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Nurses Respond to Healthcare Restructuring: The Transformation of the Massachusetts Nurses Association

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Abstract

The most recent period of Massachusetts healthcare system reorganization began in the early 1980s. In part, this has been a response to soaring healthcare costs, countering them with diminished reimbursements. To decrease labor costs and survive in an increasingly competitive and market-driven healthcare environment, hospitals downsized and laid off nursing staff. Patient care and safety has concomitantly suffered. These efforts severely challenged nurses’ status. Radicalized rank and file members of the Massachusetts Nurses Association mobilized against the association leadership’s weak efforts to protect nurses’ social and economic interests and the deteriorating quality of care. They transformed an association whose main focus was supporting nursing’s professional image to one which became an activist labor union of professional workers. The history of this often contentious transformation is presented here within the context of these healthcare system changes. The MNA’s successes and pending challenges within the Massachusetts healthcare system are also discussed.

Keywords

Nurse unions; healthcare system restructuring; nursing profession; Massachusetts; nursing work environment; patient safety; healthcare reform advocacy; Massachusetts Nurses Association

The reorganization occurring in the US healthcare system since the 1980s conforms with the neoliberal free-market economic and political restructuring strategies promoted to remedy ever increasing and often overwhelming healthcare expenditures occurring at local, state, and national levels by governments, businesses, and individuals. Within the perspective of post-World War II liberal capitalism, the expanding availability of healthcare services

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functioned as a central feature of the social safety net (Gottschalk, 2000) and represented the realization of Roosevelt's "New Deal" economic program of the 1930s. For the past two decades, free-market restructuring has shifted greater responsibility for the cost of healthcare to individuals (Jessop, 2002; Pollin, 2003) and away from organizations. The country has seen a rapid abandonment of healthcare as a public service and its conversion to commodity status (Salmon, 1990). This change is epitomized by "consumer-directed" health insurance plans (Newhouse, 2004) and a movement to defined contributions to employee health benefits by corporations as the latest way to control costs. The resurgence of free-market ideology largely began during the Reagan Revolution of the 1980s and has grown steadily since. The emphasis on the dismantling of the welfare state through the privatization of traditional public services, accompanied by government deregulation, transformed former non-profit hospitals and insurance companies into profit driven institutions (Coburn, 2000; Hart, 2004).

A great deal of health services research has focused on the impact these changes have had on the access and availability, quality, and resultant distribution costs of healthcare services (Aday, 1993, pp. 1-21; Hellander, 2003; Himmelstein & Woolhandler, 1984, 2002; Institute Of Medicine, 2001; Institute of Medicine, 2002; Kohn, Corrigan, & Donaldson, 1999; Lasser, Himmelstein, Woolhandler, McCormick, & Bor, 2002). Somewhat less attention has been focused on the point of production of healthcare services and changes in the work environment as a result of free-market strategies for nurses and other hospital workers brought about through this restructuring.

In Massachusetts, nurses, through the Massachusetts Nurses Association (MNA), responded to these changes with activism and organizing. A long-standing emphasis upon being a professional association gave way to becoming a labor union of professional healthcare workers–nurses. This change is directly related to the hospital industry's assault upon nurses power, working conditions, and professionalism, and aims to mount successful opposition to the corporate restructuring of the healthcare sector.

We embarked upon a study of the MNA's more recent history in order to understand this transformation. Our methods included interviews conducted with practicing nurses who were MNA members as well as key staff of the union. Data were also collected through focus groups with practicing union member nurses addressing workplace health and safety, discrimination issues, and reorganization of their facilities.

CORPORATE RESTRUCTURING OF THE HOSPITAL AND NURSE'S WORK

Massachusetts, a center of healthcare excellence and innovation, passed through a turbulent financial period that demanded reorganization of its hospitals if they were to survive in the new and competitive environment. Hospitals undertook major reorganization and retrenchments in what often turned out to be futile attempts to contain costs and boost profits while trying not to compromise severely the quality of care to patients who ultimately suffered in the end and revolted against the excesses that came about. Hospitals adapted production techniques and rationales from manufacturing and other industrial sectors such as TQM and "just in time" strategies. In the process, they turned the public service model of

providing patient care into a competitive profit-driven enterprise. They merged, integrated, and consolidated, while their nursing workforce, a major variable cost center and an attractive target for economizing, was downsized, deskilled, cross-trained, and reorganized. Nurse-to-patient ratios increased dramatically and less skilled nurse's aides were assigned patient care responsibilities formally performed by nurses to try to keep personnel costs low. The results were often disastrous for the nurses, the patients and the hospitals themselves, a number of which were forced to close as a result of these changes.

Deregulation, corporatization, and managed care competition entered the healthcare mix with a vengeance (Cai, Chin, Schiff, & Scott, 2000, pp. 1-4 & 83-89; Grossman, 2000). State and federal reimbursement policies, deregulation and privatization measures took a toll on nurses, throwing them into a highly stressful health care workplace. Frontline nurses sought collective bargaining support from the MNA. But the leadership who controlled the MNA, coming from positions in academia and private and government bureaucracies for the most part, had a difficult time equating the idea of a union bargaining collectively on their behalf with the professional image of contemporary nursing which they had attempted build up and to which they were deeply committed. This rift in operating policies led to a decade of covert infighting and public battles between the MNA rank and file and its leaders. The end result was a massive overhaul of both the structure and the philosophy at the MNA and the spawning of a competitive organization, the Massachusetts Association of Registered Nurses (M.ARN). With the union transformation and splintering, the Massachusetts politicians and health care executives heard the frontline, as well as the professional, voice of Massachusetts nurses addressing hospital patient care operations and nursing employment policies in a new and more forceful and direct way.

The corporate restructuring of healthcare, and particularly the hospital sector, drove it to function more as a profitable industrial model, as opposed to a critical human service provider, and vastly changed the working conditions of nursing. During the 1980s and late 90s, under intense pressure to cut costs, hospitals hired consulting firms who guided their implementation of a combination of Taylorist and Lean Production techniques, often called high performance production systems, to follow the example of other industrial sectors and cut their workforce. With registered nurse salaries generally accounting for 30% of a hospital's average annual budget, firing nurses became the easiest way to cut costs and boost financial performance (Preuss, 1998, pp. 3-4).

Between 1981 and 1993, thousands of nurses across the country were laid-off by hospitals. The proportion of nursing personnel relative to the number of patients fell 27% in Massachusetts, 25% in New York, and 20% in California. Nationally, nursing personnel, as a percentage of the hospital labor force, dropped from 45% in 1981 to 37% in 1993 (Weinberg, 2003 p. 10). "Just-in-time" techniques were put into place, where nurses hours were cut to dangerously low levels and when a particular unit's patient volume became too high, nurses were "floated" to that unit "just in time," regardless of their experience in that area of the hospital or the care methods required to treat patients (DeMoro, 2000). Patient care quality was seriously compromised with these approaches.

A new division of labor deskilled and disempowered nurses. Lower cost, and inadequately trained (Fagin, 2001; Heaphy, Edmondson, & Bohmer, 2000, pp. 6-7) unlicensed assistive personnel (UAPs), or nurse assistants, began to represent a greater proportion of the patient care workforce. Hospitals divided up the care process into tasks, shifting nurses from hands-on-patient care to serve as team leaders of LPNs and UAPs who now performed the “mundane” tasks of changing bedpans, and comforting and bathing patients (Fagin, 2001; Schindul-Rothschild, Berry, & Long-Middleton, 1996). Over time, the inadequately trained UAPs were given broader responsibility for patients, such as assessing vital signs, changing sterile dressings, and reading electrocardiograms (Fagin, 2001; Gordon, 1997, pp. 261-265). Registered nurses were assigned leadership responsibility over the UAPs, but they protested that they had neither the time nor the training to supervise such workers (Barter, McLaughlin, & Thomas, 1997). Moreover, this often put a nurse’s license in jeopardy by shifting the emphasis away from patient care (Kreplick, 1995). These complaints were often brushed aside by hospital management as nurse’s resistance to organizational change.

Decreased nursing staff levels resulted in hospital ward “speed-up” and “intensification” (Conway, 2001; Gordon, 1997, pp. 261-268; Schindul-Rothschild et al., 1996). Nurses took on higher patient loads and, in addition to supervising the LPNs and UAPs. Hospital downsizing forced the remaining nurses to work stressful and excessive amounts of mandatory overtime (Fox, 2003; Pear, 2003). In more than a few instances, nurses were required to work 12 or more hours per shift and well over 60 hours a week (Stencel & Dobbins, 2003). Increased patient loads violated professional nursing standards which dictate a patient/staff ratio of 1:1 or 1:4 depending on unit worked. Nurses were now facing ratios starting at 1:2 and going to 1:10 or higher per shift (Fox, 2003; MNA, 2002; Pear, 2003).

Patient care protocols and practices changed, further deteriorating the quality of work for nurses. Nurses’ concerns that patients were at risk were supported by patient care research. Aiken et al. (2002) found that patients seen by a nurse with a 1:10 ratio had a 42% increase in mortality. Even a ratio of 1:6 creates a 14% increase in mortality. High patient loads made patient care risky and stressful. Needleman et al. found that patients who received care from nurses, as opposed to LPNs and aides, experienced fewer medical complications including urinary tract infections, pneumonia, shock and cardiac arrest, upper gastrointestinal bleeding and failure to rescue. The study determined that higher nurse staffing is associated with an up to 12% reduction in these negative outcomes.

Increased patient ratios were implemented even as the overall acuity levels of patients increased. Acuity is a nationally used relative measure of patient care needs, measured by the hours of care required per 24 hours, by patient type. Reorganization of hospital care delivery resulted in outsourcing lower acuity types to outpatient care facilities, while patients in the next to highest category of care needs were placed in general care units (Heaphy et al., 2000; Pindus & Greiner, 1997, section 2; Preuss, 1998, p. 13; Schindul-Rothschild et al., 1996). During an interview a twenty-year emergency room (ER) nurse stated: “The people you are seeing on the floors now used to be in ICU. The acuity has increased ten fold.”

THE IMPACT OF RESTRUCTURING

As the frontline workers who dealt head-on with the ramifications of reorganization, nurses felt its full affects. It appeared that conditions were worse in areas with high managed care penetration, like Massachusetts (Schindul-Rothschild et al., 1996). There, nurses found themselves in a cold, business-oriented health care environment. Hospitals routinely cut corners, punished employees, and risked patient safety. As the chair of a hospital MNA bargaining unit informed us:

There's very little compassion in getting all of this done, ... its ... a business model of make it fast, make it work, and keep the numbers up. ... And don't stop in the meantime to hold anybody's hand because that's not a billable hour. ... There's a big facade of things being all for the patient and all for healthcare and everything else, but in the meantime it's not even close to that. ... No patient focus; it's all business.

Nurses were forced to make impossible decisions. Not surprisingly, they became demoralized. Another nurse noted:

In the ER I would have 5-6 critical care patients myself. Well ok, this man is having a MI [myocardial infarction–heart attack], this one is having a stroke, who do I give my attention to? I was miserable. I was coming home thinking, “Did I do everything I should have done? Did I tell everyone everything that should have been done?”

Despite their efforts to provide responsible patient care, they received little support or respect from hospital administrators. A 30-year nurse stated:

Administration is less respectful of nursing. My biggest struggles are not with my patients, not with the community, ... but dealing every day with the administration that tries to run a business out of a health care atmosphere.

In surveys, nurses report being burned out by excessive patient loads and poor working conditions (MNA, 2003a); declining job satisfaction followed (Martin, 2003; MNA, 2002; Peter D Hart Research Associates, 2001). Other research demonstrated an association between these conditions and a dramatic rise in nurses' injury rates. A study by the Minnesota Nurses Association found a link between health care restructuring and an increase in back injuries. Nurse injuries increased 65.2% among 12 Minneapolis/St. Paul area hospitals that had reduced their nurse staff by 9.2% (Helmlinger, 1997). According to the U.S. Bureau of Labor Statistics reported that nurses are one of the top ten occupations with non-fatal occupational injuries (Bureau of Labor Statistics, 2001).

Hospital restructuring negatively altered nurses' work environment. According to one nurse, They were no longer able to, “treat people the way they should be treated and the way they learned how to care for people.” Hospitals attempted to turn nurses into factory workers and patients into widgets. And, as in other industrial sectors, the front line workers, the nurses, were excluded in the decision-making about changing their work processes.

Nurses considered themselves to be professionals, educated and trained to uphold standards of care and practice, and a code of conduct and ethics, but they are also workers and employees of institutions. In Massachusetts, many nurses increasingly believed that nursing could not be allowed to deteriorate further. For them, a successful challenge to corporate restructuring of healthcare required a strong labor union at workplace and a stronger, more organized voice, in the public policy arena. As a result, nurses undertook the hard work to transform the Massachusetts Nurses Association into that union.

THE MNA'S HISTORY

The Massachusetts Nurses Association (MNA) was founded in 1903 by 300 diploma nurses at Faneuil Hall in Boston. Since its establishment, the MNA's purpose has been to further the profession of nursing for the betterment of nurses and their patients. To best accomplish this, the MNA took the form of a professional organization, with nursing elites (nurse managers, educators, researchers, and other advanced degree nurses) at the forefront, putting in place both legal and educational structures that would define the practice of nursing (Schildmeier, 2003a). For more than 80 years, with little exception, this structure and philosophy remained static.

Despite the union movements of the 1930s, hospital workers were not covered under the National Labor Relations Act (NLRA). Nurses could organize, but employers were under no legal obligation to recognize or bargain with them. Believing that unions were for blue-collar workers, and not professionals, elite nurses controlling the MNA and its national affiliate, the American Nurses Association (ANA), did not object to omission from the NLRA. The MNA and the ANA maintained a no strike policy. Their members could be legally replaced by strikebreakers and had no bargaining rights.

But, early on, Massachusetts' frontline nurses had a different approach than their leaders. In 1957, for example, the nurses at a small municipal hospital formed a union and organized a mass resignation to force the city to grant them a contract and pay increase. The MNA assisted in this effort, marking the union's first successful effort to gain collective bargaining for nurses. Realizing the benefit to the profession of nurses, in 1964 MNA drafted legislation which was successfully passed authorizing nurses employed in the private sector to engage in collective bargaining activities. As a result, from 1965 to 1969 MNA organized 76 bargaining units in the state (MNA, 2003b). In 1974 NLRA coverage was extended to nurses and all employees of private, nonprofit hospitals throughout the nation under the Health Care Amendments Act (Chaison & Bigelow, 2002). Taking full advantage, from the late 1970s to mid 1980s the MNA engaged in strikes at over eight hospitals for union recognition, pay improvement, and improved patient care. These strikes gained dignity and economic rights for nurses and consequently furthered nursing professionalism. The strikes of this period are best summarized with a statement that medical historian Susan Reverby made in support of the 1986 MNA strike at Carney Hospital in Boston:

Nurses continue to struggle with what I believe is the central dilemma of American nursing: the order to care in a society that refuses to value caring. Your strike is an attempt to find a modern way to solve this dilemma: to force this hospital and the

public in Boston to understand that caring, the very central act of nursing, has to be valued if it is to be done properly. By your efforts, you are showing nurses and others that in order to obtain the right to care, nurses have to sometimes demand to have rights themselves. Your strike is an example of how that demand has to be made. Your strike is therefore, very important to all of nursing, for it shows all nurses that doing business as usual isn't good nursing care. That in order to properly care, nurses have to demand and obtain the right to care. (Schildmeier, 2003a)

As Reverby conveys, these strikes entailed gaining dignity and economic rights for nurses; they were strikes to further nursing professionalism as well as labor rights. Yet, for the most part, the nursing elite could not overcome their resistance to a strong labor union focus for the MNA. A review of *Massachusetts Nurse* articles, the house organ of the MNA, and conversations with longtime MNA members provided evidence that the elite-frontline nurses disconnect was a strong force limiting MNA's ability to mount strong opposition to the restructuring of healthcare that began in the mid-1980s. Nonetheless, frontline nurses had tasted the power of collective bargaining, and the strikes radicalized a generation of nurses and some MNA leaders who eventually drew upon their experiences to transform the MNA.

Transformation Throughout the 1990s

After the 1980s strikes, the MNA's labor activism declined and the organization returned to its focus on nursing professionalism. Reviewing issues of the *Massachusetts Nurse* from the early 1990s, would lead one to believe the strikes never happened. By then, federal cost containment policies had been in effect for over a decade and the healthcare landscape was changing. Despite the changing face of health care and its effects on staff nurses, the *Massachusetts Nurse* featured articles on nursing education, prescription rights and reimbursements for nurse practitioners, and ways to conduct publishable research. MNA hosted nurse education evenings, a dinner series for nurse managers, research commentaries, and discussed research published by nurses and educators. The newsletter, MNA member's primary source of nursing information and opinions, served the nursing elite running the MNA: nurse educators, managers, practitioners, and researchers. But, this was the period of Massachusetts hospitals closings, deregulation, and system-wide laying-off of nurses and the hiring of unlicensed assistive personnel to replace them. These issues were rarely addressed in the newsletters. For frontline nurses who worked over twelve-hour days and had family obligations, the *Massachusetts Nurse* offered little help.

As early as 1991, however, an article by Beth Piknick, the chair of the Professional, Economic and General Welfare Department (PE&GW), MNA's labor program, reflected these frustrations. Piknick stated that policies being implemented "are far removed from the realities of the bedside," mentioning the bachelor of science in nursing degree requirement for ANA certification, healthcare reform, and a workplace advocacy program which would have allowed the ANA to take away individual state nursing associations' bargaining units. She noted that NursePLAN, the political arm of MNA, endorsed the Republican William Weld for governor even though he supported policies that would make conditions worse for nurses and patients. Alluding to those who deplore collective bargaining and view it as unprofessional, she advocated that staff nurses must become involved and "move up" in the

MNA so that “all facets of nursing are represented in leadership roles” to effect badly needed change (Piknick, 1991). Subsequent newsletters included PE&GW columns about bargaining, grievances, floor representation, and how to start membership campaigns.

In 1992, the newsletter mentions the “new MNA,” and at mid year the newsletter changed from a booklet to a newspaper form for better “readability.” In August 1992 in response to a negative member letter about the MNA, the executive director of the MNA discussed the “new MNA” and how it was developing new initiatives. She cited ten new proposals that the MNA was undertaking, but only one related to the staff nurses: HIV protection for health care workers (Roderick, 1992).

In March there was an article describing managed care and how it would affect patients. Only one paragraph pertained to its effects on nurses and it was from the ANA: “... it will provide opportunities and potential threats ... nurses are prepared to function in multiple roles in managed care settings, including primary care providers and others.” The article provided no new information for staff nurses and only alluded to the opportunities for nurse practitioners as a cost effective alternative to doctors (ANA, 1992).

Staff nurses received the information most relevant to their situation from the monthly PE&GW column. Layoffs, wage freezes, speed-ups, take-aways, what the PE&GW cabinet does and why, the need for rank and file participation, health care reform, and the importance of voting were among the topics. In one article, the newly appointed chair stated that “an injury to one is the concerns of all” (Eaton, 1992). Staff nurses were in the midst of health care restructuring; yet their organization mostly turned a blind eye to it. Educators, administrators, and some nurse practitioners viewed educational requirements and additional nurse practitioner rights as the critical issues. Finally, in December, bylaws were passed to change the PE&GW title to the Labor Relations Program. The change reflected the power the Labor Relations Program was beginning to attain.

During 1993, the MNA leadership and rank and file split further. The MNA focused on nurse practitioner legislation for prescription rights and reimbursement, reflecting the MNA’s high hopes for nurse practitioners furthering the nursing profession. In February, the last labor relations column was written, leaving staff nurses with no link to the newsletter. Reminiscent of 1991, articles now revolved around research commentaries, nursing awards, nurses in the news, and scholarships. An article on nursing trends mentioned only nurse managers, nurse practitioners, and nurse educators (Donahue, 1993). There were articles about “The American Health Security Act” proposed by President Clinton, and various meetings MNA leadership and nurse practitioners had with the Clinton’s. The MNA president noted that the traditional nursing role was changing, and that nurses “need to be flexible” (Stanley, 1993). The plight of the staff nurse during restructuring was not discussed by MNA leadership in 1993.

A Power Struggle Emerges: The Safe Care Campaign

Rank and file nurses relayed their experiences in the new 1990s health care environment to the Labor Relations Program. Concerned that conditions would further deteriorate, in the winter of 1994 the MNA’s Labor Relations subcommittee appealed to the MNA’s Board of

Directors to take action on restructuring. That fall, the MNA embarked on a state-wide Safe Care campaign, with the slogan “every patient deserves a nurse,” highlighting the importance of adequate staffing both in acute care settings and community settings. The campaign included educating the nursing community and public, creating legislation, and conducting research on the issue. A series of town meetings were held throughout Massachusetts for nurses to share testimony of their experiences and form local action committees at the district levels. Later, meetings were held for other nursing, citizen, and consumer groups to form partnerships for further support of the campaign (Chaison & Bigelow, 2002). For the next few years the MNA increased its campaign through media and political efforts, holding rallies and press conferences where staff nurses voiced their experiences.

In 1996 MNA entered the legislative arena, creating “The Nurses’ Agenda for Quality Care” (MNA, 1996a). To increase national awareness, they brought Ralph Nader to Boston as the key speaker in their “patients not profits” forum (MNA, 1996b). The *Massachusetts Nurse* began focusing on staff nurse/labor topics, featuring bargaining issues among hospitals, explicit details of MNA legislation, and MNA campaign events. Articles were packed with messages of nursing power and involvement. Titles included: “Member Involvement Is The Key To MNA Power And Success,” “Get Tough And Get Going,” “It May Take A Village To Save A Hospital,” “If They Won’t Fix It, Nursing Will.”

In 1997 MNA’s first piece of legislation was passed. It required all licensed patient care workers to wear identification, so patients would know who was caring for them. Before that legislation, patients were often led to believe that UAPs were really Nurses. Also in 1997 an MNA staff nurse was fired for reporting the dangerous conditions of his health care facility. This event brought a new facet to the Safe Care campaign and the MNA successfully filed legislation to protect whistleblowers (Chaison & Bigelow, 2002). Fueling the campaign, Judith Schindul-Rothschild, a nursing researcher and MNA member, published a national patient care survey. It revealed that two out of five nurses would not want a family member to receive care at their particular health care facility (Schindul-Rothschild et al., 1996).

In the midst of this activity, the MNA instituted its MNA 2000 Plan, changing its structure by eliminating committees and subcommittees, making it less hierarchical (MNA, 1997). Nurses realized that they could successfully advocate for health care policy legislation. They had renewed faith in their organization and it showed in their increased participation. Nurses testified before the legislature on safe care, and the MNA became more grassroots oriented as it increased its visibility in the media, statehouse, and communities. The MNA structure and philosophy had changed; it was becoming a powerful labor union. One barrier remained: the MNA’s top leadership.

A Massachusetts Nursing Revolution

By 2000, the Safe Care campaign was in full throttle and staff nurses had caught and kept the eyes and ears of Massachusetts. National research reported in the *Journal of the American Medical Association*, the *New England Journal of Medicine*, and the John Hopkins School of Medicine, validated MNA claims of nurses’ vital role in safe patient care (Alspach, 2003). Respondents to surveys consistently said they trusted nurses, rating them

the highest in terms of service to patients. With 27% of Massachusetts nurses laid off, patients encountered cold and frightening experiences in the new health care system (Weinberg, 2003). Too few nurses were available to provide them information, continuity of care, and a friendly face to calm their concerns. Patients believed nursing care was being cut to improve the bottom line (Fagin, 2001). Some in the MNA knew that the public would likely support union action to improve nurses' working conditions and thereby healthcare practices.

Despite all the campaign had accomplished, a more progressive and aggressive stance had to be taken on issues like safe staffing, mandatory overtime, and UAPs. Between 1997 and 2000 the MNA organized seven hospitals, three Visiting Nurses Association (VNAs), and four school nursing units, adding more than 2,800 frontline nurses to the organization (Schildmeier, 2003b). MNA members went on strike over staffing conditions and overtime in 2000 at St. Vincent's Hospital in Worcester, and in 2001 at Brockton Hospital; the first nurses' strikes in more than a decade. After much publicity, and help from U.S. Senators Kennedy (St. Vincent Strike) and Kerry (Brockton Hospital), both strikes ended in the nurses' favor, with first ever contract language in New England prohibiting mandatory overtime and requiring hospitals to provide better staffing conditions (Schildmeier, 2003a).

While the MNA focused its activities on keeping nursing alive, its national organization, the ANA, concentrated on advancing the nursing profession, often endorsing programs and plans that hurt frontline nurses. To make matters worse, after multiple attempts from the MNA to promote stronger collective bargaining activities in the ANA, the ANA established a national labor program, which unlike the MNA labor program, would not be isolated from management (Schildmeier, 2003a). The ANA announced that affiliate membership in the national program was mandatory. Believing that this would weaken the MNA substantially, the MNA's Labor Relations Program took action.

In April 2000 the MNA's Labor Relation Program, as well as, the Congress on Occupational Health and Safety announced motions of intent to the Board of Directors to file a bylaw change for disaffiliation from the ANA (Schildmeier, 2003a). Meetings were held for nurses to discuss the issue; editorials in every issue of the *Massachusetts Nurse* called upon those who could not attend the meetings to hear both sides. It was obvious that most nursing elites, administrators, and educators were against disaffiliation, citing a need for national power and unity (MNA, 2000a). But the majority of union members and frontline nurses supported disaffiliation, citing the positive outcome of the California Nursing Association, that disaffiliated in 1995, and helped California become the first state in the nation to pass legislation to regulate nurse to patient ratios (Schildmeier, 2003a).

The first vote for disaffiliation was taken at the 2000 MNA Convention. Only 62% voted for disaffiliation, slightly lacking the required two-thirds majority (MNA, 2000b). At the following Board meeting on December 1st, a vote was taken to call for another vote on disaffiliation in March 2001. The Board fired the Executive Director, who did not favor disaffiliation, replacing her with a long time member and director of the MNA Labor Relations Program. Thereafter, four Board members supporting ANA affiliation resigned (MNA, 2000c).

On March 24, 2001, 2,400 MNA members gathered at Mechanics Hall in Worcester and 82% voted for disaffiliation. Freed from their conservative national organization, and equipped with more financial resources, the new MNA accelerated its legislative and collective bargaining efforts. Shortly after disaffiliation, the MNA joined with the California and Maine nurses associations, which had also disaffiliated from the ANA, in the new American Association of Registered Nurses; a more labor oriented national nurses' organization (Schildmeier, 2003a).

A large percentage of the more elite nurses left the MNA, and along with the former leadership who resigned or left after disaffiliation with the ANA, formed an alternative organization, the Massachusetts Association of Registered Nurses (MARN). MARN is an ANA affiliate, and like the former MNA is focused on the advancement of the profession through collegiality and unity (MARN, 2002). Although MARN does not engage in collective bargaining, it does promote passage of state legislation that benefits and supports nurses. Currently, it is promoting a bill in opposition to a MNA-originated mandatory staffing ratio bill, continuing the longstanding divisions that existed within the old MNA between front-line nurses and those who want to secure greater professional status within healthcare for nurses.

THE MNA TODAY

Since 2000, the MNA has gained increasing visibility and prominence as a powerful voice for nurses and patients in the realm of public policy and union contracts. Due to their successful organizing campaigns and contract negotiations between 1997 and 2000, MNA membership increased 10 percent, topping 22,000, the highest membership in MNA history. MNA now represents nurses for collective bargaining in 85 different health care facilities, including the nurses at 51 of the 76 acute care hospitals in the state. While other unions in health care and other industrial sectors are losing members, MNA is consistently gaining members, currently representing 65% of hospital nurses and 25% of nurses statewide, making it the national leader in nursing union penetration. The current MNA president, Karen Higgins, attributes this to the fact that, "Nurses know the MNA is not afraid to stand up to the health care industry and the insurance industry to make sure that their voice is heard and that the needs of their patients are being adequately addressed (Schildmeier, 2003b)."

In collective bargaining, MNA has helped nurses achieve the wages and benefits they demanded and it has won important language to protect both nurses and patients. To date MNA gained contract language for HIV insurance protection for nurses (the first in the nation), limiting the use of UAPs, establishing minimum staffing levels in every department in the hospital, limiting the use of mandatory overtime, limiting shifts to a maximum of 12 hours, language to assure nurses rights to refuse mandatory overtime, limiting or prohibiting floating of nurses, and granting "in-house sabbatical" rights for nurses (MNA, 2003c). These gains aim to reverse and protect nurses from some of the hospital restructuring implemented since the early 1990s.

MNA is now a force to be reckoned with by Massachusetts' state government and healthcare industry. In addition to its successful passage of laws mandating identification of licensed health care workers and providing whistleblower protection for nurses and health care workers, it helped pass legislation on safe needle systems, regulation of less than 24 hour "drive through birthing" deliveries, and a patients' bill of rights under managed care. In November, 2003, after tremendous mobilization, the MNA created House Bill 1282, titled "An Act Ensuring Quality Patient Care and Safe Registered Nurse Staffing" which addresses nurse-to-patient ratios in Massachusetts hospitals (Schildmeier, 2003b). The bill was co-sponsored by 101 out of 200 members of the Legislature, including 14 of the 17 members of the Joint Committee on Health Care. In addition to legislative support, the bill garnered strong support from 64 health care and consumer advocacy groups, such as the American Cancer Society, American Heart Association, American Lung Association, Health Care for All, League of Women Voters, and the Massachusetts Senior Action Council, which joined forces with the MNA to form the Coalition to Protect Massachusetts Patients (MNA, 2003d). The bill was passed by the Joint Committee on Health Care and is under consideration by the House Ways and Means Committee. MNA members have also been invited to serve on numerous legislative committees to study health care issues and nursing in Massachusetts.

The MNA has become a progressive labor union of professional healthcare workers—nurses, advocating for patient and nurse rights, influencing politicians, the media, and the Commonwealth. They intend to keep building power. In 2003 the MNA helped two nurses get elected to the state legislature. Moreover, in 2003, the strength of their organizing efforts required that five new staff positions be created solely for organizing nurses and contract negotiations. MNA created a Labor Education Institute to educate members about labor leadership, building unions, grievances, labor meetings, and labor history (MNA, 2003e). Its national affiliate, the American Association of Registered Nurses (AARN), has grown as well. The AARN now boasts over 80,000 members with the addition of state nurses associations from Arizona, Pennsylvania, New York, New Hampshire, Missouri, Washington DC, and Louisiana. The AARN has as many members as the ANA's affiliated union, the UAN. The AARN projects that in a few years they will surpass the ANA/UAN and be the largest organization of nurses in the country and the first to be led by frontline staff (MNA, 2003e).

MNA'S CHALLENGES

MNA has transformed itself to fight the corporate restructuring of nursing work in hospitals. It faces many challenges, not the least of which is whether it will be able to build strong labor alliances with unions that represent other healthcare workers—and even other nurses. The national AFL-CIO affiliates that represent nurses have formed an alliance to pass state and federal nurse-to-patient staffing ratio legislation. This includes seven coordinating unions and four participating unions. Since AARN affiliates are not AFL-CIO affiliated unions, it remains to be seen what kind of alliances will be built between the AFL-CIO and AARN unions. In Massachusetts, MNA is the lead union representing nurses, but not the sole union. For example, both the Service Employees International Union and the American Federation of State, County, and Municipal Employees represent Massachusetts nurses. The 2003 accord establishing policy and advocacy cooperation protocols between the California

Nurses Association and the Service Employees International Union bodes well for such cooperation between AARN and AFL-CIO unions in other states and nationally.

Another challenge facing the MNA is its aging membership. With a high percentage of MNA members and member activists nearing retirement age, the MNA will need to devote considerable resources to recruitment of new members and mobilization of existing members. This challenge, a demanding and often costly effort that challenges all labor unions, will be exacerbated by the strong anti-union ideology of most healthcare organization owners and managers. As the healthcare system continues to be restructured, mergers and decentralization measures will continue to create obstacles for labor organizing by isolating nurses from one another within healthcare structures. Hospitals in particular have continued laying off nurses in the midst of a shortage so severe that most call it a crisis. An August 13, 2004 New York Times editorial noted, “Instead of paying salaries that would attract homegrown nurses, American hospitals recruit in the Caribbean, the Philippines, India and Africa (NYT Editor, 2004).” Historically, lay-offs coupled with recruitment of lower-paid workers have long been used by industrial employers to frighten workers from organizing for greater workplace power.

Lastly, elite nurses who formed MARN are pursuing legislative strategies that will support their renewed control of nursing in Massachusetts. MARN is working with legislators and the Massachusetts Hospital Association to promote Massachusetts S.B. 2265 “An Act to Support the Nursing Profession and Promote Safe Patient Care.” Rather than mandating ratios, this bill will hold hospitals accountable for developing and implementing “... valid and reliable nurse staffing plans ... and requires nurses to be an integral part of the development, evaluation, and decision-making process (MARN, 2004).” The bill seeks funding for workforce planning strategies, including stronger nursing degree programs and support for nursing students and faculty. MNA’s former members who sought to maintain the organization as a professional association now compete against the MNA to shape directions for Massachusetts nursing. Successfully meeting this challenge will be a key element for the union’s future.

THE POLITICAL ECONOMY AND THE FUTURE OF HEALTHCARE

The U.S. healthcare system exists within a political economy which shapes its expansion, contraction, and transformation. The transformation of the Massachusetts Nurses Association occurred mainly within the context of corporate restructuring of hospitals and consequently the manner in which nurses work and care for patients. As the country forges its strategies for attaining affordable and accessible healthcare, these strategies will directly shape the lives and work of a key segment of healthcare workers and their unions. The MNA provides a model of how nurses have mobilized as part of the continuing struggle to provide quality and affordable healthcare. In Massachusetts, nurses, through the MNA, responded to these changes with activism and organizing efforts that ultimately resulted in the fracture of the organization into two distinct entities competing for the allegiance of Massachusetts nurses, as well as ways of sustaining the profession and nurses’ roles within a healthcare system. A long-standing emphasis upon being a professional association dominated by elite nurses from administration and the academy gave way to a labor union of nurses working on

the frontline of healthcare delivery. This change was directly related to the hospital industry's disregard for nurses' prestige, working conditions, and sense of professionalism, and ultimately their new found union power was aimed to mount opposition to the corporate restructuring of hospitals.

The free-market political and economic legacy of the Reagan Revolution has persisted until today and has dramatically reshaped the healthcare industry. The Massachusetts Nurses Association (MNA) is fighting against its excesses and short-comings, acting to protect their self-interests and the interests of other healthcare workers but, most importantly, the health and safety of patients whose care they see as their responsibility. The upheavals have resulted from public policy flaws and an almost religious belief that market forces can fairly and effectively distribute healthcare resources. Each part of the health care system has employed strategies to maintain itself and survive under these often draconian conditions. Reason and rational planning have been tossed aside (Sager & Socolar, 1997). Hospitals shut down beds and tried to increase the productivity of nurses and other healthcare workers. The new healthcare economy has forced some physicians to join managed care organizations. Many have had to work harder to maintain their incomes, with greater restrictions on their ability to practice quality medical care, while patient dissatisfaction increased and widespread medical errors became apparent. Health insurance costs were passed onto employees and greater cost sharing seems to be a central policy of President Bush's "Ownership Society" with the advent of Health Savings Accounts (HSAs).

What does a continuation of neoliberal economic policies mean for the future of healthcare? According to Sandy, we should anticipate healthcare professionals such as nurses, and even doctors, to continue to become more radicalized (Sandy, 2002). The American Medical Association has endorsed the idea of physicians' unions for the purposes of collective bargaining against the corporate control of healthcare. The Service Employees International Union and other labor unions are organizing the low skilled but increasingly necessary UAP workers. As real healthcare costs continue to escalate, and demand remains unabated as the population continues to grow older, healthcare workers, as in the case presented of the MNA, face the choice of remaining frustrated professionals or organizing for their own welfare and that of their patients. As neoliberal forces continue to threaten healthcare, we are likely to see organized healthcare professionals and other workers as an important countervailing force against the commodification of healthcare.

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