

**Collective Bargaining Attitudes of Registered Nurses in the United States and Canada: A Wisconsin-Ontario Comparison**  
**L'attitude des infirmières américaines et canadiennes face à la syndicalisation**

Allen Ponak and T. P. Haridas

Volume 34, Number 3, 1979

URI: <https://id.erudit.org/iderudit/028992ar>

DOI: <https://doi.org/10.7202/028992ar>

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Article abstract

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Publisher(s)

Département des relations industrielles de l'Université Laval

ISSN

0034-379X (print)

1703-8138 (digital)

[Explore this journal](#)

Cite this article

Ponak, A. & Haridas, T. P. (1979). Collective Bargaining Attitudes of Registered Nurses in the United States and Canada: A Wisconsin-Ontario Comparison.

*Relations industrielles / Industrial Relations*, 34(3), 576–591.

<https://doi.org/10.7202/028992ar>

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# Collective Bargaining Attitudes of Registered Nurses in the United States and Canada

## A Wisconsin-Ontario Comparison

**Allen Ponak**  
**and**  
**T.P. Haridas**

*This paper compares the attitudes to collective bargaining of a sample of Ontario and Wisconsin registered nurses. Contrary to expectations (in view of the general low rate of American nursing unionism), the Wisconsin nurses who were surveyed viewed collective bargaining at least as favourably as their Ontario counterparts.*

The most recent figures available on the degree of unionization of American registered nurses indicate that no more than 15 per cent are covered by collective agreements<sup>1</sup>. This level of organization stands in sharp contrast to the situation in Canada where estimates place the extent of unionization at 75 per cent<sup>2</sup>.

The respective national organizations (American Nurses' Association and Canadian Nurses' Association) formally endorsed collective bargaining at approximately the same time in the 1940's<sup>3</sup>. In terms of training, tradi-

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\* PONAK, Allen, Assistant Professor, Industrial Relations Management Division, Faculty of Commerce, The University of British Columbia.

HARIDAS, T.P., Assistant Professor, Department of Management, St. Mary's University.

\*\* The authors would like to thank Professors L. Moore, R.N. Taylor and C.R.P. Fraser for their helpful suggestions on an earlier draft.

1 American Nurses' Association, "Nurses' Association Tops 100,000 Mark in Collective Bargaining Representation", *News Release*, January 28, 1977, Kansas City, Missouri.

2 Estimate made by Glenna Rowsell, former Director of Social and Economic Welfare Committee, Canadian Nurses' Association during interview in Ottawa, Ontario in November 1975.

3 The Canadian Nurses' Association endorsed collective bargaining in 1977, the American Nurses' Association did so in 1946.

tions, and working environments nurses on both sides of the border share common characteristics<sup>4</sup>. Furthermore, trends in the wider industrial relations systems of the two countries that could be expected to influence the degree of organization of the nursing profession have been substantially the same: until very recently the overall proportions of unionized worker in Canada and the United States have been within a few percentage points of one another,<sup>5</sup> white collar and professional workers traditionally have been as reluctant in Canada to join unions as their counterparts south of the 49th parallel,<sup>6</sup> and both countries have experienced a rapid increase in the incidence of public sector unionism since 1965<sup>7</sup>. In the light of these similarities, how does one account for the markedly disparate development of nursing unionism in the two countries?

The most likely explanation would appear to lie in differences in the legislative frameworks found in the United States and Canada. Until 1974 most American nurses (and other hospital workers) were excluded from the provisions of the National Labor Relations Act<sup>8</sup>. Although a minority of states had enacted legislation covering hospitals, it is arguable that even in these states the psychological impact of unsupportive federal labour legislation greatly decreased the propensity of nurses to organize. Canadian nurses, on the other hand, faced no such restrictions, having long been accorded the same rights to organize and engage in bargaining as the majority of private sector employees<sup>9</sup>. Thus, while the great majority of American registered nurses lacked legal protection for collective bargaining activities during most of the last 20 years, the opposite was true of their Canadian counterparts.

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4 GRIFFIN, Gerald, and Joanne GRIFFIN, *Jensen's History and Trends of Professional Nursing*, sixth edition, St. Louis, V. Mosby, 1969; see especially Chapter 40 which analyses Canadian nursing development within the overall American perspective which characterizes the book.

5 *Handbook of Labor Statistics*, U.S. Department of Labor, Bureau of Labor Statistics; and, *Labour Organizations in Canada*, Labour Canada, Labour Data Branch.

6 BLUM, Albert A., et al., *White Collar Workers*, New York, Random House, 1971; Frances BAIRSTOW, *White Collar Workers and Collective Bargaining*, Study for Canadian Task Force on Labour Relations, Ottawa, Privy Council Office, 1968.

7 STIEBER, Jack, *Public Employee Unionism: Structure, Growth, Policy*, Washington, The Brookings Institution, 1973; *Collective Bargaining in the Public Service*, Toronto, Institute of Public Administration of Canada, 1973.

8 SEIDMAN, Joel, "Nurses and Labour Relations", *Industrial and Labour Relations Review*, Vol. 23, No. 3, April 1970, pp. 335-351.

9 ROWSELL, Glenna, "Nurses and Labour Relations" in Shirley Good and Janet Kerr, *Contemporary Issues in Canadian Law for Nurses*, Toronto, Holt, Rinehart, and Winston, 1973, pp. 172-185.

But are there other considerations, in addition to the legal ones, that may also help explain why American nurses have been slower to organize than Canadian nurses? There are numerous examples, particularly in the public sector, of groups which have organized and bargained despite the absence of protective legislation (e.g., firefighters, California farm workers). Research on organizing has shown that although the legal framework is an important ingredient in the organizing dynamic, other factors such as the reaction of significant managerial groups, the capabilities of the unions involved, and the disposition of the employees themselves also play influential roles<sup>10</sup>.

This latter variable (i.e., disposition of the employees) would appear to be particularly relevant with respect to registered nurses considering the historic mistrust with which collective bargaining has been viewed by professionals (and semi-professionals). Collective bargaining has been variously depicted as unprofessional, contrary to the service ideals inherent in most professions, or too adversarial in nature to square with such concepts as collegial decision making. Some professional groups, such as teachers, have chosen to lay aside their misgivings and have become highly organized on both sides of the border. Others, engineers are a good example, continue to reject collective bargaining as a mechanism for dealing with their concerns.

For a long time nurses in Canada also displayed great reluctance to engage in bargaining even though they legally had the right to do so. In the last ten years, however, they have overcome most of the ambivalence they once held and have demonstrated a willingness to accept collective bargaining. Can the same be said for American nurses? Legal considerations notwithstanding, is it possible that the lower rate of unionism among American nurses may partially be attributable to the fact that they simply perceive collective bargaining as a far less suitable mechanism for addressing their needs compared to Canadian nurses? For example, do American nurses believe more strongly that unionism and professionalism are incompatible; are they more inclined to assume that unionism will exercise a negative impact on the quality of patient care; are they more concerned about the prospect that collective bargaining might lead to strikes; are they less likely to believe that collective bargaining is capable of achieving their professional and economic goals, and finally, do American nurses generally view the whole institution of unionism and collective bargaining in a somewhat less favourable light than do Canadian nurses?

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<sup>10</sup> BAIN, George S., "The Growth of White Collar Unionism and Public Policy in Canada", *Relations Industrielles*, Vol. 24, No. 1, 1969, pp. 243-274; Roy J. ADAMS, "White Collar Union Growth: The Case of Sweden", *Industrial Relations*, Vol. 13, No. 2, 1974, pp. 164-176.

## NURSES IN WISCONSIN AND ONTARIO

This paper attempts to provide some preliminary answers to these questions by comparing the attitudes of registered nurses in Wisconsin and Ontario. In *Wisconsin*, less than ten per cent of registered nurses were unionized at the time the study was conducted (1975),<sup>11</sup> despite a history of relatively supportive state legislation<sup>12</sup>. Most bargaining was of recent origin, dating from the early 1970's. Virtually all nurses were represented by the state affiliate of the American Nurses Association, the Wisconsin Nurses Association<sup>13</sup>.

Prior to the 1970's a number of campaigns to organize nurses were undertaken by non-nursing groups (e.g. A.F.S.C.M.E.) but these attempts failed in the face of employer opposition and W.N.A. hostility. Partly in response to these "union pressures", and partly out of concern for nursing salaries and conditions, the W.H.A. adopted in this pre-bargaining period the "recommended standards" approach enunciated by the A.N.A. The W.N.A. periodically formulated a set of Recommended Personnel Policies which were submitted to hospital administrators around the state for implementation. This strategy was not particularly successful with respect to improving standards, however, as the recommendations often were not adopted.

The W.N.A.'s conversion to bargaining occurred when non-professional hospital employees began unionizing in the later 1960's and Wisconsin nurses discovered that they were liable to be swept into all-embracing bargaining units in which they were a minority. In situations of this kind, the W.N.A. was asked to intervene and did so by assisting the affected nurses in petitioning for separation from the main bargaining unit. With increasing frequency this intervention resulted in the W.N.A. being

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11 Figure based on estimates of June Watke, Director of Economic and General Welfare, Wisconsin Nurses Association.

12 The Wisconsin Employment Peace Act (1943) and state public sector Regulation (1959) extended organizational and collective bargaining protection to the majority of Wisconsin nurses. For discussions of these statutes, see: Richard A. MILLER, Brian BECKER, and Edward KRINSKY, "Union Effects on Hospital Administration Preliminary Results from a Three State Study", *Spring Conference of the Industrial Relations Research Association*, Madison: IRRRA, 1977, p. 514, and Allen PONAOK, "Public Sector Dispute Resolution: An American Twist to a Canadian Approach" *Relations Industrielles*, Vol. 31, No. 4, 1976, pp. 537-539.

13 Unless otherwise specified the foregoing discussion is based on interviews with the Director of Economic Security and other officials of the Wisconsin Nurses' Association and an unpublished paper by a former WNA field officer: William C. HOULIHAN, *Wisconsin Nurses and Collective Bargaining*, Unpublished paper, University of Wisconsin, 1974.

certified for the nurses' bargaining unit. Notwithstanding this somewhat reluctant entry into the bargaining arena, the W.N.A. has taken its new role seriously. While from 1963 and 1973, the organization provided resources for only one full time economic security staff member, a second officer was appointed in 1973, and in 1977 a third position was created.

Nurses in *Ontario* also were unorganized until relatively recently. In 1968, for example, only 16 collective agreements covering nurses were in effect and the majority of these were first collective agreements<sup>14</sup>. Nineteen sixty-eight marked the beginning of sustained organizing activity, however, and by 1975 more than 70 per cent of Ontario R.N.'s were under contract<sup>15</sup>.

The growth of nursing unions was accompanied by important changes in organizational structures<sup>16</sup>. Prior to 1973 most activity took place under the auspices of the Registered Nurses Association of Ontario, the provincial affiliate of the Canadian Nursing Association, which provided organizing and bargaining advice to local independent nurse associations. The R.N.A.O. was prevented from holding certification rights or from direct bargaining involvement because its membership included nurses who held management positions.

The spread of nursing unions and the proliferation of local independent associations rendered this arrangement unwieldy. As a result, in 1973, a completely separate labour relations organization was established, the Ontario Nurses Association. The more than 100 formally independent local associations affiliated directly to the O.N.A. and in 1975 collective bargaining was centralized on a province-wide basis.

The legal environment in Ontario has been less subject to change. As in other provinces, Ontario nurses traditionally have been considered employees under the province's general labour code, the Labour Relations Act. But, since 1965 Ontario nurses (and other hospital workers) have been subject to the special dispute resolution procedures of the Ontario Hospital Labour Disputes Arbitration Act (H.L.D.A.A.). This Act prohibits strikes

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<sup>14</sup> INGLIS, Margaret, *Collective Bargaining and the Nurse: A Study of Selected Aspects of Collective Bargaining by Graduate Nurses in the Public General Hospitals of the Province of Ontario*, University of Toronto, Thesis for Diploma of Hospital Administration, 1969, p. 47.

<sup>15</sup> Figure based on estimate of Pat Wong, Research Analyst, Ontario Nurses' Association, May 1975.

<sup>16</sup> The foregoing discussion of organizational structure is based on interviews with officers of the RNAO and ONA as well as: *Ontario Nurses' Association Brief*, Submitted to Hospital Inquiry Commission on Salaries, Wages, and Other Benefit of Hospital Employees, June 24, 1974, Toronto.

<sup>17</sup> ROWSELL, "Nurses and Labour Relations", *op. cit.*, pp. 182-183.

and stipulates that interest disputes must be submitted to binding arbitration<sup>18</sup>. The O.N.A. has publicly criticized the H.L.D.A.A. on several occasions and has called instead for a procedure similar to that used in the Canadian federal service namely, a strike/arbitration option at the discretion of the union<sup>19</sup>.

Discussions of patterns of nursing unionism in Canada and the United States demonstrate that developments have been similar to those in Ontario and Wisconsin, respectively. The U.S. experience, described by Stieber, Seidman, Baird, Jacox and Grand,<sup>20</sup> shows that the W.N.A.'s transition to collective bargaining followed a path travelled in much the same way by other state nursing associations. This is notably true with respect to experiences with the A.N.A.'s recommended standards approach and the eventual acceptance of direct bargaining roles in response to threats of nurses being "swallowed" in hospital-wide bargaining units. The prevailing low rate of nursing unionism in Wisconsin also is typical.

Descriptions of the Canadian experience, detailed by Rowsell, Cormick, and the *International Nursing Review*,<sup>21</sup> reveal that Ontario developments closely paralleled patterns in other Canadian provinces. Rapid unionization of the profession in a short time span in the late 1960's, the resultant high degrees of organization, and the unequivocal acceptance of collective bargaining by provincial associations are noteworthy similarities. The decision of Ontario nurses to form a collective bargaining organization distinct from their professional association also is not unique. Quebec nurses established a separate bargaining agency as early as 1966 and in 1973 Saskatchewan nurses did the same. Moreover in other provinces, British Columbia is a prime example, the collective bargaining departments of the professional nurses associations increasingly are acting in autonomous fashions.

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<sup>18</sup> *Ibid*, p. 182.

<sup>19</sup> *ONA Brief*, *op. cit.*

<sup>20</sup> STIEBER, *Public Employee Unionism*, *op. cit.* pp. 76-88; SIEDMAN, "Nurses and Labour Relations", *op. cit.*; William BAIRD, *Collective Bargaining by Registered Nurses*, Ph.D. Dissertation, Ohio State University, 1968, pp. 6-35; Ada JACOX, *The Nurse's Cap: A Case Study of Administrator-Nurse Conflict*, Ph.D. Dissertation, Case Western Reserve University, 1969, pp. 35-54; Norma GRAND, *The Role of Ideology in the Unionization of Nurse*, Ph.D. Dissertation, Case Western Reserve University, 1971, pp. 77-99.

<sup>21</sup> ROWSELL, "Nurses and Labour Relations", *op. cit.*, Gerald W. CORMICK, "The Collective Bargaining Experience of Canadian Registered Nurses", *Labour Law Journal*, October 1969, pp. 667-682; "Collective Bargaining - the Unmentionable Words", *International Nursing Review*, Vol. 15, No. 2, pp. 113-118.

In short, patterns of nursing unionism in Wisconsin and Ontario are typical of patterns observed elsewhere in the United States and Canada. Furthermore, interviews and analyses of collective agreements suggested that the environments and basic concerns of Wisconsin and Ontario nurses are consistent with the environment and concerns of nurses in other parts of their respective countries<sup>22</sup>. Thus, an examination of the attitudes of nurses in Wisconsin and Ontario should provide insight with respect to questions of interest. To the extent that the lack of organization of U.S. nurses is related to relatively unfavourable attitudes toward collective bargaining, it could be expected that Wisconsin nurses would hold significantly less favourable attitudes than Ontario nurses. While such a finding would not permit a general conclusion that nurses in other American states also display relatively unfavourable collective bargaining attitudes compared to Canadian nurses, it would at least reinforce the proposition that such a possibility must be seriously considered. Furthermore, given the absence of recent surveys of nurses' attitudes toward collective bargaining, especially in any kind of comparative context, the proposed investigation should also be useful in exposing issues which might be explored on a wider basis.

## RESEARCH METHODOLOGY

The data used in this paper were gathered via questionnaires administered in the Summer of 1975. Eighty-five Wisconsin nurses and 63 Ontario nurses participated, yielding a response rate of 72 per cent. All nurses at both research sites were female.

In Wisconsin, the mean age of respondents was 37, 60 per cent were employed in hospitals or nursing homes, one quarter held supervisory positions, 47 per cent held baccalaureate degrees, and 28 per cent were covered by collective agreements. The mean age of respondents in Ontario was 30, eight per cent had earned baccalaureate degrees, and 10 per cent held supervisory positions. All the Ontario respondents were employed at a single institution, a 1,000 bed acute-care hospital situated in an urban area (population, 400,000), all were covered by a collective agreement, and every respondent belonged to the local affiliate of the O.N.A. (a union shop clause was in effect).

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<sup>22</sup> As part of a larger project, approximately 25 interviews were conducted by the senior author with nurses in different regions in Canada and the United States. The interviews dealt extensively with the working environment, work functions, and job related concerns of nurses. As part of the same project, collective agreements covering nurses in all parts of North America also were examined. See: Allen PONAK, *Registered Nurses and Collective Bargaining: An Analysis of Job Related Goals*, Ph.D. Dissertation, University of Wisconsin, 1977.



**TABLE 1**  
**Respondent Characteristics**

	<i>Wisconsin Respondents N = 85</i>	<i>U.S. Nursing Population (1972)<sup>a</sup></i>	<i>Ontario Respondents N = 63</i>	<i>Canadian Nursing (1974)<sup>b</sup></i>
<i>Age</i>	37	39	30	35
<i>Hospital/ Other Institutions</i>	60%	72%	100%	83%
<i>Supervisory Status</i>	25%	25%	10%	17%
<i>Baccalaureate Degree or Higher</i>	47%	17%	8%	9%
<i>Covered by Collective</i>	28%	15%	100%	75%

<sup>a</sup> A. V. ROTH and A. R. WALDEN, *The Nation's Nurses*, Kansas City, American Nurses' Association Statistics Department, 1974.

<sup>b</sup> Canadian Nurses' Association, *Countdown 1974: Canadian Nursing Statistics*, Ottawa, Canadian Nurses' Association, 1975.

The data for both groups are reported in Table 1 along with similar information for the entire populations of U.S. and Canadian nurses. It can be seen that the composition of the sample is broadly comparable to the respective national constituencies, although certain discrepancies are apparent. The most substantial relates to the education of the Wisconsin respondents: a markedly higher proportion of the Wisconsin participants possessed baccalaureate (47 per cent) compared to the general population of U.S. nurses (17 per cent). Subsequent analysis revealed, however, that education exercised little impact on the collective bargaining attitudes of the Wisconsin respondents<sup>23</sup>.

The questionnaire comprised 10 attitudinal items presented in the form of statements. It was developed by culling items from an existing union attitude survey directed at blue collar workers,<sup>24</sup> a union attitude survey ad-

<sup>23</sup> In addition to the analysis reported in Table 1 and discussed in the next section, a comparison of collective bargaining attitudes was made between those Wisconsin respondents who had baccalaureate degrees and those who did not. Difference of means tests indicated that in no case was there statistically significant differences in attitudes (beyond the .05 level) between these two sub-groupings of Wisconsin nurses.

<sup>24</sup> UPHOFF, Walter, and Marvin DUNNETTE, *Understanding the Union Member*, Minneapolis: University of Minnesota Press, 1956.

ministered in 1967 to a sample of Ohio registered nurses,<sup>25</sup> and three nursing journal articles in which strong comments were made (pro and con) about unionism<sup>26</sup>. All 10 statements in the questionnaire were measured on a five-point scale (strongly agree, agree, undecided, disagree, strongly disagree). In another study, using a sample of 500 registered nurses, the alpha coefficient of reliability for the 10 items was found to be 0.77<sup>27</sup>. In an exploratory factor analysis (using principle components method, oblique rotation) it was found that a single factor explained 87 per cent of the variance associated with responses on the 10 items. The 10 items are listed in Table 2.

### ANALYSIS OF THE DATA

Because the Wisconsin and Ontario samples differed on several demographic dimensions, the analysis began by regressing age, education, and position on the attitudinal items in order to examine the manner in which respondent characteristics might have influenced respondent attitudes. The results of this analysis are summarized in the first column of Table 2 which reports the  $R^2$  statistics for each regression equation. The data indicate that although these three variables together proved capable of exercising a significant impact on half the attitudinal items and on a combined index (computed by summing raw scores on the 10 individual items), in no case did they account for more than 10 per cent of the variation and in a number of instances the amount of variation explained was a good deal less. The analysis also revealed (not reported) that no single respondent characteristic was consistently related to the criteria. These findings suggest that the overall influence of age, education, and position on the attitudes toward collective bargaining held by the respondents was relatively low.

Although the influence of these respondent characteristics was determined to be slight, additional examination was made of the direction of the relationship between each of these variables and the combined index of attitudes. Age turned out to be negatively correlated to overall collective bargaining attitudes ( $r = -.19$ ), nurses with baccalaureate degrees were also more negatively disposed ( $r = -.03$ ), while general staff nurses held

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<sup>25</sup> BAIRD, William, *Collective Bargaining and Registered Nurses*, op. cit.

<sup>26</sup> GRAND, Norma, "Nightingalism, Employeeism, and Professional Collectivism", *Nursing Forum*, Vol. X, No. 3, 1972, pp. 289-299; Meridean MAAS, "Nursing Autonomy and Accountability in Organized Nursing Services", *Nursing Forum*, Vol. XII, No. 3, 1973, pp. 237-259; Eva ERICKSON, "Collective Bargaining: An Inappropriate Technique for Professionals", *Nursing Forum*, Vol. X, No. 3, 1971, pp. 300-311.

<sup>27</sup> PONAK, Allen, *Registered Nurses and Collective Bargaining*, op. cit.

**TABLE 2**  
**Summary of Nurses' Responses on a Ten-Item Collective Bargaining Survey**

<i>Items Measuring Collective Bargaining Attitudes</i>	1	2		3		4
	<i>Proportion of Variation Explained by Age, Education, Position (R<sup>2</sup>)</i>	<i>Wisconsin Sample (N = 85) Means and Standard Deviations on Attitudinal Items</i>		<i>Ontario Sample (N = 63) Means and Standard Deviations on Attitudinal Items</i>		<i>Difference Between Means, 2 - Tail t Probability</i>
		$\bar{X}$	<i>S.D.</i>	$\bar{X}$	<i>S.D.</i>	
1. Collective bargaining is vital to nurses in pursuit of their professional goals.	.07*	3.99	1.16	4.24	0.91	.144
2. Mutual support between nurse associations and unions representing non-professional hospital workers is a good idea.	.07*	2.89	1.30	3.47	1.10	<u>.004</u>
3. Collective bargaining is a positive force for progress in Canadian (American) society	.01	3.95	0.87	3.76	0.73	.151
4. Collective bargaining by nurses requires a greater expenditure of time and effort than the potential gain would justify.	.00	4.05	0.95	3.76	0.86	.058
5. It is preferable to belong to an organization that is willing to go on strike if it feels such action is necessary.	.09**	3.06	0.97	2.52	1.08	<u>.002</u>
6. Economic issues affecting nurses can be dealt more effectively through collective bargaining than in any other way.	.01	4.02	0.98	3.92	0.79	.481

7. Collective bargaining by nurses will result in a higher quality of patient care.	.03	3.75	1.10	3.08	1.11	<u>.000</u>
8. Collective bargaining is not appropriate for professionals.	.03	4.15	1.10	3.84	0.94	.065
9. Nurses should be prohibited by law from striking.	.10**	3.38	1.22	3.32	1.01	.749
10. In the long run, unions will do more for employees than will management.	.06*	3.47	1.03	3.60	0.89	.404
COMBINED INDEX <sup>b</sup>	.06*	3.66	0.75	3.56	0.50	.315

\*significant at .05 level

\*\*significant at .01 level

<sup>a</sup>In those cases where 't' could not be computed because of significant differences in the Variance, an approximation to 't' was made. For details of the formula in this case, please see N.H. Nie, C.H. Hull, J.G. Jenkins, K. Steinbrenner, and D.H. Bent, *Statistical Package for the Social Sciences*, 2nd Edition (New York: McGraw Hill Book Co., 1975), pp. 269-270.

<sup>b</sup>Combined Index formed by summing raw scores on the ten individual attitudinal items.

more positive attitudes to collective bargaining than did supervisory nurses ( $r = .21$ ). Considering that respondents in Wisconsin were older, a greater proportion held baccalaureate degrees, and a higher percentage were in supervisory positions, to the extent these factors were influential, they would tend to reduce the favourableness of the Wisconsin group's attitudes relative to those of the Ontario respondents. It need be reiterated, however, that the overall impact of age, education, and position was not great.

Comparative data on the attitudes of Wisconsin and Ontario nurses are presented in columns 2, 3, and 4 of Table 2. Responses were coded so that the higher the score (to a maximum of five), the more favourable the attitude toward collective bargaining. A first look at the results indicates that differences between the two groups are not statistically significant for the majority of individual items and on the combined index. Of special interest, however, is the direction of observed differences between the two groups. On the combined index and on seven of the 10 individual items, Wisconsin nurses expressed more favourable attitudes to collective bargaining than did their Ontario counterparts. As mentioned, most of these differences are too small to be of statistical significance, but they do clearly indicate the pattern of responses. On an overall basis at least, there is no evidence to suggest that Wisconsin nurses are essentially more negatively disposed to collective bargaining than Ontario nurses. On the contrary, the opposite tends to be the case.

Responses to the individual items also failed to reveal any particular aspect of collective bargaining, with one exception, that the Wisconsin group viewed with significantly less favour than the Ontario group. Participants in both jurisdictions disagreed quite strongly (Wisconsin nurses more so) with the statement that "collective bargaining is not appropriate for professionals" (Item 7). In the terms of the possible benefits of bargaining, the two groups similarly perceived collective bargaining as a device that could enable them to achieve their economic (Item 6) and professional objectives (Item 1). Furthermore, Wisconsin nurses were somewhat more inclined to believe (Wisconsin  $\bar{X} = 4.05$ ; Ontario  $\bar{X} = 3.76$ ) that the gains they might achieve through bargaining would be worth the effort they might have to expend (Item 4). Finally, responses to two statements intended to indicate the nurses' general orientation to the institution of unionism and collective bargaining (Items 3 and 10) revealed only small differences between the two groups, although there was more variation in response among Wisconsin nurses (as indicated by higher standard deviations on the items).

Statistically significant differences in attitudes were found with respect to only three of the items. The first explored the concept of mutual support

between nurses' associations and unions of non-professional hospital workers (Item 3). Of the ten items that composed the questionnaire, Wisconsin nurses expressed the least favourableness toward this potential aspect of collective bargaining ( $\bar{X} = 2.89$ ). Ontario nurses also viewed the idea of cooperation with non-professionals with some disfavour ( $\bar{X} = 3.47$ ), but significantly less so than their Wisconsin counterparts ( $p < .01$ ). In assessing the meaning of this finding, it must be remembered that nurses on both sides of the border invariably are placed in their own separate bargaining units, and thus, any cooperation that may occur usually is of a voluntary nature. But *perceptions* among non-unionized nurses as to how voluntary such cooperation might be is another matter. The extent to which Wisconsin nurses might believe collective bargaining could compel unwanted ties with non-professional groups, combined with their expressed distaste for such ties, suggests one possible factor that may negatively effect their level of organization. This seems particularly relevant considering that in a number of instances Wisconsin nurses almost found themselves swept involuntarily into bargaining units with non-nurses.

A second area where statistically significant differences were found between the Wisconsin and Ontario samples pertained to attitudes toward strike action (Item 5). Neither group felt that "belonging to an organization that was willing to go on strike" was particularly desirable, but Ontario nurses ( $\bar{X} = 2.52$  versus  $\bar{X} = 3.06$ ) were markedly more adverse in this respect ( $p < .01$ ). On the related question of whether strikes by nurses should be prohibited by law (Item 9), relatively low mean scores (Wisconsin,  $\bar{X} = 3.38$ ; Ontario,  $\bar{X} = 3.32$ ) again indicated substantial antistrike sentiments among the respondents, but no significant differences emerged between the groups. Thus, although nurses in Wisconsin expressed misgivings about the use of strikes, the fact that Ontario nurses displayed greater equanimity suggests that attitudes in this regard alone are not sufficient to explain the lower rate of Wisconsin organization.

The final area in which significant attitudinal differences were found concerned the effects of collective bargaining on the quality of patient care (Item 7). Wisconsin nurses ( $\bar{X} = 3.75$ ) proved significantly more optimistic than Ontario nurses ( $\bar{X} = 3.05$ ) about the beneficial impact collective bargaining could exercise on patient care ( $p < .001$ ). It may well be that the more experienced Ontario respondents (*vis-à-vis* unionism) are more realistic in their appraisal in this matter, but again it would seem that perceptions are what count. The evidence implies that the lower rate of Wisconsin unionism cannot be attributed to fears about the possible negative influence of collective bargaining on patient care.

In short, analysis of the data showed that the only aspect of collective bargaining where Wisconsin nurses were found to have more negative attitudes than Ontario nurses concerned possible cooperation with non-professional hospital workers. In all other respects the perceptions of the two groups were similar or the Wisconsin nurses displayed more favourable attitudes.

## DISCUSSION

Any assessment of the implications of these findings must explicitly recognise that the 148 nurses surveyed did not constitute a representative sample of American and Canadian nursing populations. The respondents were drawn from only two jurisdictions and in terms of composition deviated in some respects from their respective national constituencies. Nevertheless, for reasons discussed earlier, it is believed that the findings might be suggestive of broader trends and could contribute some interesting insights into issues surrounding nursing unionism in general.

In terms of broader trends, the importance of this study lies in the fact that it discounts to some extent the proposition that the attitudes of U.S. nurses constitute a major impediment to their unionization. It was proposed at the outset that the substantially lower rate of unionism of American compared to Canadian nurses might partially be due to relatively more negative perceptions of collective bargaining on the part of nurses in the United States. The data demonstrated, however, that such a supposition had no efficacy in Wisconsin and Ontario, two jurisdictions in which, if the supposition was valid, evidence to that effect could have been expected to emerge. In most cases the Wisconsin respondents held more favourable perceptions than did their Ontario counterparts. Lending further strength to the results is the fact that certain differences in the composition of the two groups should have enhanced the likelihood of Ontario nurse displaying more favourable attitudes than the participants in Wisconsin.

The findings, therefore, despite their limitations, are consistent with the traditional argument that the difference in the public policy climate between the two countries has been the major ingredient in the slower adoption of collective bargaining by American nurses. As such, the results tend to support the assumption that the 1974 Taft-Hartley amendments will stimulate U.S. nursing unionism. Developments in the next few years will of course constitute the ultimate test of such speculation, but it is worth noting

that the American Nurses' Association already has reported an acceleration in the number of nurses seeking certification<sup>28</sup>.

The research also illuminated several areas relevant to nursing unionism which might warrant further scrutiny. First, it was found that the Wisconsin sample viewed with particular disfavour the idea of cooperation between nurse associations and non-professional unions operating in the health care arena. It is meaningful to ask to what extent attitudes in this regard might exercise a retrograde effect on organizing. In this context it would be worthwhile to assess: 1) how strongly non-unionized nurses believe that bargaining would compel unwanted ties to non-professional unionized employees; and 2) how important an element such perceptions are in the decision to seek or not to seek collective bargaining rights.

A second aspect of the findings that could be explored further concerns attitudes expressed toward strike activity. Neither group, the results suggested, seemed very comfortable with the strike weapon. In Ontario, however, strikes by nurses are prohibited by law and binding arbitration is placed in its stead. Nurses in several other Canadian jurisdictions (e.g. British Columbia) have the unilateral right to force interest arbitration. In other words, a majority of Canadian nurses (Ontario included) are able to opt for unionism without necessarily opting for the strike. Nurses in the United States (and Wisconsin), on the other hand, have not been provided with definitive impasse resolution techniques that can serve as alternatives to the strike. As a consequence, organizing can be associated to a far greater extent with striking. Given that nurses in both groups expressed misgivings about the use of strikes, it would be interesting to investigate whether the substitution of arbitration for the right to strike actually contributes to the unionization of Canadian nurses and conversely, whether the absence of strike substitutes in the United States is exercising just the opposite effect.

Finally, it should be recalled that by concentrating on attitudinal differences, the research did not consider additional factors that the literature on organizing suggests may be relevant (e.g. managerial behaviour). Future researchers who examine the organizing experience of nurses might be well served by directing their attention beyond the kind of attitudinal analysis undertaken here and towards variables that this study did not attempt to address.

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<sup>28</sup> American Nurses' Association, Economic and General Welfare Department, *Hotline*, May 6, 1977.



## L'attitude des infirmières américaines et canadiennes face à la syndicalisation

Bien que la condition des infirmières autorisées du Canada et des États-Unis se ressemble sous plusieurs aspects, elle diffère énormément quant au taux de syndicalisation. Soixante-quinze pour cent des infirmières autorisées du Canada sont syndiquées comparativement à moins de quinze pour cent aux États-Unis. L'explication la plus plausible d'une différence aussi marquée dans le pourcentage de syndicalisation d'un pays à l'autre provient de disparités législatives. Jusqu'à 1974, les infirmières américaines (et les autres employés des hôpitaux d'ailleurs) étaient exclues des dispositions du *National Labor Relations Act*. Au contraire, les infirmières canadiennes n'étaient pas soumises à de pareilles restrictions, car on leur avait accordé depuis longtemps déjà les mêmes droits que la majorité des salariés du secteur privé de se former en syndicats, d'être accréditées et de négocier des conventions collectives de travail.

Dans cette étude, les auteurs se demandent s'il n'est pas possible que, outre les motifs d'ordre juridique, le taux plus bas de syndicalisation des infirmières des États-Unis ne soit pas aussi attribuable au fait que les infirmières américaines perçoivent la négociation collective comme un mécanisme moins avantageux pour faire valoir leurs besoins que ne l'estiment les infirmières canadiennes.

Pour jeter un peu de lumière sur cette question, on a comparé les comportements d'un échantillon d'infirmières de l'État du Wisconsin et de l'Ontario (tableau no 1). Strictement parlant, les infirmières interrogées ne constituaient pas un échantillon représentatif de l'ensemble des infirmières canadiennes et américaines. Toutefois, les types de syndicalisme chez les infirmières et les conditions de l'exercice de la profession dans les deux régions ressemblaient à ce qui existait ailleurs dans les deux pays. On a estimé, cependant, que dans la mesure où le faible taux de syndicalisation des infirmières américaines était relié à des attitudes défavorables à la négociation collective, on aurait pu s'attendre qu'il en ressortirait que les infirmières du Wisconsin étaient beaucoup moins sympathiques au syndicalisme que leurs collègues de l'Ontario.

Les données furent recueillies au moyen d'un questionnaire en dix points présenté sous la forme d'affirmations relatives au syndicalisme et à la négociation collective. Les réponses à ces dix affirmations furent mesurées à l'aide d'une échelle en cinq points (très favorable, favorable, indifférent, en désaccord et totalement en désaccord). L'analyse des réponses (tableau no 2) a montré que le seul aspect de la négociation collective où les infirmières du Wisconsin avaient une attitude plus négative que celles de l'Ontario avait trait à la coopération possible avec les employés non-professionnels. Sur tous les autres points, les perceptions des deux groupes étaient semblables où les infirmières du Wisconsin se montraient plus favorables.

Ces résultats tendent à nier dans une certaine mesure le postulat selon lequel les attitudes des infirmières aux États-Unis constituent un obstacle majeur à la syndicalisation. Ces constatations confirment plutôt la thèse traditionnelle voulant que la différence de climat politique dans les deux pays ait été la cause principale pour laquelle les infirmières américaines tardent davantage à recourir à la négociation collective.