	20	24	186	105	72	--	16	5	428	49.3	53.0
Health-care facility	6	8	18	29	10	1	69	1	142	16.4	7.7
College or university	59	4	1	5	9	5	1	5	89	10.3	9.3
Government agency	4	3	2	10	9	2	9	4	43	4.9	2.3
School foodservice	1	15	--	2	9	--	--	1	28	3.2	5.9
Public health agency	--	--	3	1	1	21	3	1	30	3.5	4.0
Self-employed	1	--	2	2	2	1	26	4	37	4.3	2.9
Employed in field other than dietetics	9	--	--	--	4	--	1	15	29	3.3	2.1
Other	10	3	--	2	6	--	11	10	42	4.8	5.6
Total.	110	57	212	156	122	30	135	46	868	100.0	92.8
Percent.	12.7	6.6	24.4	17.9	14.1	3.5	15.5	5.3	100.0		
ADA[1] Percent	11.5	7.8	24.0	14.2	14.9	3.7	14.3	7.5	97.9		

[1]ADA Manpower Survey (Sharp, Hubbard, Sager and Andrews, 1973) included a section for research (2.1 percent) under major job responsibility, and sections for commercial or industrial (2.6 percent) and employed in more than one place (4.6 percent) under place of employment.

TABLE IV

FREQUENCY DISTRIBUTION OF RESPONDENTS BY EMPLOYMENT STATUS AS DEFINED WITHIN THEIR PLACE OF EMPLOYMENT

Place of Employment	Employment Status Number of Respondents				
	Employed full time	Employed less than full time	Part-Time Student/ Part-Time Employed	Total Number	Percent
Hospital	369	55	4	428	49.4
Health-care facility	46	94	2	142	16.4
College or university	74	11	4	89	10.3
Government agency	36	6	1	43	5.0
School foodservice	26	2	--	28	3.2
Public health agency	26	4	--	30	3.5
Self-employed	7	23	7	37	4.3
Employed in field other than dietetics	18	10	1	29	3.3
Other	29	11	2	42	4.6
Total.	631	216	21	868	100.0
Percent.	72.7	24.9	2.4	100.0	

TABLE V

MEAN COLLECTIVE BARGAINING ATTITUDE SCORES BY PLACE OF EMPLOYMENT

Place of Employment	Number of Responses		Mean Collective Bargaining Attitude Score
Hospital	428		2.66
Health-care facility	142		2.41
College or university	89		2.60
Government agency	43		3.22
School foodservice	28		2.65
Public health agency	30		3.06
Self-employed	37		2.31
Employed in field other than dietetics	29		2.56
Other	42		2.71
Total	868[1]	Mean	2.63

[1]Data excluded 203 respondents who were unemployed, retired, or full-time students.

health-care facilities (mean 2.41). The mean Collective Bargaining Attitude Score for all respondents was 2.63. The attitude score was based from 1, strongly disagree with the statement, indicating a favorable attitude toward collective bargaining and unionization, to 5, strongly agree with the statement, indicating an unfavorable attitude toward collective bargaining. If the respondent indicated a choice of 3, this was considered as being undecided, neither unfavorable or favorable toward collective bargaining.

A significant difference in the Collective Bargaining Attitude Scores (CBAS) of respondents was analyzed through use of one-way analysis of variance for unequal sample size (Table VI). The designated alpha level for the acceptance or rejection of the hypothesis was 0.01. The derived F value was $4.83 > F_{.01,\ 8,\ \infty} \doteq 2.51$, significant beyond the 0.01 level. The evidence suggested that there were differences in the CBAS of professional dietitians as related to their "place of employment" levels.

Age

The second question posed in this study focused upon the CBAS in relation to the age of the respondents. The mean CBAS as reported in Table VII ranged from a low of 2.41 for the "over 55" level to a high of 2.82 for "less than 26". The mean Collective Bargaining Attitude Score was 2.63.

A point multiserial correlation coefficient statistic was used to test for significant differences between the Collective Bargaining Attitude Scores of respondents and age levels. The designated alpha level for the acceptance or rejection of the hypothesis was 0.01; the

TABLE VI

ANALYSIS OF VARIANCE FOR COLLECTIVE BARGAINING ATTITUDE SCORES BY PLACE OF EMPLOYMENT

Source of Variation	Degrees of Freedom	Sum of Squares	Mean Square	F Value
Place of Employment	8	31.6099	3.9512	4.8339*
Error	859	702.1630	0.8174	

*Significant at the 0.01 level

TABLE VII

MEAN COLLECTIVE BARGAINING ATTITUDE SCORES
BY AGE OF RESPONDENTS

Age of Respondents	Number of Responses		Mean Collective Bargaining Attitude Score
Over 55	150		2.41
46 to 55	249		2.56
36 to 45	206		2.59
26 to 35	335		2.72
Less than 26	131		2.82
Total	1071	Mean	2.63

derived $F_{obs.}$ value was 5.22 > $F_{.01, 4, \infty} \doteq 3.32$. The evidence (Table VIII) suggested that significant differences beyond the 0.01 level were detected in the attitudes of respondents within the age classification levels.

Educational Status

Another hypothesis used in this study questioned whether there was a significant difference in the CBAS of professional dietitians based on their academic degree. In Table IX, the mean Collective Bargaining Attitude Scores for baccalaureate, master's, and doctorate were 2.57, 2.79, and 2.42, respectively. The overall mean of 2.63 indicated that dietitians tended to have an unfavorable attitude toward collective bargaining and unionization.

Further testing by use of one-way analysis of variance statistic for unequal sample size indicated a significant difference in the CBAS of respondents according to the three levels of educational status -- baccalaureate, master's, and doctorate. The derived F value of 7.39 > $F_{.01, 2, \infty} \doteq 4.61$ was significant beyond the 0.01 level (Table X). The evidence suggested that there were differences in the Collective Bargaining Attitude Scores of professional dietitians between the various educational status levels.

Annual Income

The Collective Bargaining Attitude Scores of the respondents in relation to their annual incomes were investigated and tested by the use of mean CBAS (Table XI) and point multiserial correlation coefficient statistic (Hamdan and Schulman, 1975) as shown in Table XII. The mean

TABLE VIII

POINT MULTISERIAL CORRELATION COEFFICIENT FOR
COLLECTIVE BARGAINING ATTITUDE SCORES BY AGE OF RESPONDENTS

Source	Degrees of Freedom	R^2	R^2/d.f.	$F_{obs.}$ Value
Age of Respondents	4	.0189	.0047	5.2222*
Error	1066	1 - .0189	.0009	

R = point multiserial correlation coefficient = .1374

*Significant at the 0.01 level

TABLE IX

MEAN COLLECTIVE BARGAINING ATTITUDE SCORES
BY EDUCATIONAL STATUS

Educational Status	Number of Responses		Mean Collective Bargaining Attitude Score
Baccalaureate	727		2.57
Master's	313		2.79
Doctorate	31		2.42
Total	1071	Mean	2.63

TABLE X

ANALYSIS OF VARIANCE FOR COLLECTIVE BARGAINING ATTITUDE SCORES BY EDUCATIONAL STATUS

Source of Variation	Degrees of Freedom	Sum of Squares	Mean Square	F Value
Educational Status	2	12.0498	6.0249	7.3884*
Error	1068	874.2146	0.8155	

*Significant at the 0.01 level

TABLE XI

MEAN COLLECTIVE BARGAINING ATTITUDE SCORES
BY PRESENT ANNUAL INCOME

Present Annual Income	Number of Responses		Mean Collective Bargaining Attitude Score
Less than $5,000	125		2.34
$ 5,000 to $ 9,999	124		2.64
$10,000 to $14,999	374		2.75
$15,000 to $19,999	158		2.63
$20,000 or more	87		2.63
Total	868[1]	Mean	2.64

[1]Data excluded 203 respondents who were unemployed, retired, or full-time students.

TABLE XII

POINT MULTISERIAL CORRELATION COEFFICIENT FOR
COLLECTIVE BARGAINING ATTITUDE SCORES
BY PRESENT ANNUAL INCOME

Source	Degrees of Freedom	R^2	R^2/d.f.	F Value
Present Annual Income	4	.0213	.0053	4.8182*
Error	864	1 - .0213	.0011	

R = point multiserial correlation coefficient = .1460

*Significant at the 0.01 level

Collective Bargaining Attitude Scores, as related to earnings, ranged from 2.34 for "less than $5,000", the least favorable score toward collective bargaining, to 2.75 for $10,000 to $14,999" income level. The mean Collective Bargaining Attitude Score for all respondents was 2.64.

Data from the respondents indicated a significant difference in the Collective Bargaining Attitude Scores as related to the five annual income levels. Table XII indicated the $F_{obs.}$ value of $4.82 > F_{.01,\ 4,\ \infty} \doteq 3.32$.

Length of ADA Membership

The fifth hypothesis stated in this study focused upon the Collective Bargaining Attitude Scores of the respondents based on length of membership in The American Dietetic Association. The mean Collective Bargaining Attitude Scores (Table XIII) ranged from a low of 2.34 for "30 years or more" to a high of 2.83 for "less than 5 years". The mean for all respondents was 2.63.

This hypothesis was tested further by the use of point multiserial correlation coefficient statistic (Hamdan and Schulman, 1975). The analyzed data (Table XIV) suggested there was a significant difference in the Collective Bargaining Attitude Scores of respondents according to the five length of membership classification levels. The alpha level of this hypothesis was set at 0.01 with a derived $F_{obs.}$ value of $10.22 > F_{.01,\ 4,\ \infty} \doteq 3.32$. The evidence indicated differences in the CBAS of respondents in relation to length of membership in The American Dietetic Association.

TABLE XIII

MEAN COLLECTIVE BARGAINING ATTITUDE SCORES
BY LENGTH OF MEMBERSHIP IN
THE AMERICAN DIETETIC ASSOCIATION

Length of ADA Membership	Number of Responses		Mean Collective Bargaining Attitude Score
Less than 5 years	278		2.83
5 to 9 years	181		2.79
10 to 19 years	257		2.53
20 to 29 years	219		2.51
30 years or more	136		2.34
Total	1071	Mean	2.63

TABLE XIV

POINT MULTISERIAL CORRELATION COEFFICIENT FOR COLLECTIVE BARGAINING ATTITUDE SCORES BY LENGTH OF MEMBERSHIP IN THE AMERICAN DIETETIC ASSOCIATION

Source	Degrees of Freedom	R^2	R^2/d.f.	$F_{obs.}$ Value
Length of ADA Membership	4	.0369	.0092	10.2222*
Error	1066	1 - .0369	.0009	

R = point multiserial correlation coefficient = .1923

*Significant at the 0.01 level

Geographical Area

When the Collective Bargaining Attitude Scores of respondents within the six defined geographic areas of the United States and also within the states or locations of each area were measured, as reported in Table XV, the mean CBAS for areas varied from a low of 2.54 for Area B to a high of 2.79 for Area A. Individual states or locations within the defined areas varied from a low of 1.81 for South Dakota to a high of 3.35 for the District of Columbia. In addition, Table XV shows the states or locations of respondents having mean Collective Bargaining Attitude Scores above 3 (favorable attitudes toward collective bargaining and unionization): Hawaii, Minnesota, Puerto Rico, District of Columbia, and Maine. The mean Collective Bargaining Attitude Score for all respondents was 2.63 for both areas and states or locations.

When the use of one-way analysis of variance for unequal sample size was applied to the areas (Table XVI), data indicated a significant difference in the Collective Bargaining Attitude Scores of respondents according to the six geographic areas. One-way analysis of variance was used also to test the states or locations. The designated alpha level for the acceptance or rejection of the hypothesis was 0.01. The derived F value for areas was $1.53 < F_{.01, 5, \infty} \doteq 3.02$ and $2.21 > F_{.01, 52, \infty} \doteq 1.50$ for state or location. The evidence suggested that no differences were detected in the CBAS of the respondents in relation to the six geographic areas; however, significant differences were detected among the individual states or locations composing these geographic areas.

In this study, the attitudes of professional dietitians were investigated through their responses regarding collective bargaining and

TABLE XV

MEAN COLLECTIVE BARGAINING ATTITUDE SCORES BY AREAS AND BY STATES OR LOCATIONS

Area	State or Location	Number of Responses		Mean Collective Bargaining Attitude Score
A	Alaska	3		2.79
	California	136		2.83
	Hawaii	3		3.25
	Idaho	6		2.69
	Montana	5		2.98
	Nevada	1		2.50
	Oregon	11		2.18
	Utah	7		2.55
	Washington	25		2.88
	Total	197	Mean	2.79
B	Iowa	19		2.36
	Kansas	18		1.99
	Michigan	44		2.78
	Minnesota	27		3.02
	Nebraska	11		2.61
	North Dakota	7		2.41
	South Dakota	2		1.81
	Wisconsin	31		2.33
	Wyoming	4		2.22
	Total	163	Mean	2.54
C	Arizona	12		2.56
	Arkansas	4		2.38
	Colorado	20		2.48
	Illinois	61		2.80
	Missouri	22		2.47
	New Mexico	4		2.38
	Oklahoma	12		2.17
	Texas	64		2.52
	Total	199	Mean	2.55

TABLE XV (Continued)

Area	State or Location	Number of Responses		Mean Collective Bargaining Attitude Score
D	Alabama	11		2.69
	Florida	31		2.41
	Georgia	16		2.84
	Kentucky	8		2.63
	Louisiana	12		2.39
	Mississippi	7		2.34
	Puerto Rico	4		3.21
	South Carolina	7		2.11
	Tennessee	18		2.56
	Total	114	Mean	2.55
E	Delaware	4		3.19
	District of Columbia	5		3.35
	Indiana	20		2.28
	Maryland	26		2.98
	North Carolina	16		2.52
	Ohio	50		2.59
	Pennsylvania	49		2.66
	Virginia	30		2.46
	West Virginia	5		2.38
	Total	205	Mean	2.71
F	Connecticut	17		2.45
	Maine	3		3.17
	New Hampshire	6		2.46
	Massachusetts	45		2.56
	New Jersey	23		2.73
	New York	70		2.83
	Vermont	3		2.08
	Rhode Island	8		2.43
	Total	175	Mean	2.59
	No Information	18		2.19

Grand Total -- 1071 Overall Mean -- 2.63

TABLE XVI

ANALYSIS OF VARIANCE FOR COLLECTIVE BARGAINING ATTITUDE SCORES BY AREAS AND BY STATES OR LOCATIONS

Source of Variation	Degrees of Freedom	Sum of Squares	Mean Square	F Value
Areas				
Area	5	8.4294	1.6859	1.5328
Error	1065	811.6192	0.7621	
States or Locations				
State or Location	52	64.3491	1.2375	2.2122*
Error	1018	821.9153	0.8073	

*Significant at the 0.01 level

unionization. Based on their response profiles for this study, the respondents appeared to be representative of documented ADA membership. When investigating the respondents' attitudes, it was possible to utilize the above-mentioned classification variables (place of employment, age, educational status, annual income, and length of ADA membership) in order to draw inferences and conclusions regarding attitudes of dietitians toward collective bargaining. While geographic areas of respondents did not appear to have use in predicting attitudes, individual states or locations may provide some insight.

Union Membership

Another question posed in this study centered upon the Collective Bargaining Attitude Scores of the respondents based on representation by a professional union or labor organization. Respondents had three choices in answers for this question: (1) yes; (2) no; or (3) not employed, retired, or full-time student. In Table XVII, the mean Collective Bargaining Attitude Scores ranged from 3.62 for those belonging to professional union or labor organizations to 2.57 for respondents not belonging to professional union or labor organizations. The Collective Bargaining Attitude Score for all respondents was 2.63.

This question, Hypothesis 7, was tested further by use of one-way analysis of variance for unequal sample size. The data in the analysis (Table XVIII) indicated a significant difference in the Collective Bargaining Attitude Scores of respondents among the three response levels. An F value of $37.21 > F_{.01, 2, \infty} \doteq 4.61$ was highly significant beyond the .01 level. The evidence suggested that significant differences existed

TABLE XVII

MEAN COLLECTIVE BARGAINING ATTITUDE SCORES BY UNION MEMBERSHIP

Union Membership	Number of Responses		Mean Collective Bargaining Attitude Score
Belong to Union	57		3.62
Do Not Belong to Union	811		2.57
Not Employed, Retired, or Full-Time Student	203		2.58
Total	1071	Mean	2.63

TABLE XVIII

ANALYSIS OF VARIANCE FOR COLLECTIVE BARGAINING ATTITUDE SCORES BY UNION MEMBERSHIP

Source of Variation	Degrees of Freedom	Sum of Squares	Mean Square	F Value
Union Membership	2	59.6046	28.8023	37.2123*
Error	1068	826.6598	0.7740	

*Significant at the 0.01 level

in the CBAS of the respondents as related to membership in a professional union or labor organization.

Employment Status

The next question postulated in this study centered upon the Collective Bargaining Attitude Scores of the respondents in relation to employment status. The mean Collective Bargaining Attitude Scores for respondents employed less than full time appeared to be more unfavorable toward collective bargaining than the scores of those employed full time (Table XIX). Full-time students appeared to have the most favorable attitudes toward collective bargaining although this category of respondents was the smallest group. The mean for all respondents to this question was 2.63 indicating an unfavorable attitude toward collective bargaining and unionization.

This hypothesis was tested by the use of one-way analysis of variance for unequal sample size (Table XX). These data indicated a significant difference in the CBAS of respondents according to the six employment status levels. An F value of $5.95 > F_{.01,\ 5,\ \infty} \doteq 3.02$ was derived, significant beyond the designated 0.01 level, giving evidence suggesting differences in the Collective Bargaining Attitude Scores of respondents in relation to their employment status.

Major Job Responsibility

The Collective Bargaining Attitude Scores as related to the major job responsibility of the respondents were tested to study whether or not job responsibility might influence a dietitian's attitude toward collective bargaining and unionization. Eight major job responsibilities were

TABLE XIX

MEAN COLLECTIVE BARGAINING ATTITUDE SCORES
BY EMPLOYMENT STATUS

Employment Status	Number of Responses		Mean Collective Bargaining Attitude Score
Employed full time	631		2.72
Employed less than full time	216		2.38
Full-time student	17		3.11
Part-time student/ part-time employed	21		2.82
Not employed	141		2.55
Retired	45		2.49
Total	1071	Mean	2.63

TABLE XX

ANALYSIS OF VARIANCE FOR COLLECTIVE BARGAINING ATTITUDE SCORES BY EMPLOYMENT STATUS

Source of Variation	Degress of Freedom	Sum of Squares	Mean Square	F Value
Employment Status	5	24.1485	4.8297	5.9670*
Error	1065	862.1159	0.8094	

*Significant at the 0.01 level

listed, ranging from therapeutics to work in public health. As reported in Table XXI, the mean Collective Bargaining Attitude Scores of respondents for the eight major job responsibilities ranged from a low of 2.34 for the consultant dietitian to a high of 3.19 for dietitians working in the area of public health. The overall mean Collective Bargaining Attitude Score for all 868 respondents was 2.64. These data excluded 203 respondents who were either unemployed, retired, or full-time students.

When these data were tested by the use of one-way analysis of variance for unequal sample size (Table XXII), the F value, 6.65, significant beyond the 0.01 level, suggested that differences were detected in the CBAS of the respondents as related to their major job responsibilities.

Employment Location

The final question posed in the first ten hypotheses focused upon the Collective Bargaining Attitude Scores of the respondents as related to employment location. Five employment location levels were defined ranging from rural area to city of 100,000 or larger. As reported in Table XXIII, the mean Collective Bargaining Attitude Scores as related to employment location ranged from a low of 2.03 for "Town 2,499 or less" to a high of 2.96 for "Rural (farm or open country)". The greatest number of respondents, 47.05 percent (504 responses), indicated their employment location to be "City 100,000 or larger". This group of respondents had a Collective Bargaining Attitude Score mean of 2.76, slightly higher than the mean CBAS for all respondents, 2.63.

TABLE XXI

MEAN COLLECTIVE BARGAINING ATTITUDE SCORES
BY MAJOR JOB RESPONSIBILITY

Major Job Responsibility	Number of Responses	Mean Collective Bargaining Attitude Score
Teaching	110	2.82
Food service	57	2.55
Therapeutic	212	2.81
General (administration, therapeutic, and teaching)	156	2.62
Management	122	2.44
Public health	30	3.19
Consultant	135	2.34
Other	46	2.61
Total	868[1]	2.64

[1]Data excluded 203 respondents who were unemployed, retired, or full-time students.

TABLE XXII

ANALYSIS OF VARIANCE FOR COLLECTIVE BARGAINING ATTITUDE SCORES BY JOB RESPONSIBILITY

Source of Variation	Degrees of Freedom	Sum of Squares	Mean Square	F Value
Job Responsibility	7	37.8120	5.4017	6.6573*
Error	858	696.1984	0.8114	

*Significant at the 0.01 level

TABLE XXIII

MEAN COLLECTIVE BARGAINING ATTITUDE SCORES
BY EMPLOYMENT LOCATION

Employment Location	Number of Responses		Mean Collective Bargaining Attitude Score
City 100,000 or larger (including suburb)	504		2.76
City 10,000 to 90,000	273		2.48
Town 2,500 to 9,999	73		2.45
Town 2,499 or less	11		2.03
Rural (farm or open country)	7		2.96
Not employed, retired, or full-time student	203		2.57
Total	1071	Mean	2.63

This hypothesis was further tested by the use of one-way analysis of variance for unequal sample size. The data in the analysis of variance table (Table XXIV) indicated a significant difference in the CBAS of the respondents as related to the six listed levels for employment location. An F value of 5.60 was derived, significant beyond the 0.01 level, suggesting that differences were detected in the CBAS of the respondents as related to their employment location.

It was found that significant differences existed in the mean CBAS expressed by respondents for the following classification categories: union membership, employment status, major job responsibility, and employment location. The above-mentioned classification variables, in addition to the previously investigated variables (place of employment, age, educational status, annual income, and length of ADA membership), were utilized to determine the attitudes of dietitians toward collective bargaining and unionization.

Further Tests of Hypotheses

The Duncan's New Multiple Range test was employed to determine significant differences at the 0.05 alpha level between the mean CBAS of respondents and the levels of the following classifications: place of employment, educational status, union membership, employment status, major job responsibility, and employment location. As the geographic area classification was non-significant, the Duncan's New Multiple Range test was not applied.

In Table XXV, the Duncan's New Multiple Range test on mean CBAS for the place of employment classification indicated a significant

TABLE XXIV

ANALYSIS OF VARIANCE FOR COLLECTIVE BARGAINING ATTITUDE SCORES BY EMPLOYMENT LOCATION

Source of Variation	Degrees of Freedom	Sum of Squares	Mean Square	F Value
Employment Location	5	22.7646	4.5529	5.6153*
Error	1065	863.4999	0.8108	

*Significant at the 0.01 level

TABLE XXV

DUNCAN'S NEW MULTIPLE RANGE TEST APPLIED TO CLASSIFICATION DIMENSIONS FOR MEAN COLLECTIVE BARGAINING ATTITUDE SCORES

Classification Dimension	Mean Collective Bargaining Attitude Score	Significance[1]	
Place of Employment			
Government agency	3.22	aa	
Public health agency	3.06		bb
Other	2.71	ac	
Hospital	2.66	ad	
School foodservice	2.65	ae	
College or university	2.60	af	
Employed in field other than dietetics	2.56	ag	
Health-care facility	2.41	ah	bh
Self-employed	2.31	ai	bi
Educational Status			
Master's	2.79	aa	
Baccalaureate	2.57	ab	
Doctorate	2.42	ac	
Union Membership			
Yes (Belong)	3.62	aa	
No (Do not belong)	2.58	ab	
Not employed, retired, full-time student	2.57	ac	
Employment Status			
Full-time student	3.11	aa	
Part-time student/ Part-time employed	2.82		
Employed full time	2.73		
Not employed	2.55	ad	
Retired	2.49	ae	
Employed less than full time	2.39	af	

[1]The difference between two means is significant if one has double letters and the other has one of the same letters (P = .05).

TABLE XXV (Continued)

Classification Dimension	Mean Collective Bargaining Attitude Score	Significance[1]
Major Job Responsibility		
Public health	3.19	aa
Teaching	2.82	
Therapeutic	2.81	
General	2.62	
Other	2.61	
Food service	2.55	
Management	2.44	ag
Consultant	2.34	ah
Employment Location		
Rural (farm or open country)	2.96	a
City 100,000 or larger (including suburb)	2.76	b
Not employed, retired, full-time student	2.56	c
City 10,000 to 90,000	2.48	d
Town 2,500 to 9,999	2.45	e
Town 2,499 or less	2.03	f

[1]The difference between two means is significant if one has double letters and the other has one of the same letters (P = .05).

difference between government agency and each of the following classification levels: hospital, school foodservice, college or university, employed in field other than dietetics, health-care facility, self-employed, and other. A difference at the 0.05 level was indicated also between public health agency and each of the following: (1) self-employed, and (2) health-care facility. A significant difference was observed between the master's degree level paired with, first, the baccalaureate, and then with the doctorate.

The Duncan's New Multiple Range test was applied also to the classification, union membership, where significant differences were found between respondents belonging to unions and each of the following: (1) respondents not belonging, and (2) respondents who were unemployed, retired, or full-time students. Significant differences were also found in the employment status classification between full-time students and each of the following: (1) not employed, (2) retired, and (3) employed less than full time. Differences were reported (Table XXV) for the major job responsibility classification between public health level and each of the following: (1) management, and (2) consultant. In the employment location classification, no significant differences were detected at the 0.05 level.

Statistical methods, as described in Chapter III, were devised and employed to determine contrasting relationships between the grouped Collective Bargaining Attitude Scores and the following classification variables that were previously investigated: age, annual income, and length of ADA membership (Schulman, 1976). Frequencies were determined by utilizing chi square (χ^2) statistic methods to determine whether

there were differences between the mean grouped Collective Bargaining Attitude Scores in relation to the classification levels under investigation. A scatter diagram was constructed utilizing plus (+) and double-plus (++) signs. A plus sign (+) was used to indicate data where observed frequencies exceeded expected frequencies, and a double-plus (++) was used where observed frequencies highly exceeded expected frequencies.

Where a significant difference was found in the CBAS in relation to the age of the respondents, a definite relationship was observed (Figure 1) between the grouped CBAS in relation to the ages of the respondents. As the age levels of respondents decreased from "over 55" to "less than 26", there was a general increase in the grouped Collective Bargaining Attitude Scores. This indicated a linear degree of association of the younger respondents with more favorable attitudes toward collective bargaining and unionization. The scatter diagram (Figure 2) for length of ADA membership plotted against grouped CBAS also confirmed that respondents with less membership time in the ADA had more favorable attitudes toward collective bargaining than respondents with longer membership.

In a final test to determine where differences were found in the CBAS in relation to present annual income of the respondents, a definite relationship was observed (Figure 3) between the income levels of the respondents and the grouped CBAS. As income levels decreased from "20,000 or more to "less than $5,000", there was a general increase in the mean grouped CBAS. This indicated a linear degree of association of those respondents earning less income with more favorable attitudes toward

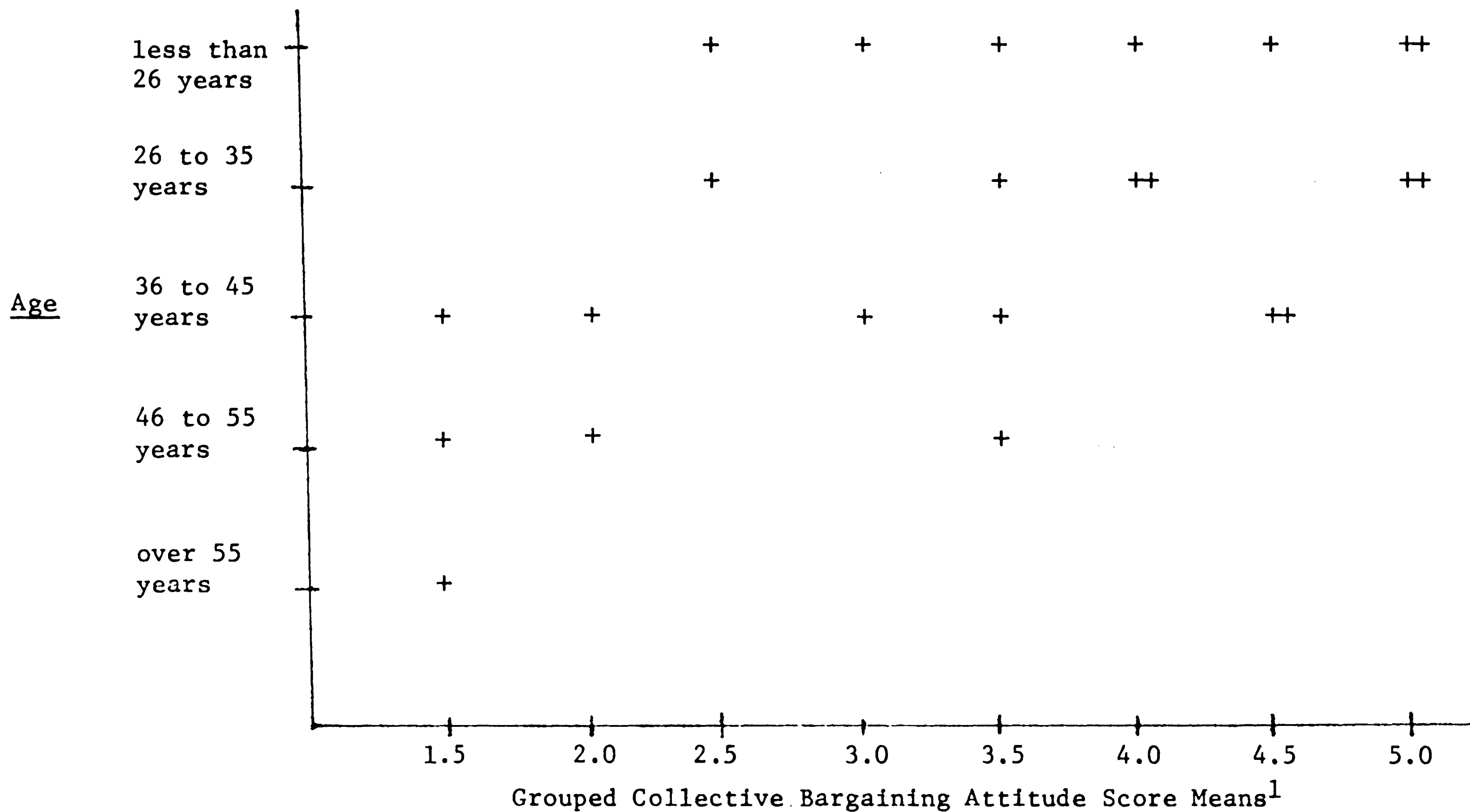

Figure 1. Scatter Diagram For Age of Respondents Plotted Against Grouped Collective Bargaining Attitude Scores.

---

[1]The range of the CBAS (1 through 5) was arbitrarily assigned into eight ordered groups, equally spaced. The number of respondents within each classification level was assigned to a group; for example, respondents having mean CBAS greater than 1 and equal to or less than 1.5 were assigned to group 1.5. Similar groups were designated for 2.0, 2.5, 3.0, 3.5, 4.0, 4.5, and 5.0.

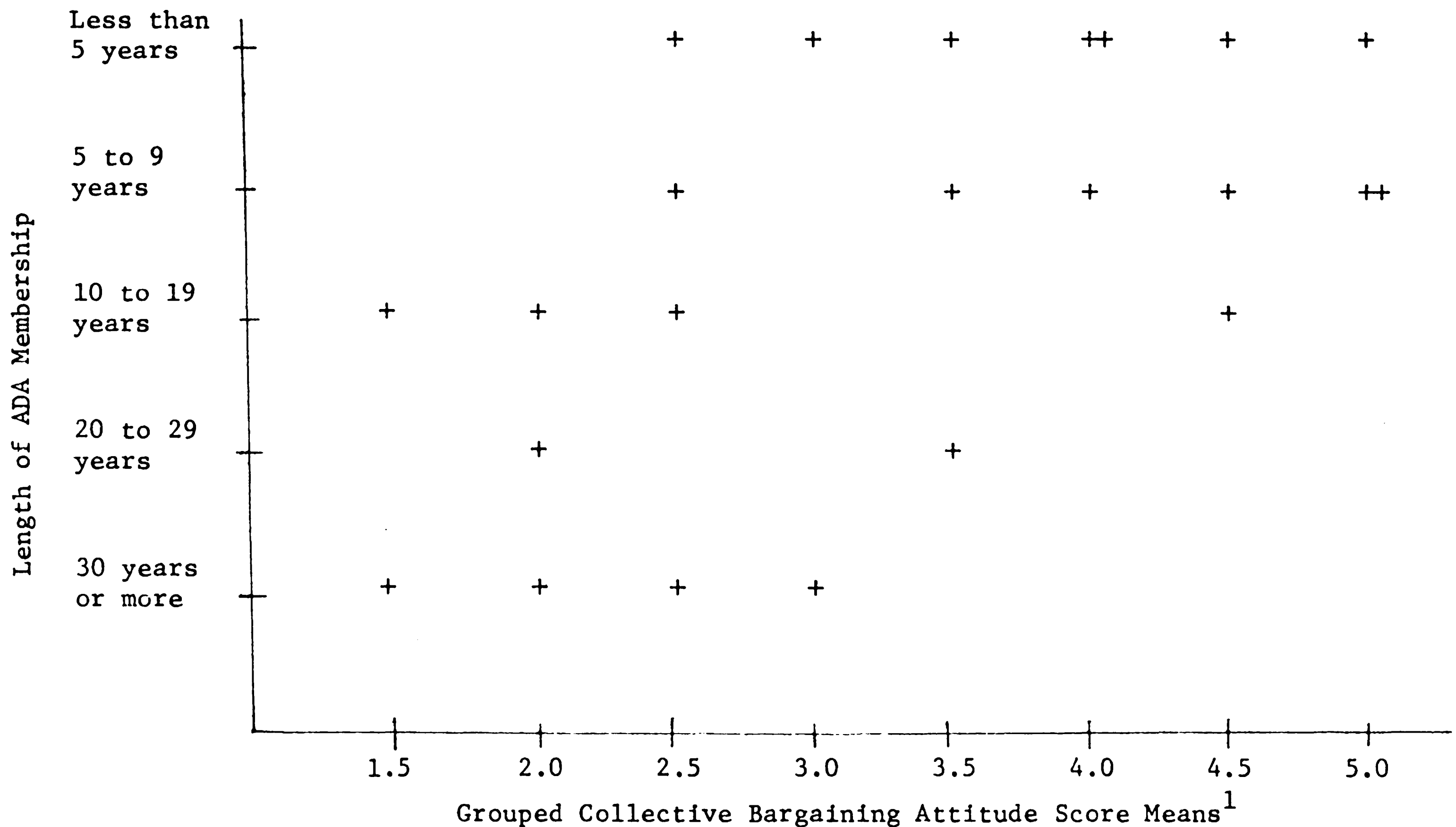

Figure 2. Scatter Diagram For Length of ADA Membership Plotted Against Grouped Collective Bargaining Attitude Scores.

[1]The range of the CBAS (1 through 5) was arbitrarily assigned into eight ordered groups, equally spaced. The number of respondents within each classification level was assigned to a group; for example, respondents having mean CBAS greater than 1 and equal to or less than 1.5 were assigned to group 1.5. Similar groups were designated for 2.0, 2.5, 3.0, 3.5, 4.0, 4.5, and 5.0.

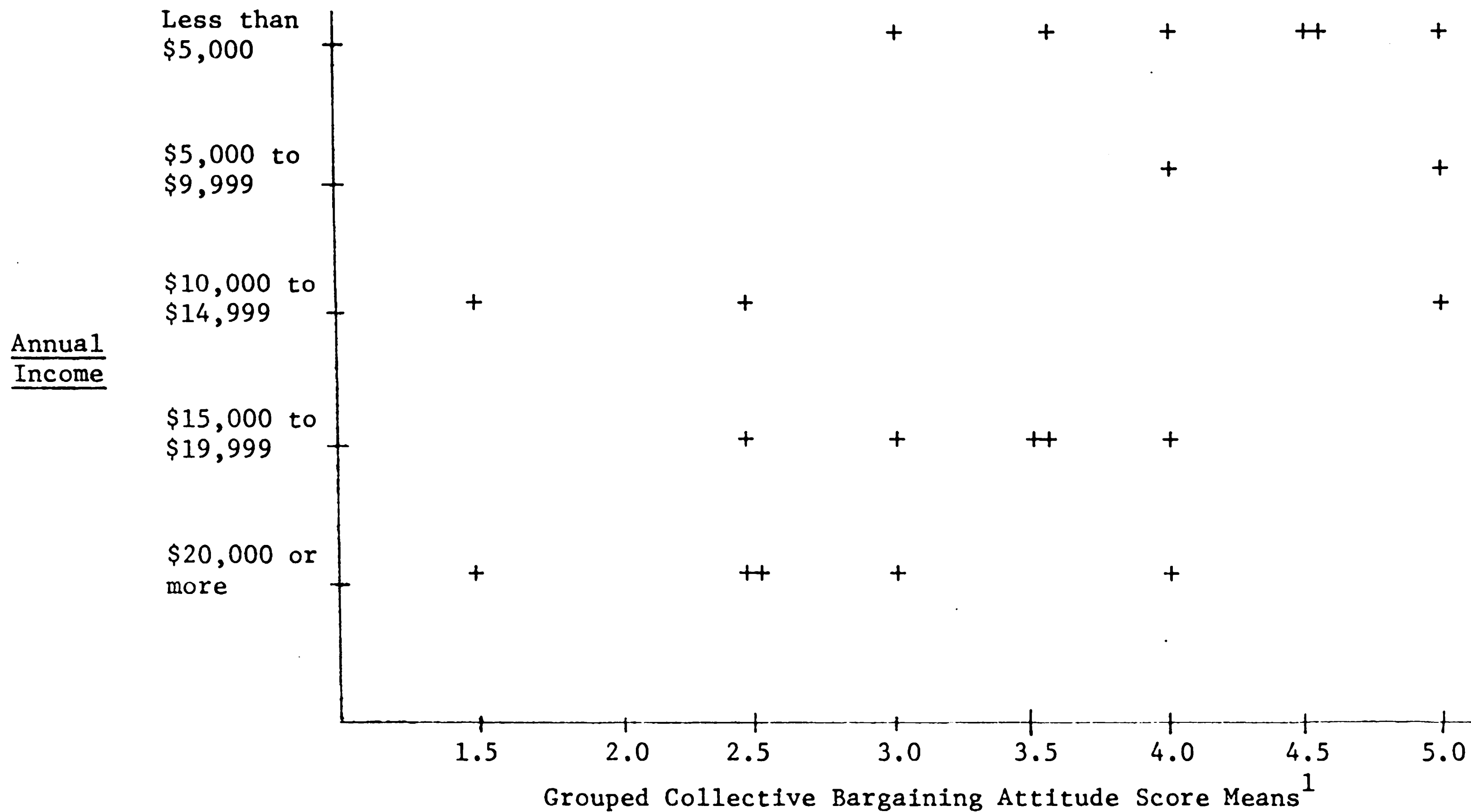

Figure 3. Scatter Diagram For Annual Income Plotted Against Grouped Collective Bargaining Attitude Scores.

---

[1]The range of the CBAS (1 through 5) was arbitrarily assigned into eight ordered groups, equally spaced. The number of respondents within each classification level was assigned to a group; for example, respondents having mean CBAS greater than 1 and equal to or less than 1.5 were assigned to group 1.5. Similar groups were designated for 2.0, 2.5, 3.0, 3.5, 4.0, 4.5, and 5.0.

collective bargaining. In Figure 3, respondents in the "$15,000 to $19,999" level, with mean grouped CBAS above 3.0, appeared to be favorable toward collective bargaining.

Results of the Tests of Hypotheses 11 Through 17

In the next six hypotheses, specific questions aimed at eliciting internalized attitudes of dietitians toward collective bargaining and unionization were investigated. The hypotheses focused upon (a) union organization of other professionals or groups, (b) wages, hours, and conditions of employment, as well as (c) changes in dietitians' attitudes over a period of time.

Collective Bargaining Attitude Scores were based from 1, strongly disagree with the statement, indicating an unfavorable attitude toward collective bargaining, to 5, strongly agree with the statement, indicating a favorable attitude toward collective bargaining and unionization. Hypotheses 11 through 14 were represented by single questions in Section II of the questionnaire. Each question was analyzed through use of a one-tailed, one-group t-statistic (Table XXVI). The predicted direction for all hypotheses, except Hypothesis 13, was represented by mean values above 3. Identical procedures were utilized for testing Hypothesis 13; however, predicted direction was represented by mean values below 3. The designated alpha level for the acceptance or rejection of the hypotheses was 0.05.

As reported in Table XXVI, a significant difference was found in Hypothesis 13. The derived t-statistic was $-3.04 > t_{.05, \infty} \doteq -1.645$; therefore, the hypothesis was rejected. Respondents disagreed with the

TABLE XXVI

t-TEST ON STATEMENTS REGARDING DIETITIANS' ATTITUDES TOWARD COLLECTIVE BARGAINING

Hypothesis	Statement Mean	Standard Deviation	t-Statistic
11. Collective bargaining is the best means to deal with employers	2.685	1.211	- 8.50
12. Published ADA salary and wage guidelines are realistic to employment practices	3.066	1.023	1.44
13. Dietitians' wages, hours, and conditions of employment compare favorably to other groups	2.896	1.114	- 3.04*
14. Specialization, increased knowledge, and future changes make dietitians vulnerable in their employment	2.675	1.107	- 9.53
15. Dietitians' attitudes have become more favorable to unionization	2.440	1.308	-13.39
16. Unionization is acceptable for other professions or groups	2.615	1.117	-11.14

*Significant at the .05 level ($t_{.05, \infty} \doteq -1.645$)

statement that dietitians think their wages, hours, and terms and conditions of employment compare favorably with those in similar professional groups. In Hypothesis 12, the derived t-statistic $1.44 < t_{.05, \infty} \doteq 1.645$ was not significant. Indications were that respondents were undecided as to whether the recommended salary ranges and employment guidelines as published by the ADA were realistic to actual practices. Hypothesis 11 ($-8.50 < t_{.05, \infty} \doteq 1.645$), Hypothesis 14 ($-9.53 < t_{.05, \infty} \doteq 1.645$), Hypothesis 15 ($-13.39 < t_{.05, \infty} \doteq 1.645$), and Hypothesis 16 ($-11.14 < t_{.05, \infty} \doteq 1.645$) were clearly non-significant in the opposite direction indicating slightly unfavorable attitudes of the respondents toward collective bargaining and unionization.

A major question propounded in the area of attitudes of professional dietitians was concerned with the appropriate role The American Dietetic Association might undertake, if given the opportunity by the membership, to exercise in collective bargaining and labor relations. The final hypothesis was tested by use of a one-tailed binomial test statistic, with an alpha level of 0.01.

A response favorable to ADA involvement in labor relations [Section III, Questions 1(a) or 1(b) or 1(c) or all three] was recorded as a single response for each subject. Those responses unfavorable to ADA involvement in labor relations [Section III, Questions 1(d) or 1(e) or both] were recorded as a single subject response. Failure to respond to the question or providing conflicting choices (favorable or unfavorable) resulted in no tabulation of these data. Total useable responses from the subjects were 975 responses.

As reported in Table XXVII, the derived z-value was 5.92 > $z_{.01}$, $\doteq$ 2.33. The evidence indicated highly significant differences. Respondents indicated that the ADA should involve the Association in collective bargaining, grievance matters, and labor relations on behalf of its members.

Additional Analysis

Additional statistical methods were utilized in the data analysis phase of this study. From a visual inspection of the data, it appeared that respondents had provided other information that was pertinent to the overall questions raised in this study.

Sex

As indicated in Table XXVIII, the mean Collective Bargaining Attitude Scores for male and female respondents were 3.03 and 2.61, respectively. While male dietitians represented only a small number of the respondents (2.8 percent), they appeared to have more favorable attitudes toward collective bargaining and unionization than did their female counterparts based on the Collective Bargaining Attitude Scores (mean 3.03 and 2.61, respectively). The overall mean CBAS for all respondents was 2.63.

The CBAS of respondents were analyzed through use of one-way analysis of variance for unequal sample size (Table XXIX). The designated alpha level for the acceptance or rejection was 0.01; the derived F value was $6.17 < F_{.01,\ 1,\ \infty} \doteq 6.63$. The evidence suggested that there was no significant difference in the CBAS of male and female respondents.

TABLE XXVII

BINOMIAL TEST ON ATTITUDES OF RESPONDENTS TOWARD APPROPRIATE ROLE OF ADA IN LABOR RELATIONS

Role of ADA in Labor Relations	Number of Responses	Observed Proportion	z-Value
1. To serve as the representative of professional dietitians in collective bargaining negotiations with employers			
2. To represent dietitians in employment-related grievance matters			
3. To continue to investigate the labor relation options open to the ADA			
Total	580	.595	5.92*[1]
4. Undecided			
5. Not become involved in labor relations			
Total	395	.405	

[1] $z_{obs.} > z_{.01, \infty} \doteq 2.33$

*Highly significant beyond the .01 level

TABLE XXVIII

MEAN COLLECTIVE BARGAINING ATTITUDE SCORES BY SEX

Sex	Number of Responses		Mean Collective Bargaining Attitude Score
Male	30		3.03
Female	1041		2.61
Total	1071	Mean	2.63

TABLE XXIX

ANALYSIS OF VARIANCE FOR COLLECTIVE BARGAINING ATTITUDE SCORES BY SEX

Source of Variation	Degrees of Freedom	Sum of Squares	Mean Square	F Value
Sex	1	5.1200	5.1200	6.1769[1]
Error	1069	886.1444	.8289	

[1]Not significant at the 0.01 level

Types of Labor Organization Activity

Another question raised was the type of participation in labor activity of respondents. In Table XXX, a description of the type of participation of respondents is indicated; however, because this was a multiple-response question, the information could not be meaningfully analyzed in percentages. Conflicting responses (both participation in labor organization activities and "none of these") were not tabulated; this amounted to 12 responses. It is evident (Table XXX) that more respondents have not been involved in labor organization activities than those who have participated.

Profile of Union Membership

In Table XXXI, union membership of the respondents indicating present membership (5.32 percent) was illustrated by both area and state or location. Area F had the highest union membership (2.24 percent) with New York State having the highest percentage of total union members (1.21 percent).

As reported in Table XXXII, a profile of union members was given for the following classifications: sex, age, educational status, income level, employment location, major job responsibility, length of ADA membership, employment status, and place of employment. Limited statistical methods were performed on these data because of the very small number of responses achieved. A visual inspection of the data did indicate several things. Of the questionnaire response rate, 2.8 percent were male ADA members and 97.2 percent were female ADA members. However, in looking at union membership, 7 percent were male union members

TABLE XXX

PARTICIPATION OF RESPONDENTS IN LABOR ORGANIZATION ACTIVITIES

Statement Description		Number Who Indicated Type of Participation[1]
Attended membership meeting sponsored by a union		63
Attended social events sponsored by a union		42
Attended educational program by a union		56
Organized or attempted to organize a union at their employment		13
Investigated potentialities of joining professional union		77
None of these		920
	Total	1171

[1]Number of responses greater than n = 1071 because respondents participated in more than one activity.

TABLE XXXI

FREQUENCY DISTRIBUTION OF RESPONDENTS BY UNION MEMBERSHIP AS DEFINED WITHIN THEIR AREA AND STATE OR LOCATION

Area	State or Location		Belong to Union: Number	Belong to Union: Percentage of Total Responses (N=1071)
A	California		8	0.747
	Hawaii		1	0.093
	Oregon		1	0.093
	Washington		1	0.093
		Total Area A	11	1.027
B	Kansas		1	0.093
	Michigan		1	0.093
	Minnesota		1	0.093
	North Dakota		1	0.093
	Wisconsin		1	0.093
		Total Area B	5	0.465
C	Arkansas		1	0.093
	Illinois		3	0.284
	Missouri		1	0.093
	Texas		1	0.093
		Total Area C	6	0.560
D	Georgia		2	0.187
	Kentucky		1	0.093
		Total Area D	3	0.280
E	Delaware		1	0.093
	Indiana		1	0.093
	Maryland		4	0.374
	Ohio		1	0.093
	Pennsylvania		1	0.093
		Total Area E	8	0.746
F	Connecticut		3	0.280
	Massachusetts		4	0.373
	New Jersey		3	0.283
	New York		13	1.214
	Rhode Island		1	0.093
		Total Area F	24	2.243
		Grand Total	57	5.322

TABLE XXXII

PROFILE OF UNION MEMBERS

Description	Belong to Union	
	Number	Percentage of Total Union Membership Response (N=57)
Sex:		
Male	4	7.02
Female	53	92.98
Total	57	100.00
Age:		
Over 55	7	12.28
46 to 55	16	28.07
36 to 45	11	19.30
26 to 35	15	26.31
Less than 26	8	14.04
Total	57	100.00
Educational Status:		
Baccalaureate	29	50.88
Master's	27	47.37
Doctorate	1	1.75
Total	57	100.00
Annual Income:		
Less than $5,000	3	5.26
$5,000 to $9,999	4	7.02
$10,000 to $14,999	24	42.11
$15,000 to $19,999	21	36.84
$20,000 or more	5	8.77
Total	57	100.00
Employment Location:		
City 100,000 or larger (including suburbs)	37	64.92
City 10,000 to 90,000	13	22.80
Town 2,500 to 9,999	5	8.77
Town 2,499 or less	2	3.51
Rural (farm or country)	--	--
Not employed, retired, or full-time student	--	--
Total	57	100.00

TABLE XXXII (Continued)

Description	Number	Belong to Union Percentage of Union Membership (N=57)	Total Response
Major Job Responsibility:			
Teaching	16	28.07	
Food service	2	3.51	
Therapeutic	9	15.79	
General	12	21.05	
Management	7	12.28	
Public health	7	12.28	
Consultant	2	3.51	
Other	2	3.51	
Total	57	100.00	
Length of ADA Membership:			
Less than 5 years	18	31.58	
5 to 9 years	11	19.30	
10 to 19 years	12	21.05	
20 to 29 years	13	22.81	
30 years or more	3	5.26	
Total	57	100.00	
Employment Status:			
Employed full time	50	87.72	
Employed less than full time	7	12.28	
Full-time student	--	--	
Part-time student/ part-time employed	--	--	
Not employed	--	--	
Retired	--	--	
Total	57	100.00	
Place of Employment:			
Hospital	17	29.82	
Health-care facility	5	8.77	
College or university	8	14.04	
School foodservice	2	3.51	
Government agency	10	17.54	
Public health agency	9	15.79	
Self-employed	--	--	
Employed in field other than dietetics	4	7.02	
Other	2	3.51	
Total	57	100.00	

and 93 percent were female union members; therefore, males made up a higher proportion of union membership than ADA membership response to the questionnaire. Union membership was predominantly represented in the $10,000 to $14,999" and $15,000 to $19,999" income levels; and union members were largely in hospitals, government agencies, and public health agencies. Any further conclusions drawn for this segment of the study would be of a highly speculative nature.

Additional Observations

Additional data were collected during the study upon which only limited analysis was performed. Some respondents provided unsolicited remarks and letters regarding their attitudes toward collective bargaining and unionization.

Approximately 3.8 percent (41 responses) of the total of 1071 returned questionnaires included additional comments. These comments were categorized into four general groupings as follows: (1) favorable remarks toward collective bargaining (22.0 percent), (2) unfavorable remarks toward collective bargaining (31.7 percent), (3) general remarks neither favorable or unfavorable toward collective bargaining (34.1 percent), and (4) unfavorable remarks directed against The American Dietetic Association (12.1 percent).

Selected favorable comments toward collective bargaining included:

1. Unionization is a means of maintaining our professional status in a changing society.

2. We, as dietitians, are helpless in our jobs. . . other health professionals are banning together and receiving their due recognition.

3. Merit consideration is worth nothing when the dietitian is one insignificant individual in the organization's eyes -- unions provide a voice.

Conversely, unfavorable remarks toward collective bargaining included:

1. I can do my own negotiating and don't need a mouth-piece who gets a fat kick-back to sit on his behind and ride in a black Cadillac.

2. This is a Right-to-Work state, and we plan to keep it that way.

3. Unions may have had their place years ago but in this day and age. . . unions have gone far beyond their purpose for being; their demands will eventually ruin all our country.

4. Our professional reputation would suffer. . . not worth the cost. Doesn't anyone consider the patients anymore?

General comments included:

1. I have been retired a number of years and have not kept abreast of unions and bargaining among dietitians.

2. Whether unionization will add to or subtract from the intrinsic value of this profession, I'm not sure.

3. Dietitians lack clout but I'm not sure unions are the answer.

Selected unfavorable comments toward The American Dietetic Association included:

1. The ADA did nothing for me in the last twenty-five years except charge dues. . . asking the ADA to function as a union will only increase dues.

2. The ADA will never be the AMA in the area of economic benefits to its members, why even consider such a possibility?

3. How does one expect the ADA to operate efficiently in 1976 when it's still concerned with its 1920 image?

CHAPTER V

SUMMARY AND CONCLUSIONS

The purpose of this study was to investigate the attitudes of professional dietitians toward collective bargaining and unionization. Data derived served as a means for analyzing the dietitian's position regarding labor relations and provided inferences concerning the possible implications for all dietitians who are members of The American Dietetic Association.

This study focused primarily upon providing answers to several major questions which were developed into seventeen hypotheses. A questionnaire was constructed, pre-tested, and administered to randomly selected members of The American Dietetic Association. An overall response rate of 1071 (59.22 percent) was achieved.

Attitudinal responses of dietitians were first investigated among the following classification dimensions: employment status, age, sex, educational status, major job responsibility, employment location, geographic area and state or location, length of ADA membership, and whether or not the respondent was a member of a professional union or labor organization. In addition, statement-response questions were developed to elicit the dietitians' attitudes toward collective bargaining and unionization. The response choices ranged from 1, strongly disagree with the statement, indicating an unfavorable attitude toward collective bargaining, to 5, strongly agree with the statement, indicating a favorable attitude toward collective bargaining. Responses to selected questions were designated as Collective Bargaining Attitude

Scores (CBAS) which were utilized to analyze the classification and geographical data.

Finally, individual questions were provided to elicit attitudes of dietitians toward (a) union organization of other professionals or groups, (b) The American Dietetic Association's position regarding labor relations, and (c) actual labor organization involvement by dietitians, as well as, (d) changes in attitude over a period of time.

Five major statistical methods were employed in analyzing the data obtained: one-way analysis of variance; one-tailed, one group t-statistic; point multiserial correlation coefficient; one-grouped binomial test; and Duncan's New Multiple Range test procedure. These analysis techniques focused upon seventeen hypotheses.

In general, the respondents were representative of ADA membership (Table III). The greatest percentages of dietitians in this study were: female (97.2 percent), employed full time (58.9 percent), living in a city of 100,000 or larger population (47.0 percent), and were receiving annual incomes of $10,000 to $14,999 (43.1 percent). The majority of dietitians (approximately two-thirds) had baccalaureate degrees. Approximately 5.3 percent of the dietitians belonged to a professional union or labor organization.

The overall mean Collective Bargaining Attitude Scores (CBAS) for all respondents was 2.63 indicating slightly unfavorable attitudes toward collective bargaining. However, mean CBAS widely varied within each classification level; for example, mean CBAS of dietitians by state

or location ranged from a low of 1.81 for South Dakota to a high of 3.35 for the District of Columbia.

Significant differences in the attitudes expressed by dietitians resulted when CBAS were statistically analyzed in relation to the classification dimensions. The evidence suggested that significant differences at or beyond the designated 0.01 alpha level were detected within the following classifications: place of employment, age, educational status, annual income, length of ADA membership, union membership, employment status, major job responsibility, and employment location. No significant difference was determined for the six geographic areas as defined by the ADA. Further statistical techniques were applied to the mean CBAS of dietitians to determine significant differences within the levels of each classification. The designated alpha level for acceptance or rejection was set at 0.05.

Several inferences can be drawn from the results of this study. Younger dietitians with fewer years of ADA membership appeared more favorable toward collective bargaining than dietitians in advanced age levels with more years of ADA membership. Dietitians employed in government agencies and public health agencies were more favorable toward collective bargaining than those in health-care facilities and those self-employed. Unfavorable attitudes were registered at all levels of the educational status and employment location classifications even though significant differences existed among levels. While the percentage of dietitians having union membership was small (5.32 percent) in comparison to those not belonging to unions, indications were that union members had a favorable attitude toward collective

bargaining in comparison to non-union members. Dietitians who were full-time students (employment status classification) or whose major job responsibility (classification) was public health indicated a favorable attitude toward collective bargaining compared to those indicating retired or consultant for each classification respectively.

Specific questions were investigated concerning dietitians' attitudes toward collective bargaining. While dietitians did not think their wages, hours, and terms and conditions of employment compared favorably with other professionals or groups, they failed to indicate collective bargaining as the best means of increasing the dietitian's overall professional well-being. However, dietitians strongly expressed interest in The American Dietetic Association continuing its efforts in the area of labor relations.

This study was intended to provide data-based inferences related to the attitudes of professional dietitians toward collective bargaining and unionization; that objective was successfully achieved. The study was an initial attempt at providing empirically founded input regarding the attitudes of professional dietitians. As such, it can provide useful insights into and specific direction for additional research needed in the area of labor relations for dietitians.

CHAPTER VI

RECOMMENDATIONS

There is a general absence of data-based research regarding collective bargaining and unionization activities of professional dietitians. Therefore, there remains an almost limitless amount of research to be conducted. Further investigation would be useful if data were obtained from dietitians belonging to professional unions or labor organizations. In the same manner, various factors contributing to the need to belong to or to maintain membership in labor organizations might be identified and compared conversely with those pertaining to dietitians who are not union members. Such a study would be of value to dietitians within the Association in formulating positions and policies regarding labor relations. Studies might concentrate also on assessing the level of knowledge of dietitians regarding collective bargaining and labor relations.

Continuous input of data from the membership should be obtained for the Association through channels such as a committee or panel. Such channels should also consider environmental factors relevant to labor relations which would be of value to the Association. Research on a national scale could produce new generalizations regarding collective bargaining desires of dietitians; this information could provide useful insight for a labor relations staff representative in order to develop educational materials and programs and in communicating labor relations information to the entire membership and to employers of dietitians.

LITERATURE CITED

Allen, A. D. 1972. Organizing the egghead: professors and collective bargaining. Labor Law J. 23(6):606.

Aluto, J. A. and Belasco, J. A. 1974. Determinants of attitudinal militancy among nurses and teachers. Labor Rel. R. 27(1):216.

Anderson, H. J. 1975. "Primer of Labor Relations," 20th ed. The Bureau of National Affairs, Inc., Washington, D.C.

Anonymous. 1972a. The hospital physician. Med. Econ. 8:103.

Anonymous. 1972b. "The Report of the Study Commission on Dietetics: The Profession of Dietetics," The American Dietetic Association, Chicago, Illinois.

Anonymous. 1972c. The unionizing push in the professions. Nation's Bus. 60(1):39.

Anonymous. 1972d. Women workers: gaining power, seeking more. U.S. News. 73:104.

Anonymous. 1973. MD unions split over issue of labor ties. Med. World News. 14(3):17.

Anonymous. 1974a. Labor relations committee begins series of reports. ADA Courier. 13(2):1.

Anonymous. 1974b. Position paper on recommended salaries and employment practices for members of The American Dietetic Association. J. Am. Dietet. Assoc. 64(2):188.

Anonymous. 1974c. The NLRA and private hospital. Commerce Clearing House, Inc., New York.

Anonymous. 1974d. Unions to step up white-collar organizing. Banking J. 66(1):12.

Anonymous. 1974e. The ANA: can a professional association be a trade union, too? J. Am. Hosp. Assoc. 48(a):103.

Anonymous. 1974f. "White-colar power": its meaning to union movement. U.S. News. 75(1):99.

Anonymous. 1975a. Position paper on the administrative dietitian. J. Am. Dietet. Assoc. 67(5):479.

Anonymous. 1975b. Position paper on the role of the registered dietitian in consultative services to group care facilities. J. Am. Dietet. Assoc. 67(6):579.

Anonymous. 1976a. Collective bargaining for physicians: 'something' new in AMA policy. J. Am. Hosp. Assoc. 50:121.

Anonymous. 1976b. News flash. ADA Courier. 15(2):1.

Anonymous. 1976c. Questions from members on labor trends and their implications in the health field. ADA Courier. 15(1):1.

Anonymous. 1976d. Officers, 1975-1976. J. Am. Dietet. Assoc. 68(1):4.

Aussieker, B. and Garbarino, J. 1973. Measuring faculty unionism: quantity and quality. Ind. Rel. 12(5):117.

Barber, M. I. 1959. "History of The American Dietetic Association," J. B. Lippincott, Co., Phila., Pa.

Beal, E. F. and Wickersham, E. D. 1967. "The Practice of Collective Bargaining," 3rd ed. Richard D. Irvin, Inc., Homewood, Ill.

Bedford, M. R. 1971. Opinions of hospital dietitians toward unionization of food service personnel. Master's thesis, Kansas State University, Manhattan, Kansas.

Bedford, M. R. 1976. Private communication. Virginia Polytechnic Institute and State University, Blacksburg, Virginia.

Belcher, D. W. 1974. "Compensation Administration," 3rd ed. Prentice-Hall, Inc., Englewood Cliffs, New Jersey.

Blaker, G. 1973. Confusion in the identity of the dietitian. J. Am. Dietet. Assoc. 63(4):427.

BLS. 1964. Brief history of the American labor movement. Bull. 1000, U.S. Department of Labor, Washington, D.C.

BLS. 1971. Area wage surveys: metropolitan areas, U.S. reg. summaries, 1969-1970. Bull. 1660-1692, Washington, D.C.

BLS. 1974a. Hospitals, August 1972. Industry Wage Rev. Bull. 1829, Washington, D.C.

BLS. 1974b. Women workers today. Women's Bureau of Employment, Standards Admin., Washington, D.C.

BLS. 1975a. Occupational outlook handbook, 1974-1975. Bull. 1785, U.S. Department of Labor, Washington, D.C.

BLS. 1975b. The changing economic role of women, manpower report to the president -- 1975, Washington, D.C.

BNA. 1975. White collar report Number 973. Washington, D.C.

Bok, D. C. and Dunlop, J. T. 1970. "Labor and the American Community," Simon and Schuster, New York.

Bognanno, M. F., Dworkin, J. B. and Omotayo, F. 1975. Physicians' and dentists' bargaining organizations: a preliminary look. Mo. Labor R. 98(4):33.

Borg, W. R. 1963. "Educational Research: an Introduction," David McKay, Co., New York.

Brown, S. 1969. The history and development of unions and collective bargaining in hospitals in the U.S. Master's thesis, University of Iowa, Iowa City, Iowa.

Bunker, C. S. 1973. "Collective Bargaining: Non-Profit Sector," Grid, Inc., Columbus, Ohio.

Burger, C. 1975. Private communication. American Dietetic Association, Chicago, Illinois.

Butte Medical Properties dba. Medical Center Hospital, 168 NLRB No. 52, 1968-ICCH, NLRB par. 21, 915.

Cheek, N. H. 1967. The social role of the professional. Quoted in Abrahamson, M. (ed.), "The Professional in the Organization," Rand McNally Co., Chicago, Ill.

Cleveland, S. E. 1963. Personality characteristics of dietitians and nurses. J. Am. Dietet. Assoc. 43(1):104.

Chamberlain, N. W. and Kuhn, J. W. 1965. "Collective Bargaining," 2nd ed. McGraw-Hill, New York.

Cogan, M. L. 1953. Toward a definition of profession. Harvard Ed. R. 23:33.

Davey, H. W. 1965 Professional security is your professional right. Iowa Nurses Bull. 1:2.

Demarko, K. 1976. An empirical investigation of the priorities of various demands by recently-organized nonprofit hospital employees. Master's thesis, Virginia Polytechnic Institute and State University, Blacksburg, Virginia.

Dewey, L. M. 1971. Women in labor unions. Mo. Labor R. 94(2):42.

Douty, H. M. 1971. Prospects for white collar unionism. Mo. Labor R. 92(1):31.

Dugdale, K. 1967. "A Manual on Writing Research," University Book Store, Bloomington, Indiana.

Edmondson, M. T. and Simon, A. J. 1974. Arbitration in higher education. Ind. Rel. 29(3):217.

Edward, W. and Mahan, S. P. 1970. Organized labor in non-profit agencies. Amer. J. Occup. Ther. 24(3):1.

Epstein, R. L. 1975. The legal perspective. Trustee. 28(7):7.

Epstein, R. L. and Stickler, K. B. 1976. The nurses as a professional and as a unionist. J. Am. Hosp. Assoc. 50(1):44.

Estey, M. 1967. "The Unions: Structure, Development, and Management," Harcourt, Brace, and World, Inc., New York.

Etzioni, A. 1964. "Modern Organizations," Prentice-Hall, Inc., Englewood Cliffs, New Jersey.

Evans, L. J. 1964. "The Crisis in Medical Education," University of Michigan Press, Ann Arbor, Michigan.

Evans, W. A. 1970. Pay for performance: fact or fable. Personnel J. 49:726.

Foster, K. E. 1961. What is merit increase? Personnel. 38(11):18.

Garbarino, J. W. 1974. Faculty unionism in the west. Ind. Rel. 13(1):1.

Garbarino, J. W. and Aussieker, B. 1975. "Faculty Bargaining: Change and Conflict," McGraw-Hill Co., New York.

Gellerman, S. W. 1963. "Motivation and Productivity," American Management Association, New York.

Goode, W. J. 1960. Encroachment, charlatanism, and the emerging professions: psychology, sociology, and medicine. Amer. Soc. R. 25(12):903.

Gordon, T. J. and Le Bleu, R. E. 1970. Employee benefits, 1970-1985. Harvard Bus. R. 48(1):93.

Gosman, M. L. and Krishnamurty, G. B. 1971. "Occupational Analysis: Hospital Food Service Department," U.S. Office of Education, Bureau of Research, Washington, D.C.

Haire, M., Ghiselli, E. E. and Gordon, M. E. 1967. A psychological study of pay. J. App. Psychol. 51(2):1.

Hallahan, I. A. 1974. Implications of the 1974 Taft-Hartley Amendment. J. Am. Dietet. Assoc. 65(5):554.

Hamdan, M. A. and Schulman, R. S. 1975. On point multiserial correlations. Australian J. Stat. 17(2):84.

Hart, M. and Sharp, J. 1975. The dietitian and credentialing. J. Am. Dietet. Assoc. 66(5):455.

Hayford, S. L. 1975. An investigation into the role description and collective bargaining-related desires of front line supervisors in public employment in the state of Iowa. Ph.D. thesis. The University of Iowa, Iowa City, Iowa.

Hepner, J. O. and Hepner, D. M. 1973. "The Health Strategy Game: A Challenge for Reorganization and Management," The C. V. Mosby Co., St. Louis, Missouri.

Herrick, N. Q. and Quinn, R. P. 1971. The working conditions survey as a source of social indicators. Mo. Labor R. 94(3):15.

HEW. 1970. State salary ranges. Department of Health, Education, and Welfare, Washington, D.C.

Hershey, N. 1969. "Labor Relations in Hospitals in the Private Sector: Proceeding of the Twenty Second Winter Meeting," Industrial Relations Association, Chicago, Illinois.

Hicks, C. R. 1964. "Fundamental Concepts in the Design of Experiments," Holt, Rinehart and Winston, Inc., New York.

Hillway, T. 1969. "Handbook of Educational Research," Houghton-Mifflin Co., Boston.

Hughes, E. C. 1945. Dilemmas and contradictions of status. Amer. J. Soc. 50:353.

Hyatt, J. C. 1974. Unions are stepping up efforts to secure bargaining rights for public employees. Wall Street J. Aug. 6, p. 38.

Kassalow, E. M. 1965. The prospects for white collar union growth. Ind. Rel. 5(1):37.

Kaufman, M. 1970. Putting a union label on white-collar employees. Conf. Bd. Rec. 7(9):46.

Kelly, J. and Bilek, D. 1973. White-collar unions: does middle management want them? Canadian Bus. 43(6):56.

Kerlinger, F. N. 1964. "Foundations of Behavioral Research," 2nd ed. Holt, Rinehart, and Winston, Inc., New York.

Kinney, H. C. 1969. A study of dietary department operations in 49 unionized and non-unionized hospitals in New York State. Master's thesis, Cornell University, Ithaca, New York.

Kleingartner, A. 1967. Nurses, collective bargaining, and labor legislation. Labor Law J. 82(4):236.

Klugh, H. E. 1974. "Statistics: the Essentials for Research," 2nd ed. John Wiley and Sons, Inc., New York.

Kralewski, J. E. 1974. Collective bargaining among professional employees. Hosp. Admin. 19(3):30.

Kruger, D. H. 1964. Labor relations in an era of change. J. Am. Dietet. Assoc. 44(6):472.

Kuhli, R. C. 1973. Accreditation of allied health professionals. Allied Health Education Newsletter, 4:9.

Lawler, E. E. and Porter, L. W. 1966. Predicting managers pay and their satisfaction with their pay. Personnel Psy. 19:363.

Levy, L. S. and Sampson, R. J. 1962. "American Economic Development," Allyn and Bacon, Boston.

Lewis, E. R. 1966. The New York City hospital story. Amer. J. Nur. 65:1526.

Lipscomb, M. and Donaldson, B. 1964. Management activities of director of dietetics. J. Am. Dietet. Assoc. 37(6):27.

Lipset, S. M. 1965. The future of non-manual unionism, Unpublished data. Institute of Industrial Relations, Berkeley, Ca. Quoted in Kassalow, E. M. (ed.). 1965. The prospects for white collar union growth. Ind. Rel. 5:37.

Lyle, J. R. and Ross, J. L. 1973. "Women in Industry," Lexington Books, Lexington, Mass.

Marcus, S.A. 1975. The purposes of unionization in the medical profession: the unionized profession's perspective in the United States. Inter. J. Health Services. 5(1):37.

Miller, G. A. 1960. Academic preparation for food service. II. Recent graduates evaluate their education. J. Am. Dietet. Assoc. 37(1):27.

Miller, R. L. 1971. Development and structure of collective bargaining among registered nurses. Personnel J. 50:134.

Moser, C. A. and Kalton, G. 1972. "Survey Methods in Social Investigation," Basic Books, Inc., New York.

Mosher, R. C. 1968. "The Professions, Professional Education, and the Public Service," Chandler Pub. Co., San Francisco, Ca.

Nash, A. 1972. Labor-management conflict in a voluntary hospital. Ph.D. thesis, New York University, New York, New York.

NLRB v. Jones and Laughlin Steel Corporation, 301 U.S. at 33.

Nolte, C. M. 1970. "Status and Scope of Collective Bargaining in Education," University of Oregon Press, Eugene, Oregon.

Oppenheimer, V. K. 1970. "The Female Labor Force in the United States," University of California Press, Berkeley, Ca.

Paxton, H. T. 1972. Union now? Yes, say 61% of surveyed doctors. Med. Econ. 49:31.

Petersen, D. J. 1972. Labor trends: white-collar unionization and the pay board. Personnel. 49(7):34.

Plowman, S. 1975. Woman's place in the home? Labor Gaz. 75(4):245.

Pointer, D. D. 1971. Employee organization in health care facilities: an exploratory analysis and evaluation. Ph.D. thesis, University of Iowa, Iowa City, Iowa.

Pointer, D. D. and Cannedy, L. L. 1972. Organizing of professionals. J. Am. Hosp. Assoc. 46(3):70.

Reynolds, L. G. 1964. "Labor Economics and Labor Relations," Prentice-Hall, Inc., Englewood Cliffs, New Jersey.

Robinson, J. W. 1974. Collective bargaining for college and university faculties: the other viewpoint. Marquette Bus. R. 18(4):164.

Robinson, J. W. and Walker, R. W. 1973. "Labor Economics and Labor Relations," The Ronald Press Company, N.Y.

Rosmann, J. 1975. One year under Taft-Hartley. J. Am. Hosp. Assoc. 49(24):64.

Rummel, J. F. and Ballaine, W. C. 1963. "Research Methodology in Business," Harper and Row Pub. Co., New York.

Sackley, A. and Gavett, T. W. 1971. Blue collar/white collar pay trends: analysis of occupational wage differences. Mo. Labor R. 94(6):5.

Sargent, C. W. 1963. Fringe benefits: do we know enough about them? The Amos Tuck School of Business Administration, Dartmouth Press, Hanover, N.H.

Schramm, C. L. 1976. Why the slowdown in faculty bargaining? Mo. Labor R. 99(3):43.

Schulman, R. S. 1976. Private communication. Department of Statistics, Virginia Polytechnic Institute and State University, Blacksburg, Virginia.

Scott, R. 1965. Reaction to supervision in a heteronomous professional organization. Adm. Sci. Q. 10(6):65.

SCPA. 1959. Swedish Professional Association as trade union. Swedish Confederation of Professional Associations, Stockholm, Sweden.

Seidman, J. 1965. The trend among professional groups today. Am. J. Nurs. 65(1):72.

Seidman, J., Kelly, L. and Edge, A. 1974. Faculty bargaining comes to Hawaii. Ind. Rel. 13(1):5.

Selden, W. K. 1969. Just one big happy family. Am. J. Med. Technol. 35(6):357.

Selden, W. K. 1972. SASHEP looks at forces affecting health care. J. Am. Dietet. Assoc. 61(1):22.

Selltiz, C., Jahoda, M., Deutsch, M. and Cook, S. W. 1964. "Research Methods in Social Relations," Holt, Rinehart, and Winston, Inc., New York.

Seymour, F. J. C. 1963. What is professionalism? Alberta Teachers Assoc. 43:20.

Siegel, S. 1956. "Nonparametric Statistics for the Behavioral Sciences," McGraw-Hill Book Co., New York.

Simmons, A., Freedman, A. E., Dunkle, M. C. and Blau, F. 1975. "Exploitation from 9 to 5: Report of the Twentieth Century Fund Task Force on Women and Employment," Lexington Book Co., New York.

Sharp, J. L., Hubbard, R. M., Sager, J. F. and Andrew, J. 1973. The dietetic profession -- a manpower survey. J. Am. Dietet. Assoc. 63(4):430.

Somers, D. 1974. Occupational ranking for men and women by earnings. Mo. Labor R. 97(5):34.

Stanton, E. S. 1974. Unions and the professional employee. Hosp. Prog. 54(2):58.

Strauss, G. 1963. Professionalism and occupational association. Ind. Rel. 2(5):7.

Stumpf, G. L. 1974. Labor relations among professional groups. J. Am. Dietet. Assoc. 65(2):138.

Svetlik, B., Prien, E. and Barrett, G. 1964. Relationship between job difficulty, employee's attitudes toward his job, and supervisory ratings of the employee's effectiveness. J. App. Psychol. 48(10):320.

Tannenbaum, A. S. 1965. Unions. Quoted in March, J. G. (ed.). "Handbook of Organizations," Rand-McNally and Co., Chicago, Ill.

Tannenbaum, F. 1960. The restoration of social status. Quoted in Bakke, E. W., Clark, K. and Anrod, C. W. (eds.). "Unions, Management, and the Public," Harcourt, Brace, and World, Inc., New York.

Torrence, W. D. 1973. Educating and training management in collective bargaining and labor relations. Hosp. Prog. 54(7):78.

Tyler, G. 1972. Why they organize. Public Admin. R. 32(3-4):97.

University Nursing Home, Inc., 1968 NLRB No. 53, 1968-1CCh NLRB par. 21, 916. Commerce Clearing House, New York.

Urlick, S. 1973. Will your appendectomy be performed by a member of the AFL-CIO? This button is fictitious, but doctors' unions are very real. Mod. Hosp. 121(10):63.

Wagner, L. A. and Bakerman, T. 1960. Wage earners' opinions of insurance and fringe benefits. J. Insur. 21:17.

Walker, J. W. 1974. Transition to bargaining in a multi-campus system. Ind. Rel. 13:23.

Weatherford, J. 1975. Professional associations and bargaining agents. Library J. 100(3):99.

Weisman, J. D. 1975. Chicago doctors and strike. The Washington Post, No. 344, A6.

Wertheimer, B. M. and Nelson, A. H. 1975. "Trade Union Women: A Study of their Participation in New York City Locals," Praeger Pub. Co., Inc., New York.

Winterfeldt, E. 1974. Professional standards review organization (PSROs). J. Am. Dietet. Assoc.

Wykstra, R. A. and Stevens, E. V. 1970. "Labor Law and Public Policy," The Odyssey Press, New York.

Yoder, D. 1970. "Personnel Management and Industrial Relations," 6th ed. Prentice-Hall, Inc., Englewood Cliffs, New Jersey.

APPENDIX A

DEFINITIONS

Definitions

Union

An organization sometimes referred to as a labor organization designed to protect and enhance the economic, political, and social welfare of its members (Edwards and Mahan, 1970). For example, the union may be specifically involved in grievance procedures, labor relations and disputes, wages and salaries, rates of pay, hours of employment, and terms and conditions of work for its members. The above listing should not be considered all inclusive.

Collective Bargaining

The process by which representatives of employees and employers confer to negotiate a working contract or agreement. Collective bargaining accomplishes three primary functions: (1) a method of establishing, revising, or administering rules of the organization; (2) a procedure to determine the compensation an employee receives and an influence on the distribution of economic surplus; and (3) a method for settling disputes during or after the life of the contract or agreement (Stumpf, 1974; Wykstra and Stevens, 1970). Collective bargaining not only means the negotiating process but takes on the broader meaning to include the theory, the law, the unions and all other interactions that occur between the employees and management (Chamberlain and Kuhn, 1965).

Professional Employee

Any individual requiring a high level of training and proficiency. The task performed is predominantly intellectual and extremely varied in

nature as opposed to routine, mental, mechanical, or physical tasks. Professional tasks require the continual exercise of discretion in addition to consistent judgment in task performance details (Stumpf, 1974).

Bargaining Unit

An employee group that has been appropriately designated, usually by the National Labor Relations Board (NLRB), as a unit for collective bargaining with its employer (Wykstra and Stevens, 1970).

APPENDIX B

COVERLETTER AND QUESTIONNAIRE

COLLEGE OF HOME ECONOMICS

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Blacksburg, Virginia 24061

OFFICE OF THE DEAN

March 26, 1976

Dear Colleague:

A study, as part of my doctoral research in Human Nutrition and Foods at Virginia Polytechnic Institute and State University, is being conducted to determine the attitudes of dietitians toward collective bargaining and unionization. Your assistance and participation is needed and would be appreciated. This opinionnaire is being sent to a random sample of dietitians throughout the United States, and your name was among those chosen. Complete anonymity of your response is assured.

Please mark according to instructions provided on the questionnaire the answers which Most Nearly indicate your opinions.

The results of this study may have significant implications for The American Dietetic Association and our members. Your answers will be most valuable in this investigation; therefore, as fellow dietitians, we urge you to participate in this study. Please place the questionnaire in the enclosed, stamped envelope and return no later than April 12, 1976. Place your name and address on the return envelope ONLY if you wish to receive a summary of the results of the study.

Thank you for your cooperation and your time in providing this information.

Sincerely,

Dana R. Spencer, R.D.
Capt, USAF, (Ret)

Mary E. Quam, Ph.D., R.D.
Assistant Dean
College of Home Economics

/jgm

Enclosures: 2

SURVEY OF THE AMERICAN DIETETIC ASSOCIATION MEMBERSHIP CONCERNING PROFESSIONAL UNIONIZATION

GENERAL INSTRUCTIONS: THE QUESTIONS IN SECTION I WILL PROVIDE BACKGROUND INFORMATION THAT WILL BE USED FOR CLASSIFICATION PURPOSES ONLY. SECTION II AND III REQUEST YOUR OPINION REGARDING LABOR ORGANIZATIONS AND COLLECTIVE BARGAINING. PLEASE ANSWER ALL QUESTIONS AS DIRECTED AND AS OBJECTIVELY AS POSSIBLE. ALL REPLIES WILL BE KEPT CONFIDENTIAL WITH NO ATTEMPT TO IDENTIFY YOU.

SECTION I

CLASSIFICATION DATA

YOUR STATE OF RESIDENCE ______________________________

PLEASE CHECK APPROPRIATE ANSWER (✓)

1. Employment Status:
   (1) _____Employed full time
   (2) _____Employed less than full time
   (3) _____Full time student
   (4) _____Part time student/part time employed
   (5) _____Not employed
   (6) _____Retired

2. Place of Employment:
   (1) _____Hospital
   (2) _____Health care facility
   (3) _____College/university
   (4) _____Government agency
   (5) _____School foodservice
   (6) _____Public health agency
   (7) _____Self-employed
   (8) _____Employed in field other than dietetics
   (9) _____Other (Please Specify)

   ____

3. Major Job Responsibilities:
   (1) _____Teaching
   (2) _____Food Service
   (3) _____Therapeutic
   (4) _____General (administration, therapeutic, and teaching)
   (5) _____Management
   (6) _____Public Health
   (7) _____Consultant
   (8) _____Other (Please Specify)

   ____

4. Present Annual Income:
   (1) _____Less than $5,000
   (2) _____$5,000----$9,999
   (3) _____$10,000--$14,999
   (4) _____$15,000--$19,999
   (5) _____$20,000 or more

5. Employment Location:
   (1) _____City 100,000 or larger (including suburbs)
   (2) _____City 10,000 to 90,000
   (3) _____Town 2,500 to 9,999
   (4) _____Town 2,499 or less
   (5) _____Rural (farm or open country)
   (6) _____Not employed, retired, or full-time student

6. Sex:
   (1) _____Female
   (2) _____Male

7. Educational Status:
   (1) _____Baccalaureate
   (2) _____Masters
   (3) _____Doctorate
   (4) _____Other (Please Specify)

   ____

8. Date of Birth:
   (1) _____Before 1920
   (2) _____1920---1929
   (3) _____1930---1939
   (4) _____1940---1949
   (5) _____1950 or later

9. Length of ADA Membership
   (1) _____Less than 5 years
   (2) _____ 5------- 9 years
   (3) _____10-------19 years
   (4) _____20-------29 years
   (5) _____30 years or more

10. Are you represented by a professional union or labor organization in negotiations with your employer?
   (1) _____Yes
   (2) _____No
   (3) _____Not employed, full-time student or retired.

SECTION II

STATEMENTS

INSTRUCTIONS: CIRCLE THE NUMBER WHICH MOST ACCURATELY DESCRIBES THE DEGREE TO WHICH YOU AGREE OR DISAGREE WITH THE STATEMENTS BASED ON THE FOLLOWING SCALE.

STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE
5	4	3	2	1

1. The guidelines for recommended salary ranges and employment conditions published by the ADA are a realistic reflection of the situation of most professional dietitians. 5 4 3 2 1

2. Dietitians' wages, hours, and conditions of employment compare favorably with those in similar groups or professions. 5 4 3 2 1

3. Trends toward specialization, increased academic knowledge, and possible changes in ADA membership requirements (i.e., licensure) may make dietitians vulnerable to unemployment, underemployment, or discharge. 5 4 3 2 1

4. Collective bargaining action is an effective means by which dietitians could achieve better wages, hours, and conditions of employment. 5 4 3 2 1

5. Professional employees who provide services affecting life, health, or property of others should not join labor organizations. 5 4 3 2 1

6. The American Dietetic Association should act as a professional union and enter into negotiations for its members. 5 4 3 2 1

7. Labor organizations have a significant influence on management, particularly in obtaining better salaries and other benefits for professional employees. 5 4 3 2 1

8. Professional unionization of dietitians can be considered a means of gaining and enhancing the status of dietitians. 5 4 3 2 1

9. Presently, dietitians gain more from individual bargaining with employers based on personal merit than they could from collective bargaining. 5 4 3 2 1

10. Professional employees <u>do not</u> need collective bargaining to assure that they will receive equitable rates of pay, hours, and conditions of employment. 5 4 3 2 1

11. Public reaction toward professional dietitians participating in collective bargaining would be positive. 5 4 3 2 1

SECTION III

GENERAL QUESTIONS

INSTRUCTIONS: PLEASE ANSWER QUESTIONS AS DIRECTED.

1. Which of the following is the appropriate role for The American Dietetic Association in labor relations matters? (Check more than one if necessary.)

   (1) _____To serve as the representative of professional dietitians in collective bargaining negotiations with employers.

   (2) _____To represent dietitians in employment-related grievance matters.

   (3) _____To continue to investigate the labor relations options open to the ADA.

   (4) _____Not become involved in labor relations.

   (5) _____Undecided.

2. With regards to a labor organization involving dietitians, have you ever---? (Check all that you have done.)

   (1) _____Attended membership meeting sponsored by a union

   (2) _____Attended social events sponsored by a union

   (3) _____Attended educational program by a union

   (4) _____Organized or attempted to organize a union at your employment

   (5) _____Investigated potentialities of joining professional union

   (6) _____None of these

INSTRUCTIONS: IN THE NEXT TWO QUESTIONS, CIRCLE THE NUMBER WHICH MOST ACCURATELY DESCRIBES THE DEGREE TO WHICH YOU AGREE OR DISAGREE BASED ON THE FOLLOWING SCALE:

STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE
5	4	3	2	1

3. Professional unions or labor organizations are acceptable for the following professions.

(a) Policepersons/firepersons	5	4	3	2	1
(b) Physicians	5	4	3	2	1
(c) Military personnel	5	4	3	2	1
(d) College/university faculty	5	4	3	2	1
(e) Registered nurses	5	4	3	2	1
(f) Professional athletes	5	4	3	2	1
(g) Elementary/secondary school teachers	5	4	3	2	1

4. Over the past five years, your attitude toward unionization of professional dietitians has become more positive. 5 4 3 2 1

THANK YOU FOR YOUR COOPERATION AND INPUT! PLEASE RETURN THE COMPLETED OPINIONNAIRE IN THE ENCLOSED, STAMPED ENVELOPE ADDRESSED TO:

Dana R. Spencer, R.D.
305 E. Roanoke Street
Blacksburg, Virginia 24060

APPENDIX C

GEOGRAPHIC AREAS

SIX GEOGRAPHICAL AREAS OF THE UNITED STATES
AS DEFINED BY THE AMERICAN DIETETIC ASSOCIATION

Area A:

(1) Alaska
(2) California
(3) Hawaii
(4) Idaho
(5) Montana
(6) Nevada
(7) Oregon
(8) Utah
(9) Washington

Area B:

(10) Iowa
(11) Kansas
(12) Michigan
(13) Minnesota
(14) Nebraska
(15) North Dakota
(16) South Dakota
(17) Wisconsin
(18) Wyoming

Area C:

(19) Arizona
(20) Arkansas
(21) Colorado
(22) Illinois
(23) Missouri
(24) New Mexico
(25) Oklahoma
(26) Texas

Area D:

(27) Alabama
(28) Florida
(29) Georgia
(30) Kentucky
(31) Louisiana
(32) Mississippi
(33) Puerto Rico
(34) South Carolina
(35) Tennessee

Area E:

(36) Delaware
(37) District of Columbia
(38) Indiana
(39) Maryland
(40) North Carolina
(41) Ohio
(42) Pennsylvania
(43) Virginia
(44) West Virginia

Area F:

(45) Connecticut
(46) Maine
(47) New Hampshire
(48) Massachusetts
(49) New Jersey
(50) New York
(51) Vermont
(52) Rhode Island

The vita has been removed from the scanned document

DIETITIANS' ATTITUDES TOWARD COLLECTIVE BARGAINING AND UNIONIZATION: AN EMPIRICAL INVESTIGATION

by

Dana Richard Spencer

(ABSTRACT)

This study was an empirical investigation regarding attitudes of professional dietitians toward collective bargaining and unionization. It focused upon providing answers to several questions which were developed into seventeen hypotheses. A questionnaire was constructed, pre-tested, and administered to 1,881 randomly selected members of The American Dietetic Association (ADA). An overall response rate of 59.22 percent was obtained.

Attitudes were investigated along demographic and geographic dimensions. Statement-response question choices ranged from 1, strongly disagree with the statement, indicating an unfavorable attitude toward collective bargaining, to 5, strongly agree with the statement, indicating a favorable attitude. Responses to selected questions were designated as Collective Bargaining Attitude Scores (CBAS) which were utilized in analyzing the classification and geographical data. Major statistical methods employed to evaluate responses were analysis of variance, binomial test, t-test, correlation coefficient, and Duncan's New Multiple Range test.

In general, the respondents were representative of The American Dietetic Association membership. Approximately 5.3 percent of the dietitians responding belonged to a professional union or labor

organization. The overall mean Collective Bargaining Attitude Score for all respondents was 2.63, indicating slightly unfavorable attitudes toward collective bargaining.

Significant differences in the attitudes expressed by dietitians were indicated when the Collective Bargaining Attitude Scores were statistically analyzed in relation to the classification dimensions. The evidence suggested significant differences at the designated 0.01 level within the following classifications: place of employment, age, educational status, annual income, length of ADA membership, union membership, employment status, major job responsibility, and employment location. No significant difference was determined for the six geographic areas as defined by The American Dietetic Association.

Several inferences were drawn from the above results. Younger dietitians with less years of ADA membership appeared more favorable toward collective bargaining than dietitians in advanced age levels with more years of ADA membership. Dietitians employed in government agencies and public health were more favorable toward collective bargaining than those in health-care facilities and self-employed levels. While the percentage of dietitians having union membership was small (5.32 percent) in comparison to non-union members, indications were that union members had a favorable attitude toward collective bargaining.

Overall, dietitians did not indicate collective bargaining as the best means of increasing their professional well-being. However, dietitians did strongly express interest in The American Dietetic Association continuing its efforts in the area of labor relations.