FORGING NEW CLASS SOLIDARITIES: ORGANIZING HOSPITAL WORKERS

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In 1935, the US Congress, under pressure from an angry and increasingly activist labour force passed the Wagner Act, the legal framework that made it possible for workers who fought hard and smart to form strong unions. Twelve years and one world war later, Congress, under pressure from big business, passed the Taft-Hartley Act, which essentially gutted the Wagner Act. US workers have been slipping backward ever since. Over the past several decades, that slide became an avalanche, and today workers and the unemployed are all but buried. Amid the acrimonious debates about unions’ future direction, too little attention is being paid to the central question of power. There is a fundamental lack of clarity about the relationship between power and strategy, and between what kinds of strategies lead to what kind of power. Far too little attention is paid to the following questions: Is this strategy actually expanding our base of organic worker leaders? Is this strategy deepening working-class solidarity? Is this strategy helping workers and the unemployed to overcome racism, sexism and the other ‘isms’ capitalists use as weapons to defeat the building of class? Is this strategy building measurable power?

Marx was right in his observation that large groups of (mostly) men, toiling side-by-side under an exploitive employer were likely to join together in sheer self-defence. But forging the kind of solidarity needed to actually win substantial concessions from capital requires high levels of unity and workplace organization, the building of worksite structures so tight that workers can routinely display their unity and strength to their employers. Between 1935 and 1947, workers were doing this in large numbers. It took Taft-Hartley, McCarthyism, self-serving business unionists, US postwar capitalist hegemony, jailings, expulsions and assassinations, to wrestle the US working class back into nearly complete submission; not to mention several decades of capital mobility that shifted jobs from highly organized states with
better union laws to non-union and repressive political geographies in and outside the US.

Beverly Silver is probably right that oppressive factory conditions in other parts of the globe will reproduce the organizing impulse noted by Marx worldwide.¹ But what about in the US itself where there are many fewer industrial-era factories and many other kinds of worksites with different production processes? All of the fastest growing occupations in the US are in the female-dominated and people of color-heavy healthcare sector.² Hospitals, with five million non-management staff, have the largest concentrations of healthcare workers. Just barely 20 per cent of the current workforce is unionized, and the sector is growing, meaning the percentage of hospital workers in unions will drop unless strategic organizing expands. With four million unorganized workers presently, there’s a cornucopia of possibilities.

This essay will focus on one example of mostly female healthcare workers who were engaged in bold organizing drives that substantially improved their material and nonmaterial condition at work and at home.³ Their worksite organizations were every bit as strong as the industrial unions of the 1930s and 1940s. And they did it using many of the same methods. Central to their strategy, and to their subsequent ability to win substantial gains, was their decision to build their organizations wall-to-wall, putting not only registered nurses but all other hospital workers together in a single union. Nurses have more individual skill-based power than any other type of unionizable worker in a given healthcare system, but in a typical hospital they make up only 40 per cent of the total workforce.⁴ There are several dozen typical job classifications in a common general medical and surgery hospital, including cooks, clericals, housekeepers, technologists and technicians, care aids and assistants, and many different strata among and between all of these categories as well as within the single largest workforce inside any hospital, the registered nurses. Typically, the physicians and managers are excluded from unionization efforts.

In 2006, hospital workers in Las Vegas made history when they walked off the job in the first-ever hospital strike in the Nevada city’s history. The strikes came as part of a comprehensive city-and-suburbs-wide multiemployer hospital fight, also a first in the mostly non-union Southwest. Nine thousand hospital workers, nurses and non-nurses, from seven hospitals collectively struggled and succeeded in massively improving their quality of work life, and their home life, by winning region-wide wage scales and other standards that represented some of the largest single-contract gains in recent times in the entire southern US.⁵ Significantly, other
workers took part in the same struggle, including an additional 6,000 non-hospital municipal employees who were members of the organizing union, the Service Employees International Union (SEIU). These 15,000 workers not only won unprecedented workplace victories but also local elections; they thereby not only altered the power structure in the workplace, but also shifted the balance of power in the local government from politicians hostile to unions to those supportive of labour’s cause.

Wall-to-wall hospital organizing of the type described in this essay has great potential implications. In terms of collective power against an employer, the sheer number of workers involved matters a lot. There can be little question that today, just as in the 1920s, 1930s and 1940s, uniting workers who are harder to replace with those who are easier to replace and building intense levels of solidarity among and between them on a large scale results in the strongest possible worker organization. But developing workplace solidarities that bridge intra-class differences, such as racism, sexism and more, has a ripple effect beyond the walls of the workplace, too. Forging a true labour alliance across skill, craft, experience, ethnicity, gender and more helps transform how workers understand their relationship to each other, to their neighbours, to their nation and even their world.

ORGANIZING HOSPITAL WORKERS TOGETHER

The mentality of a nurse is to care for those in need, at least it should be, and most of us are doing this because we want to care for those in need, meaning everyone, our entire team, our community, not just our patients. The few nurses who come with the elitist attitude, they should be doctors, not nurses. It’s important to focus on why we went into nursing in the first place, to care for others. I didn’t come into nursing to have initials behind my name. Some nurses do come into the field that way; until someone shits all over them and they realize they are just a nurse in a big system.6 – Alfredo Serrano, Operating Room Nurse

Alfredo Serrano is Mexican-American, queer, a reformed alcoholic and a highly regarded nurse. He was one of ten children. He drives a pick-up truck so enormous it resembles one of those mountaintop removal machines found hulking in the Appalachian hills. His other wheels spin on a turbo-charged, Japanese-built motorcycle. He has three kids from an early marriage, before he came out, one of whom – his daughter, along with her husband and baby – recently moved back in with him: her husband lost his job just after the young couple gave birth to their first child. Serrano is without question the leader of all the workers in his hospital, starting with the nurses and right through the union-negotiated wage-scale classifications including the EVS (environmental services, a.k.a. housekeeping) and the dietary unit
(cooks) and every type of worker in between, from techs to phlebotomists. He used to be the chief nursing steward, elected from among his nurse peers, but recently he decided he prefers the highest-level position in his union local, vice president, because it is elected by and responsible to all the workers in the hospital, not just the nurses. And as vice president, he gets to work on political and community issues, too, rather than simply handling worksite grievances. The vice president from each hospital also serves on the statewide union’s executive board.

Serrano has been through three rounds of collective bargaining between 2003 and 2014. In 2003, and again in 2006, he experienced firsthand how hospital employers divide the nurses from the rest of the workers by offering them bigger raises and flattering them with praise for their suddenly appreciated profession while dismissing other health workers as nonessential and unimportant. Management had good reason to repeat an approach that had worked in 2000, when the workers negotiated the first contract for their newly formed union. In that year, the boss strategy succeeded: the union leadership was weak and incompetent and very few rank-and-file workers were involved, and management was able to divide and conquer by giving the nurses a bigger raise than the other members. That experience had demoralized and demobilized the rest of the workers. It would take new leadership and the involvement of many more workers in their own collective bargaining process – workers like Serrano – and several years before the nurses at the very same hospital would learn that they could get a substantially larger raise by standing united with all of the workers.

Serrano has been key among those new union leaders, helping to educate the nurses about the importance of solidarity between nurses and other hospital staff. This was a harder conversation for him, and other nurses like him, to carry during the 2003 negotiations because the nurses hadn’t yet experienced winning significantly more by rejecting management’s divisive offers. Material self-interest aside, Serrano routinely challenges his fellow nurses to understand that all the hospital workers matter equally. ‘I think it’s funny’, he told me. ‘I ask the nurses, “Excuse me, does gasoline cost more for you and I than everyone else here? How about groceries? Why on earth would we be getting more when the cost of living is the same for everyone in our hospital and we already earn more money than everyone else based on our skill-based wage scale?”’ He continued, ‘I haven’t ever said this, but I want the nerve to just say, “Is this your inferiority complex talking? Do you have an inferiority complex that management is playing on?”’ Several years later, conversations about sticking together became significantly easier, because in 2003 the nurses won far better money and more rights by standing
strong with their non-nurse coworkers.

Serrano works for the single largest hospital corporation in the US – in fact the largest in the world – the Healthcare Corporation of America or HCA, which owns more than 200 for-profit hospitals. Nearly all of them are in so-called right-to-work states; the employer takes advantage of the Taft-Hartley Act’s provision that, even if a majority of workers vote to form a union which is certified as the bargaining agent, membership and dues are on a purely voluntarily basis. For hospital corporations like HCA, operating near exclusively in right-to-work states is a business model, a way to lower labour costs and squeeze even more profit out of the taxpayer-funded but privately managed, over-priced and substandard US healthcare system. Pay is kept lean and, worse, the conditions under which most employees work are frightful. HCA has an HR philosophy called ‘staffing to the bone’ – an interesting policy name for a healthcare corporation, which means saving costs by grossly understaffing their hospitals. And because this creates working conditions ripe for union organizing, they site their hospitals in union-busting states. The corporation’s growth plan also depends on controlling federal healthcare regulations through its massive political power.

Serrano and his colleagues work at Sunrise, a sprawling HCA hospital complex in the heart of the city that includes a children’s hospital with specialized pediatric care, a level III trauma unit and outpatient clinics. HCA has two other Las Vegas area operations, Mountain View and Southern Hills, which they call their suburban hospitals (though to any urban dweller, all of Vegas looks like one continually expanding suburb). Sunrise was initially organized in 1998, in one of the first of the SEIU’s top down, corporate campaigns in healthcare, resulting in a weak union inside the hospital. The corporate deal that resulted essentially condemned the workers to a bad first contract that also, as noted, drove a wedge between the nurses and other workers. But the foundation of a wall-to-wall union had been laid, and years later, after a change in union leadership, a real hospital workers’ union was built on it.

Between the mid-1990s and the great recession in 2008, the population of Las Vegas exploded – showing the single highest growth rate in the nation – and the healthcare sector struggled to keep pace, opening one hospital after another, some right down the street from each other. Yet the hospital workers’ union stagnated. The SEIU in Nevada was worse than weak and faced a very sophisticated employer in HCA, which was successfully pummelling its unionized Sunrise workers from the inside out, teaching them the lesson that forming a union was a futile endeavour. Nurses and Technical Workers (more than nurses, but less than the whole hospital) at
two other private hospitals in the region, owned by Quest, had also organized in the 1990s, with help from the national, not local, union, but the employer there, too, was systematically reversing what little gains had been achieved in weak agreements. Several years later, Quest sold the hospitals to Universal Health Services (UHS). By 2002, under the new owners – viciously anti-union and, like HCA, grounded in a right-to-work-state business plan – the technical workers had voted to decertify the ‘Techs’ (technical unit) at one of the two UHS hospitals, and UHS began to campaign for decertification at the other.\(^8\) The timing of this synced with healthcare division leadership changes in the national union; the new leaders had been analyzing a plan for an all-out organization of the US hospital industry. By 2003, the national union had come to see Vegas, with its hospital-sector growth and particular constellation of national chains with soaring profits, as a key launching pad for hospital union organizing nationwide.

**LEMONS TO LEMONADE**

*Is there any nurses-only union that actually works well?*

– Joan Wells, Intensive Care Unit nurse

Joan Wells was born and raised in Canada. Her first full-time hospital job was in British Columbia. At that time, she was what US hospitals call a licensed practical nurse, or, LPN, not yet a registered nurse (RN). At Nanaimo Regional General Hospital there was a union, the Hospital Employees Union, HEU, but it didn’t include the nurses, who were in a separate non-union association. Twenty years later, dissatisfied with her work, Joan returned to university to become a registered nurse. Recently divorced, with two daughters, a new degree in hand and needing a change, Joan left for the US, where she soon found herself working in right-to-work Texas, in Corpus Christi. On her first day, she asked a coworker what seemed like a normal question, ‘Where do I sign up for the union?’ She was immediately told you don’t talk about unions in Texas.

This conversation would be repeated several years later, when she relocated to Vegas, lured by the whopping sign-on bonuses the hospitals were offering RNs. Except this time, the answer was a little different. There was a union, Joan’s new colleagues told her – but then added the same hush-hush-we-don’t-talk-union-here warning. Days later, because she had asked aloud for the union, a nurse approached her and handed her a card, but furtively, as if passing her the code to a secret society. Less than a year later, Joan Wells would become a leader in the resurgent effort to build a powerful hospital workers’ union in Vegas. Her local union posted her picture high above the biggest freeway in Vegas on a massive billboard, declaring, ‘We stand for
patients before profits’. Within four years of coming to work in Vegas, Joan would be fired in the line of duty for taking on hospital management. She went on to work with the union as a full-time hospital organizer, entered a multiyear legal battle to win her job and her dignity back, and helped lead thousands of hospital workers to victory in the 2006 fight.

Before Joan was fired for union activity, she’d had 20 years of stellar reviews, including for her work as an ICU (intensive care unit) nurse in Vegas. Joan Wells is a nurse’s nurse. Doctors requested her for their patients; other nurses turned to her for help. On the day they fired her, it wasn’t just because there was a new billboard in town showing Joan in her scrubs, towering as big as the Vegas casinos. That day, when she arrived for her shift, the other nurses had told her, ‘They are going to work us in the ICU at a 3:1 today’. In an intensive care unit, a 3:1 staffing level – three patients per nurse – is unacceptably high: a serious risk to patients’ lives. Well-run ICUs operate on a 1:1 or at most 2:1 ratio. But in the hyper-greedy hospitals in right-to-work-states spreading across the US, ratios of 3:1 and even 4:1 are becoming more common. As Joan entered work, all of the dayshift nurses were waiting for her not because she had a union title – back then, she didn’t – but because she was a top nurse whose first and foremost concern was caring for people, which meant her patients, as well as her team of coworkers.

The nurses asked her what they should do. If a patient is injured, it’s the nurse, not the hospital, who loses the license. After a quick discussion, the nurses decided to refuse to ‘take report’, meaning that they wouldn’t take over any patient-care duties from the nightshift nurses, and demanded that the hospital call in some backup nurses. When Joan was fired, she went from being a leader in her hospital to a heroine for all hospital workers in Vegas. By standing her ground for patient care, and, after surviving the humiliation of being fired when she had enormous pride in her work, she became an invaluable part of the effort to build power for workers in the region:

In the US, the only time I’ve been in a union is in a right-to-work state, and that’s Nevada. The climate politically is filled with corporate greed, the way the entire entrepreneurial system is set up in the US, you don’t have much power unless you have big numbers and stand together with all your coworkers.

HOW THEY DID IT

From late 2003 to 2007, in spite of employer divide-and-conquer attempts, there was never disagreement between nurses and non-nurses about whether
or not being in one union made sense. Nurses were winning more than they ever had, including on issues very specific to nurses, like staffing, and a related issue, floating (the process of the hospital management moving them around the hospital, generally against their will, to plug intentional short staffing). Every conversation in any hospital began and ended with a clear understanding that whatever issue the nurse or non-nurse wanted to resolve, a win would only be possible if every worker stood together and acted together. A new union-organizing team was hired and developed; it included more than a dozen nurses and a few other hospital workers brought onto full-time staff as organizers. Not all of them, like Joan, switched to full-time union work after being fired for their bold organizing. Most of them were nurses who had just experienced their first big contract wins and wanted to devote their energy full-time to expanding union ranks and growing union power. Because the union was making improvements in patient care, they understood the union as advancing their profession and their pay.

After the first decent Sunrise contract victory in 2003, when Serrano got involved, the hospital workers set new contract expiration dates for 2006, with the intention of aligning with the big public hospital expiration that was set for 2006. The Sunrise workers made a few real improvements in 2003, substantial enough to raise the expectation that they could win even more. The expanded union rights, which they immediately took advantage of, enabled two workers to do union work full-time for up to six months with the guarantee that afterward they could return to their positions and shifts in the hospital. Crucially, they won a 2006 contract expiration, the first of many steps in beginning to line up Vegas hospital contracts. Next, in 2004, the two UHS hospital contracts expired. Their contract terms had been so hideous that almost any improvement would have constituted a victory, but low expectations and weak settlements weren’t the plan. The UHS workers, building on the 2003 Sunrise victory, led an incredible struggle, including taking their first strike votes, and secured a new contract that won average raises of 10 per cent a year for two years and the first fully employer-paid healthcare plans in Nevada’s healthcare sector, along with improvements in on-call pay, shift differentials and more. Standards were escalating, and so were the hopes and dreams of the workers. The UHS workers demanded a 2006 expiration date, too. But by this time, it had dawned on the employers that hospital workers in Vegas were lining up their contract-expiration dates.

With total brinkmanship, the UHS workers made a 2006 expiration the final issue on the negotiating table for both UHS hospitals. Only because of intense and systematic worker-to-worker education about the importance
of building worker power through lining up their contracts – discussions that began before the opening of negotiations and months before the eventual settlement – were the workers able to tell management across the table ‘No’ when the employer offered the richest financial package in Vegas history, but not the right expiration date. Under Byzantine US labour laws, hospital workers legally must give their employer 10 days’ notice before they strike. The 2006 expiration date was secured and the contract settled seven days into that countdown to what might have been the first hospital strikes in Vegas. The UHS workers prioritized union-leave language too, and immediately more nurses were brought out of their workplaces and into six-month rotating organizer positions. Six months is perfect, incidentally, to ask nurses to come out of their hospitals and do full-time union work, any more than that and they typically balk because there are constantly new procedures and techniques being introduced and they don’t want to fall behind or get rusty. The UHS settlement was finalized in June 2004, with a two-year contract lining up their next period of negotiations with those of Sunrise and the big public hospital.

Within days of the UHS settlements, which received banner headlines, workers at two non-union hospitals, run by Catholic Healthcare West (CHW), called the union office and declared they wanted to do what it took to win the same contract. By mid-October 2004, 1,500 more hospital workers, nurses and non-nurses, had voted to form new wall-to-wall unions in their hospitals. And just six months later, workers at these two hospitals voted for contracts with standards that surpassed even the UHS workers’ settlements. To top it off, the newly organized workers bargained for a 15-month agreement, far less than two years, so that they, too, would have their contract expiration set for 2006. And during the first contract negotiations for the CHW hospitals, the nurses and non-nurses also voted to form a union at a smaller, brand new hospital, HCA Southern Hills, bringing to three the number of wall-to-wall hospitals organized in five months.

When 2006 arrived, the payoff of all this solidarity of purpose and longsighted strategy surpassed all expectations. Hospital workers across southern Nevada ratified contracts with new standards unprecedented in the US South. The Catholic Healthcare West workers led off the 2006 negotiations because their employer was smart enough to realize a war was brewing and, being less ideologically bound, wanted to avoid it. The price tag for opting out of the fight was an even higher new contract standard, one that would establish the pattern for negotiations at the other hospitals. Their wages were already significantly above market, since their first union contract had been settled so recently, so the priority became other kinds of
gains, including contractually negotiated mandatory staffing levels – the best ever negotiated in a US collective bargaining agreement at that time – and better work rules, pensions, retiree healthcare and more.¹⁰

The HCA Sunrise hospital workers, along with HCA Southern Hills (the hospital organized in early 2005), won a contract with average wage increases of 17 per cent over three years; 100 per cent employer-paid healthcare (employees had previously paid for their own healthcare through payroll deductions, if they could afford it; many lower-wage hospital workers simply did without); new differentials for evening and weekend work; a contractual right to strike over staffing mid-contract (breaking the US norm of signing no-strike clauses) and much more. Only UHS, with two hospitals, held out. The UHS workers sustained a brutal 12-month-long war with their employer and mounted the first-ever nurses’ strike. For more than a year, two of the top private Pinkerton-style union-busting firms turned the two UHS hospitals into hell zones, revealing how little their employer cared about quality patient care or their employees. In the end, these workers also won the new area-wide wage and benefit standards, though there were many casualties along the way, such as the firing of Joan Wells.

On the heels of the 2006 Vegas wins, nurses in two more hospitals, in eastern and northern Nevada, also voted to form new unions, making Nevada the highest-density state in the US for registered nurses.¹¹ A crucial difference here from other states in the US was that all these Nevada nurses and hospital workers were in the same union, with commonality of purpose.

STRATEGIC CONSIDERATIONS

Theory and practice were merging in Nevada. Thousands of hours of discussion among and between the workers and with the organizers were required to move from conceptual discussions of power to the active construction of working-class identity formation and working-class solidarities. The following strategic considerations were key to the effort.

*Struggling together*

Hospitals have a fairly predictable stratification by ethnicity and gender. Among the nurses, the nurses with the most power, generally the Intensive Care Units (adults, neonatal, post-anaesthesia, etc), Surgical (operating room) and Emergency Department nurses, tend to be white. Among the Intermediate Care (IMC) and a catch-all category called General Medical-Surgical nurses (which includes telemetry, oncology, radiology, rehabilitation, etc), there can be larger numbers of Filipinas. But nursing units overall are more white than not, and the diversity generally stems from US schemes that import significant numbers of Filipinas. Most men in
hospitals are found in the technical units, and are also typically more white than not. They crush and mix medicines in the pharmacy, administer EKG and X-rays and generally spend more time with machines than patients. Housekeeping staff trends Latino. Dietary trends Black.

Confronting racism and the many other ‘isms’ the boss throws in the way of a class-based movement is obviously done best when all of the hospital workers have to struggle together. By separating out the nurses, labour has destroyed the chance to help heal intra-class divisions. In Nevada, discussing the politics of race, gender and education/skill were central to building and holding hospital-wide solidarity. And because the union drove a community and political programme through the worksite structure and not outside of it, the workers were learning to overcome the bifurcation of work and home.Undoing racism and sexism at work, through collective struggle that demanded total unity, was forging a better class politics inside and outside the workplace. The left was advanced on these issues in the 1930s early on, when simply pushing for the inclusion of blacks and women (whether they were wives or workers) was radical. But the left’s reaction to recent identity politics has been largely a failure, with far too many discussions about ‘class versus race’ or ‘class versus gender’. It’s how class, race, gender and more intersect, and in wall-to-wall organizing campaigns, workers’ chances of winning are best when the discussions of intra-class divisions are explicit, not denied.

Developing a common vision

From early 2004 onward, a hospital by hospital, worker by worker conversation began about why Las Vegas healthcare workers in the state and region were so far behind their counterparts in places like New York, California, Pennsylvania and Washington. These conversations were rolled out as part of a plan to rebuild the union into a fighting force, and with a keen understanding that the best way to expand the union was for the existing workers to own and lead the plan. Expectations were being raised, and at all times the vision was anchored in the core principle of industrial unionism, commonly discussed as building wall-to-wall power, including registered nurses and everyone else. Winning would be contingent on mass participation and the word power was constantly discussed.

Vegas was in the boom years in its cyclical boom-bust tradition, and nurses from across the country, including quite a few from Canada and the Philippines, were arriving in droves, along with all other kinds of workers. This influx of hospital workers who had worked previously in strong union states or countries with union traditions helped make the conversations
about what was possible more realistic. In every hospital there were workers like Tim Kearny, who helped build the hospital workers union in New York City two decades earlier at Columbia Presbyterian and had come to Vegas for cheap housing. And Shauna Hamel, another Canadian nurse who, like Joan Wells, had experienced a better healthcare system that had been heavily unionized. And Becky Estrella, a Filipina nurse who during tough negotiations would mutter under breath about going to get her machete when the employer was insulting the workers across the table. Becky had been a part of the revolutionary movements in the Philippines and all it took to get her involved was asking her. Becky brought an entire informal network of the Filipina nurse leaders along with her once she had confidence that the plan to win was real. Organizers deliberately plied these experiences at every turn so that workers were learning from workers that strong unions could extract big concessions and real changes.

**Attending to semantics**

Workers who don’t know about unions (that’s most in the USA today), or who are members of unions where participation is undervalued if not squashed regularly, base their initial ideas about the union on how union leaders, including organizers, talk about the union. Far from trivial, semantics are central. How leaders talk about the union is also how workers will talk about the union in conversations among themselves. In every one-on-one conversation, or speech, or interview, union leaders are giving an impression of what the union is to other workers. If the language conveys that the union is a fee for service, or only for professionals, or perhaps not for professionals at all, or a place where lawyers and negotiators work everything out, workers will be less likely to engage or see themselves as the union.

Talking about developing a wall-to-wall hospital union helped convey the power needed, but it would be another set of words that would reflect the mission-driven nature of most nurses and healthcare workers: a ‘patient-centred hospital workers union’. By keeping the focus on patients, not professional status or lack thereof, semantics helped drive the discussion about what high quality patient care required. Was it sufficient to heal a patient if the cooks in the dietary unit accidentally delivered the wrong food to a diabetic patient? What if the anti-bacterial techniques were being compromised because of short staffing in housekeeping, or the technicians responsible for sterilizing equipment misses a millimeter of a piece when their boss called them away – would simply having a good nurse solve the problem? As Joan Wells put it:
Healing a patient is a team effort. If everyone is working well together, the patient heals faster. Being together in one union actually promoted team building in our hospitals by reducing animosity between workers, including the many layers of nurse-on-nurse power trips that can play out between ICU nurses and, say, less technically skilled nurses in the general medical surgical units.

This bottom-up approach was key to overcoming cynicism about genuine team building because just about every nurse and hospital worker has been forced by bad management into on-again-off-again ‘Team Nursing’ schemes, almost all of which are cost saving measures dressed up in colourful language.

The organizing teams in Nevada, comprised of a dozen nurses out on union leave at any one time and other organizers who were showing up in Vegas because the words ‘real organizing’ were spreading through the organizer grapevine, knew to expect ‘semantics drills’ almost every day. The organizing team was building a culture, along with the rest of the union, and the organizing culture demanded that every action, including every word, needed to help workers understand two ideas: power, ‘all workers together up against management’; and purpose, ‘patient-centred’. With their first or second cup of coffee in hand each morning, organizers at the mandatory 9 a.m. ‘briefing meetings’ would practice ‘drills’ and ‘raps’ regularly. Semantics, meaning how we talk, drives learning and discussions.

**Leader identification**

The process of correctly identifying what organizers call the ‘organic leader’ is what often separates winning from losing union campaigns. Unions have been losing a lot of campaigns in the US and it’s not only due to external factors. Organic leader identification, or the building of a network of the ‘most trusted workers in every shift and in every unit’, isn’t a new technique; nor, however, is it commonly done well, if at all, in many campaigns today. In every workplace, on every shift, among every type of worker, a power structure exists. Organizing is all about power, how to disrupt it, but also how to build it. Human social relationships and networks reflect power relations, whether it’s overt, as in the military, or, subtle and informal, as it might be among a group of nurses, each with different years of experience and different types of training. When good organizers use the word *leader* it means only one thing: the person has *followers*. It has nothing to do with whether or not the person speaks well, dresses nicely, pleases people or even supports the union. The leader on a shift could be anti-union, which spells
trouble if the identified leader doesn’t come to change their position to pro-union. If the majority of real, informal organic leaders are pro-union, they can mobilize the majority of workers to stay the course, even during a tough fight.

In hospitals most workers are mission-driven, not just the nurses. People arrive at work with a calling to care for others. More often than not it’s a nurse in any given unit and shift who actually leads most of the workers. For hospital workers to win, to build the strongest possible worksite organization, the organic leaders can’t be in a separate union, expressing occasional solidarity. Solidarity is built in common struggle, with high stakes, where the accountability to take risk is between people.

_Bargaining together_

In Nevada, from 2003 to 2007, all hospital workers negotiated collective bargaining agreements together. Nurses of all types sat with every other worker in the union. Even though anti-worker labour laws cut up and divide various types of hospital workers into as many pieces as a surgeon’s scalpel, workers can demand, and if strong enough win, the right to bargain together and negotiate a common collective bargaining agreement. By electing whole hospital bargaining teams, with representation from all types of workers across shifts and units, and preparing for and executing collective bargaining together, bottom-up team building flowers. As Serrano said: ‘Nurses going to the bargaining table without the rest of the hospital workers is like going to a dollar store with 40 cents in your pocket. You can’t really get anything.’

Of course, there are some issues, not many, that relate to specific groups of workers and that can be long, tedious and downright boring for other workers. A good example is what’s called nurse floating rules. Floating is the term for when management wants to send, or _float_, a nurse from one unit, say, the ICU, into another unit, such as the general medical surgical unit or ‘Med-Surg’ unit, (the unit where patients go before being discharged, when they are on the mend, or at least not acute, where there can be anywhere from five to 12 patients). Nurses hate this practice; cheap or greedy hospitals love it. ICU nurses don’t spend their day juggling multiple patients; their expertise is keeping one or two critical patients alive. Nurse floating discussions can be divisive among and between nurses, and can put everyone else to sleep as fast as any good anaesthesia. But it’s incredibly easy to simply set up a side table in bargaining, where nurses and nurse managers can hammer out their floating policies. This simple solution is only possible when large numbers of workers are involved in their own collective bargaining process, because having several of each classification of worker
from all different units in one room sets the stage for sub-teams to go off into their corners or adjacent rooms to work on specific issues.

Making commitments public

Just like a married couple can cheat, a public statement of commitment and a ring helps hold relationships together. It’s true for other types of social relationships, too, including bargaining relationships among and between workers in the same hospital and across hospitals. In Nevada, to set the stage for the hospital-wide bargaining, all workers across all hospitals met as one giant bargaining team. Every other week hundreds of workers would arrive in the union hall by shift to discuss, strategize, update each other, eat a meal, break into hospital-specific breakouts, return to the big group and generally ratify plans of action for the weeks to come. Before the negotiations kicked off in the first hospitals, nurses and non-nurses had taken public votes together, including on what the minimum standards for bargaining would be, how they would support each other by attending, en masse, each others’ bargaining tables and developing the camaraderie that allows for effectively implementing high-participation strategic planning.

CONCLUSION

Nurses are extraordinary natural leaders. To be good at their job, which the vast majority aspires to be, they either arrive with or have to develop a strong sense of confidence. Central to their job is making real decisions that impact patients’ lives (decisions often made in the presence of distraught family members). Nurses possess persuasion skills, leading patients and their families through trying and scary moments where they must explain a plan of action for a successful recovery. They build instant and intimate relationships with patients and patients’ families; the kind of intimacy that happens when they have to do what amounts to an invasion of their patients’ most intimate personal space, their bodies. They are often the most trusted workers throughout the hospital. This means there’s a large number of organic leaders, perhaps more than usual, but perhaps just more obvious. For nurses, learning how to quickly earn someone’s trust is essential. Joan Wells explains it this way:

Once we have the patient stable, our next most important job is making the family comfortable with our care. In order to do our job, our many tasks, with the patient, we have to be able to do it without a lot of interruptions. So if we don’t establish a good rapport with the family right away, if they don’t have confidence in you, your job becomes very difficult.
To waste this kind of compassion and this kind of leadership on a craft union, when nurses have and can lead thousands more workers around them, is a travesty. Some days it feels criminal. The qualities, skillsets and experiences of nurses are the same qualities and skillsets needed to build strong unions with all the workers. Nurses don’t prioritize themselves; they are, in Serrano’s words, about caring for people. The often repeated and accepted notion that nurses are ‘professionals’, and have a ‘professional identity that requires a separate, professional union’, is a myth constructed to rationalize the empire building objectives and turf wars of some union leaders. Nurses, as Serrano and Wells articulate, are mission-driven, caring people. It’s a strategic choice to either play up their profession while playing down their care mission or play up their care mission and down their sense of professionalism.

Tragically, by early 2009, turf wars among rival unions would succeed where the employers had failed. The solidarity between nurses and non-nurses would be undone by a tightly-held secret national agreement between the California Nurses Association and the SEIU. The two national unions had been in a pitched turf war for several years, with CNA asserting it would be the ‘only’ national union for nurses. There was more to this battle, including ideological differences, outsized egos and political power ambitions between the heads of each national union. The nurses’ organizing gains achieved in such a short timeframe in Nevada were unprecedented in the SEIU and a perceived threat to the CNA. Nevada workers got caught in the very ugly crosshairs of the escalating turf war between these national unions. But Nevada’s example of seven hospitals’ worth of nurses choosing a wall-to-wall union model still provides plenty of evidence of what strategic choices are needed today for forging new working-class solidarities, even in the face of existing union organizations which do not value them.

NOTES

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3 This account is based on my own personal involvement as Executive Director of the SEIU in Nevada, where I was hired by the Executive Board early in 2004 and stayed until 2008. This is also based on discussions and interviews I have undertaken with key rank-and-file activists in the spring of 2014. This essay goes beyond the account offered in my book Raising Expectations and
Raising Hell (London: Verso, 2012) by focusing on the strategic question of why nurses teamed up so readily with their non-nursing coworkers, and the broader implications of this for forging new class solidarities.

4 See http://www.bls.gov.

5 The hospitals included: the University Medical Center, UMC; Healthcare Corporation of America or HCA owned Sunrise and Southern Hills; Universal Health Services or UHS-owned Desert Springs and Valley; and Catholic Healthcare West or CHW-owned Rose Delima and Siena (CHW did a corporate branding name change to lose the word ‘Catholic’ and it now calls itself ‘Dignity Health’). The municipal units included workers for the largest local government, Clark County, as well as three smaller city area housing authorities.

6 Author interview, April 2014.

7 Bill Frist, of the Frist family of Nashville, TN, world headquarters of HCA, was a two-term Republican senator who served as the Majority Leader in the George W. Bush years, from 2003 to 2007. The family founded HCA. See his page at http://en.wikipedia.org.

8 Part of ‘management law’ in the US, commonly called ‘labour law’, is that each different unit of workers has to vote to be certified or to decertify. There are up to eight different units, PROs or professionals, RNs, Techs (which of course isn’t just techs, it’s technical workers like EKG folks and all of many types, plus also, LPNs or Licensed Practical Nurses – what Joan Wells was prior to getting her Registered Nursing degree), the S & M or Service and Maintenance Units, the Operating Engineers units, and on and on.

9 Author interview, April 2014.

10 The uniqueness of the contractually negotiated nurse-to-patient staffing levels in the CHW Nevada contracts was that there was language stating that ‘in the implementation of these new staffing ratios, the hospital agrees there will be no reduction in a single position in the non-nursing staff’. This language, according to the many nurses who had worked in California, where staffing ratios were set by a hard-fought state law, didn’t have protections for the numbers of positions of the non-nurses and the result has been a profound undermining of the California law: the hospitals gutted thousands of positions in the non-nurse staff to pay for the increased nursing staff required by the law. So much so that nurses were asked to pick up new duties, duties that had been done by a more robust non-nursing staff. Though it wasn’t the intent of the workers who campaigned to pass the California law, because it was only an RN focus, the RNs undermined themselves by creating a law that didn’t actually solve the problem of RNs having workloads that are way too large to give the kind of patient care they desire.

11 By the end of 2007, nine out of 10 nurses were in the union. The Renown Hospital victory in Northern Nevada, in Reno, added 1,000 more RNs, and the Elko Regional hospital in eastern Nevada added first nurses and, in a second vote, the rest of the workers to the union.

The CNA spent much of 2008 attempting to ‘raid’ the nurses from the three CHW hospitals in Vegas. Despite the CNA setting up a ground operation in Vegas with forty nurses shipped in from California, churning out reams of literature about how the nurses didn’t belong ‘in a janitors union, but in a professional union’, the CNA failed to win a majority of the nurses in two successive elections. But opportunity for rival union deal-making soon emerged when the SEIU was about to ‘trustee’ its big California healthcare local. Suddenly, it was in the SEIU’s interest to give something to the CNA, something the CNA wanted. In a deal that succeeded in the SEIU preventing the CNA from joining forces with the new breakaway union that emerged out of the California local, one of the many poker chips the SEIU played was effectively handing over the nurses to the CNA. Notably, in his important essay ‘Rethinking Unions, Registering Socialism’ (Socialist Register 2013, Pontypool: Merlin Press, 2012), Sam Gindin speaks eloquently to the issue of rival unions competing for turf, and points to the urgent need for new left formations to succeed inside of unions so that solidarity and developing working-class power, not competing egos or business plans, dictate the mission of unions.